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Post Natal Contraception Guidelines

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Guidelines Definition

Clinical guidelines are systematically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
New guideline					

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1. Introduction

At least 30% of pregnancies are unintended in the UK every year ¹. Unplanned pregnancies are known to have poorer obstetric outcomes and also result in an inevitable increase in women seeking Abortion care. The immediate post-partum period is particularly high risk with a rapid return to fertility in most women.

A short inter- pregnancy interval (<1year) is associated with an increase in pre term labour, small for gestational age babies, stillbirth and an increase in the Caesarean Section rate. One in 13 women in the UK have a short inter-pregnancy interval or an abortion within the first year after childbirth ².

The routine six-week post-natal check is most likely no longer offered, and when offered has a high rate of non-attendance. There is a 50 per cent rate of non-attendance for appointments made in sexual health clinics during the immediate post-natal period^{3, 4}. Most methods of contraception can be safely initiated soon after birth, reducing barriers for women trying to access contraception.

“In line with RCOG guidance, services providing care to pregnant women should be able to offer all appropriate methods of contraception, including long-acting reversible contraception (LARC) to women before they are discharged from the service” (Public Health Wales 2018).

All progesterone only contraceptives are safe for use by breast feeding women, and have no effect on milk production or infant outcome.

Progesterone only contraception is immediately effective if started before day 21 of the Puerperium. Immediate use of LARC is associated with a higher continuance at 1 year. There is no increase in the rate of postpartum bleeding with the use of DMPA postnatally^{5, 6}.

This Guideline covers the use of Depo – Medroxyprogesterone Acetate (DMPA, Depo-Provera®) and the Progesterone only Pill (Desogestrel 75mcg) in the immediate post-natal period.

2. Aims and Standards

The aim of this guideline is to ensure:

- All women are informed during pregnancy of the effectiveness of different forms of contraception, including the superior effectiveness of LARCS when choosing appropriate modes of contraception in the post-natal period.
- That appropriate patient information is available to cover all aspects of contraception available post-natally.
- That contraception counselling should be made available early in the pregnancy by either Midwives or Doctors to enable women the time to choose the method which is best for them. This discussion should be clearly documented.
- Women should be advised that an inter-pregnancy interval of less than 12 months is associated with an increase in the incidence of pre term labour, low birthweight and small for gestational age babies.
- Contraception should be initiated immediately after childbirth if desired, taking into account medical suitability.
- Clinicians should refer to the relevant UK Medical Eligibility Criteria for contraception Use (UKMEC) www.fsrh.org/ukmec when making a clinical judgement on safe and appropriate methods of contraception after pregnancy.
- Women should be able to access their chosen method of contraception before being discharged from care either in hospital or in the community setting. Or, if not available at that time, have the information to be able to access sexual health services.
- Women may be advised that if they are within 6 months post-partum, amenorrhoeic and fully breast feeding, that the lactational amenorrhea method (LAM) is a highly effective method of contraception.
- Women using LAM should be advised that the risk of pregnancy increases if the frequency of breastfeeding decreases.
- Male and Female Condoms can be safely used after childbirth.
- Women using a diaphragm should be advised to wait 6 weeks until fitting one.

3. For women requesting Progesterone only contraception

A discussion should be initiated during the antenatal period by either the midwife or Doctor to allow adequate time for patient choice. Patient information leaflets on both Progesterone only pill (POP) and Depomedroxyprogesterone acetate (DMPA) should be available in the Antenatal Clinic and in the community setting. (Appendix 1)

For women requesting either POP or DMPA please follow the pathway for progesterone only contraception in the immediate postpartum period.

To be used in combination with The Checklist for health professionals providing contraception.
(Appendix 2 and 3)

4. For women requesting Postpartum intrauterine contraception (PPIUC) - Use of the Intrauterine System (IUS) in the immediate postnatal period -

Women should be informed that a coil is one of the most effective methods of contraception and that they may have this fitted just after their baby is born.

Women should be informed of the advantages of PPIUC to include the convenience of onsite fitting, immediate contraception, less painful insertion, low risk of complications, and high continuation rate.

There are exceptions for suitability which may preclude PPIUC to include signs of Sepsis, Pre-labour premature rupture of the membranes (PPROM) of more than 36 hours, or ongoing Postpartum Haemorrhage (PPH).

For PPIUC, regardless of mode of delivery there is no increased risk of uterine perforation and no increased risk of infection.

The use of PPIUC is associated with higher expulsion rates (between 8 and 20% c.f up to 8% at more than 4 weeks) but also higher continuation rates at 6 to 12 months regardless of type of IUCD or mode of delivery.

Expulsion more likely within the first 3 months and may be slightly higher after vaginal delivery. Patients should be advised that another form of contraception will be required if this occurs.

Patients should complete a self-assessment checklist (appendix 4) which will be signed and filed in advance of delivery in her maternity notes.

All women should have written information explaining the risk of expulsion and signs and symptoms of infection for which they should seek medical attention. This will be included in the post insertion advice leaflet along with advice to attend the 6-week IUS check with their GP or Integrated Sexual Health (ISH) service provider as agreed locally.

For women who have chosen this method of contraception, this may be done at Caesarean Section or just after vaginal delivery and up to 48hrs after delivery (UKMEC1) with evidence to support efficacy and safety.

If threads are not visible at the 6-week check, the patient should be sent for ultrasound and alternative contraception advised including the need for emergency contraception.

Threads should ideally be trimmed to between 2 to 3 cms from the cervix.

If the tip of the device is seen, consider partial expulsion and remove with consideration of further contraception including the need for emergency contraception.

5. Auditable Standards

Number of women who have a discussion documented regarding contraception during their antenatal period.

Number of women whom are given either POP or DMPA before leaving hospital or in the community setting within 6 weeks of delivery. (Pathway in patient notes)

Adherence to the checklist for administration of DMPA and POP.

6. Training implications

Two stage approach

Midwives can be supported to administer POP/DMPA if prescribed by a doctor with use of the checklist devised as an adjunct to the pathway. The Integrated Sexual Health department will provide training by means

of bedside and/or workshops to a selected team of midwifery contraception champions (to cover both high-risk obstetric patients and midwifery led care). This team would be able to roll out the training locally.

The second stage of training would allow the service to develop and would involve the support of a number of midwives to complete the Faculty Diploma in Sexual and Reproductive Health (DFSRH). They would then be able to prescribe via a PGD (patient group directive) for DMPA and POP and have the opportunity to become implant fitters. With PGDS in place to offer training to other midwives to both counsel and administer DMPA/POP.

7. References

1. FSRH Clinical Guideline: Contraception after Pregnancy 1 Jan 2017
Kaye Wellings, Prof, FRCOG, Kyle G Jones et al. Lancet 2013 Nov 30; 382 (9907): 1807-1816. www.fsrh.org
2. Heller R, Cameron S, Briggs R et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter pregnancy intervals. J Fam Plann Reprod Health Care 2016;42:93-98.
3. Gurtcheff SE, Turok DK, Stoddard g et al. Lactogenesis after early postpartum use of the contraceptive implant: RCT Obstet/Gynecol 2011;117:1114-1121.
4. Ogburn JAT, Espey E, Stonehoker J. Barriers to intrauterine device insertion in postpartum women. Contraception 2005;72:426-429C
5. Cameron S . Postabortal and Postpartum Contraception. Best Pract Res Clin Obstet Gynaecol 2014;28:871-880.
6. Aiken ARA, Aiken CEM, Trussell J et al. Immediate postpartum provision of highly effective reversible contraception. BJOG 2015;122:1050-1051.
7. UK Medical Eligibility Criteria for Contraceptive use
NHS Contraceptive guide www.nhs.uk/conditions/contraception

Appendix 1 Pathway for Postpartum Women Requiring Contraception

Discuss and offer contraception available for postpartum women, up to 21 days post-delivery.

Offer **Depo-Provera (Medroxyprogesterone acetate 150mg/ml – IM)**

If declines: Remind her of fertility.
RCOG advise against pregnancy within 12 months postpartum.
Offer condoms. Offer leaflet with ICASH telephone details.

If patient accepts: follow UKMEC checklist below

UKMEC / WHO 4 - ABSOLUTE CONTRAINDICATIONS, Patient CANNOT have if:

- Currently pregnant.
- Has current breast cancer.
- Has an allergy to any constituent (consider peanut or soya allergy with

UKMEC / WHO 3 – RELATIVE contraindications

- Current/History of Ischaemic Heart Disease, CVA, TIA.
- Multiple risk factors of cardiovascular disease (obesity, smoking, diabetes, lipid abnormalities).
- Liver Tumour/ Severe Liver Cirrhosis.
- Past History of Breast Cancer.
- Severe vascular complications.
- Vaginal bleeding problems, needing investigation.

UKMEC / WHO 2 – CONDITIONS REQUIRING CAUTION – Advantages outweigh the theoretical or proven risk:

If the woman has any conditions that are of concern please refer to the WHO 2 checklist

Please ensure you supply our information leaflet, highlighting the next due date (for Depo-Provera). Please highlight our contact details.
Please note the contraceptive effectiveness of DPMA is not reduced by the concurrent use of enzyme inducing medication. Please refer to current FSRH guidelines for drug interactions with hormonal contraception
<https://www.fsrh.org/home/>

Appendix 2 MEDROXYPROGESTERONE ACETATE – Depo-Provera (DMPA) & Desogestrel (POP) CHECKLIST:

Name: _____

DOB: ____/____/____

Height: ____ cm Weight: ____ Kg BMI: _____

UKMEC 4

ABSOLUTE contraindications / she CAN NOT have this medication:

Condition:	Present	Absent	Details
Current / Possible Pregnancy			
Known Allergies – Consider Nut / Soya etc. (POP)			
Current Breast Cancer			

UKMEC 3

RELATIVE contraindications / please refer to medic to consider safety to give:

Condition:	Present	Absent	Details
Current/History of Ischaemic Heart Disease, CVA, TIA			
Multiple risk factors of Cardiovascular disease (obesity, smoking, diabetes, lipid abnormalities)			
Liver Tumour/ Severe Liver Cirrhosis			
Past History of Breast Cancer			
Hypertension (vascular complications)			
Vaginal bleeding problems, needing investigation			

UKMEC / WHO 2 – Advantages generally outweigh the theoretical or proven risks. We would ask you to consider these conditions and if a patient has 2 or more of these please speak to our family planning doctor:

Migraine with Aura	Diabetes	Age <18 or >45 DMPA	Rheumatoid Arthritis
Controlled hypertension	VTE	Thrombogenic mutations	Dyslipidaemias
Atrial fibrillation	BRCA1 gene	CIN awaiting treatment	Organ transplant
Ischaemic heart disease	Liver tumour	Unexplained heavy vaginal bleeding	Gall bladder disease.
Postpartum with cardiovascular risks.		Chronic systemic disease: Crohns & ulcerative colitis (POP) malabsorption	

Appendix 3: Check List for Health Professionals

Check list for health professional providing contraception:

POP	Informed	For DMPA, please discuss:	Informed
Mode of Action.		Mode of Action.	
Administrative route: Take every day, within 3 hours (12 hours for Desogestrel).		Route of administration IM injection (deltoid, gluteal or thigh).	
When: Can be started immediately postpartum but before day 21.		When: Can be given immediately postpartum up until time of discharge.	
Failure rate: POP is 99% effective in perfect use, But 91% effective in typical use.		Depo is due every 12-14 weeks. The next dose (12 wks) will be due: _____/_____/_____ Make sure date on patients leaflet.	
48 hour rule. Vomiting, diarrhoea, missed pills. Concurrent use of other medication.		Failure Rate: Depo is over 99% effective if administered every 12 weeks.	
Side effects/ disadvantages: <ul style="list-style-type: none"> • Irregular periods, • Breast tenderness, • Mood Changes. 		Side effects/ disadvantages: <ul style="list-style-type: none"> • Irregular periods, • Amenorrhoea, • Small weight gain, • Mood changes, • Breast tenderness, • Can delay return of fertility up to 12 months, • Bone density effects: smokers/ poor diet/ anorexia/ steroid use. 	

Midwife Name: _____

Signature: _____

_____/_____/_____

Date:

APPENDIX 4

Patient informed consent

Preparing for the insertion of an intrauterine device directly after delivery

We will aim to insert either a copper Intrauterine Device or Mirena Intra Uterine System directly after delivery. It is important that you have read this checklist and have it with you at the time of delivery.

Please tick the boxes to say that you have understood and accept the following

1. I have read the leaflet or seen the website information and am familiar with my chosen method
2. I understand that no contraception is 100% effective but that the IUD/IUS has a very low risk of pregnancy (less than 1 pregnancy in 100 women over 1 year)
3. I understand that there may be up to 2 in 1000 chance of injury to the womb (perforation) at the time of insertion
4. I understand that there is a 1 in 7 chance of the device being expelled (either partially or fully) after insertion which is slightly higher than if it was inserted a little later
5. I understand that the device does not protect me against sexually transmitted infections.
6. I understand that there is a slight risk of infection (1 in 100) but this is no higher than having the device fitted at another time
7. I know that the copper IUD may make my periods heavier and more painful
8. I know that the Mirena may make my periods less heavy but can result in irregular bleeding especially in the first few months after insertion
9. I understand that I need a check at 6 weeks at which time the device threads may need to be trimmed. If they are not visible then an ultrasound scan may be required to make sure the device is present
10. I understand that in rare circumstances it may not be deemed appropriate to insert the device after delivery and this may need to be delayed for 4 weeks afterwards

Signed and printed by patient

And to be filed in her hand held notes