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Postnatal Contraception

Introduction and Aim

Postpartum family planning (PPFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth [1]. Childbirth presents an opportunity for providing contraception at a time when women are attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be highly motivated to start using an effective method. Health professionals working within the maternity services should discuss and support women in their choice of contraception during the antenatal and postnatal period. The benefits of long-acting reversible contraception (LARC) methods in terms of efficacy should be highlighted to all pregnant women [2].

There is a high rate of unplanned pregnancies amongst women from 'hard to reach' groups such as teenagers and vulnerable adults within 12 months of delivery. This risk of a subsequent/accidental pregnancy is significantly reduced by using LARC [3]. Thus PPFP must be regarded as essential component of maternity care.

Objectives

To prevent unintended pregnancy and closely spaced pregnancies after childbirth

Scope

This policy applies to all healthcare professionals in all locations including those with honorary contracts

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	*Antenatal Care* *Postnatal Care* *FSRH (2017) contraception following childbirth*
Approved by	*Maternity Professional Forum and Obstetrics & Gynaecology Quality & Safety*

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
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Disclaimer

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Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*Dec 2016*	*Dec 2016*	New Document
2	*Aug 2020*		Updated UKMEC guidance

1 Table of Contents

Contents

2 Summary and purpose

This guideline lists effective postpartum family planning methods and proposes various ways in which it can be implemented in Cardiff and Vale UHB. It is based on the following clinical guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH), Progestogen-only Injectable Contraception (2014, amended in 2020)[4], Progestogen-only Pills (2017)[5], Intrauterine Contraception (2015)[6], Progestogen-only Implants (2014, statement on insertion 2020)[7] and UKMEC (2019) [8].

The main areas for consideration are the administration of, Progestogen-only pills (Desogesterel 75mcg, Levonorgestrel 30mcg), Depo Medroxyprogesterone acetate 150mg (Depo-Provera). Special Patient Group Directives (PGD) have been formulated to be used by Midwives after completion of PGD training. Etonogestrel Implant 68mg (Nexplanon), the copper-bearing Intrauterine device and Levonorgestrel-releasing intrauterine system (Mirena) are also discussed and will be fitted by trained practitioners. UKMEC clinical assessment sheets are to be used when counselling women about each method, (see appendix 1 for UKMEC summary table and counselling sheets)

Back to Contents

3 Background

Short spaced and unplanned pregnancies increase the chances of mortality and morbidity in the mother and child. The World Health Organization (WHO) recommend 24-month inter-pregnancy interval for all women (IPI) [9] however, short pregnancy intervals remain common. A UK study reported that around 1 in 13 women presenting for an abortion or birth had conceived within a year postpartum[10,11].

Many women do not desire a short inter-pregnancy interval[12,13], The Royal College of Obstetricians and Gynaecologists (RCOG) and The Faculty of Sexual and Reproductive Health (FSRH) recommend that contraception should be part of maternity care, The FSRH has the target auditable outcome of 50% of postnatal women choosing long-acting reversible contraception (LARC) prior to hospital discharge with 97% given a choice of appropriate contraceptive methods within 7 days of birth. There is further evidence which suggests that young women and women from vulnerable groups are generally less likely to attend sexual health establishments and GP surgeries for contraceptive advice, increasing the risk of unintended pregnancy.[14] A recent study in Edinburgh identified 96.7% of women did not plan to conceive in the first year postpartum and 42.8% would use long-acting reversible contraception (LARC) if it were available prior to discharge from hospital[15]. A recommendation from this study was to implement patient-group directives (PGD) to enable midwives to counsel and administer postpartum contraception. The PGD enables healthcare professionals to supply and administer a medicine directly to pre-defined patients without the need of a prescription signed by a doctor[16].

Back to Contents

4 Pathway

4.1 In the antenatal period:

- Women should be given verbal and written information (see contraceptive choices leaflet) about all contraceptive options. Women should be told about the particular benefits and excellent efficacy of LARC such as intrauterine contraception and implants.
- Women should be given the opportunity to ask questions about contraception every time they are seen in the antenatal clinic.
- The woman's favoured method should be documented in the appropriate case record so that it can be provided as soon as possible after childbirth.

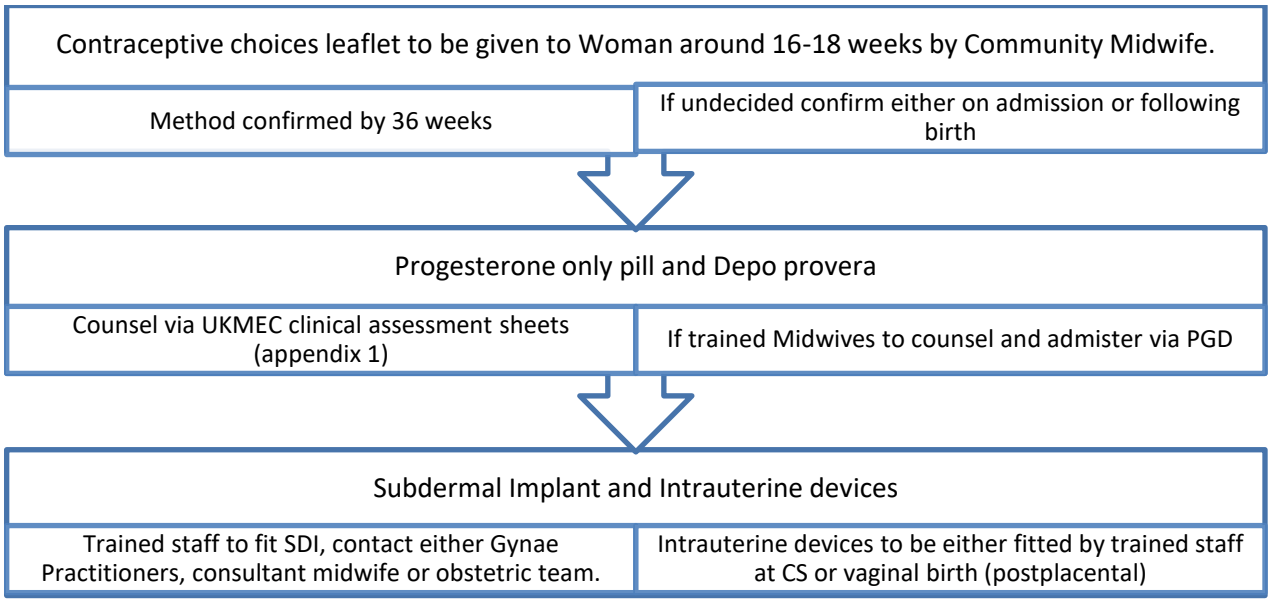
Back to Contents

4.2 In the labour ward setting:

- Contraception should not be discussed with women who are in active labour.
- If admitted antenatally (not in labour), contraceptive choices to be discussed so arrangements can be made following birth.
- Confirm method following birth and arrange administration. (contraceptive supplies are kept on the ward/MLU/DS)
- Using the UKMEC clinical assessment sheet (see appendix 1), Midwives can counsel and administer DMPA and POP as per PGD.
- For LARC methods, Implant or Intra-uterine contraception fitting. Cu-IUD/ LNG-IUS need to be fitted within 48 hours of birth. Ideal time for fitting is 'post-placental', i.e. immediately following third stage and prior to suturing. In women having a caesarean section, Coils can be fitted as soon as the placenta has been delivered. Expulsion rates are low (1:7).
- More midwives and obstetricians will be trained to fit SDI's and IUC in line with the RCOGs 'Leading Safe choices' PPFP programme.
- Provide patient information regarding after care and expiration dates.
- If a woman has not had the chance to discuss contraception before she arrives on the postnatal ward, it should be discussed with her before she leaves the hospital and her chosen method (including an implant, or Coils if within 48 hours of birth) should be provided.

Back to Contents

4.3 Flowchart



Back to Contents

5 Auditable Standards

The FSRH has the target auditable outcome of 50% of postnatal women choosing long-acting reversible contraception (LARC) prior to hospital discharge with 97% given a choice of appropriate contraceptive methods within 7 days of birth. In order to achieve this national target and sustain the postnatal contraceptive service the following standard are to be audited.

Standard	Audit method	Target
Where appropriate, all women to have a discussion around postnatal contraception during the AN period	Documentation in hand held maternity records	97%
Discussion around postnatal contraception prior to discharge	Postnatal pathway and E3	97%
Women receiving postnatal contraception prior to discharge form Maternity	E3	50%
Women requesting and receiving Long acting methods	E3	50%
UKMEC sheets used for counselling and filled in Maternal notes	Maternal notes audit	100%

Back to Contents

6 References

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Back to Contents

7 Appendix: UKMEC clinical assessment forms

7.1 Depo-Provera Check List

(Starts on Next Page)

Back to Contents

Depo-Provera check list

Name

DOB **BMI**

Risk Factors:

UK MEC 4: Absolute Contraindications

Condition	Present	Absent
Current breast cancer		

UK MEC 3: Relative contraindications

Conditions requiring careful consideration where risks generally outweigh advantages, if present discuss with senior SRH doctor and or issue (as) bridging contraception

Condition	Present	Absent
Multiple risk factors for cardiovascular disease (smoking, diabetes, hypertension, obesity and dyslipidaemias)		
Vascular disease		
Current and history of ischaemic heart disease		
Stroke (history of CVA, including TIA)		
Unexplained vaginal bleeding		
Past history of breast cancer		
Planning a pregnancy in the near future		
Severe liver cirrhosis, liver tumours		

UK MEC 2:

Conditions for which the advantages generally outweigh the theoretical or proven risks.

Age <18 or >45
Postpartum < 6 weeks
Organ transplant
Adequately controlled hypertension
Known dyslipidaemias
History of VTE or current VTE on anticoagulants
Major surgery with prolonged immobilisation
Thrombogenic mutations (Factor V Leiden, prothrombin mutation, protein S, C and antithrombin deficiencies)
Impaired cardiac function
Cardiac arrhythmias (atrial fibrillation and long QT syndrome)
Migraine with or without Aura any age.
Cervical intraepithelial neoplasia (CIN)
Cervical cancer
Undiagnosed breast lump, carrier BRCA1 and 2
Diabetes (insulin and non-insulin dependent, nephropathy, retinopathy neuropathy)
Gallbladder disease
Cholestasis
Rheumatoid arthritis

Systemic lupus erythematosus (SLE)
Positive antiphospholipid antibodies

Counselling

	Discussed
Mode of action (inhibits ovulation)	
Failure rate (very low if regularly attending, <4/1000 in 2 years)	
Administration route – intramuscular injection (haematoma, infection)	
Administration site – arm, buttock or thigh	
10 – 13 week intervals possible, ideally 12 weeks	
Side effects:	
Irregular periods (up to 50% of women discontinue by 1 year of use for this reason)	
Potential amenorrhoea (up to 70% at 1 year)	
Weight gain (more common <18 with raised BMI)	
Fertility (may delay return to woman's own fertility for 1 year)	
Bone density effect (small loss of BMD, usually reversible)	
Starting regime day 1-4 of cycle or up to day 21 postpartum	
Alternative LARC discussed if <18 or >45	
Leaflet given	
Safer Sex discussed	

Name:

Signature:

Date:

7.2 Progesterone Only Pill (POP) Check List

(Starts on Next Page)

Back to Contents

Progesterone only Pill (POP) check list

Name:

DOB:

Risk Factors

UK MEC 4: Absolute contraindication.

Condition	Present	Absent
Current breast cancer		

UK MEC 3:
Conditions requiring careful consideration. Refer to or discuss with senior SRH.

Condition	Present	Absent
Ischaemic heart disease if developed while taking POP		
Stroke if developed while taking POP		
Past breast cancer		
Severe Cirrhosis		
Liver tumours		
Concurrent use of liver enzyme inducing drugs, Some epileptic medication, St John's wort, (see FSRH guidance on drug interactions)		

UK MEC 2
A condition for which the advantages of using the method generally outweigh the theoretical or proven risks

- Organ transplant
- Multiple risk factors for Cardiovascular disease (CVD) (smoking, diabetes, hypertension, obesity and dyslipidemias)
- Vascular disease
- Current history of ischameic heart disease (initiation)
- Stroke (including CVA and TIA) (initiation)
- Known dyslipidemias
- Venous thromboembolism (VTE) history of VTE; current VTE (on anticoagulants); major surgery with prolonged immobilisation
- Known thromobogenic mutations (e.g. factor V Leiden; prothrombin mutation; protein S, protein C and antithrombin deficiencies)
- Cardiomyopathy (impaired cardiac function)
- Cardiac arrhythmias
- Migraine (or history of) with aura any age
- Unexplained vaginal bleeding
- Breast disease, undiagnosed mass; carriers of known genetic mutations (e.g. BRCA1)
- Diabetes non-vascular disease; nephropathy/retinopathy/neuropathy; other

vascular disease
- Gall bladder disease
- Cholestasis
- Inflammatory bowel disease
- Rheumatoid arthritis
- Systemic lupus erythematosus (SLE), Positive antiphospholipid antibodies.

Starting regime

Day 1-4	no extra precautions
Postpartum within 21 days	no extra precautions
< 5 days after TOP/miscarriage	no extra precautions
Other times in cycle	48 hours extra precautions

UK MEC: _____ **Leaflet issued** yes
no

Counselling:

	initial
Mode of action discussed (thickens cervical mucus)	
Failure rate discussed (low if taken punctiliously) (1:10 ectopic risk if does fail)	
Side effects discussed (irregular bleeding, breast tenderness, mood,)	
48 hr rule discussed (after missed /late pill, D+V)	
Availability and accessibility of emergency contraception discussed	
Drug interactions discussed (St John's wort and other liver enzyme inducers)	
Leaflet issued	

Name:

Signature:

Date:

7.3 Sub-dermal Implant Checklist

(Starts on Next Page)

Back to Contents

Sub-dermal Implant checklist

Name:

DOB:

Risk Factors

UK MEC 4: Absolute Contraindications.

CONDITION	PRESENT	ABSENT
Current breast cancer		

UK MEC 3: Relative contraindications

If present refer to Consultant care or discuss and issue bridging contraception as required.

CONDITION	PRESENT	ABSENT
Current history of ischaemic heart disease		
Stroke (history of CVA, TIA)		
Severe Liver cirrhosis, Liver tumours, active viral hepatitis		
Unexplained vaginal bleeding suspicious for serious condition		
Severe Cirrhosis		
Liver tumours		
Past history pf breast cancer.		
Concurrent use of Liver enzyme inducing drugs (St John's wort and others see FSRH guidance)		

UK MEC 2:

A condition for which the advantages of using the method generally outweigh the theoretical or proven risks

- Organ Transplant
- Multiple risk factors for arterial cardiovascular disease
- Vascular disease
- Current and history of ischaemic heart disease (initiation)
- Stroke (initiation)
- Known dyslipidemias
- History of VTE or current VTE on anticoagulants
- Major surgery with prolonged immobilisation
- Known thrombogenic mutations
- Cardiomyopathy, impaired cardiac function
- Cardiac arrhythmias, (atrial fibrillation, long QT syndrome)
- Migraine headaches with or without aura at any age
- Irregular bleeding patterns, with or without heavy bleeding.
- Cervical cancer
- Breast disease undiagnosed mass; carriers of known gene mutations associated with

breast cancer (e.g. BRCA1)

- Diabetes NIDDM and IDDM, with or without vascular disease
- Gallbladder disease
- History of cholestasis past COC-related
- Rheumatoid arthritis
- Systemic lupus erythematosus (SLE), positive antiphospholipid antibodies.

Counselling	**Discussed**
3 year life span and visible on x-ray	
Very effective < 1:1000 pregnancy in 3 years	
Changes to bleeding pattern (may increase lochia initially), (intermittent spotting)	
Changes to skin may occur and may be for better or worse	
Drug interactions, St John's wort, Most ART and Epileptic drugs)	
Fertility should return to normal when removed.	
Allergies	
Procedure, local anaesthetic, dressing to remain on for 24 hours.	
To attend, GP, local sexual health if any concerns.	
alternative choices and safer sex	

Timing of insertion:

Day 1-4 cycle		Currently on POP, COC, DMPA	
1st trimester abortion Day 1-4		Postnatal Day 1-21	

Outside of these times:

- if no risk of pregnancy extra precautions for 7/7
- If risk of pregnancy, extra precautions for 7/7 and PT after 4/52.

Procedure:

UKMEC for this patient	
Checklist and Consent	
Uncomplicated insertion of sub-dermal implant in left or right arm	
Implant Palpated	
Local anaesthetic used	
Prior removal of implant	
Steristrips applied	
Extra precautions for 7 days	
Pregnancy test advised in 4/52	
Leaflet and check card given	

Name:

Date

7.4 Levonorgesterel Intrauterine System (LNG-IUS) Checklist

(Starts on next page)

Back to Contents

LNG-IUS checklist

Name:

DOB:

Risk Factors

UK MEC 4: Absolute Contraindications.

CONDITION	PRESENT	ABSENT
Current breast cancer		
Postpartum/post abortion Sepsis		
Persistently elevated hCG levels or malignant disease		
Cervical cancer		
Endometrial cancer		
PID		
Symptomatic Chlamydial infection		
Gonorrhoea		
Pelvic TB		
Unexplained vaginal bleeding suspicious for serious condition		

UK MEC 3: Relative contraindications

If present refer to Consultant care or discuss and issue bridging contraception as required.

CONDITION	PRESENT	ABSENT
Organ Transplant - Complicated (rejection, vasculopathy, cardiac allograft)		

Current history of ischaemic heart disease
Stroke (history of CVA, TIA)
Long QT syndrome
Gestational trophoblastic disease
Uterine fibroids
Asymptomatic Chlamydial infection
Severe Liver cirrhosis, Liver tumours,
Decreasing hCG levels
Radical Trachelectomy
Distorted uterine cavity
Past history breast cancer.
HIV infection CD4 count <200cells/mm^3
48hours to <4weeks

UK MEC 2:

A condition for which the advantages of using the method generally outweigh the theoretical or proven risks

- Multiple risk factors for arterial cardiovascular disease
- Vascular disease
- Current and history of ischaemic heart disease (initiation)
- Stroke (initiation)
- Known dyslipidemias
- History of VTE or current VTE on anticoagulants
- Major surgery with prolonged immobilisation
- Known thrombogenic mutations
- Cardiomyopathy, impaired cardiac function
- Cardiac arrhythmias, (atrial fibrillation)
- Migraine headaches with or without aura at any age
- Irregular bleeding patterns, with or without heavy bleeding.
- Breast disease undiagnosed mass; carriers of known gene mutations associated with breast cancer (e.g. BRCA1)
- Vaginitis, increased risk for STI's
- Diabetes NIDDM and IDDM, with or without vascular disease
- Gallbladder disease
- History of cholestasis past COC-related

- Rheumatoid arthritis
- Systemic lupus erythematosus (SLE), positive antiphospholipid antibodies.

Counselling	**Discussed**
5 year life span	
Low failure rates, 1:20 expulsion. (1:7 postpartum)	
Changes to bleeding pattern, (intermittent spotting in first 3-6months)	
If pregnancy does occur, increased risk of an ectopic with Intrauterine method insitu.	
Rate of uterine perforation associated with IUC is 2 per 1000 insertions. (higher if breastfeeding)	
Fertility should return to normal when removed.	
Threads to be checked +/- trimmed at 6 weeks (GP/Maternity unit, give leaflet)	
Alternative choices and safer sex	

Timing of insertion:

Day 1-4 cycle		Currently on POP, COC, DMPA	
1st trimester abortion Day 1-4		Postpartum <48hrs or >4weeks	

Outside of these times:

- if no risk of pregnancy extra precautions for 7/7
- If risk of pregnancy, extra precautions for 7/7 and PT after 4/52-

UKMEC for this patient	

Name: **Signature:**

Date:

7.5 Copper Intrauterine Device (Cu-IUD) Checklist

Starts on next page

Back to Contents

Cu-IUD checklist

Name:

DOB:

Risk Factors

UK MEC 4: Absolute Contraindications.

CONDITION	**PRESENT**	**ABSENT**
Postpartum/post abortion Sepsis		
Persistently elevated hCG levels or malignant disease		
Cervical cancer		
Endometrial cancer		
PID		
Symptomatic Chlamydial infection		
Gonorrhoea		
Pelvic TB		
Unexplained vaginal bleeding suspicious for serious condition		

UK MEC 3: Relative contraindications

If present refer to Consultant care or discuss and issue bridging contraception as required.

CONDITION	**PRESENT**	**ABSENT**
Organ Transplant - Complicated (rejection, vasculopathy, cardiac allograft)		
Long QT syndrome		

Gestational trophoblastic disease
Uterine fibroids
Asymptomatic Chlamydial infection
Decreasing hCG levels
Radical Trachelectomy
Distorted uterine cavity
Past history breast cancer.
HIV infection CD4 count <200cells/mm^3
48hours to <4weeks

UK MEC 2:

A condition for which the advantages of using the method generally outweigh the theoretical or proven risks

- Cardiomyopathy, impaired cardiac function
- Valvular and congenital heart disease (complicated)
- Heavy or prolonged bleeding
- Endometriosis
- Severe dysmenorrhea
- Thalassaemia, sickle cell disease, iron deficiency anaemia.
- Vaginitis, increased risk for STI's

Counselling	**Discussed**
10 year life span	
Low failure rates, 1:20 expulsion. (1:7 postpartum)	
Changes to bleeding pattern, (may have heavy or prolonged bleeding)	
If pregnancy does occur, increased risk of an ectopic with Intrauterine method insitu.	
Rate of uterine perforation associated with IUC is 2 per 1000 insertions. (higher if breastfeeding)	
Fertility should return to normal when removed.	

Threads to be checked +/- trimmed at 6 weeks (GP/Maternity unit, give leaflet)	
Alternative choices and safer sex	

Timing of insertion:

Day 1-4 cycle		Currently on POP, COC, DMPA	
1st trimester abortion Day 1-4		Postpartum <48hrs or >4weeks	

Outside of these times:

- if no risk of pregnancy extra precautions for 7/7
- If risk of pregnancy, extra precautions for 7/7 and PT after 4/52-

UKMEC for this patient	

Name:

Signature: **Date:**

Back to Contents