Contraception After Pregnancy: CEU Response to Public Consultation

The CEU would like to thank the individuals and representatives from our stakeholder organisations who have provided feedback.

Comments on recommendations and main body of text

Individual/ organisation	Location in guideline	Comments	CEU's Response
Marie Stopes International (MSI)	Grading of recommendation	Grading of recommendations - Not all readers will understand what the evidence level (e.g. 1++) refers to. Appendix 3 should be at top of page.	As per comment, reference to appendix for full explanation of the classification of evidence and grading of recommendations have been moved to the top of the section on Grading of Recommendation.
MSI	General point	A lot of these points are repeated unnecessarily. Should just keep in the points that are extra to the discussion points in the introduction Section 1 Contraception after pregnancy or sign post the reader to relevant sections	The Guideline was written with a digital format in mind; we anticipate users to potentially go directly to specific pregnancy outcomes [i.e. after childbirth, abortion, ectopic pregnancy/ miscarriage or gestational trophoblastic disease (GTD)] and therefore felt that it would be important that the general recommendations from the introductory section is also included in each pregnancy outcome section. This avoids these important recommendations being missed. Moreover, the availability of evidence may differ for the different pregnancy outcomes; relevant evidence is presented in the relevant section and recommendations graded as appropriate.
MSI	1.4.3 Effectiveness of contraceptive method	Should include [reference to CDC] as an appendix for easy reference.	A link to the Centres for Disease Control and Prevention (CDC) website has been included in text instead as a citation.
British Association for Sexual Health and HIV (BASHH)	1.4.4 Information giving and counselling	Several references to audio-visual material, and information in a variety of languages. Please could the document signpost to where this is available.	The CEU plans to develop a resource toolkit to accompany the Guideline. More information will be available in the resource toolkit.

MSI	1.4.4 Information giving and counselling	It would be useful to have some detailed practical guidance on providing counselling and contraception, including consent , in adolescents and young people , other marginalized groups	This will be considered when the CEU develops additional resources to accompany the Guideline.
MSI	1.4.4 Information giving and counselling 1.4.7 Record keeping and obtaining valid consent	There is no guidance on counselling and the information regarding consent is minimal. Adding some key points on this as well as reference for further guidance would be good. Clear guidance on which methods mandate a written consent and what critical information should be documented for each method while taking a 'valid consent' , would also be useful	Advice on clinical/ service management and standards is beyond the scope of this Guideline. The Guideline identified evidence around the effectiveness of contraceptive counselling provision on contraceptive uptake and signpost clinicians to refer to the FSRH Clinical Standards Service Standards on Obtaining Valid Consent in Sexual Health Services.
BASHH	1.4.5 Provision of contraception	"Services providing care to pregnant women should be able to offer all appropriate methods of contraception, including LARC, to women before they are discharged from the service." There are other passages within the document that suggest pathways of referral and bridging methods are acceptable. Please could there be clarification between the two recommendation.	It is hoped that the publication of this Guideline will encourage service leads to consider development of their services to enable contraception to be prioritised in the care of women who are pregnant and require contraceptive care. Further this recommendation is inspirational in term of noting what should be the highest standard of service delivery that service should aspire towards. It is acknowledged, however, that not all service will have capacity to do provide the full range of methods to women they care for. It is therefore important that recommendation are included which support services to be involved in a woman's contraceptive care by ensuring she receives temporary contraception and/or an appointment to other services to have her SRH needs met. The wording of the recommendation is clear in terms of the situation where the recommendation is appropriate.
BASHH	1.4.6 Discussing women's contraceptive needs	It may be helpful to include how to ask about sexual risk (e.g. STI) by signposting to sexual history documents e.g. BASHH. Or that support from a specialist STI service e.g. GUM/Sexual Health could be beneficial.	An additional sentence have been added in the section to signpost users to access the relevant guidelines from BASHH website.

MSI	1.4.6 Discussing women's contraceptive needs	A simplified checklist could be added here in a table format with two columns one for considerations and the other for further assessment	The CEU encourages clinicians to develop checklist tailored to their own services based on FSRH guidelines. The CEU plans to develop resources (e.g. flowcharts. pro-forma) to accompany this guideline in the future and will take note to include consideration of this.
BASHH	1.2.1 Prevention of unintended pregnancies: a national health priority 2.1.1 When should contraception after childbirth be discussed/ provided?	Both sections discuss a recent UK study giving references 4 and 47. The phrasing is similar and may cause some confusion about the abortion rate as the first section states 1 in 8, the second section 1 in 13.	Duplicate reference removed; both sections should be citing reference 4. Text in introduction (section 1.2) has been edited to reflect the same information that appears later in the document (section 2.1.1).
MSI	2.1.1 When should contraception after childbirth be discussed/ provided?	"Maternity services (including services providing antenatal, pregnancy, intrapartum and postpartum care) should be designed to meet the sexual and reproductive health (SRH) needs of all women who may require additional care and support." Currently this design is not apparent in the UK	It is hoped that the publication of this Guideline will encourage service leads to consider development of their services to enable contraception to be prioritised in the care of women who are pregnant and require contraceptive care. Further this recommendation is aspirational in term of noting what should be the highest standard of service delivery that service should aspire towards.
MSI	Section 2.1 *Should antenatal contraceptive counselling be provided?*	"Any contraceptive counselling (general or specialist) needs to be provided in conjunction with availability of method provision at delivery or shortly after." Currently there is a disconnect as AN midwives that work for busy maternity hospitals will not be able to provide the contraception method of choice	It is hoped that the publication of this Guideline prompt service providers to take a joint-up approach to provision of contraception such that the range of methods a woman is counselled on is follow-up with availability of provision.

MSI	Section 2.1 *When should contraception after childbirth be discussed/ provided?*	"Services should ensure that there are sufficient numbers of staff able to provide intrauterine contraception (IUC) or progestogen-only implants (IMP) so that women who are medically eligible and choose these methods can initiate them immediately after pregnancy." At present this is just not realistic so would be problematic if women were counselled to take these methods immediately after Childbirth. Currently midwives working in maternity care are not well trained especially in IUC or implants. Dr's do not have the time to provide this even if are trained in it.	It is hoped that the publication of this Guideline will encourage service leads to consider development of their services to enable contraception to be prioritised in the care of women who are pregnant and require contraceptive care. Further this recommendation is aspirational in term of noting what should be the highest standard of service delivery that service should aspire towards. It is hoped that the publication of this Guideline will help lead to greater support of improving nurses' and midwives' access to IUC and IMP insertion training.
MSI	Section 2.1.1 *Should antenatal contraceptive counselling be provided?*	For effective informed ANC counselling to be done in the UK more time is needed for each ANC appointment. The current set up of ANC does not allow for enough time to include this in a typical ANC appointment For this to be a realistic possibility major changes need to occur in NHS hospital. This current point in this Guideline (GL) is not realistic or in line with the current style of NHS hospitals which do not have trained contraceptive personnels or the time to provide a full contraception method service.	It is hoped that the publication of this Guideline will encourage service leads to consider development of their services to enable contraception to be prioritised in the care of women who attend ANC appointments.
MSI	2.1.2 When can contraception after childbirth be initiated?	This is the case in many London based boroughs and across England generally	The CEU agree that this is likely to be a widespread issue across the UK. It is hoped that the publication of this Guideline will encourage service leads to consider development of their services to enable quicker access to LARC in general practice as part of postpartum care.

MSI	2.1.4 Who should provide contraception to women after childbirth?	"Maternity services should ensure that there are sufficient numbers of staff able to provide IUC or IMP so that women who are medically eligible and choose these methods can initiate them immediately after childbirth." This is a good recommendation but is not currently realistic, very few maternity ward midwives are qualified to do this and midwives on post natal ward will not have time whilst also caring for up to 9 women and babies in the immediate PN period. Also very few women are counseled sufficiently in the AN period to know what method they want immediately after birth. For this to work there should be additional staff dedicated to PPFP on each shift.	It is hoped that the publication of this Guideline will encourage maternity service leads to consider development of their services to enable contraception to be prioritised in the care of women who are pregnant and require contraceptive care. Further this recommendation is aspirational in term of noting what should be the highest standard of service delivery that service should aspire towards.
MSI	2.1.4 Who should provide contraception to women after childbirth?	“Ideally, referrals to specialist contraceptive services (e.g. community SRH) could be made antenatally, if required, so that a plan for contraception can be made before delivery and contraception can be initiated as soon as possible after childbirth.” Referral will need to be made in many cases as many maternity services will not have the appropriately trained clinicians.	It is therefore important that we make recommendations to highlight the need for maternity services to have agreed pathways of care to appropriate local services if women's SRH needs are not able to be met in the maternity services.
MSI	2.1.4 Who should provide contraception to women after childbirth?	“Women who choose to have IUC or sterilisation should have their decision to have the method clearly documented before they are admitted for delivery.” This is not currently done and would need to have widespread sensitization of all clinicians for this to be commenced and to be done routinely	It is therefore important that the guideline include recommendation "Clinicians should clearly document the discussion and provision of contraception after childbirth. Valid consent must be obtained before providing women with their chosen method." It is hoped that this will make this routine as part of a woman’s contraceptive counselling.

MSI	2.2.1 Which methods of contraception are safe to use after childbirth?	See MSI job tool, similar could be developed based on UKMEC?	Thank you for sharing your resource - this will be a helpful visual aid that the CEU will consider developing as a resource to accompany the Guideline.
BASHH	2.2.3 Is emergency contraception (EC) safe to use after childbirth?	Because of formatting the section about breast feeding and UPA-EC is on a different page and could be easily missed if the document was “searched” and only the first two recommendation boxes were read. Is it possible to make this explicit next to the initial text?	All efforts are made to ensure that the layout of the guideline is easy to navigate and follow. It is fair to assume that clinicians, once locating the relevant of text in the guideline, will be likely to read all relevant text even if it is over multiple pages.
BASHH	2.3.1 Does initiation of hormonal contraceptives affect breastfeeding or infant outcomes?	[Last] Paragraph starts “women should be informed about the full range of safe alternative…" Should this be a recommendation?	This advice is already covered sufficiently in preceeding sections (e.g. 2.2.1)
MSI	2.3.2 Can women who breastfeed effectively use lactational amenorrhoea method (LAM) as contraception?	Should clearly state the 3 requirements here for LAM to be effective	This is clearly stated in the recommendation "Women may be advised that if they are less than six months postpartum, amenorrhoeic and fully breastfeeding, that lactational amenorrhoea method (LAM) is a highly effective method of contraception."
BASHH	2.4.1 Intrauterine contraception (IUC)	Please could the offer of an STI screen (Chlamydia/Gonorrhoea) at the time of fitting IUC be mentioned – as there may have been a new risk since conception.	Suggested advice added with reference to the FSRH Guideline Intrauterine Contraception.
MSI	2.4.2 Progestogen-only implant (IMP)	“IMP can be safely started at any time after childbirth including immediately or at any time before 21 days,” This point needs clarifying, clinicians might feel this method is then not allowed due to lack of license	The recommendation relating to use of the methods immediately after childbirth being outside the terms of the product licence have been removed to avoid the potential issue highlighted.

MSI	2.4.3 Progestogen-only injectable (POI)	MSI follows the 2015 WHO MEC criteria for progesterone injectable so our GL's as released this year in January are to wait 6 weeks before administering this	This Guideline is intended to be used by Clinicians and Services based in the UK and therefore refers to UK-based guidelines (e.g. UKMEC 2016).
MSI	2.4.5 Combined hormonal contraception (CHC)	"The use of CHC in women who breastfeed is outside the terms of the product licence." This point needs clarifying, clinicians might feel this method is then not allowed due to lack of license	The recommendation relating to use of the methods immediately after childbirth being outside the terms of the product licence has been removed to avoid the potential issue highlighted.
BASHH	2.4.7 Barrier methods	Please could the document specify about the use of Caya within the section about diaphragms.	The guideline does refer to/ promote use of individual/ specific products. The text and recommendations is relevant to Caya.
Individual/ FSRH member	3.2.3 Is additional contraception required after initiation of a method after abortion? 4.2.3 Is additional contraception required after initiation of a method after ectopic pregnancy or miscarriage?	Previous guidance suggested that additional precautions were not required when starting contraception < 5 days after abortion – why the move to 7 days? Is there new evidence to suggest that ovulation is delayed until at least 14 days after TOP and therefore that contraception may started as late as day 7 without the need for additional precautions? "...ovulation has been reported to recommence after seven days after medical abortion. Seven days is considered a sufficient timeframe for adequate clearance of mifepristone and for progestogen-only contraception to be effective." If this is true then how can we say that we can start contraception as late as by day 7 without the need for additional precautions As per my comments above re page 56 – this used to read as <5 days – why the change to 7.	There is a lack of robust evidence with regards to when ovulation returns after abortion. The suggested revision (from 5 to 7 days) was based on expert opinion and re-examination of existing literature. Following up on the comments made about this proposed revision, GDG discussed and agreed that given there is no new evidence to support a substantive change in practice as highlighted by the reviewer, hence the advice will not be revised (i.e. additional precaution not require when starting contraception < 5 days after abortion).

Family Planning Association (FPA)	3.3.2 Progestogen-only contraception	Although the lack of evidence is recognised, it is unclear whether there is a recommendation on the initiation of DMPA following early medical abortion. It would be helpful if this were clarified for professionals.	Recommendation relating to this has been added.
Individual/ FSRH member	4.1.2 How long should a woman wait before trying to conceive again after ectopic pregnancy or miscarriage?	Women who wish to conceive after ectopic pregnancy or miscarriage can be advised there is no need to delay as pregnancy outcomes after miscarriage are more favourable when conception occurs within six months of miscarriage compared with after six months. This directly contradicts with the next recommendation: "Women who have been treated with methotrexate should be advised that effective contraception is recommended during and for at least three months after treatment in view of the teratogenic effects of this medication."	We have reworded the recommendation such that it now only refers to miscarriage.
FPA	4.3.1 Does hormonal contraception have an effect on bleeding after ectopic pregnancy or miscarriage?	“Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started seven days or more after miscarriage or treatment for ectopic pregnancy. Additional contraceptive precaution is not required if contraception is initiated immediately or within seven days of miscarriage or treatment for ectopic pregnancy.” This does not answer the question, but repeats the information on page 18, paragraph 4. Pages 45 and 46 do provide this information later on in the guidance and this should be moved to page 18.	The recommendation was added in error and has now been removed. Evidence on bleeding patterns associated with use of different methods after childbirth cannot be extrapolated to abortion/ miscarriage.

BASHH	Other	Please could consideration be given to a move toward non medicalisation of pregnancy and midwifery lead care including home birth. Immediate placement of IUC could be difficult in some units.	It is anticipated that the publication of this guideline will facilitate the development of improved provision of contraceptive care, by midwives and other HCP, to women in different care settings The guideline encourages development of care pathways for referring women on to services where they can be provided with their chosen method of contraception to use after giving birth.
MSI	Other	Updates to previously available information can be highlighted in a separate chapter or under a separate heading Updates that show how this guidance differs from previous guidelines. In particular the UK MEC differs from WHO and I think this should be made clear, as if this is to be used globally this will confuse many practitioners with the differences.	This is a new Guideline and therefore does not include a section on "changes from previous Guideline". This Guideline is intended to be used by Clinicians and Services based in the UK. While it is acknowledged that FSRH Clinical Guidelines is widely used by a Global audience, the content and recommendations in the Guideline is focused on the UK context and refers to UK-based guidelines (e.g. UKMEC 2016).
MSI	Other	A section on contraception after pregnancy in humanitarian crisis settings e.g. war, natural disasters will be useful as this document is likely to be used globally	While it will be useful to consider the circumstances suggested (e.g. humanitarian crisis), this is out of the remit of the Guideline. This guideline is written for the intended use by UK clinicians involved in advising and caring for women during and after pregnancy in UK Clinical settings and refers to UK-based guidelines (e.g. UKMEC 2016).
MSI	Other	It would be useful to have some detailed practical guidance on how administration of methods in busy maternity wards should be managed. At present this Guideline does not acknowledge the huge work burden maternity wards are already under in the UK. Providing PPFP is not possible with the current number of staff who lack PPFP training. Practical guidance on number of personnel needed and length of training needed would be hugely beneficial and make following this guideline a possibility.	Advise on clinical management, workload and training is beyond the remit of this guidelines. It is hoped that the publication of this Guideline will provide a strong evidence-based approach to encourage better resourcing of services to provide the highest possible quality of care to women as indicated in many of the recommendations in this Guideline.

Other comments

Overall usefulness

We are grateful for the very kind comments from reviewers that recognises the value of this Guideline in informing clinical practice and also in providing a strong case to commissioners regarding he need for additional funding to ensure that women who are pregnant and have unmet contraceptive needs receive the highest possible of care in the UK.

MSI	This is very useful as it has all the topical information in one guidance document
FPA	Overall, a really useful document, particularly as it sets out the comprehensive offer of all methods to women during abortion assessments and postnatally. As well as its usefulness for daily practice, it will be helpful for services when presenting their case for funding to commissioners.
MSI	I think this is useful in terms of having all the relevant issues in one document. I think to ease the everyday use of it and to make it more practice friendly, job aides could be added to the appendices. These should summarise the methods that could be used in each group of women.
BASHH	I do not think clinicians will use this as a "go to" document for advice about contraception provision for certain groups, and they would be more likely to use UKMEC or method specific guidance. The document is well placed for ensuring the wider variety of services delivering contraception after pregnancy meet the same recommendations.
BROOK	Really useful document – I think clinicians from a variety of specialities will find it useful – however I wonder if the title may be interpretated to mean just viable pregnancy that has ended in a live birth as opposed to all the other catergories – maybe the title of the guidance should reflect this
Individual/ FSRH member	Very good

Guideline layout, writing style and length

We fully acknowledge that the Guideline is lengthy. The guideline was written with a digital format in mind; we anticipate users to potentially go directly to specific pregnancy outcomes (i.e. after childbirth, abortion, ectopic pregnancy/ miscarriage or GTD) and therefore felt that it would be important that the general recommendations from the introductory section is also included in each pregnancy outcome section. This avoids these important recommendations being missed. Where possible, to avoid duplication of text, readers have been signposted to the relevant sections in the introduction or other sections of the Guideline for further details.

MSI (Reviewer 1)	▶ Fairly easy to read. Sometimes the information regarding all the research goes into too much detail, detracting from making this document easy for everyday practice. ▶ Good structure and chapter headings. At times there is a lot of information that is very repetitive, especially in the introduction. Readers should be signposted to the relevant section and only issues that differ from the previous section should be included. ▶ Too long. This length is not practice friendly. If the repeated sections at the beginning were not included this could cut down the length.
MSI (Reviewer 2)	▶ Moderately easy to read ▶ Good structure with recommendations highlighted at the beginning and important information in boxes and tables in the body of the document ▶ Slightly long

FPA	▶ The document is well written, clear and simple to understand. ▶ The question and answer format makes it easy to follow. However, some of the questions are not directly answered. ▶ The well-structured format means that the document, although long, is easy to navigate without compromise on detail.
BASHH	▶ There is a degree of repetition if all users are anticipated to meet the identified recommendations within the introduction and then any appropriate additional chapters. Perhaps there could be a short statement suggesting the "all services" meet the recommendations within the introduction, and this may reduce the repetition and length. ▶ For services which use a RAG rating to demonstrate compliance with recommendations, repetition could lead to errors in monitoring compliance. ▶ Systematic ad easy to follow ▶ It is a very lengthy document if intended to be read in its entirety.
BROOK	▶ Good – clear ▶ Well laid-out ▶ Only criticism – the document is very long – I appreciate that there is a lot of information to include
Individual/ FSRH member	▶ Excellent

FSRH guideline Contraception After Pregnancy can be accessed here.

All comments on the FSRH Contraception After Pregnancy can be sent directly to the CEU via the FSRH website (www.fsrh.org).

The Clinical Effectiveness Unit (CEU) was formed to support the Clinical Effectiveness Committee of the Faculty of Sexual and Reproductive Healthcare (FSRH), the largest UK professional membership organisation working at the heart of sexual and reproductive healthcare. The CEU promotes evidence based clinical practice and it is fully funded by the FSRH through membership fees. It is based in Edinburgh and it provides a member's enquiry service, evidence based guidance, new SRH product reviews and clinical audit/research. Find out more here.