FSRH The Faculty of Sexual & Reproductive Healthcare

FSRH Guideline Executive Summary

Contraception After Pregnancy

January 2017 | FSRH

RCGP Royal College of General Practitioners

THE ROYAL COLLEGE OF MIDWIVES

Royal College of Nursing

Royal College of Obstetricians & Gynaecologists

Faculty of Sexual & Reproductive Healthcare (FSRH) provided funding to the Clinical Effectiveness Unit (of the FSRH) to assist them in the production of this guideline, *Contraception After Pregnancy* (2017).

Published by the Faculty of Sexual & Reproductive Healthcare.
Registered in England No. 2804213 and Registered Charity No. 1019969

Contraception After Pregnancy first published in January 2017.

Published in the UK

NICE has accredited the process used by the Faculty of Sexual & Reproductive Healthcare to produce this guideline. More information on accreditation can be viewed at www.nice.org.uk/accreditation.

Grading of Recommendations

The evidence used in this guideline was graded using the scheme below and the recommendations formulated in a similar fashion with a standardised grading scheme.

Classification of evidence levels		Grades of recommendations	
1++	**High quality systematic reviews or meta-analysis of randomised controlled trials (RCTs) or RCTs with a very low risk of bias.**	A	**At least one systematic review, meta-analysis or RCT rated as 1++, and directly applicable to the target population; *or* A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.**
1+	**Well conducted systematic reviews or meta-analysis of RCTs or RCTs with a low risk of bias.**		
1-	**Systematic reviews or meta-analysis of RCTs or RCTs with a high risk of bias.**		
2++	**High-quality systematic reviews of case-control or cohort studies or high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.**	B	**A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results; *or* Extrapolated evidence from studies rated as 1++ or 1+.**
2+	**Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.**	C	**A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; *or* Extrapolated evidence from studies rated as 2++.**
2-	**Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.**	D	**Evidence level 3 or 4; *or* Extrapolated evidence from studies rated as 2+.**
3	**Non-analytical studies (e.g. case report, case series).**	✓	**Good Practice Points based on the clinical experience of the guideline development group.***
4	**Expert opinions.**		

*On the occasion when the guideline development group find there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

FSRH Guideline (January 2017)

Contraception After Pregnancy

(Revision due by January 2022)

Purpose and scope

This new guideline brings together evidence and expert opinion on the provision of contraception to women after childbirth, abortion, ectopic pregnancy, miscarriage or gestational trophoblastic disease (GTD). It replaces the 2009 Faculty of Sexual & Reproductive Healthcare (FSRH) clinical guideline *Postnatal Sexual and Reproductive Health*.

This guideline is for use by UK clinicians including sexual and reproductive health (SRH) clinicians, obstetricians, gynaecologists, midwives, general practitioners (GPs), nurses, and health visitors involved in caring for women during and after pregnancy. Typical settings where this guideline would be relevant include maternity services, abortion services, early pregnancy assessment units, general gynaecology services, integrated sexual health clinics and general practice.

It is hoped that this guideline will be implemented across all relevant services in the UK and will promote a more collaborative and consistent approach to providing the highest standard of contraceptive care to all women after pregnancy.

Key considerations of this guideline include:

- When should contraception be discussed/provided?
- Who should provide contraception?
- Which contraceptive methods are most effective?
- Which methods of contraception are safe to use?
- Are there method-specific issues to consider?
- Are there other SRH issues to consider?

This guideline was developed by the FSRH and endorsed by the Royal College of General Practitioners (RCGP), Royal College of Midwives (RCM), Royal College of Nursing (RCN) and Royal College of Obstetricians and Gynaecologists (RCOG).

Identification and assessment of the evidence

This guideline was developed in accordance with standard methodology for developing FSRH clinical guidelines. The recommendations made within this document are based on the best available evidence and the consensus opinion of experts and the guideline development group (GDG).

The recommendations included should be used to guide clinical practice but are not intended to serve alone as a standard of medical care or to replace clinical judgement in the management of individual cases.

Executive Summary of Recommendations

Introduction: Contraception After Pregnancy

Discussion and provision of contraception after pregnancy

What methods of contraception are available in the UK?

✓	Clinicians should refer to the relevant current FSRH guidelines, including the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), when making a clinical judgement on safe and appropriate methods of contraception for a woman after pregnancy.

Effectiveness of contraceptive method

✓	Women should be informed during pregnancy about the effectiveness of different contraceptives, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after pregnancy.

Information giving and counselling

✓	All clinicians involved in the care of pregnant women should provide the opportunity to discuss contraception.
✓	Whenever contraceptive counselling is provided, care should be taken to ensure women do not feel under pressure to choose a method of contraception.
D	Clinicians should adopt a person-centred approach when providing contraceptive counselling.
✓	Clinicians who are giving advice to women about contraception after pregnancy should ensure that this information is timely, up-to-date and accurate.
✓	Comprehensive, unbiased and accurate information on contraceptive methods after pregnancy should be made available in different languages and formats including audio-visual.

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.
✓	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 choose these methods and are medically eligible can initiate them immediately after pregnancy.
✓	Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated.

Discussing women's contraceptive needs

✓	Clinicians should discuss with the woman any medical or social factors that may be relevant to her choice of contraceptive method after pregnancy.

Record keeping and obtaining valid consent

D	Clinicians should clearly document the discussion and provision of contraception. Valid consent must be obtained before providing women with their chosen method.

Provision of continuing care and support

✓	Clinicians should facilitate opportunities to discuss issues with the woman in private without a partner, friend or relative being present.
D	Clinicians should know how to enquire about gender-based violence (GBV) and how to support women affected by GBV and abuse, including providing access to information and referral to specialist support.
✓	Services involved in the care of pregnant women should have agreed pathways of care to local community sexual and reproductive health (SRH) services for women with complex medical conditions or needs which may require specialist contraceptive advice.
✓	Services should have agreed pathways of care to local services for women who may require additional non-medical care and support.

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.
D	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.

✓	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.
D	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.

When can contraception after childbirth be initiated?

D	The choice of contraceptive method should be initiated by 21 days after childbirth.
D	A woman's chosen method of contraception can be initiated immediately after childbirth if desired and she is medically eligible.
C	Women should be advised that intrauterine contraception (IUC) and progestogen-only implant (IMP) can be inserted immediately after delivery.
B	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.
B	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.

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

B	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.

Who should provide contraception to women after childbirth?

✓	Appropriately trained clinicians including sexual and reproductive health (SRH) doctors and nurses, obstetricians, midwives, nurses, general practitioners (GPs) and health visitors should be able to provide women with contraception after childbirth.
✓	Maternity services should be able to provide IUC and progestogen-only methods, including IMP, injectable (POI) or pill (POP), to women before they are discharged from the service after childbirth.
✓	Maternity services should ensure that there are sufficient numbers of staff able to provide IUC or IMP so that women who choose these methods and are medically eligible can initiate them immediately after childbirth.
✓	Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated.
✓	Maternity services should have agreed pathways of care to local specialist contraceptive services (e.g. community SRH services) for women with complex medical conditions or needs which may require specialist contraceptive advice.
✓	Maternity services should have agreed pathways of care to local services for women who may require additional non-medical care and support.

Record keeping and obtaining valid consent

D	Clinicians should clearly document the discussion and provision of contraception after childbirth. Valid consent must be obtained before providing women with their chosen method.

Medical eligibility

Which methods of contraception are safe to use after childbirth?

C	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).

Can women who develop medical problems during pregnancy safely use contraception after childbirth?

D	Clinicians should discuss with the woman any personal characteristics or existing medical conditions, including those that have developed during pregnancy, which may affect her medical eligibility for contraceptive use.

Is emergency contraception (EC) safe to use after childbirth?

✓	Emergency contraception (EC) is indicated for women who have had unprotected sexual intercourse (UPSI) from 21 days after childbirth, but is not required before this.

✓	Oral EC levonorgestrel 1.5 mg (LNG-EC) and ulipristal acetate 30 mg (UPA-EC) are safe to use from 21 days after childbirth. The copper intrauterine device (Cu-IUD) is safe to use for EC from 28 days after childbirth.
C	Women who breastfeed should be informed that available limited evidence indicates that LNG-EC has no adverse effects on breastfeeding or on their infants.
D	Women who breastfeed should be advised not to breastfeed and to express and discard milk for a week after they have taken UPA-EC

Is additional contraception required after initiation of a method after childbirth?

✓	Women should be advised that additional contraceptive precautions (e.g. barrier method/abstinence) are required if hormonal contraception is started 21 days or more after childbirth. Additional contraceptive precaution is not required if contraception is initiated immediately or within 21 days after childbirth.

Breastfeeding and contraception

Does initiation of hormonal contraceptives affect breastfeeding outcomes or infant outcomes?

A	Women who are breastfeeding should be informed that the available evidence indicates that progestogen-only methods of contraception (LNG-IUS, IMP, POI and POP) have no adverse effects on lactation, infant growth or development.
B	Women who are breastfeeding should wait until 6 weeks after childbirth before initiating a CHC method.
B	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).

Can women who breastfeed effectively use lactational amenorrhoea method (LAM) as contraception?

C	Women may be advised that, if they are less than 6 months postpartum, amenorrhoeic and fully breastfeeding, the lactational amenorrhoea method (LAM) is a highly effective method of contraception.
C	Women using LAM should be advised that the risk of pregnancy is increased if the frequency of breastfeeding decreases (e.g. through stopping night feeds, starting or increasing supplementary feeding, use of dummies/pacifiers, expressing milk), when menstruation returns or when more than 6 months after childbirth.

Method-specific considerations

Intrauterine contraception (IUC)

B	IUC can be safely inserted immediately after birth (within 10 minutes of delivery of the placenta) or within the first 48 hours after uncomplicated caesarean section or vaginal birth. After 48 hours, insertion should be delayed until 28 days after childbirth.

Progestogen-only implants (IMP)

C	IMP can be safely started at any time after childbirth including immediately after delivery.

Progestogen-only injectable (POI)

C	POI can be started at any time after childbirth, including immediately after delivery.

Progestogen-only pills (POP)

C	POP can be started at any time after childbirth, including immediately after delivery.

Combined hormonal contraception (CHC)

C	All women should undergo a risk assessment for VTE postnatally. CHC should not be used by women who have risk factors for venous thromboembolism (VTE) within 6 weeks of childbirth. These include immobility, transfusion at delivery, body mass index (BMI) ≥30 kg/m^2, postpartum haemorrhage, post-caesarean delivery, pre-eclampsia or smoking. This applies to both women who are breastfeeding and not breastfeeding.
B	Women who are not breastfeeding and are without additional risk factors for VTE should wait until 21 days after childbirth before initiating a CHC method.

Female sterilisation

A	Female sterilisation is a safe option for permanent contraception after childbirth.
A	For sterilisation after childbirth, both Filshie clips and modified Pomeroy technique are effective. Filshie clip application is quicker to perform.
D	Women should be advised that some LARC methods are as, or more, effective than female sterilisation and may confer non-contraceptive benefits. However, women should not feel pressured into choosing LARC over female sterilisation.
C	Tubal occlusion should ideally be performed after some time has elapsed following childbirth. Women who request tubal occlusion to be performed at the time of a delivery should be advised of the possible increased risk of regret.

C	Clinicians should ensure that written consent to be sterilised at caesarean section is obtained and documented at least 2 weeks in advance of a planned elective caesarean section.

Barrier methods

D	Male and female condoms can be safely used by women after childbirth.
D	Women choosing to use a diaphragm should be advised to wait at least 6 weeks after childbirth before having it fitted because the size of diaphragm required may change as the uterus returns to normal size.

Fertility awareness methods (FAM)

D	Fertility awareness methods (FAM) can be used by women after childbirth. However, women should be advised that because FAM relies on the detection of the signs and symptoms of fertility and ovulation, its use may be difficult after childbirth and during breastfeeding.

Contraception After Abortion

Discussion and provision of contraception after abortion

When should contraception after abortion be discussed/provided?

D	Abortion service providers should give women requesting abortion opportunities to discuss contraception.
✓	Whenever contraceptive counselling is provided, care should be taken to ensure women do not feel under pressure to choose a method of contraception.
✓	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 abortion.
C	Choice of contraception should be initiated at the time of abortion or soon after, as sexual activity and ovulation can resume very soon after abortion.
D	Clinicians should adopt a person-centred approach when providing women with contraceptive counselling.
✓	Clinicians who are giving advice to women about contraception after abortion should ensure that this information is timely, up-to-date and accurate.
D	Comprehensive, unbiased and accurate information on contraceptive methods after abortion should be made available in different languages and in a range of formats including audio-visual.

When can contraception be initiated after abortion?

B	A woman's chosen method of contraception should be initiated immediately after abortion (medical and surgical).
B	Clinicians should be aware that insertion of intrauterine contraception (IUC) at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IUC is delayed.
B	Clinicians should be aware that insertion of progestogen-only implants (IMP) at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IMP is delayed.

Who should provide contraception to women after abortion?

✓	Abortion service providers should be able to offer all methods of contraception, including LARC, to women before they are discharged from the service after abortion.
✓	Abortion services should ensure that there are sufficient numbers of staff able to provide IUC or IMP so that women who choose these methods and are medically eligible can initiate them immediately after abortion.
✓	Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated.
✓	Abortion services should have agreed pathways of care to local specialist contraceptive services [e.g. community sexual and reproductive health (SRH) services] for women with complex medical conditions or needs which may require specialist contraceptive advice.
✓	There should be agreed pathways of care to local services for women who may require additional non-medical care and support.

Which contraceptive methods are most effective in preventing another abortion?

A	Clinicians should be aware that women who choose to commence LARC immediately after abortion have a significantly reduced likelihood of undergoing another abortion within 2 years, compared with women provided with medium-acting, short-acting or no contraceptive methods.

Record keeping and obtaining valid consent

D	Clinicians should clearly document the discussion and provision of contraception. Valid consent must be obtained before providing women with their chosen method.

Medical eligibility

Which methods of contraception are safe to use after abortion?

D	Women should be advised that any method of contraception can be safely initiated immediately after an uncomplicated abortion.
D	IUC should not be inserted in the presence of postabortion sepsis.

Is emergency contraception (EC) safe to use after abortion?

✓	Emergency contraception (EC) is indicated for women who have had unprotected sexual intercourse (UPSI) from 5 days after abortion.
✓	Women should be advised that any method of EC can be safely used after an uncomplicated abortion.

Is additional contraception required after initiation of a method after abortion?

✓	Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after abortion. Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of abortion.

Method-specific consideration

Intrauterine contraception (IUC)

A	IUC can be safely used by women after an uncomplicated abortion. Women may be advised that they may benefit from reduced uterine bleeding when using levonorgestrel-releasing intrauterine system (LNG-IUS).
D	With medical abortion, IUC can be inserted any time after expulsion of the pregnancy.
A	With surgical abortion, IUC can be inserted immediately after evacuation of the uterine cavity.

Progestogen-only contraception

B	Progestogen-only contraception can be safely started at any time, including immediately, after medical or surgical abortion.
B	Women should be advised that IMP can be safely initiated at the time of mifepristone administration.
B	Women should be advised that there may be a slightly higher risk of continuing pregnancy (failed abortion) if DMPA is initiated at the time of mifepristone administration.
✓	Women should be advised that scant or absent bleeding should not be attributed to a hormonal method of contraception that has been initiated, but that it may be due to failed medical abortion. Under such circumstances, urgent medical review should be sought.

Combined hormonal contraception (CHC)

B	Combined hormonal contraception (CHC) can be safely started immediately at any time after abortion.

Female Sterilisation

D	Female sterilisation is a safe option for permanent contraception after abortion.
✓	Women should be advised that some LARC methods are as, or more, effective than female sterilisation and may confer non-contraceptive benefits. However, women should not feel pressured into choosing LARC over female sterilisation.
B	Tubal occlusion should ideally be performed after some time has elapsed after abortion. Women who request tubal occlusion to be performed at the time of abortion should be advised of the possible increased failure rate and risk of regret.
✓	Clinicians should ensure that consent from the woman to conduct female sterilisation at the same time as surgical abortion is taken and documented in advance of the abortion.

Barrier methods

D	Condoms (male and female) can be used by women after abortion.
D	Women choosing to use a diaphragm should be advised to wait at least 6 weeks after second-trimester abortion because the size of diaphragm required may change as the uterus returns to normal size.

Fertility awareness methods (FAM)

D	Fertility awareness methods (FAM) can be used by women after abortion. However, women should be advised that because FAM relies on the detection of the signs and symptoms of fertility and ovulation, its use may be difficult after abortion.

Contraception After Ectopic Pregnancy or Miscarriage

Discussion and provision of contraception after ectopic pregnancy or miscarriage

When should contraception be discussed/provided?

✓	Services providing care to women with ectopic pregnancy or miscarriage should give them 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.
D	If a woman wishes to delay or prevent a further pregnancy, effective contraception should be initiated as soon as possible as sexual activity and ovulation may resume very soon after ectopic pregnancy or miscarriage.

D	A woman's chosen method of contraception should ideally be initiated immediately after treatment for ectopic pregnancy or miscarriage.
✓	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 ectopic pregnancy or miscarriage.
D	Clinicians should adopt a person-centred approach when providing women with contraceptive counselling.
✓	Clinicians who are giving advice to women about contraception after ectopic pregnancy or miscarriage should ensure that this information is timely, up-to-date and accurate.

How long should a woman wait before trying to conceive again after ectopic pregnancy or miscarriage?

D	Women who wish to conceive after miscarriage can be advised there is no need to delay as pregnancy outcomes after miscarriage are more favourable when conception occurs within 6 months of miscarriage compared with after 6 months.
D	Women who have been treated with methotrexate should be advised that effective contraception is recommended during and for at least 3 months after treatment in view of the teratogenic effects of this medication.
✓	Women should be advised that effective contraception can be started on the day of methotrexate administration or surgical management of ectopic pregnancy.

Who should provide contraception after ectopic pregnancy or miscarriage?

✓	Services involved in the care of women who have had an ectopic pregnancy or miscarriage should be able to offer all methods of contraception, including LARC, to women before they are discharged from the service.
✓	Services should ensure that there are sufficient numbers of staff able to provide intrauterine contraception (IUC) or progestogen-only implant (IMP) so that women who choose these methods and are medically eligible can initiate them immediately after treatment.
✓	Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated.
✓	Services should have agreed pathways of care to local specialist contraceptive services [e.g. community sexual reproductive health (SRH) services] for women with complex medical conditions or needs which may require specialist contraceptive advice.

✓	Services should have agreed pathways of care to local services for women who may require additional non-medical care and support.

Record keeping and obtaining valid consent

D	Clinicians should clearly document the discussion and provision of contraception. Valid consent must be obtained before providing women with their chosen method of contraception.

Medical eligibility

Which contraceptive methods are safe to use after ectopic pregnancy or miscarriage?

✓	Clinicians should refer to the method-specific recommendations for abortion which may be extrapolated for use after ectopic pregnancy or miscarriage.
D	Women should be advised that any method of contraception can be safely initiated immediately after methotrexate administration or surgical treatment of ectopic pregnancy.
D	Women should be advised that any method of contraception can be safely initiated immediately after treatment for miscarriage.
C	IUC can be inserted after miscarriage as soon as expulsion has occurred at surgery or after medical or expectant management.
C	IUC should not be inserted in the presence of sepsis after ectopic pregnancy or miscarriage.

Is emergency contraception (EC) safe to use after ectopic pregnancy or miscarriage?

✓	Emergency contraception (EC) is indicated if unprotected sexual intercourse (UPSI) takes place more than 5 days after methotrexate administration or surgical treatment of ectopic pregnancy.
B	Women should be advised that any method of EC can be safely used after ectopic pregnancy or miscarriage.

Is additional contraception required after initiation of a method 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 5 days or more after miscarriage. Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of miscarriage.

✓	Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after surgical treatment or administration of methotrexate for ectopic pregnancy. Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of treatment of ectopic pregnancy.

Specific issues

What are the implications of recurrent miscarriage on contraceptive choice?

D	Women who have had recurrent early miscarriage (REM) should be investigated for any underlying causes. However, investigations should not lead to a delay in initiation of a contraceptive method if the woman does not wish to become pregnant.
D	Combined hormonal contraception (CHC) should be avoided by women with REM until antiphospholipid syndrome (APS) has been excluded.

Is there any method associated with a risk of another ectopic pregnancy?

C	Women should be advised that the absolute risk of ectopic pregnancy when contraception is used is extremely small and that the risk of pregnancy is lowest with LARC.
D	Women should be advised to seek medical advice if they suspect they may be pregnant and have symptoms suggestive of ectopic pregnancy, even while using contraception.
C	Women who have had an ectopic pregnancy should be advised that the IUC is one of the most effective methods of contraception and so the absolute risk of any pregnancy including ectopic pregnancy is extremely low.
C	Women should be informed that if pregnancy occurs with an IUC *in situ*, there is an increased risk of ectopic pregnancy and therefore the location of the pregnancy should be confirmed by ultrasound as soon as possible.

Contraception After Gestational Trophoblastic Disease (GTD)

Discussion and provision of contraception after GTD

When should contraception be discussed/provided?

✓	Services that provide care to women who have/had gestational trophoblastic disease (GTD) should give them 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.
D	Women should be advised to avoid subsequent pregnancy until GTD monitoring is complete. Effective contraception should be started as soon as possible as sexual activity and fertility may resume very soon after GTD.

✓	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 GTD.
D	Clinicians should adopt a person-centred approach when providing women with contraceptive counselling.
✓	Clinicians who are giving advice to women about contraception after GTD should ensure that this information is timely, up-to-date and accurate.
✓	Comprehensive, unbiased and accurate information on contraceptive methods after GTD should be made available in different languages and in a range of formats including audio-visual.

Are fertility and pregnancy outcomes affected after GTD?

C	Clinicians should reassure women with GTD that fertility and pregnancy outcomes are favourable after GTD, including after chemotherapy for gestational trophoblastic neoplasia (GTN). However, there is an increased risk of GTD in subsequent pregnancy.

How long should a woman wait after GTD before trying to conceive?

D	After complete molar pregnancy, women should be advised to avoid subsequent pregnancy for at least 6 months to allow human chorionic gonadotrophin (hCG) monitoring for ongoing GTD.
D	After partial molar pregnancy, women should be advised to avoid pregnancy until two consecutive monthly hCG levels are normal.
D	Women who have had chemotherapy for GTD should be advised to avoid pregnancy for 1 year after treatment is complete.

Who should provide contraception to women after GTD?

✓	Services involved in the care of women with GTD should be able to offer all methods of contraception, including LARC, to women before they are discharged from the service.
✓	Services should ensure that there are sufficient numbers of staff able to provide progestogen-only implant (IMP) so that women who choose this method and are medically eligible can initiate the method immediately after treatment.
✓	Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated.
✓	Services should have agreed pathways of care to local specialist contraceptive services (e.g. community sexual and reproductive health (SRH) services) for women with complex medical conditions or needs which may require specialist contraceptive advice.

✓	Services should have agreed pathways of care to local services for women who may require additional non-medical care and support.

Record keeping and obtaining valid consent

D	Clinicians should clearly document the discussion and provision of contraception. Valid consent must be obtained before providing women with their chosen method of contraception.

Medical eligibility

Which contraceptive methods are safe to use after GTD?

D	Women should be advised that most methods of contraception can be safely used after treatment for GTD and can be started immediately after uterine evacuation, with the exception of intrauterine contraception (IUC).
D	IUC should not be inserted in women with persistently elevated hCG levels or malignant disease.
D	IUC should not normally be inserted until hCG levels have normalised but may be considered on specialist advice with insertion in a specialist setting for women with decreasing hCG levels following discussion with a GTD centre.

Is emergency contraception (EC) safe to use after GTD?

✓	Emergency contraception (EC) is indicated if unprotected sexual intercourse (UPSI) takes place from 5 days after treatment for GTD.
D	Women should be advised that use of oral EC is safe after treatment for GTD. Insertion of copper intrauterine device (Cu-IUD) for EC may be considered in a specialist setting for women with decreasing hCG levels following discussion with a GTD centre.

Is additional contraception required after initiation of a method after GTD?

✓	Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after treatment for GTD. Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of treatment for GTD.

Method-specific considerations

Intrauterine Contraception (IUC)

D	IUC should not normally be inserted until hCG levels have normalised after GTD. Insertion of Cu-IUD as EC may be considered in a specialist setting for women with decreasing hCG levels following discussion with a GTD centre.

✓	IUC insertion at surgical evacuation where GTD is suspected but not confirmed should be made on an individual case basis based upon the individual woman's risk for GTD, clinical findings and her preference for IUC insertion at this time.

Hormonal contraception

B	Hormonal contraception can be started immediately after uterine evacuation for GTD.

Female sterilisation

D	Female sterilisation is a safe option for permanent contraception after GTD.
✓	Women should be advised that some LARC methods are as, or more, effective than female sterilisation and may confer non-contraceptive benefits. However, women should not feel pressured into choosing LARC over female sterilisation.
D	Tubal occlusion should ideally be performed after some time has elapsed after surgical evacuation for GTD. Women who request tubal occlusion to be performed at the time of surgical treatment should be advised of the possible increased failure rate and risk of regret.

Barrier methods

D	Condoms (male and female) can be used by women after treatment for GTD.
✓	Women who choose a diaphragm should be advised to wait at least 6 weeks after treatment for GTD because the required size of diaphragm may change as the uterus returns to normal size.

Fertility awareness methods (FAM)

✓	Fertility awareness methods (FAM) can be used by women after treatment for GTD. However, women should be advised that because FAM relies on the detection of the signs and symptoms of fertility and ovulation, its use may be difficult after treatment for GTD.

Specific issues

Is there any method associated with a risk of GTD in subsequent pregnancies?

D	Clinicians should inform women that there is no evidence that the use of any contraceptive method after an episode of GTD increases the risk of GTD in a subsequent pregnancy.

Comments and Feedback on Published Guideline

All comments on this published guideline can be sent directly to the Clinical Effectiveness Unit (CEU) of the Faculty of Sexual & Reproductive Healthcare (FSRH) via the FSRH website www.fsrh.org.

The CEU may not respond individually to all feedback. However, the CEU will review all comments and provide an anonymised summary of comments and responses, which are reviewed by the Clinical Effectiveness Committee and any necessary amendments made subsequently.

www.fsrh.org

Published by the Faculty of Sexual and Reproductive Healthcare
Registered in England No. 2804213 Registered Charity No. 1019969
FSRH, 27 Sussex Place, London, NW1 4RG