Postnatal Contraception

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12TH AUGUST 2017
MCHN VIC CONFERENCE
A quick survey...
Mother’s group survey
The reality

So we just...err...take this small human home now do we?!

I um...guess so...
Get a foot in the door!
1. Background – unplanned pregnancy and fertility
2. Contraceptive options
3. Emergency contraception
“let’s talk about sex”

I HEARD THAT BIRTH CONTROL MAKES YOU FAT AND CRANKY

SO DOES PREGNANCY
### When can contraception after childbirth be initiated?

<table>
<thead>
<tr>
<th>Grade</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D</strong></td>
<td>The choice of contraceptive method should be initiated by 21 days after childbirth.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>A woman’s chosen method of contraception can be initiated immediately after childbirth if desired and she is medically eligible.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Women should be advised that intrauterine contraception (IUC) and progestogen-only implant (IMP) can be inserted immediately after delivery.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Clinicians should be aware that insertion of IMP soon after childbirth is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk of unintended pregnancy.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Clinicians should be aware that insertion of IUC at the time of either vaginal or caesarean delivery is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk of unintended pregnancy.</td>
</tr>
</tbody>
</table>
2. Contraception After Childbirth

Discussion and provision of contraception after childbirth

When should contraception after childbirth be discussed/provided?

- Maternity services (including services providing antenatal, intrapartum and postpartum care) should give women opportunities to discuss their fertility intentions, contraception and preconception planning.

- Whenever contraceptive counselling is provided, care should be taken to ensure women do not feel under pressure to choose a method of contraception.

- Effective contraception after childbirth should be initiated by both breastfeeding and non-breastfeeding women as soon as possible, as sexual activity and ovulation may resume very soon afterwards.

- Maternity service providers should ensure that all women after pregnancy have access to the full range of contraceptives, including the most effective LARC methods, to start immediately after childbirth. This should not be limited to those women with conditions that may pose a significant health risk during pregnancy and vulnerable groups (including young people) at risk of a short interpregnancy interval (IPI) or an unintended pregnancy.

Faculty of Sexual and Reproductive Healthcare, 2017
Women should be informed about the effectiveness of the different contraceptive methods, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after childbirth.

Clinicians should adopt a person-centred approach when providing women with contraceptive counselling.

Clinicians who are giving advice to women about contraception after childbirth should ensure that this information is timely, up-to-date and accurate.

Comprehensive, unbiased and accurate information on contraceptive methods postpartum should be made available in different languages and in a range of formats including audio-visual.

Contraceptive counselling should be made available to women in the antenatal period to enable them to choose the method they wish to use after childbirth.

Any contraceptive counselling (general or specialist) needs to be given in conjunction with easy access to contraception in the immediate postpartum period.
“Have you considered what contraception you would like? We recommend having a plan in place early.”

“Implanon and IUD are the most reliable options but many have not considered them, what are your thoughts?”

“Have you thought about if and when you might like to pregnant again?”

“Are you aware of how long women are recommended to wait to get pregnant again? Does this fit with your family planning?”

Avoid “should” / “need” / “must” language, new mums are very sensitive!
1. Background

- Unplanned pregnancy
- Dispelling fertility myths
- Birth-to-pregnancy interval recommendations
- Patient factors to consider
Unplanned pregnancies

- $\frac{1}{3} - \frac{1}{2}$ pregnancies unplanned
  - UP to $\frac{1}{4}$ pregnancies aborted
- 84.6% pregnancies unplanned (Coombe 2016), 73.4% while using contraception
  - COCP 39.1%
  - Condoms 29.4%
  - None 26.6%
  - Withdrawal 18.5%
- Limited estimates of postpartum unplanned pregnancy prevalence (Rowe 2016)
  - 15-17% of 2nd, 3rd and 4th pregnancies unplanned
  - 9% abortions due to having a young baby
Fertility

- **Fertility**
  - 85% normal couples pregnancy within 12 months

- **Fercundity**
  - Ability to achieve pregnancy in one menstrual cycle
  - Normal couple – 20-25% for first 3 months, 15% next 9 months

- **Postpartum fertility**
  - Exclusive breastfeeding – unlikely to ovulate < 6 weeks
  - Not breastfeeding – can ovulate from 3-4 weeks
Dispelling fertility myths

- “If I needed IVF for this pregnancy I don’t need contraception”
- “If I have PCOS I don’t need contraception”
- “I’m too old to need contraception”
- “I can’t get pregnant if I’m breastfeeding”

- “My friend took [contraceptive] but it ruined her periods / made her infertile” etc
How soon is too soon to get pregnant again?

- World Health Organization (WHO) recommends 24 months for birth-to-pregnancy interval.
WHO birth-to-pregnancy interval

- \( \leq 6-12 \) months
  - ↑ risk maternal mortality/morbidity
- \( \leq 18 \) months
  - ↑ risk infant, neonatal, perinatal mortality
  - ↑ risk low birth weight, small for gestational age, preterm
- \( \geq 27 \) months – minimal adverse maternal, perinatal and infant outcomes
- 18-27 months - may be “residual” risk
- VBAC < 16 months : ↑ risk uterine rupture
Faculty of Sexual and Reproductive Healthcare
birth-to-pregnancy interval

- RANZCOG Statements and Guidelines
  (Royal Australian and New Zealand College of Obstetrics and Gynaecology)

How long should a woman wait before trying to conceive again?

Women should be advised that an interpregnancy interval (IPI) of less than 12 months between childbirth and conceiving again is associated with an increased risk of preterm birth, low birthweight and small for gestational age (SGA) babies.
Medical factors – birth to pregnancy interval

- Caesarean
- Pelvic floor and perineum recovery
- Medical conditions / medications
- Mental health
- Social / financial
2. Contraception Options

- Breast feeding
- “Natural” planning
- Barrier method
- Hormonal
- LARCs
  (long acting reversible contraception)
  - Contraceptive insert (Implanon®)
  - Intrauterine device (IUD - Mirena®, Copper-T)
- Sterilisation
Patient Factors - choosing contraception

- **Efficacy** - importance of fertility control
- **Breastfeeding**
- **Acceptability**
  - Personal experience / preference
  - Knowledge vs misinformation
  - Personal values (cultural, religious, body view)
  - Cost, convenience, accessibility
- **Patient safety**
  - Medical conditions (physical conditions, chronic illness, mental health, medications)
  - Social situation (age, vulnerability, access)
Explaining efficacy to patients
Efficacy of contraceptive methods available in Australia

Long-Acting Reversible Contraception

- **Etonogestrel implant**
  - Typical & Perfect use 99.95%
  - Lasts 3 years
  - Inserted and removed by clinician

- **Levonorgestrel IUD**
  - Typical & Perfect use 99.8%
  - Lasts 5 years
  - Inserted and removed by clinician

- **Copper IUD's**
  - Typical use 99.2%
  - Perfect use 99.4%
  - Lasts 5-10 years
  - Inserted and removed by clinician

Sterilisation

- **Vasectomy**
  - Typical use 99.85%
  - Perfect use 99.9%
  - Considered permanent
  - Performed by clinician

- **Tubal occlusion by metal microinsert (Essure*)**
  - Typical & Perfect use 99.8%
  - Hysteroscopic procedure
  - Considered permanent

- **Female tubal ligation**
  - Typical use 99.5%
  - Perfect use 99.5%
  - Laparoscopic procedure requiring anaesthesia
  - Considered permanent

More Effective

Sexual Health & Family Planning Australia
Leading the way in sexual and reproductive health
Barriers and natural methods

Diaphragm
Typical use 88%
Perfect use 94%
On each occasion of intercourse

Male Condom
Typical use 82%
Perfect use 98%
On each occasion of intercourse

Female Condom
Typical use 79%
Perfect use 95%
On each occasion of intercourse

Withdrawal
Typical use 78%
Perfect use 96%
On each occasion of intercourse

Fertility awareness
Typical use 76%
Perfect use 95-99.6%
Breastfeeding – lactational amenorrhoea method

- Nursing → prolactin → hypothalamic suppression ovulation
  - 50% begin to ovulate between 6-12 months

Efficacy: 98% (perfect use)
- Exclusively and regularly breastfed (nil formula / solids)
  - ≤4 hour intervals during day, ≤6 hour intervals overnight
- No menses
- Baby < 6 months old

Efficacy: 45-85% (actual use)
- Will still need a contraception plan from 6 months
Coitus interruptus

- Efficacy: 78% (typical use)
  96% (perfect use)

- Pros: pregnancy
- Cons: pregnancy
Natural Planning

- **Efficacy**: 76% (typical) – 99.5% (perfect)
- **Types**:
  - Symptom based: Cervical secretions, basal body temperature
  - Calendar based: Calendar Rhythm or Standard Days Method
    - Breastfeeding
- **Cycle dependent. Can use postpartum**:
  - Calendar rhythm method once had 3 cycles and regular.
  - Standard Days Method after 4 cycles.
- **Pros**: no cost
- **Cons**: low efficacy. Requires abstinence / barrier contraception until cycles regular
Natural Planning cont.

- **Calendar Rhythm Method:**
  - shortest cycle – 19 → longest cycle – 10 (eg 30-36 day cycle, would be fertile days 12-25)

- **Standard Days Method:**
  - avoid intercourse on days 8-19 if cycle is 26-32 days long
Barrier Methods

- **Condoms**
  - Efficacy: 82% (typical use) - 98% (perfect use) per encounter
  - Pros: STI protection, non-hormonal
  - Cons: high failure rate

- **Diaphragm**
  - Efficacy: 88% (typical use) - 94% (perfect use) per encounter
  - > 6 weeks postpartum (uterine involution complete)
  - Cons: Needs to be fitted, higher risk failure in parous women
Hormonal Options – progestin only

- **Minipill (levonorgestrel)**
  - Efficacy: 91% (typical use) - 99.7% (perfect use)
  - Changes cervical mucus, does not reliably prevent ovulation
  - Safe for breastfeeding
  - Side effects: irregular bleeding, amenorrhea.
  - Less common side effects: acne, breast pain, abdominal pain, dizziness, mood changes
  - Cost: $13.50 / 4 months
  - Pros: cheap, acceptable
  - Cons: narrow therapeutic window (2-3 hours)
Hormonal Options – progestin only

- **Depo-Provera® (Medroxyprogesterone 150mg IM)**
  - Efficacy: 94% (typical use) - 99.8% (perfect use)
  - Prevents ovulation
  - Safe in breastfeeding
  - Side effects: irregular bleeding, amenorrhoea (50% by 12 months), delayed fertility upon cessation (up to 18 months)
  - Less common side effects: weight gain, acne, mood changes, depression, increased risk of bone loss (with prolonged use)
  - Cost: $25 / 3 months
  - Pros: cheap, can improve menorrhagia / dysmenorrhoea etc
  - Cons: 12 weekly injection, not appropriate in age extremes due to bone loss (adolescents, > 45 yo)
### Table 2.3 Interpretation and application of the categories in practice

<table>
<thead>
<tr>
<th>Category</th>
<th>With good resources for clinical judgement</th>
<th>With limited resources for clinical judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstances</td>
<td>Yes (Use the method)</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Use of method not usually recommended unless other more appropriate methods are not available or not acceptable</td>
<td>No (Do not use the method)</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td></td>
</tr>
</tbody>
</table>
### Initiating postpartum progestin-only

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CATEGORY</th>
<th>CLARIFICATIONS/EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>POP</td>
<td>DMPA/NET-EN</td>
</tr>
<tr>
<td>Initiating postpartum progestin-only</td>
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</table>

<table>
<thead>
<tr>
<th>BREASTFEEDING†</th>
<th>POP</th>
<th>DMPA/NET-EN</th>
<th>LNG/ETG</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) &lt; 6 weeks postpartum</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>b) ≥ 6 weeks to &lt; 6 months postpartum (primarily breastfeeding)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>c) ≥ 6 months postpartum</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Clarification: There is theoretical concern about the potential exposure of the neonate to DMPA/NET-EN during the first 6 weeks postpartum. In many settings, however, pregnancy-related morbidity and mortality risks are high, and access to services is limited. In such settings, DMPA/NET-EN may be among the few methods widely available and accessible to breastfeeding women immediately postpartum.

Evidence: Direct evidence demonstrates no harmful effect of POCs on breastfeeding performance (61–109) and generally demonstrates no harmful effects on infant growth, health or development (74, 76, 89, 99); however, these studies have been inadequately designed to determine whether a risk of long-term effects exists. Animal data suggest an effect of progesterone on the developing brain; whether similar effects occur following progestogen exposure in humans is unclear (110–112).
Hormonal options - combined

- **Combined oral contraceptive pill (COCP)**
  - Efficacy: 91% (typical use) - 99.7% (perfect use)
  - > 3-6 weeks postpartum (VTE risk)
  - Common side effects: headache, nausea, breakthrough bleeding + progestin side effects
  - Cost: depends on brand, (Levlen $13 / 4 months)
  - Pros: high acceptability, cheap, reduce ovarian & endometrial cancer, improve gynaec symptoms
  - Cons: contraindicated in smokers > 35 yo, VTE risk etc
  - Extended regimens – same efficacy contraception with reduced hormonal withdrawal symptoms and reduced menses
    - Continuous pack use, Yaz Flex, Seasonique
Hormonal Options - combined

- **Nuva ring**
  - Efficacy: 91% (typical use) - 99.7% (perfect use)
  - > 6 weeks postpartum (VTE RISK)
  - Cost: $33 / month
  - Cons: expensive, acceptability

Family Planning NSW
Timing of combined hormonal contraception

2.2 Medical eligibility
2.2.1 Which methods of contraception are safe to use after childbirth?

Women should be advised that although contraception is not required in the first 21 days after childbirth, most methods can be safely initiated immediately, with the exception of combined hormonal contraception (CHC).
COCP & breastfeeding “debate”

RANZCOG (O&G) vs Therapeutic Guidelines (GP) vs WHO (the world)

YES vs NO vs MAYBE
Women who are breastfeeding should be informed that there is currently limited evidence regarding the effects of CHC use on breastfeeding. However, the better-quality studies of early initiation of CHC found no adverse effects on either breastfeeding performance (duration of breastfeeding, exclusivity and timing of initiation of supplemental feeding) or on infant outcomes (growth, health and development).

Although contraceptive hormones are excreted into breast milk in very small amounts (less than 1% of the maternal dose), there have been concerns about their potential impact on breastfeeding and on infant growth and development. A Cochrane review which included 11 randomised trials (RCTs) that compared CHC, non-hormonal contraception and progestogen-only contraception use among women who breastfeed found that most trials did not show or report significant differences between study arms in breastfeeding duration, breast milk composition, or infant growth.

Evidence level 1++
Breastfeeding is as reliable as hormonal methods of contraception if the baby is younger than 6 months and the mother is fully breastfeeding and has not yet had a period. Lactation is not a reliable contraceptive method once any of these criteria is not met—if the mother is still breastfeeding, a progestin-only method is advised.
"MAYBE" - breastfeeding & combined hormonal

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<td>COC</td>
<td>P</td>
</tr>
<tr>
<td>BREASTFEEDING†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) &lt; 6 weeks postpartum</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>b) ≥ 6 weeks to &lt; 6 months postpartum (primarily breastfeeding)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>c) ≥ 6 months postpartum</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Non-breastfeeding & COCP

### POSTPARTUM (IN NON-BREASTFEEDING WOMEN)

Although the risk of venous thromboembolism (VTE) is the same in breastfeeding and non-breastfeeding women, use of CHCs is generally not recommended prior to 6 months postpartum in women who are breastfeeding.

<table>
<thead>
<tr>
<th></th>
<th>COCP</th>
<th>Ring</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) &lt; 21 days</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>i) without other risk factors for VTE</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>ii) with other risk factors for VTE</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>b) &gt; 21 days to 42 days</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>i) without other risk factors for VTE</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>ii) with other risk factors for VTE</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>c) &gt; 42 days</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Clarification:** For women up to 6 weeks postpartum with other risk factors for VTE, such as immobility, transfusion at delivery, BMI > 30 kg/m², postpartum haemorrhage, immediately post-caesarean delivery, pre-eclampsia or smoking, use of CHCs may pose an additional increased risk for VTE.

**Evidence:** One study examined use of CHCs during the postpartum period and found that VTE rates were higher for CHC users compared with non-users at all time points postpartum. Rates were significantly different only after 13 weeks postpartum, but the numbers needed to harm were lowest in the first 6 weeks postpartum (132). VTE risk is elevated during pregnancy and the postpartum period; this risk is most pronounced in the first 3 weeks after delivery, declining to near baseline levels by 42 days postpartum (127-131).
### Combined oral contraceptives

<table>
<thead>
<tr>
<th>Oestrogen dose (mcg)</th>
<th>Progestin dose (mcg)</th>
<th>Brand*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monophasic preparation: low dose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oestradiol (hemihydrate) 1500</td>
<td>nomogestrol acetate 2500</td>
<td>Zoely^a</td>
</tr>
<tr>
<td>ethinyloestradiol 20</td>
<td>drospirenone 3000</td>
<td>Yaz^x, Yaz Flex^y</td>
</tr>
<tr>
<td>ethinyloestradiol 20</td>
<td>levonorgestrel 100</td>
<td>Femme-Tab ED 20/100, Loette^x, Microgynon 20^x, Microgynon^x</td>
</tr>
<tr>
<td><strong>Monophasic preparation: standard dose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ethinyloestradiol 30</td>
<td>desogestrel 150</td>
<td>Marvelon^x</td>
</tr>
<tr>
<td>ethinyloestradiol 30</td>
<td>dienogest 2000</td>
<td>Valette^x</td>
</tr>
<tr>
<td>ethinyloestradiol 30</td>
<td>drospirenone 3000</td>
<td>Yasmin^x</td>
</tr>
<tr>
<td>ethinyloestradiol 30</td>
<td>gestodene 75</td>
<td>Minulet^x</td>
</tr>
<tr>
<td><strong>ethinyloestradiol 30</strong></td>
<td><strong>levonorgestrel 150</strong></td>
<td><strong>Femme-Tab ED 30/150, Levlen, Microgynon 30, MonoPem, Nordette</strong></td>
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<tr>
<td>ethinyloestradiol 35</td>
<td>cyproterone 2000</td>
<td>Brenda-35^x, Diane-35^x, Estelle-35^x, Juliet-35^x</td>
</tr>
<tr>
<td>ethinyloestradiol 35</td>
<td>norethisterone 500</td>
<td>Brevinin, Norimin</td>
</tr>
<tr>
<td>ethinyloestradiol 35</td>
<td>norethisterone 1000</td>
<td>Brevinin-1, Norimin-1</td>
</tr>
<tr>
<td><strong>Monophasic preparation: high dose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ethinyloestradiol 50</td>
<td>levonorgestrel 125</td>
<td>Microgynon 50</td>
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<tr>
<td><strong>Monophasic preparation: extended regimen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ethinyloestradiol 10 to 30</td>
<td>levonorgestrel 150</td>
<td>Seasonique^z</td>
</tr>
<tr>
<td><strong>Other multiphasic preparations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ethinyloestradiol 30 to 40</td>
<td>levonorgestrel 50 to 125</td>
<td>Logynon, Trifeme, Triphasil, Triquiler</td>
</tr>
<tr>
<td>ethinyloestradiol 35</td>
<td>norethisterone 500 to 1000</td>
<td>Improvil</td>
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<tr>
<td>oestradiol valerate 1000 to 3000</td>
<td>dienogest 2000 to 3000</td>
<td>Qiara^d</td>
</tr>
</tbody>
</table>

*MDBriefCase Australia 2017*
LARCs (long acting reversible contraception)

- Contraceptive insert (Implanon®)
- IUD (Mirena®, Copper-T)

- Most reliable contraceptives for “typical use”
- Low uptake in Australia despite relative affordability compared to other countries

- LARCs used by < 10% Australian women
  - Largely attributed to lack of patient awareness and medical access
Implanon® (etonogestrel)

- Efficacy: 99.95%
- 3 years
- Safe for breastfeeding
- Can insert immediately
- Side effects: irregular bleeding, progestin side effects
- Cost: $37.80 + insertion cost
- Pros: reliable, cheap
- Cons: irregular bleeding (1/5 stop), clinician to insert/remove
Hormonal IUD - Mirena® (levonogestrel)

- Efficacy: 99.8%
- 5 years
- Safe in breastfeeding
- Common side effects: spotting (3-6 months), amenorrhea, pelvic pain
- Uncommon side effects: expulsion, perforation, infection, acne, weight gain, breast tenderness, headache, nausea, mood changes, ovarian cysts, ectopic pregnancy
- Cost: $37.80 + insertion
- Pros: reliable, cheap, improve gynae conditions
- Cons: insertion

Non-hormonal IUD - CopperT

- Efficacy: 99.2%
- 5-10 years
- Safe in breastfeeding
- Side effects: heavier menses
- Cost: $73.39 + insertion
- Pros: reliable,
- Cons: insertion, heavier menses
IUD insertion timing:
< 48 hours or
> 4 weeks postpartum
(for uterine involution)
<table>
<thead>
<tr>
<th>SUBURB</th>
<th>PRACTICE NAME</th>
<th>DOCTOR NAME</th>
<th>PRACTICE ADDRESS</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIRPORT WEST</td>
<td>Your Family Health Clinic</td>
<td>Dr. Shaheen Begum</td>
<td>29 Louis Street Airport West VIC 3029</td>
<td>9338 3121</td>
</tr>
<tr>
<td>ASPENDALE</td>
<td>Aspendale Clinic</td>
<td>Dr. Vanessa Huang</td>
<td>147 Station Street Aspendale VIC 3156</td>
<td>9580 1200</td>
</tr>
<tr>
<td>BALLARAT</td>
<td>The Annexes</td>
<td>Dr. Claire Pickett</td>
<td>12 Littlewood St Ballarat Vic 3350</td>
<td>5338 4541</td>
</tr>
<tr>
<td>BALLARAT</td>
<td>Tritar Medical Group</td>
<td>Dr. Fathma Hashem</td>
<td>1010A Sturt Street Ballarat Vic 3350</td>
<td>9331 7155</td>
</tr>
<tr>
<td>BALLARAT</td>
<td>Tritar Medical Group</td>
<td>Dr. Ferhima Khan</td>
<td>364 Belmore Road Ballarat Vic 3103</td>
<td>9857 7016</td>
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<tr>
<td>BELMONT</td>
<td>Kentfield Health Clinic</td>
<td>Dr. Sarah Wurthn</td>
<td>2/16 Colac Road Belmont Vic 3216</td>
<td>5202 9333</td>
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<tr>
<td>BELMONT</td>
<td>Kentfield Health Clinic</td>
<td>Dr. Annette Docherty</td>
<td>2/18 Colac Road Belmont Vic 3216</td>
<td>5202 9333</td>
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<td>BELMONT</td>
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<td>BELMONT</td>
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<td>Dr. John Ding Yee</td>
<td>1036 Dandenong Rd Dandenong Vic 3163</td>
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<td>CHELSEA HEIGHTS</td>
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<td>Dr. Eivolene Tjantramuali</td>
<td>7/205 Thames Promenade Chelsea Heights Vic 3196</td>
<td>9785 9900</td>
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<td>Dr. Gerah Tetschotchi</td>
<td>7/205 Thames Promenade Chelsea Heights Vic 3196</td>
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<td>COOLINGG</td>
<td>Cobin Medical Centre</td>
<td>Dr. Susan Milburn</td>
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<tr>
<td>COODRACO</td>
<td>Coodraco Clinic</td>
<td>Dr. Nataliya Lischenko</td>
<td>512 Barry Street Coburg Vic 3048</td>
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<td>GEELONG</td>
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<td>Dr. Dafid Kafi</td>
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<td>GEELONG WEST</td>
<td>Health E Medical Centre</td>
<td>Dr. Alison Marren</td>
<td>256 Shannon Avenue Geelong West Vic 3218</td>
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<tr>
<td>GLEN IRIS</td>
<td>Glen Iris Medical Group</td>
<td>Dr. Martine Burke</td>
<td>177 Burke Road Glen Iris 3146</td>
<td>9568 7633</td>
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<tr>
<td>HAWTHORN</td>
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<td>Dr. Luella Knight</td>
<td>168 Aurora Road, Hawthorn Vic 3122</td>
<td>1320 637 832</td>
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<tr>
<td>HIGHTON</td>
<td>The Highton Clinic</td>
<td>Dr. Liz Lesser</td>
<td>10 Belle Vue Road Highton Vic 3216</td>
<td>5243 5666</td>
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<tr>
<td>HOPPERS CROSSING</td>
<td>Werribee Group Healthcare</td>
<td>Dr. Sobia Rashid</td>
<td>1 Barber Drive Hoppers Crossing Vic 3029</td>
<td>9748 7070</td>
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<tr>
<td>HOPPERS CROSSING</td>
<td>G1 Medical Centre</td>
<td>Dr. Suda Chalal</td>
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<td>9754 2828</td>
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<tr>
<td>MOUNT ELIZA</td>
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<td>Dr. Bill Kendal</td>
<td>129 Eliza Way, Eliza Vic 3300</td>
<td>9787 4999</td>
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<td>MOUNT Waverley</td>
<td>Waterfley Family Healthcare</td>
<td>Dr. Eilene Hong</td>
<td>58 Pinelea Drive, Mount Waverley Vic 3149</td>
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<tr>
<td>NEWCOMBE</td>
<td>Bellerine Medical Centre</td>
<td>Dr. Miren Calame-Umita</td>
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<td>5249 1337</td>
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<td>Dr. Dafid Kafi</td>
<td>46 Bellerine Highway Newcombe Vic 3129</td>
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<td>NOBLE PARK</td>
<td>Hill Medical Services</td>
<td>Dr. Tizhara Ghaly</td>
<td>51 Chandler Rd Noble Park Vic 3174</td>
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<td>NORTH FITZROY</td>
<td>Northside Clinic</td>
<td>Dr. Ruth McNaire</td>
<td>370 St Georges Rd North Fitzroy Vic 3069</td>
<td>9485 7700</td>
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<tr>
<td>NORTHCOITE</td>
<td>The Corner Medical Clinic</td>
<td>Dr. Julie Spicer</td>
<td>28 Ett Street Northcote Vic 3070</td>
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<td>Pakenham</td>
<td>Lakeside Sa Am Medical Centre</td>
<td>Dr. Ernest Anderson</td>
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<tr>
<td>Pascoe Vale</td>
<td>P.V.H Medical</td>
<td>Dr. William Harvey</td>
<td>12 Kent Road, Pascoe Vale Vic 3044</td>
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<td>PRESTON</td>
<td>Preston Family Medical Centre</td>
<td>Dr. Michele Leadston</td>
<td>227 Bell Street, Preston Vic 3072</td>
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<td>RINGWOOD EAST</td>
<td>Ringwood East Clinic</td>
<td>Dr. Eily Durr</td>
<td>44 Warrandy Road, Ringwood East Vic 3134</td>
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<td>RINGWOOD EAST</td>
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<td>Dr. Hua-Min Chen</td>
<td>110-112 Railway Avenue, Ringwood East Vic 3135</td>
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<tr>
<td>ROWVILLE</td>
<td>Wellness on Wellington</td>
<td>Dr. David Ringenburg</td>
<td>88 Lower Plenty Rd Rosanna Vic 3084</td>
<td>9457 1463</td>
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<tr>
<td>ROXBURD</td>
<td>Rosedale Superclinic</td>
<td>Dr. Craig Negri</td>
<td>12-16 Bosco Road Rosbudd Vic 3938</td>
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<tr>
<td>ROWVILLE</td>
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<td>Dr. Lorna Brown</td>
<td>1190 Wellington Rd, Rowville Vic 3179</td>
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<td>STRATHFIELDAYE</td>
<td>Strathfield Primary Health</td>
<td>Dr. Aun Teeling (Kat) Ritchie</td>
<td>34 Blucher Street, Strathfielday Vic 3551</td>
<td>5499 4444</td>
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<td>34 Blucher Street, Strathfielday Vic 3551</td>
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<td>SUNBURY</td>
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<td>Dr. Kate Beales</td>
<td>81 Evans Street Sunbury Vic 3329</td>
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<td>SURREY HILLS</td>
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<td>Dr. Lucila Knight</td>
<td>176 Union Road, Surrey Hills Vic 3214</td>
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<td>TARNETT</td>
<td>My Clinic Tamir</td>
<td>Dr. Anuradha Panich Survan</td>
<td>412 Dorset Street Tarnet Vic 3052</td>
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<td>TEMPLESTOWE</td>
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<td>Dr. Mark Sparrow</td>
<td>200 High Street, Lower Templestow Vic 3107</td>
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<td>TORQUAY</td>
<td>Surfcoast Medical Centre</td>
<td>Dr. Skye Humeke</td>
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<td>WARRNAMBOOL</td>
<td>The Healthspace</td>
<td>Dr. Natalie Ryan</td>
<td>275 Korilal Road Warrnambool Vic 3280</td>
<td>5662 4528</td>
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<td>Dr. Natalie Ryan</td>
<td>275 Korilal Road Warrnambool Vic 3280</td>
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<td>WAURU N PONDS</td>
<td>Medical One Waurn Ponds</td>
<td>Dr. Melissa Galtbriath</td>
<td>180 Colac Road Waurn Ponds Vic 3216</td>
<td>5243 6111</td>
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<tr>
<td>WEST HEDELBERG</td>
<td>Barvule Community Health</td>
<td>Dr. Ermanto Alexi</td>
<td>21 Nairn Road West Heidelberg Vic 3061</td>
<td>9450 3031</td>
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<tr>
<td>WINDANGI</td>
<td>Wonthaggi Medical Centre</td>
<td>Dr. Nola Waintree</td>
<td>42 Murray Street Wonthaggi Vic 3995</td>
<td>5672 1333</td>
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<tr>
<td>WOODEND</td>
<td>Brooke Street Medical Centre</td>
<td>Dr. John Dorello</td>
<td>14 Brooke Street Woodend Vic 3422</td>
<td>5427 1002</td>
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</tbody>
</table>
Female Sterilization

- Tubal occlusion by metal insert (Essure®) efficacy: 99.8%
- Tubal ligation efficacy: 99.5%
- > 30 yrs old
- Side effects: pain
- Pros: high efficacy, can be done during caesarean
- Cons: private gynae cost vs long public waitlists, surgical risks (perforation), regret, reversal costs
Vasectomy

- Efficacy: 99.9%
- Vas deferens
- > 30 yo
- Cost: GP, private urologist, public hospital
- Side effects: pain, bruising, infection
- Pros: outpatient procedure, few side effects
- Cons: 3 months bridging contraception
Table 3: Summary of UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) categories applicable to women after childbirth

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUS</th>
<th>IMP</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
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</thead>
<tbody>
<tr>
<td><strong>Postpartum (in breastfeeding women)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) 0 to &lt;6 weeks</td>
<td>See below</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td></td>
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<tr>
<td>b) ≥6 weeks to &lt;6 months (primarily breastfeeding)</td>
<td>See below</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>c) ≥6 months</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Postpartum (in non-breastfeeding women)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) 0 to &lt;3 weeks</td>
<td>See below</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(i) With other risk factors for VTE*</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Without other risk factors</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) 3 to &lt;6 weeks</td>
<td>See below</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) With other risk factors for VTE*</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Without other risk factors</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ≥6 weeks</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Postpartum (in breastfeeding or non-breastfeeding women, including post-caesarean section)</strong></td>
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<tr>
<td>a) 0 to &lt;48 hours</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>b) 48 hours to &lt;4 weeks</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>c) ≥4 weeks</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d) Postpartum sepsis</td>
<td>4</td>
<td>4</td>
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</table>

* In the presence of other risk factors for VTE, such as thrombophilia, immobility, transfusion at delivery, body mass index ≥30 kg/m², postpartum haemorrhage, post-caesarean delivery, pre-eclampsia or smoking, use of CHC may pose an additional increased risk for VTE.

CHC, combined hormonal contraception; Cu-IUD, copper intrauterine device; DMPA, progestogen-only injectable: depot medroxyprogesterone acetate; IMP, progestogen-only implant; LNG-IUS, levonorgestrel-releasing intrauterine system; POP, progestogen-only pill; VTE, venous thromboembolism.
3. Emergency contraception

- Not needed if < 3 weeks postpartum
- Recommended if > 3 weeks and if lactational amenorrhea method cannot be relied upon, eg:
  - Need to be exclusively and regularly breastfeeding
    - < 4 hour intervals during day
    - < 6 hour intervals overnight
Emergency contraception

- **Levonogestrel (eg Postinor®)**
  - 1.5g single dose
  - Within 72 hours intercourse
  - Prevents/delays ovulation
  - Safe in breastfeeding

- **Ulipristal acetate (EllaOne®)**
  - 30 mg single dose tablet
  - Within 5 days (150 hours) of intercourse
  - Prevents/delays ovulation
  - No breastfeeding for 1 week

- **Copper IUD**
  - Insertion within 5 days of intercourse
  - Can use from 28 days postpartum
Levonorgestrel vs Ulipristal acetate

Mazza, Ulipristal acetate: An update for Australian GPs. AFP.

Table 1. Percentage of pregnancies in meta-analysis according to time from unprotected sex to administration of emergency contraception

<table>
<thead>
<tr>
<th>Administration</th>
<th>Levonorgestrel</th>
<th>Ulipristal acetate</th>
<th>Odds ratio (95% CI)*</th>
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<tbody>
<tr>
<td>Within 24 hours</td>
<td>2.3%</td>
<td>0.9%</td>
<td>0.35 (0.11, 0.93)</td>
</tr>
<tr>
<td>Within 72 hours</td>
<td>2.2%</td>
<td>1.4%</td>
<td>0.58 (0.33, 0.99)</td>
</tr>
<tr>
<td>Within 120 hours</td>
<td>2.2%</td>
<td>1.3%</td>
<td>0.55 (0.32, 0.93)</td>
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</table>
Sexually transmitted infections

Hey Baby
I put the STD in STUD now all I need is U
Summary – key points

- Contraception conversations – the more the merrier
- Patient centered discussions
- LARCs (Implanon®, IUD) are highly effective and we should encourage women to consider them
Resources for Patients

- **Contraceptive counselling card**

- **Family Planning Vic**
  - Postnatal contraception overview
    - “Contraception options : Which one is best for me?”
  - List of Victorian IUD providers
  - The Action Centre – if < 25 years old
  - COCP – English, Arabic, Hindi, Chinese, Vietnamese

- **Family Planning NSW**
  - More extensive language options, under “Resources in your language”
  - Arabic, Assyrian, Burmese, Chinese, Dinka, Farsi, Khmer, Korean, Lao, Serbian, Swahili, Thai, Turkish, Vietnamese

- **Royal Women’s Hospital**
  - “Contraception – your choices” : English, Arabic, Hindi, Chinese, Vietnamese

- **Better health channel**
Family Planning Vic - Patient Resources

Contraceptive Options
Which one is best for me?

Postnatal Contraception

The main points:
- The contraceptive choices you have depend on your needs and whether or not you are breastfeeding.
- If you are not breastfeeding, you can choose any type of contraception.
- Using an effective method of contraception such as a contraceptive implant or intrauterine device (IUD) will help in preventing an unplanned pregnancy.

Contraception after you have a baby
After having a baby, using an effective method of contraception such as a contraceptive implant or intrauterine device (IUD) will help in preventing an unplanned pregnancy. The contraceptive options you have will depend on your individual needs and whether or not you are currently breastfeeding.

When deciding which contraceptive method is suitable for you, it is important to know:
- what each method involves
- how the method works
- how reliable the method is
- when you can start using it
- when it will start to work

It is important to remember that no contraceptive method is 100% effective and some methods are more effective than others.
Thank you!

**Cartoon Text:**

- Man: Does it hurt? Can I get you a beer or something?
- Woman: Why no one uses midhusbands.
References

- Family Planning New South Wales
- Family Planning Victoria
- Therapeutic Guidelines
- Uptodate
- World Health Organization – Medical eligibility criteria for contraceptive use. 5th edition.