

Provision of contraception during the COVID-19 pandemic: FSRH update and overview statement

Introduction

FSRH considers that at all times during and beyond the COVID-19 pandemic, provision of effective contraception including LARC, management of LARC complications, emergency contraception and abortion care remains essential. See [Ensuring provision of Sexual and Reproductive Healthcare \(SRH\) services during the second COVID-19 wave and beyond in the UK.](#)

The prevalence of COVID-19 is changing over time and is not the same across the UK. During the pandemic, unnecessary face-to-face contact should always be avoided to minimise risk of COVID-19 transmission. Providers should adapt their contraceptive services depending on workforce capacity along with local COVID-19 prevalence and the resulting risk transmission associated with face-to-face procedures.

All services should ensure that there is clear, up-to-date signposting for patients requiring contraception care including what is being provided, how this can be accessed, and pharmacy/online contraception provision.

Services should ensure that those individuals at highest risk of unplanned pregnancy can access the most effective contraceptive methods. This should include young people and individuals attending abortion and maternity services. See [FSRH, RCOG & RCM statement provision of postpartum contraception during COVID-19.](#)

Local pathways for urgent referral from organisations supporting vulnerable groups (for example social services, sexual assault referral centres, black, Asian and minority ethnic groups and young people's outreach) must be maintained, using translation services where necessary. Safeguarding individuals at risk of violent crime using a 'safe' word or phrase is to be encouraged.

1. Avoiding unnecessary face-to-face contact for contraceptive provision

It is recommended that much of the contraceptive consultation process is achieved remotely. This includes assessment of medical eligibility, support with choice of contraceptive method, information-giving prior to any procedure and provision of essential information to support ongoing use. Patient information to support contraceptive choice, effective use of short-acting contraceptive methods and long-acting reversible contraception (LARC) aftercare should be made available in a choice of formats e.g. texting links to leaflets, websites.

Providers should check FSRH guidance to ensure that only *necessary* examinations/ investigations are done. For example, *routine* STI testing is not a requirement prior to

insertion of intrauterine contraception *and routine* thread checks by healthcare professionals are not required - users should be encouraged to check their own threads.

2. Maintaining essential contraceptive services at all times during the COVID-19 Pandemic

The provision of effective contraception remains essential during the COVID-19 pandemic irrespective of the COVID-19 restrictions in place. These essential services include:

- Emergency contraception (oral and the copper intrauterine device - IUD)
- Provision of new contraceptive methods and support for ongoing contraception, including Long-Acting Reversible Contraception (LARCs)
- Contraception provision for vulnerable groups
- Management of complications with existing contraception including LARC
- Post-pregnancy contraception including LARC

[FSRH guidance for the provision of all other essential SRH services and the prioritisation of patients during the COVID-19 pandemic can be found here.](#)

The following FSRH recommendations support contraceptive provision at any time during the COVID-19 pandemic:

Emergency contraception

FSRH recommends that remote assessment for emergency contraception (EC) is prioritised so that EC can be offered as soon as possible after unprotected intercourse (UPI) to maximise effectiveness.

At all times during the COVID-19 pandemic, insertion of an IUD for EC should continue to be offered first line to qualifying individuals. If there is a delay prior to Cu-IUD insertion, immediate oral EC should be given in addition.

For individuals who do not meet the criteria for emergency IUD insertion, or who decline this option, remote assessment should be undertaken to identify the most appropriate oral emergency contraception. They should receive both oral EC and a 3-month supply of desogestrel POP plus clear written/digital advice about additional contraceptive precautions, when to start the POP, and follow up pregnancy testing.

Postal delivery of oral EC should be avoided (to avoid delay) and either electronic prescribing or a 'click and collect' system encouraged. If POP is not acceptable, CHC may be quick started by eligible individuals in this situation.

Nexplanon®

- ▶ New Nexplanon users should start or quick start according to existing FSRH guidance. See [FSRH Clinical Guideline Progestogen-only Implants](#).
- ▶ **Extended use of Nexplanon.** Risk of pregnancy during the fourth year of Nexplanon use appears to be very low, although evidence is limited. See [FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID restrictions](#).

To avoid unnecessary risk of coronavirus transmission, replacement can be deferred for up to a year after expiry. Women should be advised that contraceptive effectiveness is not guaranteed during the fourth year and they may wish to use additional contraceptive precautions (e.g. condoms or POP) until the implant can be replaced.

- ▶ *During the COVID-19 pandemic, when replacing* a Nexplanon that has been *in situ* for:*

 - ▶ **Up to 3 years** - there is no requirement for additional contraceptive precaution or pregnancy testing prior to or after replacement
 - ▶ **3 to 4 years** – there is no requirement for additional contraceptive precaution or pregnancy testing prior to replacement. Condoms should be advised for the first seven days after replacement and a urinary pregnancy test recommended at 21 days after the last UPSI.
 - ▶ **Over 4 years** – so long as pregnancy test is negative, replacement can proceed; condoms should be advised for the first seven days after replacement and a urinary pregnancy test taken at 21 days after the last UPSI.

(*removal followed immediately by insertion of the same device type)

- ▶ *During the COVID-19 pandemic, decisions about whether to undertake **deep or difficult implant removals** that require longer contact time with a healthcare professional should be made at a local level after a risk assessment. The existing implant can safely remain *in situ* in the short term. If the implant has expired and contraception is required, any effective contraceptive method can be started with the expired implant still in situ. If the individual opts for another Nexplanon, the new implant should be inserted in the other arm.*

Levonorgestrel-releasing intrauterine systems (LNG-IUS) and copper intrauterine devices (Cu-IUD)

- ▶ **New LNG-IUS/Cu-IUD** users should have existing pregnancy or risk of pregnancy excluded prior to insertion (unless Cu-IUD is fitted for emergency contraception). See [FSRH Clinical Guideline Intrauterine Contraception](#). Bridging contraception can be provided where pregnancy cannot be excluded.
- ▶ **52mg LNG-IUS (Mirena® or Levosert®)**
Extended use of Mirena and Levosert
Risk of pregnancy during the 6th year of use of a 52mg LNG-IUS appears to be very low, but evidence is limited. See [FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID restrictions](#).

To avoid unnecessary risk of coronavirus transmission, Mirena or Levosert replacement may be delayed for up to a year after expiry. Users should be advised

that contraceptive effectiveness is not guaranteed during the sixth year and that they may wish to use additional contraceptive precautions (e.g. condoms or POP) until the IUS can be replaced.

It is standard practice that individuals aged over 45 years at the time of 52mg LNG-IUS fitting can rely on the device **FOR CONTRACEPTION** until age 55 years.¹ Note that if a 52mg LNG-IUS is used for endometrial protection as part of HRT it must be either changed at 5 years or a combined HRT preparation commenced.

▶ **13.5mg and 19.5mg LNG-IUS (Jaydess® and Kyleena®)**

Additional contraceptive precautions are required after 3 years for Jaydess and 5 years for Kyleena.

▶ **Cu-IUD**

Individuals due for replacement of a banded Cu-IUD with a 10 year licence can be advised that the risk of pregnancy up to 12 years of use is likely to be low^{2,3}; contraception cannot, however, be guaranteed and individuals may wish to use additional contraceptive precautions until it is considered safe to attend for replacement. Additional contraceptive precautions are required after the licensed 5 years for all 5-year Cu-IUDs.

During the COVID-19 pandemic, when replacing*:

- ▶ Mirena, Levosert or Kyleena *in situ* for up to 5 years, Jaydess *in situ* for up to 3 years or a Cu-IUD within its licence – pregnancy testing is not required, no additional contraceptive precautions are required after replacement.
- ▶ Mirena or Levosert *in situ* for up to 7 years or 10-year Cu-IUD that has been *in situ* for up to 12 years – so long as pregnancy test is negative, replacement can proceed, with advice to use condoms for 7 days and to take a follow up urinary pregnancy test at 21 days after the last UPSI.
- ▶ Mirena or Levosert *in situ* for over 7 years, Kyleena *in situ* for over 5 years, Jaydess *in situ* for over 3 years, 5 year Cu-IUD *in situ* for over 5 years or 10 year Cu-IUD *in situ* for over 12 years – a negative pregnancy test after 3 weeks of additional contraceptive precautions is required prior to replacement; condoms should be advised for 7 days after replacement of Mirena/Levosert/Kyleena/Jaydess.

(*removal followed immediately by insertion of the same device type)

Depot medroxyprogesterone acetate (Depo Provera® and Sayana Press®)

- ▶ DMPA (IM or subcutaneous) can be repeated at 14-week intervals without requirement for additional contraceptive precautions or pregnancy testing.
- ▶ If the interval is >14 weeks but there has been no UPSI since 14 weeks, DMPA may be given, with advice to use condoms for 7 days.

- ▶ If the interval is >14 weeks AND there has been UPSI since 14 weeks, IF a high sensitivity urinary pregnancy test is negative, DMPA may be given, with advice to use condoms for 7 days. A follow up urinary pregnancy test MUST be taken at 21 days after the last UPSI.
- ▶ Individuals may be taught to self-administer Sayana Press. Since the start of the COVID-19 pandemic, some services have successfully designed, tested and delivered teaching via video link. Once the user is trained, a one-year supply can be given, so that contact with healthcare professionals for repeat injections is avoided.

Combined hormonal contraception

During the COVID-19 pandemic, remote assessment of past medical and family history plus associated health risks can be undertaken as per FSRH guidance. See [FSRH Clinical Guideline Combined Hormonal Contraception](#).

An accurate blood pressure and BMI measurement should have been documented within the past year and can be self-reported during COVID-19 restrictions. A one-year supply of combined oral contraception, Evra or SyreniRing may be prescribed for eligible individuals. Note that Nuvaring can only be dispensed three months at a time.

Progestogen-only pill

The desogestrel POP is ideal for remote provision as no physical examination (e.g. blood pressure) is required. A one year supply may be prescribed for eligible individuals. It is hoped that the desogestrel POP may be bought from pharmacies without prescription in the near future.

3. Provision of contraception at times of high local COVID-19 prevalence (when risk of COVID-19 transmission may outweigh the benefit of non-urgent face-to-face contact)

At times of highest local COVID-19 prevalence, when there is no service capacity to provide face-to-face consultations, individuals requiring contraception should be offered an effective contraceptive method that does not require a face-to-face procedure. Clear supporting information must be provided. If this is not their contraceptive method of choice, individuals should be referred to services that have capacity to offer face-to-face consultations, or offered a bridging method to provide effective contraception until COVID-19 transmission risk allows commencement of their chosen method.

A desogestrel progestogen-only pill (POP) is an ideal bridging method. It can be used safely by most individuals and is over 99% effective for contraception if taken correctly. Note that the effectiveness of POP may be reduced if an individual is taking an enzyme-inducing drug. Assessment, information-giving and prescription can take place remotely (no physical examination is required). It is hoped that in the near future the desogestrel POP can be bought from pharmacies without the need for a prescription.

If the desogestrel POP is not suitable or not acceptable, alternative options for providing effective contraception without a face-to-face procedure are:

- ▶ **Combined hormonal contraception (CHC).** Prescription of CHC requires assessment of medical eligibility, blood pressure and BMI. This may be achieved

remotely, with self-reported BP and BMI (existing CHC users with an accurate blood pressure and BMI measurement documented within the past year do not need these repeated during lockdown). A 12-month supply of combined oral contraception, Evra® or SyreniRing® may be provided remotely to eligible individuals. Note that other brands of combined vaginal ring (e.g. Nuvaring®) can only be dispensed three months at a time.

- ▶ **Sayana Press®.** Existing self-administering users of Sayana Press may be assessed remotely and provided with a further prescription for Sayana Press if eligible. New Sayana Press users may be taught to self-administer via video consultation.
- ▶ **Extended use of LARC methods.** Existing Nexplanon® users and users of Mirena®, Levosert® and copper IUDs with 10 year licence may consider extending use (see below).

In-clinic administration of depot medroxyprogesterone acetate (DMPA) or insertion of Nexplanon or intrauterine contraception may be considered in individual cases, for example if there are about concerns adherence, individual intolerance of oral contraceptives or use of teratogens making longer-acting reversible contraception the only suitable option. DMPA and intrauterine contraception should be considered for individuals taking enzyme-inducing drugs.

Emergency contraception

Insertion of an IUD for EC should continue to be offered first line to qualifying individuals at all times during the COVID-19 pandemic. If there is a delay prior to Cu-IUD insertion, immediate oral EC should be given in addition. See Section 2 for further details.

4. Provision of contraception at times of lower local COVID-19 prevalence (when benefit of face-to-face contact for non-urgent contraceptive procedures may outweigh COVID-19 transmission risk)

In addition to the services described in sections 2 and 3, when local COVID-19 prevalence is lower, services can reinstate provision of non-urgent contraception that requires a face-to-face procedure or blood pressure measurement. Contraceptive choice consultation, assessment of medical eligibility and information-giving should continue to be done remotely prior to attendance for the procedure.

LARC methods offer the most effective contraception and should be prioritised. This includes quick-start of Nexplanon after oral emergency contraception.

5. Attendance for face-to-face contraceptive procedures: practicalities

Current local protocols for minimising risk of transmission of COVID-19 must always be followed when undertaking a contraceptive procedure. FSRH also makes the following recommendations (see [FSRH guidance on planning for LARC Procedures following the](#)

[publication of the NICE COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services](#):

- ▶ As much of the consultation process as possible should be done remotely prior to attendance (see Section 1).
- ▶ Individuals are **not** required to self-isolate or undertake COVID-19 testing prior to attending for contraceptive procedures including those undertaken at hospital-based contraceptive clinics. They should, however, be reminded of the importance of social-distancing and hand-hygiene measures to reduce transmission risk prior to their procedure date. They should be advised not to attend if they are diagnosed with COVID-19, develop COVID-19 symptoms or are required to self isolate in the ten days prior to the clinic appointment. All individuals must be assessed for symptoms of COVID-19 on the day of their procedure either by phone, email or prior to entry to the building.
- ▶ By staggering appointment times, minimising the time that patients are waiting in the building and managing patient footfall and flow (ideally there should be separate entrance and exit), patient overlap can be kept to a minimum.
- ▶ Contact at reception should be minimised. The largest available clinic room with good ventilation should be used. Clinic rooms should be kept clutter-free to facilitate cleaning and should be set up for the procedure prior to the patient entering. Appropriate PPE should be used, according to local policy. A chaperone should be offered in line with guidance, while maintaining a two metre distance between them and the patient. Where this cannot be maintained PPE should be worn by the chaperone. Conversation should be minimised, especially when within two metres.

References

1. Faculty of Sexual and Reproductive Healthcare. *Clinical Guideline Contraception for women aged over 40 years*. August 2017, amended September 2019. Available online [here](#) (accessed 05/10/2020)
2. Wu JP, Pickle S. Extended use of the intrauterine device: a literature review and recommendations for clinical practice. *Contraception*. 2014;89:495-503.
3. Ti AJ, Roe AH, Whitehouse KC, Smith RA, Gaffield ME and Curtis KM. Effectiveness and safety of extending intrauterine device duration: a systematic review. *American Journal of Obstetrics and Gynecology* 2020 Jan 15.

About us

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of SRH care.

For our latest COVID-19 resources, visit: www.fsrh.org/covid19.