FSRH
Clinical Effectiveness Unit

The Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists

FSRH CEU: Provision of contraception by maternity services after childbirth during the Covid-19 outbreak
9 April 2020

- **Effective contraception should be started as soon as possible after childbirth[1]**
  Fertility returns rapidly after childbirth. Existing FSRH guidance[1] recommends that effective contraception is commenced as soon as possible after delivery by both breastfeeding and non-breastfeeding mothers. This allows individuals to plan any subsequent pregnancy and avoid short inter-pregnancy intervals with their associated poorer pregnancy outcomes.

- **Most contraceptive methods (except combined hormonal contraception) can be started safely by most individuals (both breastfeeding and non-breastfeeding) immediately after delivery[1]**
  The *UK Medical Eligibility Criteria (UKMEC) 2016* should be used to support assessment of suitability of contraceptive methods.[2]

  See also *"fast facts"* appendix to this document.

- **Where possible, in line with current FSRH guidance, information about contraception after childbirth should continue to be provided in the antenatal period to support informed decision-making[1]**

- **After childbirth, effective contraception should be provided prior to discharge from maternity services**
  As a result of the Covid-19 outbreak, access to sexual health and primary care contraceptive services is significantly reduced. Maternity services are ideally placed to provide effective post-partum contraception before discharge.

During the current Covid-19 outbreak:-

- **Where possible, long-acting reversible contraceptive (LARC) methods should continue to be offered by maternity services that already offer this option. If suitable and accepted, LARC should be inserted prior to discharge from maternity services**

  It is acknowledged that potential additional risk of exposure of patients and maternity staff to Covid-19 must be assessed when considering provision of LARC methods immediately after childbirth.

  The most effective LARC methods, including the copper IUD, the levonorgestrel-releasing IUS and the etonogestrel implant can be inserted at, or immediately after delivery, in the maternity setting, by appropriately trained maternity staff. LARC methods have the significant advantage of providing immediate, user-independent contraception that is effective for several years without requirement for routine follow up.

  See *'LARC fast facts'* below when assessing suitability and providing information to the individual.

FSRH – CEU Chalmers Centre 2A Chalmers Street Edinburgh EH3 9ES +44 (0)131 536 3830
Ceu.Chalmers@nhslothian.scot.nhs.uk www.fsrh.org

- **As standard, individuals for whom LARC methods cannot be provided, those that decline LARC and those for whom LARC is unsuitable can be given a 6-12 month supply of the desogestrel progestogen-only pill (POP) prior to discharge.**

  The POP is extremely safe and there are few contraindications to its use. *See 'desogestrel POP fast facts'* below when assessing suitability and providing information to the individual.

  The desogestrel POP can be started immediately after delivery (or by Day 21) without any requirement for additional contraceptive precautions. The POP is highly user-dependent and may not be suitable where there is concern about adherence to pill-taking.

Follow up:-

- **Etonogestrel implant and progestogen-only pill**

  No routine follow up is required after post-partum initiation of the etonogestrel implant or desogestrel progestogen-only pill. See *'fast facts'* below for information that should be provided to the user.

- **Intrauterine contraception**

  Individuals that have had insertion of intrauterine contraception after childbirth may require follow up for pain, bleeding, or expulsion, or if threads are very long or cannot be felt. Clear local pathways must be established to manage these relatively common problems. Clear advice must be provided to users as to how to follow these pathways. The following models are suggested during the Covid-19 outbreak:-

  Problem: Unable to feel threads
  Advice to user, and pathway: use condoms; contact local contraceptive provider for POP to use in addition; contact local SRH service to arrange deferred ultrasound.

  Problem: Very long threads
  Advice to user, and pathway: do not pull threads; trim threads to vaginal entrance; use condoms; contact local contraceptive provider for additional POP; contact local SRH service to arrange review and further trimming of threads (may be deferred depending on circumstances).

  Problem: Expulsion
  Advice to user, and pathway: use condoms; contact local contraceptive provider for supply of POP; defer insertion of IUC until restrictions on face-to-face contact allow.

  See *'fast facts'* below for standard information that should be provided to users.

FSRH – CEU Chalmers Centre 2A Chalmers Street Edinburgh EH3 9ES +44 (0)131 536 3830
Ceu.Chalmers@nhslothian.scot.nhs.uk www.fsrh.org

What about other effective contraceptive methods?

- ***Depot medroxyprogesterone acetate (DMPA)***

  DMPA can be given immediately after childbirth and could be administered prior to discharge if other methods are unsuitable, unacceptable or unavailable. It is, however effective for contraception for only 13 weeks; the person would then have to access further contraception at a time when face-to-face services could still be limited.[1]

- ***Combined hormonal contraception (CHC)***

  Contraception is required from Day 21 after childbirth unless the individual is fully breastfeeding and amenorrhoeic. CHC should not be started until 6 weeks after delivery in breastfeeding individuals or in non-breastfeeding individuals with additional risk factors for venous thromboembolism (VTE). It is noted that caesarean section is a VTE risk factor. Individuals who are not breastfeeding and have no additional VTE risk factors may consider use of CHC from 3 weeks after childbirth.[1]

  There are, however, significant potential health risks associated with use of CHC, therefore prior to provision, medical eligibility must be carefully assessed, blood pressure and BMI measured, and users advised about CHC-associated health risks. Such requirements could be a barrier to provision of CHC by maternity services. CHC may be offered to eligible individuals where other methods are unsuitable, unacceptable or unavailable. In these circumstances, a 6-12 month supply of CHC could be provided prior to discharge with clear instructions as to when to start and interim requirement for alternative contraception.

- ***Lactational amenorrhoea***

  It is recognised that fully breastfeeding individuals can rely on lactational amenorrhoea for contraception for the first six months after delivery, so long as they remain amenorrhoeic **AND** continue to breastfeed fully. An individual may, however, reduce breastfeeding or have their first period at any time, with resulting loss of contraceptive effect; this could come at a time when access to contraception services is still restricted by Covid-19. It is recommended, therefore, that breastfeeding individuals commence additional contraception as soon as possible after delivery.[1]

- ***Female sterilisation***

  Existing guidance recommends that, because of concern about potential regret, written consent to female sterilisation at the time of caesarean section should be obtained at least two weeks prior to delivery.[1]

FSRH – CEU Chalmers Centre 2A Chalmers Street Edinburgh EH3 9ES +44 (0)131 536 3830
Ceu.Chalmers@nhslothian.scot.nhs.uk www.fsrh.org

Fast facts to support safe provision of LARC and the desogestrel POP by maternity services

LARC fast facts

Copper IUD (Cu-IUD)

The Cu-IUD can be inserted by maternity staff *already trained in the technique* at the time of caesarean section, immediately after vaginal delivery or at any time up to 48 hours post-partum.

Contraindications	Postpartum sepsis, current symptomatic pelvic chlamydia or gonorrhoea infection, current pelvic TB, current gestational trophoblastic disease, current cervical or endometrial cancer, copper allergy, Wilson's disease.
Potential contraindications include	Previous heavy menstrual bleeding, anaemia; current asymptomatic chlamydia or gonorrhoea infection, complications after organ transplant, long QT syndrome, previous trachelectomy, uterine cavity significantly distorted by fibroids or structural abnormality, HIV infection with CD4<200.
Contraceptive effectiveness	0.6-0.8% first year contraceptive failure (effective immediately). Enzyme-inducing drugs do not affect contraceptive effectiveness.
Duration of use	Device-dependent, 5 or 10 years.
Bleeding	Often heavier, longer, more painful; pattern usually unchanged.
Follow up information required by user	How to check for threads, possibility of long threads, how to access review of pain/bleeding/very long or missing threads, replacement date (5 or 10 years).

For further information see FSRH Clinical Guidelines *Contraception After Pregnancy*[1] and *Intrauterine Contraception.*[3] See FPA website for access to contraceptive booklets.[4]

Levonorgestrel intrauterine system (LNG-IUS)

The 52mg LNG-IUS can be inserted by maternity staff *already trained in the technique* at the time of caesarean section or immediately after vaginal delivery or at any time up to 48 hours post-partum.

Contraindications	Allergy to content; postpartum sepsis, current symptomatic chlamydia or gonorrhoea infection, current pelvic TB, current breast, endometrial or cervical cancer, current gestational trophoblastic disease.
Potential contraindications include	Current asymptomatic chlamydia or gonorrhoea infection, previous breast cancer, previous arterial thromboembolic event during use, decompensated cirrhosis, hepatocellular adenoma or carcinoma, complications after organ transplant, long QT syndrome, HIV infection with CD4 count <200, uterine cavity significantly distorted by fibroids or structural abnormality, previous trachelectomy.
Contraceptive effectiveness	0.2% first year contraceptive failure rate (effective immediately if inserted post-partum). Enzyme-inducing drugs do not affect contraceptive effectiveness.
Duration of use	5 years (for 52mg LNG-IUS)
Bleeding	Initially erratic, likely to become light over first year of use, may become amenorrhoeic.
Follow up information required by user	How to check for threads, possibility of long threads, how to access review of pain/bleeding/very long or missing threads, replacement date.

For further information see FSRH Clinical Guidelines *Contraception After Pregnancy*[1] and *Intrauterine Contraception.*[3] See FPA website for access to contraceptive booklets.[4]

FSRH – CEU Chalmers Centre 2A Chalmers Street Edinburgh EH3 9ES +44 (0)131 536 3830
Ceu.Chalmers@nhslothian.scot.nhs.uk www.fsrh.org

Etonogestrel implant (ENG-IMP)

The ENG-IMP can be inserted by maternity staff *already trained in the technique* immediately after delivery or at any time prior to discharge from maternity services. If inserted by Day 21 after childbirth, no additional contraceptive precautions are required.

Contraindications	Allergy to content (including barium); current breast cancer
Potential contraindications include	Previous arterial thromboembolic event during use, previous breast cancer, decompensated cirrhosis, hepatic adenoma or adenocarcinoma.
Contraceptive effectiveness	0.05% first year contraceptive failure rate (effective immediately if inserted by Day 21 after childbirth). Enzyme-inducing drugs may affect contraceptive effectiveness.
Duration of use	3 years.
Bleeding	Unpredictable.
Follow up information required by user	How to feel for implant, how to access review of e.g. bleeding/ non-palpable implant, potential for drug interaction, replacement date.

For further information see FSRH Clinical Guidelines *Contraception After Pregnancy*[1] and *Progestogen-only Implants.*[5] See FPA website for access to contraceptive booklets.[4]

Desogestrel POP fast facts

The desogestrel POP can be started immediately after delivery. If started by Day 21 after childbirth, no additional contraceptive precautions are required. One pill is taken at the same time every day. The pill can be taken up to 12 hours late without affecting contraceptive effectiveness; subsequent pills should be taken at the intended time.

Contraindications	Allergy to content; current breast cancer
Potential contraindications include	Previous arterial thromboembolic event during use, previous breast cancer, decompensated cirrhosis, hepatic adenoma or adenocarcinoma.
Contraceptive effectiveness	0.3% first year contraceptive failure rate if taken perfectly; 9% with typical use (effective immediately if started by Day 21 post-partum). Enzyme-inducing drugs and conditions that affect GI absorption may affect contraceptive effectiveness.
Bleeding	Unpredictable.
Follow up information required by user	How to take, missed pill rules (including after vomiting), possibility of drug interaction, how to access further supplies (including direction to local and online services).

For further information see FSRH Clinical Guidelines *Contraception After Pregnancy*[1] and *Progestogen-only Pills.*[6] See FPA website for access to contraceptive booklets.[4]

FSRH – CEU Chalmers Centre 2A Chalmers Street Edinburgh EH3 9ES +44 (0)131 536 3830
Ceu.Chalmers@nhslothian.scot.nhs.uk www.fsrh.org

References

All references accessed on 9th April 2020.

1. Faculty of Sexual & Reproductive Healthcare. *Clinical Guideline Contraception After Pregnancy.* January 2017. Available online here
2. Faculty of Sexual & Reproductive Healthcare. UK Medical Eligibility Criteria for Contraceptive Use 2016. January 2016 (amended September 2019). Available online here
3. Family Planning Association (UK). *Leaflet and Booklet Downloads*. Available online here
4. Faculty of Sexual & Reproductive Healthcare. Clinical Guideline *Intrauterine Contraception*. April 2015, amended September 2019. Available online here
5. Faculty of Sexual & Reproductive Healthcare. Progestogen-only Implant. February 2014 Available online here
6. Faculty of Sexual & Reproductive Healthcare. Progestogen-only Pills. March 2015 (amended April 2019). Available online here

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.

FSRH – CEU Chalmers Centre 2A Chalmers Street Edinburgh EH3 9ES +44 (0)131 536 3830
Ceu.Chalmers@nhslothian.scot.nhs.uk www.fsrh.org