| | |
|---|---|
| **Reference Number: UHBOBS375**<br>**Version Number: 3** | **Date of Next Review: 8th May 2029**<br>**Previous Trust/LHB Reference Number: n/a** |

# Postnatal Contraception Guideline

## 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*<br>*Postnatal Care*<br>*FSRH (2017) contraception following childbirth*<br>*CoSRH (2025) Best practice guideline, post pregnancy contraception* |
| **Approved by** | *Maternity Professional Forum and Obstetrics & Gynaecology Quality & Safety* |

| | |
|---|---|
| **Accountable Executive or Clinical Board Director** | *Abigail Holmes Director of Midwifery*<br>*Henry Cole Clinical Director* |
| **Author(s)** | *Judith Cutter* |

| Disclaimer<br>If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate. | | | |
|---|---|---|---|
| **Summary of reviews/amendments** | | | |
| **Version Number** | **Date of Review Approved** | **Date Published** | **Summary of Amendments** |
| 1 | *Dec 2016* | *Dec 2016* | New Document |
| 2 | *2020* | | Updated UKMEC guidance |
| 3 | *2026* | | Updated UKMEC guidance for Postnatal DMPA |

# Contents



## 1. 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 (2025) [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)

## 2. 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 suggest 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].

## 3. Pathway

### 3.1 In the antenatal period:

- Women should be given verbal and written information via Badgernet (contraceptive choices leaflet, Animation) about all contraceptive options and the importance of birth spacing. Women should be informed 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.

### 3.2 In the labour ward setting:

- Contraception should not be discussed with women who are in active labour.

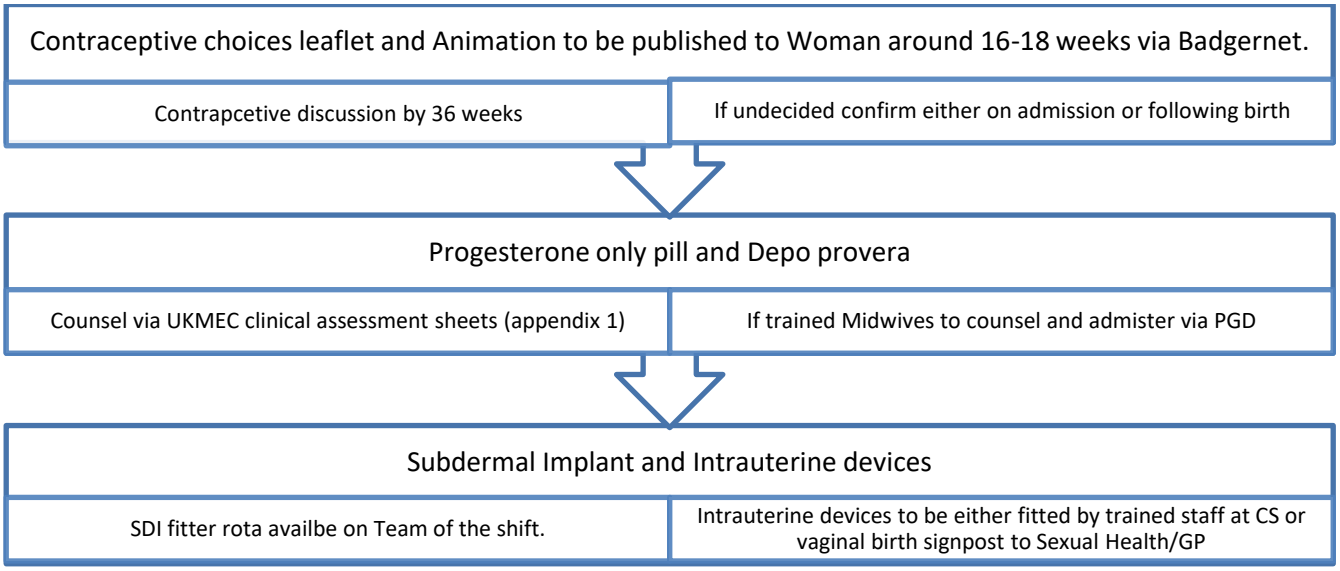
- If admitted antenatally (not in labour), contraceptive choices to be discussed so arrangements can be made following birth.
- Confirm method following birth and arrange administration. (contraceptive supplies are kept on the ward/MLU/DS)
- Using the UKMEC clinical assessment sheet (see appendix 1), 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.

# 4 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 BadgerNet maternity records | 97% |
| Discussion around postnatal contraception prior to discharge | BadgerNet | 97% |
| Women receiving postnatal contraception prior to discharge form Maternity | BadgerNet | 50% |
| Women requesting and receiving Long acting methods (SDI, IUD/IUS) | BadgerNet | 50% |

## 5. Flowchart:


Contraceptive choices leaflet and Animation to be published to Woman around 16-18 weeks via Badgernet.
Contrapcetive discussion by 36 weeks
If undecided confirm either on admission or following birth
Progesterone only pill and Depo provera
Counsel via UKMEC clinical assessment sheets (appendix 1)
If trained Midwives to counsel and admister via PGD
Subdermal Implant and Intrauterine devices
SDI fitter rota availbe on Team of the shift.
Intrauterine devices to be either fitted by trained staff at CS or vaginal birth signpost to Sexual Health/GP

## 6. References:


1. RCOG (2015) 'Leading Safe Choices', Best practice in Postpartum Family Planning, https://www.rcog.org.uk/en/guidelines-research-services/guidelines/bpp1/
2. Faculty of Sexual & Reproductive Healthcare Clinical Guidance (2017) '', Clinical Effectiveness Unit, 'Contraception after pregnancy' January 2017. http://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/
3. Trussell (2011) 'Contraceptive failure in the United States' International Reproductive Health Journal, May 2011, Vol 83, Issue 5, Pages 397-404.
4. Faculty of Sexual & Reproductive Healthcare Clinical Guidance (2014) Progestogen-only Injectable Contraception', Clinical Effectiveness Unit, December 2014. ISSN 1755-103X. http://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-injectables-dec-2014/
5. Faculty of Sexual & Reproductive Healthcare Clinical Guidance (2015) 'Progestogen-only Pills', Clinical Effectiveness Unit, March 2015. ISSN 1755-103X. http://www.fsrh.org/standards-and-guidance/documents/ceuguidanceprogestogenonlypills/
6. Faculty of Sexual & Reproductive Healthcare Clinical Guidance (2015) 'Intrauterine Contraception', Clinical Effectiveness Unit, June 2015. ISSN 1755-103X. http://www.fsrh.org/standards-and-guidance/documents/ceuguidanceintrauterinecontraception/
7. Faculty of Sexual & Reproductive Healthcare Clinical Guidance (2014) 'Progestogen-only Implants', Clinical Effectiveness Unit, February 2014. ISSN 1755-103X. http://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-implants-feb-2014/
8. College of Sexual and Reproductive Health (CoSRH) 2025, UK medical Eligibility Criteria for Contraceptive Use UKMEC_2025.pdf UKMEC_2025_Summary_Tables.pdf
9. World Health Organization, Department of Reproductive Health, and Research. Report of a WHO Technical Consultation on Birth Spacing. [Internet]. World Health Organization (WHO); 2007. Available from: http://www.who.int/reproductivehealth/publications/family_planning/WHO_RHR_07_1/en
10. Bexhell H, Guthrie K, Cleland K, *et al.* Unplanned pregnancy and contraceptive use in Hull and East Yorkshire. *Contraception* Published Online First: 28 October 2015.
11. Lakha F, Glasier A. Unintended pregnancy, and use of emergency contraception among a large cohort of women attending for antenatal care or abortion in Scotland. *Lancet* 2006; 368:1782–1787.
12. Cameron S, Craig A, Sim J, Gallimore A, Cowan S, Dundas K, et al. Feasibility and acceptability of introducing routine antenatal contraceptive counselling and provision of contraception after delivery: the APPLES pilot evaluation. BJOG An Int J Obstet Gynaecol [Internet]. 2017 May 19.
13. Sonalkar S, Gaffield ME. Introducing the World Helath Organisation postpartum family planning compendium. *Int J Gynaecol Obstet* 2017; 136;2-5.
14. Lunniss H, Cameron S, Chen ZE. Views of General practitioners on providing contraceptive advice and long-acting reversible contraception at the 6-week postnatal visit: A qualitative study. J Fam Plan Reprod Health Care, 2016; 42:99-106.

15. Heller R, Cameron S, Briggs R, Forson N, Glasier A. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plan Reprod Heal Care. 2016;42(2):93–98
16. National Institute for Health and Care Excellence (NICE). Patient group directions. Medicine Practice guidleine (MPG2), 2013. Available from: http://www.nice.org.uk/guidance/MPG2
17. CoSRH (2025) Beyind Barriers: Reimaging Access to post pregnancy contraception, A guide for best practice Best Practice Guide – Beyond Barriers – CoSRH RCOG.pdf


## 7. Resources:

**Animation:**
https://youtu.be/mXrmnNGiq1k?si=KlXSspbMdaZ4cBA6

## 8. Appendix (UKMEC clinical assessment forms)

# Depo-Provera check list

**Name**

**DOB** **BMI**

**Risk Factors:**

**UK MEC 4: Absolute Contraindications**

| Condition | Present | Absent |
|---|---|---|
| Currently being treated for breast cancer | | |

**UK MEC 3: Relative contraindications**

Conditions not recommended as risks generally outweigh advantages. If present discuss with specialist SRH doctor, or issue alternative method in the interim

| Condition | Present | Absent |
|---|---|---|
| Postpartum 0-6 weeks with VTE risk factors (as per below and consider puerperium-specific: multiple pregnancy, pre-eclampsia, caesarean section, prolonged labour >24 hours, mid-cavity or rotational operative delivery, stillbirth, preterm birth, postpartum haemorrhage >1L/requiring transfusion) | | |
| More than ONE risk factor for cardiovascular disease (smoking, diabetes, hypertension, obesity and dyslipidaemias) | | |
| Vascular disease | | |
| Current and history of ischaemic heart disease | | |
| Stroke (history of CVA, including TIA) | | |
| History of VTE or current VTE (on anticoagulants) | | |
| Major surgery (>30 minute duration, all lower limb surgery, prolonged immobilisation of a lower limb) | | |
| More than ONE risk factor for VTE (BMI >30, thrombotic or inflammatory disorders, smoking, first degree family history) | | |
| Known thrombogenic mutations (Factor V Leiden, prothrombin mutation, protein S, C and antithrombin deficiencies) | | |
| Unexplained vaginal bleeding that is suspicious for serious condition, and has not yet been evaluated | | |
| Completed treatment for breast cancer | | |
| Chronic kidney disease (CKD), including current nephrotic syndrome | | |
| Severe liver cirrhosis, liver tumours | | |
| Systemic lupus erythematosus (SLE) with positive antiphospholipid antibodies | | |

**UK MEC 2:**

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

Age <18 or >45
Postpartum <3 weeks without VTE risk factors
Breastfeeding 0 to <6 weeks
BMI ≥35
History of bariatric surgery with BMI ≥35
Organ transplant
Hypertension: systolic >140 and/or diastolic >90
Known dyslipidaemias
First degree relative history of VTE, unprovoked or provoked
Cardiomyopathy with impaired cardiac function
Cardiac arrhythmias (atrial fibrillation and long QT syndrome)
Migraine with or without Aura any age
Multiple sclerosis (MS)
Irregular, heavy or prolonged vaginal bleeding patterns
Cervical intraepithelial neoplasia (CIN)
Cervical cancer
Undiagnosed breast mass, carrier BRCA1 and 2
Ovarian and endometrial cancers
Diabetes (insulin and non-insulin dependent, vascular disease, nephropathy, retinopathy neuropathy)
Gallbladder disease
Cholestasis
Inflammatory bowel disease (IBD) including Crohn's disease and ulcerative colitis
Sickle cell disease
Rheumatoid arthritis
Systemic lupus erythematosus (SLE) WITHOUT 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:**

# 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 ischemic 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 thrombogenic 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:**

# 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:**

**Signature:** **Date:**

# 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** |
|---|---|
| 8-year life span (Mirena) (levosert 6 years) | |
| 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, seek urgent medical advice if pregnancy is suspected. | |
| 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), may need USS if threads not visible or felt. | |
| 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:**

# 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
- Thalassemia, 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. Seek urgent medical advice if pregnancy is suspected. | |
| 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) May need a USS to if threads not visible or felt. | |
| 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:**

**Leave threads untrimmed**
**Ensure appropriately recorded in Badgernet and on Aqua Theatre man.**
**Woman must be given patient information sheet, coil fitters card with date for removal and written information: -**
**The coil fitting should also be included on the WCP discharge summary**

# Postpartum Coil (IUD/IUS) Fitting at Caesarean Section

**Simple Information for Women and Community Staff**

When a coil (IUD or hormonal IUS) is fitted **during a caesarean section**, it is placed directly into the uterus **immediately after the baby and placenta are delivered**, before the uterus is closed.
This is a safe, effective, and convenient method of contraception after birth.

Because of the way the coil is inserted, the **threads (strings)** behave a little differently compared to a coil fitted in clinic. Here is what you need to know:

## 1. Threads May Be Very Long at First — This Is Normal

- During the caesarean, **the threads are left long** and **not cut**.
- This is so they can naturally **move down through the cervix** as your uterus returns to its normal size.
- As this happens, the threads may become visible at the vaginal opening — and sometimes they can even hang down the leg.
  **This looks alarming but is completely normal. The coil has *not* fallen out.**

### What to do:

- **Do NOT pull the threads.** Pulling can remove the coil by accident.
- Reassure the woman that this is expected.
- Arrange a same day review —
- To have the threads trimmed – either with practice nurse or the OAU.

.

## 2. "Lost Threads" — Sometimes the Strings Are Not Visible

Up to 40% of women will find that they **cannot feel or see the threads** after a post caesarean coil insertion.

This is also common because:

- The cervix may still be closed or high.
- The threads may still be inside the cervix and not yet visible.
- They may temporarily retract and later reappear.

### What to do:

- Arrange an **ultrasound scan** to confirm that the coil is still in the correct place.
- Advise using **condoms** or another method of additional contraception until the position is confirmed just in case the coil has been expelled.
- If the scan shows the coil is correctly positioned, no further action is needed.

Many women later report that the threads "reappear" once healing continues.

## Key Reassurance Messages for Women

- A coil fitted at caesarean section is **safe, highly effective**, and avoids the need for a separate procedure later.
- Long threads or "no threads" are **very common** after a post-CS insertion.
- The threads can be trimmed if needed.
- If the threads cannot be found, an ultrasound will check the coil's position.
- **Always avoid pulling the threads**