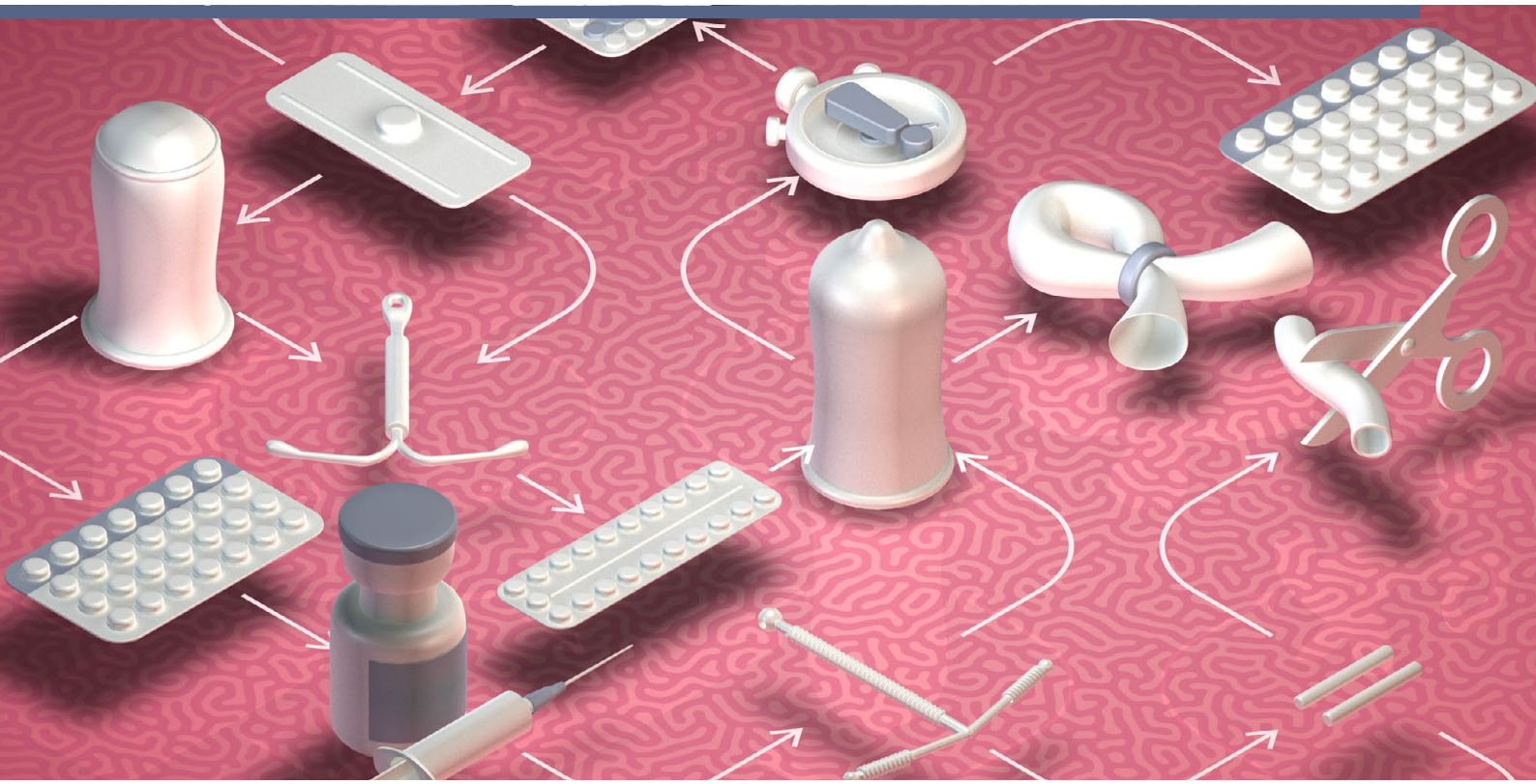

Contraception: which option for which patient?

Prescribing contraception is a core part of primary care practice. A patient's co-morbidities and concurrent medicines can influence the balance of risks and benefits and therefore the choice of contraceptive. Long-acting reversible contraceptive methods, such as the levonorgestrel implant or intrauterine contraception, are recommended first-line at any age. For those taking "the pill", continuous use is encouraged as it reduces the risk of unintended pregnancy and symptoms associated with the hormone-free interval; monthly withdrawal bleeding is not medically necessary.

KEY PRACTICE POINTS:

- Appropriate contraceptive options vary depending on the specific needs, preferences and co-morbidities of each patient. A funded option is available for everyone.
- Long-acting reversible contraceptives (LARC) are recommended as a first-line choice for people of all ages, including adolescents
- Combined oral contraceptive regimens can be tailored: advise patients that withdrawal bleeds are not necessary and extended use is safe and effective
- Clinicians should ensure that people of all ages recognise the need for condoms to protect against STIs, even when other forms of contraception are used
- Contraception is needed until patients reach menopause or age 55 years

This article is the first in a series on prescribing contraceptives in primary care. For further information on specific contraceptive methods, see the accompanying articles in this series:

- **Condoms: advising on the options**
- **Oral contraceptives: selecting a pill**
- **Depot medroxyprogesterone acetate injections: an intermediate option**
- **Long-acting reversible contraceptives: implants and IUCs**

This is a revision of a previously published article. What's new for this update:

- Includes recommendations from New Zealand Aotearoa's guidance on contraception, Ministry of Health (Dec, 2020), available from: **https://www.health.govt.nz/system/files/documents/publications/final_aotearoa_contraception_guidance.pdf**
- New Zealand guidance recommends a long-acting reversible contraceptive first-line, including for adolescents and nulliparous people
- The recommended dosing interval for DMPA is now 13 weeks; this is an evidence-based change from the previously recommended 12-week dosing interval. Injections can be administered up to seven days late (i.e. a dosing interval of 14 weeks) without the need for additional contraception.
- Addition of the World Health Organization's definition of fully breastfeeding
- Updated terminology in line with national guidance:
  - Levonorgestrel IUS (or LNG-IUS) – levonorgestrel intrauterine system (i.e. Mirena or Jaydess)
  - Intrauterine contraception (IUC) – includes levonorgestrel IUS and copper intrauterine device (IUD)

Counselling patients on contraception: it's better out in the open

Patients may find discussing contraception and the prevention of sexually transmitted infections (STIs) a sensitive or awkward topic, as it touches on issues such as their sexuality and sexual practices, as well as relationship issues and their future plans for children. In addition, their views and behaviours can be influenced by social, family, religious or cultural factors. However, there is much to be gained and little to be lost when patients and healthcare providers have open discussions about contraception and prevention of STIs. The goal of counselling patients about contraception is to ensure they are using a safe, effective option which is the most appropriate for their clinical needs and preferences. Clinicians should be aware that transgender patients may still require contraception even when using gender affirming hormone treatment (see: "Contraception in transgender patients").

For further information on discussing sex and contraception with younger people, see:

- "Contraception in early adolescence": **www.bpac.org.nz/bpj/2011/april/contraception.aspx**
- "Let's talk about sex": **www.bpac.org.nz/bpj/2009/april/sexhealth.aspx**

Evidence suggests people are interested in hearing more

The most commonly used form of contraception in New Zealand is the oral contraceptive pill.[1, 2] However, data from international surveys and focus groups in New Zealand show that people are eager to know more about the contraceptive options available to them, and that many would be interested in trying other options, such as long-acting reversible contraceptives, if they had information about them.[3, 4]

A variety of contraceptive options are available

Methods of contraception available* in New Zealand include:

- Condoms; external (funded) and internal (not funded) varieties – ensure that patients of all ages recognise the need for condoms to protect against STIs, even when other forms of contraception are used[5]
- Long-acting reversible contraceptives (LARCs); progestogen implants, copper and levonorgestrel (progestogen) intrauterine contraceptives (IUCs)
- Depot medroxyprogesterone acetate (DMPA) injections†
- Oral contraceptives; combined and progestogen-only formulations
- Sterilisation options; vasectomy or tubal ligation
- Emergency contraception
- Natural family planning

* Diaphragms and vaginal rings are not funded in New Zealand

† Depot medroxyprogesterone acetate injections are no longer classified as a long-acting contraceptive as they are less effective than IUCs or implants and require patients to return for an injection every 13 weeks[6]

Depending on co-morbidities, other prescribed medicines or recent pregnancy, some options may be inappropriate due to a high risk of adverse effects (Table 1).

Patients may base their preference for a contraceptive method on factors such as effectiveness (Table 2), adverse effects and risks, ease of use, future pregnancy plans, cost or particular symptoms they wish to manage. For example, some people may want greater cycle control, relief from menstrual pain or heavy menstrual bleeding, while others may be concerned about age-related adverse effects, such as venous thromboembolism.

Table 1: Recommendations regarding the likely benefits and risks of different contraceptive options. Adapted from New Zealand Aotearoa's guidance on contraception (2020) and the Faculty of Sexual and Reproductive Healthcare, United Kingdom.[6, 11]

	Oral contraceptives		Depot medroxyprogesterone acetate injections (DMPA)	Long-acting reversible contraceptives		
					IUCs	
Patient characteristics	Combined oral contraceptives (COCs)	Progestogen-only oral contraceptives (POPs)		Levonorgestrel implant	Levonorgestrel IUS	Copper IUD
Younger (e.g. age < 18 years) or nulliparous			a			
Aged ≥ 50 years or over[6]	b		b			
Taking hepatic-enzyme inducing medicines, e.g. some anticonvulsants						
At increased risk of venous thromboembolism (VTE)	c					
With, or at increased risk of, cerebro- or cardiovascular diseases						
Hypertension			d			
Smoking in patients aged over 35 years	e					
Valvular heart disease or atrial fibrillation						
Stroke or ischaemic heart disease						
Vascular disease						
With multiple cardiovascular risk factors						
With diabetes and complications, or diabetes for > 20 years						
Migraine with aura						
Post-partum						
Immediately						
< 4 weeks	g				f	f
4 - 6 weeks	g					
> 6 weeks						
Following termination of pregnancy or spontaneous abortion					h	h
Current or previous breast cancer		i	i	i	i	

Benefits are likely to outweigh risks | Risks may outweigh benefits for some patients, see footnotes for details | Not recommended, risks are likely to outweigh benefits

a. Medroxyprogesterone acetate injections are associated with a decrease in bone mineral density; other contraceptive options should be considered first in patients aged < 18 years
b. Use in patients aged 50 years and over is not recommended due to an increased risk of venous thromboembolism (COC) or a decrease in bone mineral density (DMPA)
c. For example, personal history of VTE or prolonged immobility due to surgery or disability
d. Risks are likely to outweigh benefits for patients with poorly controlled hypertension, i.e. systolic blood pressure ≥ 160 mmHg or diastolic ≥ 100 mmHg
e. Risk increases with age. Use is generally not recommended in people aged over 35 years who smoke, however, clinicians should consider the patient's overall level of risk when considering the use of COCs in a patient who smokes, rather than relying on a strict age criterion
f. IUCs can be safely inserted within 48 hours of delivery, otherwise insertion should be delayed until after four weeks post-partum
g. COC may be considered from three weeks post-partum if not breastfeeding and no additional risk factors for VTE (e.g. caesarean section delivery, pre-eclampsia, haemorrhage, transfusion at delivery, immobility, BMI ≥ 30 kg/m^2 or smoking)
h. IUCs can be inserted after a first or second trimester termination, but should not be inserted immediately after a termination where sepsis has occurred
i. Should not be used in patients with current breast cancer; use of hormonal contraceptives in people with a history of breast cancer is generally not recommended unless other methods are not available or acceptable, as the theoretical or proven risks usually outweigh the benefits. Any consideration should ideally be discussed with an oncologist.

Table 2: Effectiveness of different contraceptive methods after one year. Adapted from the Faculty of Sexual and Reproductive Healthcare, United Kingdom.[12, 13]

	Number of pregnancies per 1,000 females of reproductive age after one year		Funding status	For further information, see:
	Perfect Use*	Typical Use*		
No contraception	850			
Barrier and short-term options:				
Male condoms	20	130 – 180	●	*"Condoms: advising on the options"*
Female condoms	50	210		
Diaphragm†	60	120		
Spermicide†	180	280		
Oral contraceptives:				*"Oral contraceptives: selecting a pill"*
Combined oral contraceptive (COC)	3	90	●	
Progestogen-only contraceptive (POP)	2	90	●	
Injectable options:				*"Depot medroxyprogesterone acetate injections: an intermediate option"*
Depot medroxyprogesterone acetate injections (DMPA)	2 – 6	60	●	
Long-acting reversible contraceptives:				*"Long-acting contraceptives: implants and IUDs"*
Levonorgestrel implants	< 1		●	
Levonorgestrel IUS	2 – 6		●	
Copper IUD	6 – 8		●	
Non-pharmacological options				"Natural family planning" below
Fertility awareness methods	Varies with method: See Table 3			
Permanent contraceptive methods:				"Sterilisation methods" below
Tubal occlusion/ligation	5		**	
Vasectomy	1 – 2		**	

● Fully funded options available

* Perfect use refers to using the contraceptive exactly as recommended. Typical use is when contraception is not always used consistently or correctly, e.g. forgetting to take a dose of medicine, condom applied incorrectly.

† Diaphragms and spermicide have not been funded in New Zealand for some time. Diaphragms may be available for purchase at some pharmacies. If patients already have a diaphragm they wish to keep using, support is available from Family Planning: **www.familyplanning.org.nz/advice/contraception/diaphragms**

** Some patients may qualify for a tubal ligation or vasectomy performed in the public health system, depending on local eligibility criteria

Contraception is needed until age 55 years or menopause

Patients can cease using contraceptives at age 55 years, as pregnancy is very rare beyond this age even if they continue menstruating.[7] Some patients may discontinue contraceptives earlier if menopause has occurred.[7] A clinical diagnosis of menopause can be made after one year of amenorrhoea; contraception can be ceased at this time for patients aged over 50 years, but is recommended for an additional year in patients aged 40 – 50 years, i.e. for two years after the onset of amenorrhoea.[7]

Increased use of long-acting contraceptives could help reduce disparities

Conventionally, IUCs were most commonly used by women who had completed their families and wished to have a long-term form of contraception. There was some resistance to the idea that an IUC could be an appropriate contraceptive option for younger women and those who had not yet given birth, due to concerns such as ease of insertion. However, there is no clinical basis for this concern, and an IUC should be considered as an appropriate option for almost anyone.[6] The levonorgestrel implant (inserted in the arm) has been funded in New Zealand since 2010, and is the most effective method of contraception available (Table 2). Some clinicians may be less familiar with this method as they do not have experience in placing the implants, but the procedure can be easily learned. Use of a long-acting reversible contraceptive (LARC) is associated with a much lower rate of unintended pregnancy, compared to shorter-acting methods such as oral contraceptives or DMPA injections.[6] In New Zealand, rates of abortion have been declining since the mid-2000s and research suggests that this is due in part to an increased use of LARCs.[2, 8] Reductions have been particularly pronounced in people aged 15 – 19 years, however, rates of abortion are still highest amongst people of Māori ethnicity and people aged 20 – 29 years.[8]

The additional appointment time and repeat visits, or visits to another provider, required for initiating a LARC can be a barrier to patients in terms of convenience and cost.[9, 10] Consider whether there are ways your practice could simplify the process for patients, e.g. by having a clinical staff member trained in insertion and removal techniques, and having a supply of LARCs at the practice (implants and copper intrauterine devices [IUDs] are available on PSO; levonorgestrel intrauterine systems [IUSs] are not). If offering these services at your practice is not possible, patients can be referred to Family Planning or Sexual Health Clinics, if locally available; these services may offer contraception services at a lower cost or for free*. Some PHOs may also offer funding for sexual health or contraception-related consultations; enquire with your PHO.

* Appointments at Family Planning are free for people aged under 22 years. Appointments cost $5 for Community Services Card holders.

Funding for insertions may be available for some people through their local DHB or PHO; check your local HealthPathway. Information will be updated as more details emerge or check the Ministry of Health website.

Withdrawal bleeds with combined oral contraceptives are not necessary

Combined oral contraceptive (COC) pills were first introduced in New Zealand in the 1960s. They were formulated to mimic the natural menstrual cycle, with three weeks of active hormone tablets followed by one week of placebo tablets at which time a withdrawal bleed usually occurs. However, there is no medical basis for this withdrawal bleed and people taking COCs can be reassured that skipping the hormone-free interval is safe, and is in fact now recommended.[6] Continuous use of hormone pills, rather than stopping and starting, may improve contraceptive effectiveness by reducing the likelihood of missing pills, as well as lessening the consequences of missed pills, e.g. compared with missing pills in the first week of a conventional regimen, thereby extending the hormone-free interval. In addition, bleeding-related adverse effects, such as headache, bloating and abdominal pain, can be avoided, which is likely to improve satisfaction and adherence with this method of contraception.

Any contraceptive can be started six weeks post-partum

If contraception is required after childbirth, any of the available options can be given from six weeks post-partum, including COCs;[6] progestogen-only pills, injections or implants can be used prior to six weeks and IUCs can either be inserted immediately post-partum or after four weeks (Table 1).[6]

It was previously recommended that COCs be avoided for the first six months post-partum if breastfeeding due to potential suppressive effects of ethinylestradiol on milk supply. While the data on COC use and breastfeeding are limited and conflicting, better quality studies investigating breastfeeding performance, i.e. duration, exclusivity and initiation of supplemental feeding, and infant growth, health and development have shown no adverse effects when COCs are started from six weeks post-partum, provided breastfeeding is well established and there are no concerns with the infant's growth.[6] COCs can be initiated at three weeks post-partum in those who are not breastfeeding, provided they do not have additional risk factors for venous thromboembolism.[6]

The lactational amenorrhoea method is an effective form of contraception if fewer than six months post-partum, amenorrhoeic and fully breastfeeding*. This method should not be relied on if the frequency of breastfeeding decreases, e.g. night feeds stopped, supplemental foods started, if

menstruation returns or if the patient is more than six months post-partum.[6]

* Defined as at least 10 – 12 times per day in the first few weeks post-partum, and 8 – 10 times per day thereafter, including at least one night feed.[6] Daytime feedings should be no more than four hours apart, and night-time feedings no more than six hours apart.[6]

Selecting a contraceptive option

Tables 1 and 2 can be used to decide, together with the patient, which types of contraception may be the most appropriate for them; detailed information on each option is available in the accompanying articles in this series:

- Condoms: advising on the options
- Oral contraceptives: selecting a pill
- Depot medroxyprogesterone acetate injections: an intermediate option
- Long-acting reversible contraceptives: implants and IUCs

Natural family planning

The use of fertility awareness to prevent conception may be preferred by people who wish to avoid other methods of contraception for religious or personal reasons. When adhered to strictly these methods can have good efficacy rates (Table 3). However, with typical use, approximately 2 – 23% of people become pregnant within one year, depending on the method used.[6, 17]

Fertility awareness methods rely on monitoring markers of fertility daily, including body temperature, changes in cervical secretions, changes in the cervix and timing of menstruation. Combining multiple markers is more effective than relying on a single marker.[17] Learning the technique can be difficult for some people and may be more complicated for those with irregular cycles.[17] People who have been using hormonal contraception should not rely on fertility markers until they have had a minimum of three regular menstrual cycles.[6]

Key practice points for the use of fertility awareness methods include:[17]

- They should not be used in patients who are taking potentially teratogenic medicines
- They require a high level of patient engagement and in typical use can have high failure rates depending on the method used
- Menstrual irregularities or recent use of hormonal contraception may make determining the fertile window difficult
- Patients wishing to avoid pregnancy should be advised to use other forms of contraception (e.g. barrier methods) unless they are using the sympto-thermal method
- All patients wanting to use a fertility awareness method should be instructed in this method by an expert, such as an educator from Natural Fertility New Zealand: **www.naturalfertility.co.nz**
- Caution patients that smartphone apps that aim to assist users with fertility awareness may be unreliable and should not replace education from an expert

Withdrawal method alone not advised for contraception

Withdrawal is not considered a natural family planning method and should not be used on its own for contraception or instead of condom use or abstinence in patients using fertility awareness methods to avoid pregnancy.[6]

Emergency contraception

Emergency contraception should be offered to patients who have had unprotected sex and do not wish to conceive:[6, 18]

- If no contraceptive method is being used, even if ovulation could be reasonably excluded based on their natural menstrual cycle
- If contraceptive failure occurs, e.g. condom breakage

Table 3: Effectiveness of fertility awareness methods.[6]

Fertility awareness method	Pregnancies per 100 females over first year of use	
	Correct and consistent	Typical
Calendar-based*	5	12
Symptoms-based:		
▪ Two-day method†	4	14
▪ Ovulation method†	3	23
▪ Sympto-thermal method**	< 1	2

* Involves tracking the menstrual cycle to identify the start and end of the fertile period

† Involves monitoring cervical secretions

** Combines basal body temperature, cervical secretions and other signs, e.g. breast tenderness, ovulatory pain

- If two or more active COC pills have been missed in the first week following the hormone-free interval*, or eight or more pills have been missed at other times or in a continuous cycle[19]
- If a POP is missed and intercourse occurs < 48 hours after restarting*
- If more than 14 weeks have passed since a DMPA injection
- In the seven-day period prior to expulsion of an IUC or discovering the threads of an IUC are missing

* Emergency contraception may also be required if patients have vomiting or diarrhoea lasting > 24 hours and have unprotected sex in the following two days if they are taking a POP or seven days if they are taking a COC: see "Oral contraceptives: selecting a pill " for more detail

Two forms of fully funded emergency contraception are available in New Zealand (Table 4). The copper IUD is recommended first-line as it is more effective and has a wider treatment window than the levonorgestrel tablet.[6] However, the tablet may be preferred by patients as it does not require an insertion procedure and is available at pharmacies without a prescription.

Table 4: Fully funded emergency contraceptives.[6, 20]

Emergency contraceptive	Pregnancy rate with correct use	To be used within
Copper IUD	Less than 1%	120 hours (5 days) of unprotected sexual intercourse ***OR*** Up to 5 days after expected date of ovulation
Levonorgestrel 1.5 mg tablet	1 – 3%	72 hours (3 days) of unprotected sexual intercourse*

* Evidence suggests that oral emergency contraceptives are not effective if taken after ovulation has occurred; they may be effective if taken more than 96 hours (four days) after unprotected intercourse, but are not approved for this timeframe

N.B. Emergency contraception providers must be familiar with the Contraception, Sterilisation and Abortion Act 1977 and the Abortion Legislation Act 2020, e.g. all people wishing to access emergency contraception must be able to do so within 48 hours of requesting it.[6] See: **https://www.legislation.govt.nz/act/public/1977/0112/latest/DLM17680.html** and **https://www.legislation.govt.nz/act/public/2020/0006/latest/LMS237550.html**

Contraception in transgender patients

Female to male transgender or gender diverse patients may require contraception, unless they have undergone surgical procedures which result in infertility. Gender affirming hormone treatment should not be relied on as a method of contraception as pregnancies can still occur in female to male transgender patients using testosterone; discussion with an endocrinologist involved in the patient's care is recommended.[14]

DMPA injections, progestogen implant, or copper or progestogen IUCs may be preferred options as they do not interfere with the process of masculinisation, however, IUC insertion may be more difficult than in other patients due to cervical atrophy associated with testosterone treatment.[15, 16] A short course of vaginal oestrogen may help with discomfort during insertion for these patients.[6] Contraceptive options more likely to result in amenorrhoea, such as DMPA or a progestogen IUC, may be preferred by some patients.[16]

For further information on contraception in transgender patients, see:

- The Faculty of Sexual and Reproductive Healthcare, UK: **www.fsrh.org/standards-and-guidance/documents/fsrh-ceu-statement-contraceptive-choices-and-sexual-health-for/**
- The New Zealand Formulary: **https://www.nzf.org.nz/nzf_70819**

The copper IUD should be considered as the first-line option whenever emergency contraception is needed, as it is the most effective method of emergency contraception and effectiveness is not altered by BMI or the use of enzyme-inducing medicines.[6] A copper IUD can be inserted either up to five days following unprotected sexual intercourse or up to five days after the expected date of ovulation. The copper IUD can be left in place for ongoing contraception, or removed once pregnancy is excluded, e.g. at the next menstrual period.[6]

Levonorgestrel emergency contraception may be less effective in patients weighing over 70 kg or with a BMI greater than 26 kg/m^2, with rates of pregnancy of up to 5% observed in some, but not all, studies.[21] For these patients, prescribing two 1.5 mg tablets is recommended if a copper IUD is not preferred or accessible, however, this is an unapproved dose.[6, 20] The effectiveness of levonorgestrel emergency contraception is also reduced in patients taking enzyme-inducing medicines; these people should be offered a copper IUD.

After use of levonorgestrel emergency contraception, patients should expect a change in menstruation, typically occurring earlier and heavier than expected.[18] Other adverse effects include headache, nausea, dizziness and, less commonly, vomiting.[20] If vomiting does occur and it is within two hours of administration, a repeat dose or use of a copper IUD is recommended.[20] There is limited evidence as to whether taking levonorgestrel emergency contraception with food, or prior administration of antiemetic medicines, can help reduce nausea.[22] However, these approaches are widely recommended and may benefit some patients. Some evidence suggests that if levonorgestrel emergency contraception fails there may be a higher risk of ectopic pregnancy, however, this has not been consistently observed in studies and the absolute rate is very low.[18]

Offer a pregnancy test 28 days after the last instance of unprotected sexual intercourse.[6]

Review contraception use and discussion options if the patient is not using regular contraception; recommend a more reliable method if adherence is an issue.[6]

Sterilisation methods

Discussion about sterilisation should cover issues such as life stage, future plans and relationship stability and ensure that both partners have an opportunity to express any questions or concerns. Information should be provided on other contraceptive options for the female partner that would offer a similar level of effectiveness, such as an implant or IUC; also consider if the patient has a history of menstrual difficulties that may reoccur when their current contraceptive is stopped, and menstruation resumes after sterilisation.

Sterilisation options include vasectomy and tubal ligation or occlusion. Tubal ligation or occlusion is carried out by laparoscopy or laparotomy and is typically performed under general anaesthesia. Vasectomy is typically performed with a local anaesthetic.

Some patients may be eligible for a sterilisation procedure performed in the public health system, however, most patients will need to seek private treatment. Vasectomies are also performed in some primary care clinics. Some patients may be eligible for assistance from Work and Income (WINZ) to assist with the cost of a vasectomy (see: **www.workandincome.govt.nz/eligibility/health-and-disability/vasectomies.html)**.

Sterilisation options are not intended to be reversed. Reversal procedures may be possible, depending on the technique used, but are more complex than the initial sterilisation procedure and may not be successful.

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