Western Cape Government
Health

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The Executive Director of City of Cape Town
Heads of Institutions

CIRCULAR: H...33...../2016

PROVINCIAL CONTRACEPTIVE GUIDELINES

1. **This circular replaces circular H151/2010.**
2. Attached please find the updated Provincial Contraceptive Guidelines.
3. Please read this circular in conjunction with the National Contraception & Fertility Planning Policy and Service Delivery Guidelines 2012.
4. The contents of this circular must be brought to the attention of all relevant staff.
5. Your cooperation in this regard is appreciated.

.....
DR B ENGELBRECHT

WCG: HEAD OF DEPARTMENT

DATE: 2016-03-15

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Western Cape Government

Health

Contraceptive and Fertility Planning Guidelines

February 2016

Western Cape Department of Health

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ACRONYMS & ABBREVIATIONS	
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Therapy
CFP	Contraceptive and Fertility Planning
COC	Combined Oral Contraceptive
Cu IUD	Copper Intra Uterine Device
DMPA	Medroxyprogesterone acetate
EC	Emergency Contraception
ECP	Emergency Contraceptive Pills
ETN	Etonorgestrel
GSH	Groote Schuur Hospital
HIV	Human Immuno Virus
IUD	Inter Uterine Device
LNG	Levonorgestrel
NET en	Norethisterone enanthate
OC	Oral Contraceptive
PID	Pelvic Inflammatory disease
POP	Progestogen only pills
PPFP	Post Partum Family Planning
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBH	Tygerberg Hospital

PROVINCIAL CONTRACEPTION & FERTILITY PLANNING (CFP) GUIDELINES WCG: DOH 2015/2016

1. Introduction

The practical application of the Provincial CFP Guidelines is based on the new National Contraception and Fertility Planning (CFP) Policy & Service Delivery Guidelines and the National Contraception Clinical Guidelines. Use in conjunction with the WHO Medical Eligibility Criteria (MEC) 2015.

PLEASE NOTE:

Nordette is the equivalent of Oralcon
Microval is the equivalent of Hy-an
Triphasil is the equivalent of Trigestrel
Ovral is the equivalent of Famynor and
Biphasil is no longer on National tender list.
Escapelle is available as first choice for oral emergency contraception
Nova T 380 (effective for 5yrs) has replaced CuT380A (effective for 10yrs)

However:

It is important to inform clients that the pills are the same, and that only the name and packaging has changed. Clients need to be shown how to transfer from old pill to new pill as packaging is different.

2. ORAL CONTRACEPTIVES (OC)

For women who fulfil the eligibility criteria for OC usage (WHO MEC 2015):

(a) Combined Pills (COC)

i) **Nordette/Oralcon:** is a monophasic pill and is the recommended pill of first choice

ii) **Triphasil/Trigestrel:** is a triphasic pill choice for clients with acne.

PLEASE NOTE:

The pill of first choice for women who experience pre-menstrual symptoms or heavy menses is Nordette/Oralcon. If problems such as bleeding or premenstrual symptoms occur on Triphasil, change to Nordette.
If bleeding problems persist, exclude other causes of breakthrough bleeding by careful history taking and pelvic examination [examples include default, drugs, diarrhoea and vomiting, disturbance of pregnancy, local disease, distress and short duration of use] and refer for medical assessment if necessary. If the contraceptive is cause of the breakthrough bleeding, consider change of method.
If problems such as acne occur on Nordette, change to Triphasil .

(b) Progestogen only Pills (POP)

i) **Microval /Hy-an:** is the oral contraceptive of choice in the immediate postpartum period. It is not the first line choice of oral contraceptive in other instances because of restrictiveness of dosing and breakthrough bleeding. Its main indication is as postpartum contraception. Please refer to the section on Best Practice in postpartum family planning.

(c) Special Considerations

i) **Marvelon:** is a monophasic pill with a different progestogen to Nordette and Triphasil. It is available only at Groote Schuur and Tygerberg Hospitals as they are too costly to be widely prescribed. Marvelon should be preferentially prescribed for those clients who have persistent problems on Triphasil/Trigestrel, or Nordette/Oralcon who request OC's and in whom alternative methods of contraception are unacceptable.

ii) Ovral 28: high dose oestrogen (ethinyl oestradiol/norgestrel 50µg/500µg). Unsuitable for regular use as an oral contraceptive except in specific situations:

- Clients using enzyme-inducing drugs [e.g. anti-convulsants such as phenobarbitone, phenytoin, some ARV's eg efavirenz, nevirapine, retinovir and anti-TB drugs viz. rifampicin] and who wish to use COC's must be advised of the effect of the above mentioned drugs on the efficacy of the COC.
- **St John's Wort**: which is a popular herbal remedy for depression and a variety of ailments has been shown to be an enzyme inducing agent which could result in break through bleeding or even pregnancy if taken with COC's or POP's. It is therefore suggested that women using COCs should be advised against using St John's Wort or advised to choose Ovral or an alternative contraceptive.
- Ovral is no longer recommended as the first choice for emergency contraception. To be used only if Escapelle/POP are not available.

3. EMERGENCY CONTRACEPTION (EC)

All women should be provided with information about emergency contraception for use in the event of unplanned/unprotected intercourse, sexual assault or contraceptive accident e.g. broken or slipped condom or forgotten pills.

(a) Emergency Contraceptive Pills (ECP's)

ECP's are known to be extremely safe and effective with few contraindications. They DO NOT act by causing abortion. All forms of ECP must be taken within 120 hours of unprotected intercourse. **Administer as soon as possible as efficacy decreases with time.**

Two types of ECP's are available:

- **Progestogen only pills**

  POP ECP's are more effective and produce fewer side effects (eg. nausea and vomiting) than the COC regimen and are therefore first line treatment.

  Levonorgestrel 1.5mgs.

  This is the equivalent of:

  Escapelle 1tablet as a single dose (the recommended method of emergency contraception)

  OR

  Microval 50 [fifty] tablets as a single does or 25 tablets stat and 25 tablets 12hours later.

- **Combined oral contraceptive regimen (Yuzpe method)**

  Norgestrel/Levonorgestrel 0.5 mg and Ethinyloestradiol 0.1 mg x2 doses.

  This is the equivalent of:

  Ovral 2 tablets + 2 tablets taken 12 hours later

  OR

  Nordette 4 tablets + 4 tablets 12 hours later

NB: ESCAPELLE IS THE FIRST CHOICE OF ECP AND IS AVAILABLE AT ALL LEVELS OF CARE.

COC TO BE USED ONLY IF THE PROGESTOGEN ONLY PILLS ARE NOT AVAILABLE.

Clients should be informed that this method does not protect against further unprotected intercourse and a barrier method should be used until an ongoing method has been established. Quick start of regular contraception at time of EC request should be advocated (see bridging to ongoing contraception below).

Emergency Contraceptive Pills may be given repeatedly if required. Whilst not ideal, ECP's should not be withheld or rationed. Clients

should be counselled that use of a regular method of contraception, is not only more effective, but also has fewer side effects.

There should be no barriers to accessing ECPs and it MUST be available at all levels of care including Emergency Centres.

For women using enzyme-inducing drugs, including ARV's, or within 30 days of stopping them, the dose should be increased by 50% e.g 2 Escapelle stat or 75 Microval tablets stat or 3+ 3 Ovral or 6+6 Nordette.

Bridging to on-going contraception

1. All clients eligible for EC should be offered Cu-IUD insertion which provides the most effective EC and can be used for ongoing, regular contraception.
2. If client prefer ECPs, discuss regular contraception and offer to quick-start combined oral contraception, injectable or sub dermal implant at time of visit.
3. Advise client that there is no evidence that hormones in ECP will harm the foetus if pregnant
4. Take ECPs today and start with COC the following day.
5. Do a follow-up urine pregnancy test in two weeks if injection/sub-dermal implant was given, or if no withdrawal bleed occurs at the end of the first cycle of COC
6. If negative, continue with method.
7. If positive, provide appropriate counselling.

(b) Copper Intra Uterine Device (Nova T 380):

It is the **most effective** form of emergency contraception **if inserted within 120 hours of unprotected intercourse.**
This is suitable for all clients who fulfil the eligibility criteria for use. The IUD may be inserted as emergency contraception and either remains in situ or can be removed at the time of the next menstruation when a more appropriate method can be started.

4. INJECTABLES

i) **Depo medroxyprogesterone acetate (DMPA)**
ii) **Norethisterone enantate (Net En)**

Both DMPA and Net En are extremely safe, effective contraceptives. It is suitable for use by most nulliparous and multiparous women of all ages who request injectable contraceptives.

There are differences in the side effects profile between DMPA and Net En. Bleeding disturbances, weight gain and delay in return to fertility are minimal with Net En. Based on current evidence there is no justification to prescribe one product in preference to the other, for reasons of age or parity alone. However it is clear that individual women may respond differently to the two products.
The obvious benefit of 4 injections versus 6 injections per year should be taken into consideration and explained to the client.

In view of the significant cost differential and additional service delivery load associated with 8 weekly injections the following guidelines for management are recommended.

- All new clients initiating injectables should be given DMPA
- Clients currently using Net En who have not previously used DMPA should be given DMPA after receiving appropriate, unbiased explanation for the change.
- Clients who then experience, or who have in the past experienced unacceptable side effects when using DMPA should be able to use/continue to use Net En.

Because of the inconclusive nature of the body of evidence on progestogen-only injectable contraception and risk of HIV acquisition, women using progestogen-only injectable contraception should be strongly advised to also always use condoms, male or female, and other preventive measures.

NB: Injectable contraceptives must be administered with Promex syringes obtainable from the Cape Medical Depot.

5. SUBDERMAL IMPLANTS

i) Implanon NXT® is a single rod containing etonorgestrel and is used for 3 years

ii) Jadelle®) is a two rod system containing levonorgestrel and is used for 5 years

Long-acting progestogen subdermal implants are proven to be highly effective and safe. Implants contain no oestrogen and are therefore suitable for most women, including those who are breastfeeding or cannot, or do not wish to, use oestrogen.

Implants have been shown to be the most effective form of contraception, with extremely low failure rates and high continuation

rates. Despite high initial costs they have proved to be cost effective compared to the use of pills and injections in one year.

A trained health care provider (doctor or nurse) is required to insert and remove implants. Whilst single and two rod systems are similar in action, the insertion techniques for each is different and health care workers will require appropriate training before attempting to fit or remove sub dermal implants.

Medicines that are strong enzyme inducers (e.g. carbamazepine, efavirenz, phenobarbital, phenytoin, rifampicin) could impair the contraceptive efficacy of the progestin subdermal implants by increasing the metabolism and lowering the concentrations of the progestins in the blood. The most effective contraceptive method under these circumstances is the Cu IUD (Nova T)

NB:

i. A 'trained nurse' refers to a Clinical Nurse Practitioner and Professional nurse that has successfully completed the Basic Contraceptive and Fertility Planning course

ii. A midwife, once trained in implant insertions, may insert if the implant has been prescribed by a doctor. See Circular H205/2014.

The main reason for discontinuation of the use of implants is abnormalities with bleeding patterns. This can be avoided if women are adequately counselled.

The following bleeding patterns may be experienced:

1 woman in 3 will experience normal menses
1 woman in 4 will have only 2-4 menses per year
1 in 5 women will experience amenorrhoea
1 in 6 women will experience nuisance bleeding [irregular, prolonged or frequent]

MANAGEMENT OF BLEEDING ABNORMALITIES WITH PROGESTOGEN ONLY CONTRACEPTION

i) AMENORRHOEA:
This is an expected bleeding pattern. If there is a change from an established bleeding pattern to amenorrhoea, exclude pregnancy. If the pregnancy test is negative, reassure.

ii) LIGHT- OR IRREGULAR BLEEDING:
Reassure the client that this type of bleeding is not uncommon during the first three to six months of use.If the bleeding is troublesome, it can

usually be controlled with a low-dose COC, such as **Nordette** given cyclically, including inactive pills for up to 3 cycles or a **non-steroidal anti-inflammatory drug (NSAID)** but not aspirin, for example Ibuprofen (400 mg 3 times a day for 3 days), if oestrogen is contraindicated.
If there are reasons to suspect another gynaecological problem examine and manage or refer as appropriate.

iii) HEAVY BLEEDING WITH DMPA
May be treated with a course of Ovral (high dose oestrogen)
Heavy, prolonged or frequent bleeding that does not improve with the above measures requires referral especially in women with anaemia. Advise iron-rich foods and iron supplements, if necessary.
If unacceptable bleeding recurs or persists, in the absence of pathology advise change to another method.

6. INTRA-UTERINE DEVICE

i) Copper intrauterine contraceptive device [Cu-IUD]:

Cu-IUD use should be promoted more widely amongst suitable clients as an extremely cost effective, safe, long acting, rapidly reversible method of contraception. Currently there are two types of Cu-IUDs available viz. Nova T 380 and Cu T 380A. The main difference is that the duration of use Nova T 380 is for 5 years and Cu T380A is for 10years.

Cu IUDs do not contain any hormones and are therefore suitable for use in women in whom hormones are contra-indicated or for those who do not wish to use hormones.

All women must have a 6-week follow up after insertion for IUD strings check. This can be provided at any health care facility and is not limited to the facility at which insertion of the IUD was performed. Ideally this should be done with a speculum, however if no speculums are available the minimum requirement is a vaginal examination to "feel" the strings.

If the strings are not seen/felt it is likely that the IUD has been either been expelled, is malpositioned or has perforated the uterus. In this case, the woman may not have contraceptive cover. It is therefore advisable that a pregnancy test be done. Alternative contraception should be provided in all cases where strings are not seen and the woman **must** be referred to a facility where ultrasound or X-rays are available.

The risk of expulsion is highest in the first few months after insertion usually at the time of a woman's menstruation. Women must be taught how to check the strings themselves and advised to check after their menstrual

period. If they cannot feel the strings they should report to their nearest health facility.

There is a chance of developing infection in the 21 days following insertion. This is due to the insertion procedure and **NOT** the IUD. Treat the infection according to the guidelines for stage 1 PID and leave the IUD in situ. If the woman is systemically unwell or not responding to treatment refer to the Emergency Centre.

ii) Levonorgestrel releasing intrauterine system

The Levonorgestrel releasing intrauterine system (Mirena ®) is available TBH and GSH for specific indications eg. women who have heavy menstrual bleeding, and is therefore unsuitable for Cu-IUD and in whom systemic hormones are contraindicated or not tolerated.

7. DUAL PROTECTION:

All clients should be assisted in assessing their personal risk of exposure to STI's including HIV with appropriate advice about safer sexual practices and condom use [male or female] either alone or in combination with the contraceptive method of choice to prevent both pregnancy and **STI's/HIV.** Female condoms must be available at all service points and staff trained to educate clients on their usage.

8. CONTRACEPTION AND ANTIRETROVIRAL THERAPY

Contraception and family planning are essential components of HIV care. Drug interactions with ARV's are important considerations with hormonal contraception.

Integration of CFP services into HIV care

All ARV sites are equipped with contraceptives, and the staff trained to render a CFP service thereby meeting the contraceptive need of all HIV+ clients.

Dual method

It is strongly recommended that all HIV-positive clients who wish to avoid pregnancy should consider dual method use – effective contraceptive method of their choice for pregnancy prevention and consistent use of male or female condoms – to prevent STI and HIV transmission between partners. If a woman chooses to rely on condoms for both pregnancy prevention and prevention of HIV transmission to her partner, then she should also be counselled about the use of emergency contraception in case condoms were not used consistently and/or correctly.

Hormonal contraceptives

Many hormonal contraceptives are metabolised (broken down) by enzymes in the liver. Enzyme inducing ARVs increase the activity of these enzymes thereby making the contraceptive less effective. The contraceptive efficacy of DMPA is not affected. **There is no evidence that progestogen only injectables (DMPA & Net-EN) intervals should be reduced in users of ARVs and other enzyme inducing drugs.**

DMPA and the Cu-IUD should be the first choice for women on these drugs.

Intrauterine devices

Women with AIDS, who do not receive ART or those who are not clinically well on ART, should not initiate intrauterine devices. Women who already have the IUD in situ and develop AIDS can continue to use it safely even if they are not on ART

ECPs see section 2 above.

9. CONTRACEPTION AND ANTI-TUBERCULOSIS THERAPY

Hormonal Contraception

Interaction with rifampicin or rifabutin may reduce the efficacy of OC's, LNG/ETN implants and NET-EN. Do not use a COC or POP. Do not insert implant while on rifampicin or rifabutin. If the woman already has an implant in situ, cover with another non hormonal form of contraception (IUD or condom) until 2 months after TB treatment completed because the effect of rifampicin may last up to 2 months after it has been discontinued.

DMPA and Cu IUD are recommended as first choice for contraception in women on the above agents. Cu IUD is contraindicated in women who have pelvic TB.

There is no evidence that DMPA injection intervals should be reduced in users of rifampicin or rifabutin.

10. BEST PRACTICE IN POSTPARTUM FAMILY PLANNING

Postpartum family planning (PPFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth. PPFP is often ignored and a number of biases and misconceptions have limited its availability. 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.

Refer to attached Addendum 1: Leading Safe Choices: Best practice in postpartum family planning

11. Acknowledgements

These guidelines were compiled by:

Prof Petrus Steyn & Dr Margaret Moss and in consultation with the provincial and District MCWH Programme Managers.

The guidelines were reviewed by:

Dr. Malika Patel
Dr. Greg Petro
Dr. Judy Kluge
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Ms. Hasina Khaki

leading SAFE choices

Royal College of Obstetricians & Gynaecologists

Best practice in postpartum family planning

Best Practice Paper No. 1

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Contents

Introduction to the *Best Practice Papers*

Professionals providing reproductive health care have a responsibility to ensure that the women and men they treat benefit from the latest evidence-based clinical practices. In support of these, and in line with the Royal College of Obstetricians and Gynaecologists' mandate of improving health care for women everywhere, by setting standards for clinical practice, this *Best Practice Paper* sets out the essential elements of a high-quality postpartum family planning (PPFP) service.

The best practices described are drawn from current evidence-based guidance produced by organisations such as such as the World Health Organization (WHO) and the UK Faculty of Sexual and Reproductive Healthcare. So as to be readable and useful to people providing health care on a daily basis, the paper has been deliberately kept short and succinct. Therefore the primary evidence for the recommendations and the strength of that evidence have been omitted but can be found in the original source documents. Very recently published evidence has been assessed to determine whether any of the recommendations from current guidelines should be amended.

The use of the clinical recommendations should be individualised to each woman, with emphasis on her clinical needs.

The recommendations may also be used as a tool to assist policy makers in moving their services forward.

While the paper may be used for reference in any country, varying legal, regulatory, policy and service-delivery contexts may require some recommendations to be adapted to the local context; however, it is important to ensure that best practice is maintained.

For support on adapting the document while still maintaining good practice, please write to leadingsafechoices@rcog.org.uk.

Acknowledgements

This document was developed by Anna Glasier in close consultation with David Baird, Paul Blumenthal, Sharon Cameron, Alison Fiander, Ailsa Gebbie, Stefan Gebhardt, Natalie Kapp, Hawa Kawawa, Judy Kluge, Patricia Lohr, Grace Magembe, Gileard Masenga, Projestine Muganyizi, Malika Patel, Gregory Petro, Lesley Regan, Sam Rowlands, Petrus Steyn and Zephne van der Spuy. It was peer reviewed by Sir Sabaratnam Arulkumaran, Angelina Namiba and Jeffrey Smith.

The Leading Safe Choices initiative

Globally, 222 million women would like to prevent or delay pregnancy but have no access to contraception. Meeting this need would allow women to control their own fertility and reduce maternal deaths by one-third, with lasting benefits for their families and communities.

Thanks to a three year, multi-million pound grant, an important new initiative called Leading Safe Choices offers the RCOG a unique opportunity to address this unmet need. Leading Safe Choices will initially pilot in Tanzania and South Africa and focus on PPFP in both countries, and on comprehensive abortion care in South Africa and comprehensive post-abortion care in Tanzania.

The initiative will take an integrated systems approach, working within existing health structures and with professionals currently working in women's health in these two countries. The pilot phase will focus on selected high-volume maternity hospitals and midwifery units, increasing skills and improving quality in PPFP and comprehensive abortion care.

The programme has three broad objectives:

1 developing RCOG *Best Practice Papers* on PPFP and comprehensive abortion care in South Africa and on comprehensive post-abortion care in Tanzania
2 training healthcare providers and supporting the delivery of high-quality PPFP and comprehensive abortion care in South Africa and comprehensive post-abortion care in Tanzania
3 establishing a formal accreditation and certification process to:
   - recognise competence
   - raise standing within professions
   - increase the uptake and quality of service provision.

The long-term vision is to expand the Initiative across South Africa and Tanzania and to other countries, following on from this pilot phase.

Why is PPFP important?

Postpartum family planning (PPFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth. PPFP is often ignored and a number of biases and misconceptions have limited its availability. 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. It is clear from the statistics below that PPFP saves lives:

- Worldwide, more than 9 out of 10 women want to avoid pregnancy for 2 years after having had a baby, but 1 in 7 of them is not using contraception.
- PPFP can save mothers' lives – family planning can prevent more than one-third of maternal deaths. PPFP can also save babies' lives – family planning can prevent 1 in 10 deaths among babies if couples space their pregnancies more than 2 years apart.
- Closely spaced pregnancies within the first year postpartum increase the risks of preterm birth, low birthweight and small-for-gestational-age babies.
- The risk of child mortality is highest for very short birth-to-pregnancy intervals (i.e. less than 12 months).
- The timing of the return of fertility after childbirth is variable and unpredictable. Women can get pregnant before the return of menstruation.

The purpose of a comprehensive PPFP service is to help women to choose the contraceptive method they want to use, to start that method, and to continue to use it for 2 years or longer, depending on their reproductive plans.

It is best practice when talking to women about using contraception postpartum to be helpful and respectful and to listen to what they have to say. Women should be given the opportunity to make an informed choice about their contraceptive method.

When should contraception be provided?

Some couples start having sex again before 6 weeks after the baby is born. Pregnancy can occur by 6 weeks if a woman does not exclusively breastfeed so it is important to make sure that a method is provided by 4 weeks postpartum. Women who do breastfeed have postpartum amenorrhoea for varying lengths of time, depending on their breastfeeding practices, but ovulation and therefore pregnancy can occur before menstruation resumes. For women who are using the lactational amenorrhoea method (LAM) as their contraceptive method, it is important to support them to choose and start another method of family planning by 6 months postpartum.

> Best practice aims to ensure that women have a method of contraception that they can start before the risk of pregnancy returns after childbirth.

Opportunities exist for making sure that women have counselling and can choose a contraceptive method to use postpartum when they attend for antenatal care, delivery, postpartum care or immunisation of their new baby.

> Best practice is for the chosen method of contraception to be started before the woman leaves the birthing facility.

> If contraception is started at any time within the first 4 weeks after delivery, there is no need to check for pregnancy.

If you miss the opportunity to help a woman start a method of contraception in the first 4 weeks after her baby is born, you can still help her to start as soon as possible.

If a method is started after 4 weeks postpartum, particularly if menstrual cycles have returned, then an assessment of the risk of pregnancy should be made. If pregnancy testing is not available, this should not be a barrier to starting a method. It is reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following WHO criteria:

- is within 7 days of the start of normal menstruation
- has not had sexual intercourse since the start of last normal menstruation
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority (at least 85%) of feeds are breastfeeds), is amenorrhoeic and is no more than 6 months postpartum.

If a woman has had intercourse since the start of last menstruation, use of emergency contraception should be considered for prevention of unintended pregnancy.

What can be done to make sure opportunities for providing PPFP are not missed?

PPFP should be discussed at every opportunity. If you can, *you should start to discuss PPFP while the woman is still pregnant* so that she is able to start her chosen method as soon as possible after delivery.

In the antenatal clinic

- Women should be given verbal and written information about all PPFP options. Women should be told about the particular benefits of PPFP, particularly of intrauterine devices (IUDs) and implants.
- For women who are considering limiting their family size, it may be appropriate to discuss vasectomy or female sterilisation with the woman and her partner at this time.
- For women who are considering limiting their family size and undergoing a planned caesarean section, the possibility of concurrent tubal ligation should be discussed.
- Women should be given the opportunity to ask questions about contraception every time they are seen in the antenatal clinic.
- The method that the woman has chosen should be documented in the appropriate case record so that it can be provided as soon as possible after childbirth.
- If hormonal pills or barrier methods are chosen, these could be provided during late pregnancy so that women have a supply at home to start at the appropriate time after childbirth.

In the labour ward

- Women should be asked whether they have received contraceptive advice antenatally and, if so, the method they have chosen should be confirmed and then provided unless complications during pregnancy or delivery indicate the need for review.
- If the chosen method is not available in the labour ward, the method should be provided before the woman leaves the hospital or she should be referred to the most convenient place where the contraceptive method can be provided.
- Contraception should not be discussed with a woman who is in active labour.
- In women having a caesarean section, IUDs can be fitted as soon as the placenta has been delivered. Insertion is simple and expulsion rates are low.

In the postnatal ward

- 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 an IUD if within 48 hours of delivery) should be provided.

In the postpartum care clinic

- Women attending for postpartum care should be asked whether they are using, or have a supply of, contraception.
- It should be confirmed with women who have chosen their method that they are happy with their choice, are knowledgeable about the method, have sufficient supplies and know where they can get more (if appropriate).
- If a woman has not chosen a contraceptive method, she should be told about all methods, particularly the most effective methods, and arrangements made to provide her with the method she has chosen.

In the baby immunisation clinic

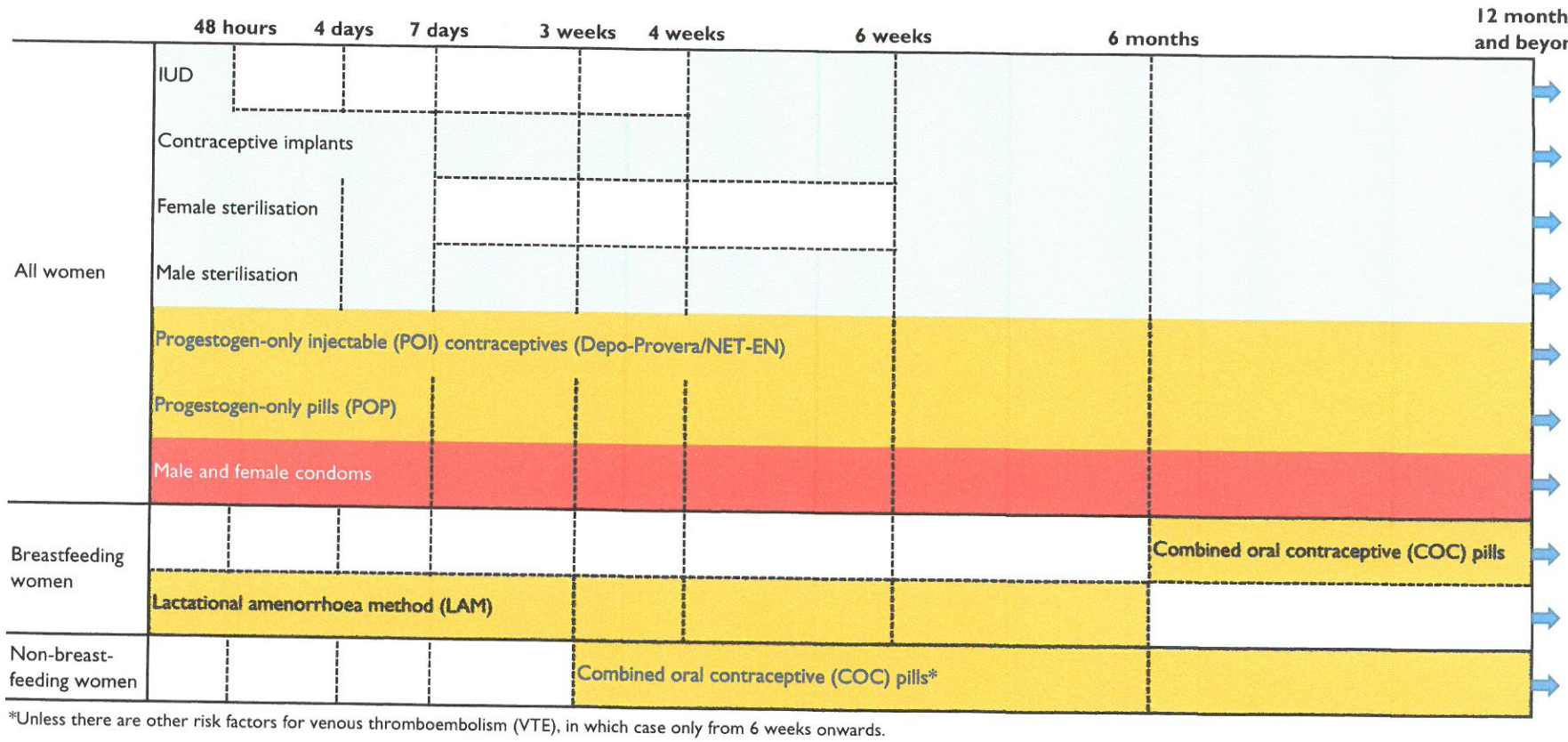
- Women bringing their babies for immunisation should be asked whether they are using contraception.
- It should be confirmed with women who have chosen their method that they are happy with their choice, are knowledgeable about the method, have sufficient supplies and know where they can get more (if appropriate).
- If a woman is not using contraception, she should be told about all methods, particularly the most effective methods, and arrangements made to provide her with the method she has chosen.

Which methods can be provided and when can they be started?

There are many myths and misconceptions about which methods of contraception can be provided to women after childbirth, including among providers. All providers should be correctly informed about which methods can be provided.

The most effective reversible methods of contraception are IUDs and contraceptive implants. Once inserted, their failure rates are extremely low (less than 1 unintended pregnancy per 1000 users within the first year of typical use). Unlike other methods of contraception, once IUDs or implants are in place the user needs to do nothing on a regular basis to ensure their effective action. They also need to take steps to get them removed (rather than simply stopping the method) and so continuation rates and pregnancy prevention are high. There is evidence that contraceptive implants, and even more so IUDs, are *much more likely* to prevent early unintended pregnancy following childbirth than all other methods.

It is best practice to advise all women at risk of HIV infection to use condoms as well as the method they have chosen for contraception. In settings where the risk of HIV infection is high, this advice should be emphasised at every opportunity.



*Unless there are other risk factors for venous thromboembolism (VTE), in which case only from 6 weeks onwards.

Postpartum contraception options: timing of method initiation for all women, for breastfeeding women and for non-breastfeeding women; adapted from WHO (2013) ***Programming Strategies for Postpartum Family Planning***

The most effective methods

These methods are generally associated with failure rates of less than 1 per 1000 users.

Intrauterine devices (IUDs)

- Copper IUDs prevent pregnancy for 5–10 years (depending on the type) and the levonorgestrel-releasing IUD (LNG-IUD, Mirena®) for up to 7 years.
- Failure rates are less than 1 per 1000 users.
- IUDs do not protect against sexually transmitted infections (STIs), including HIV, and are safe for women who have HIV/AIDS.

In the postpartum setting:

- IUDs can be inserted following expulsion of the placenta. It is most convenient and best practice to insert them immediately after the placenta has been delivered. If this is not possible, it is good practice to insert the IUD before the woman leaves the labour ward.
- It is best practice to insert the IUD before the woman leaves the labour ward.
- An IUD can be inserted up to 48 hours after the baby is born.
- If the IUD is not inserted within 48 hours, insertion should be delayed until 4 weeks after the birth (referred to as 'interval insertion') to reduce the risk of uterine perforation.
- The IUD can be inserted at the time of caesarean section via the uterine incision once the placenta has been delivered.
- While rates of IUD expulsion after postpartum insertion are slightly higher than after interval or later insertion, the benefits of providing highly effective contraception immediately after delivery outweigh this disadvantage.
- Rates of perforation and infection for postpartum IUD use appear to be similar to or even lower than those associated with interval insertion.
- Use of a copper IUD postpartum does not interfere with breastfeeding.
- Return of fertility is immediate after an IUD is removed.
- LNG-IUDs can also be used in the postpartum setting.
- There is some evidence that women who use LNG-IUDs may breastfeed for a shorter time.

Contraceptive implants

- Implants are effective for 3–5 years or more depending on which implant is used.
- Failure rates are around 1 per 1000 users.
- Implants do not protect against STIs, including HIV.
- Return of fertility is immediate after the implant is removed.

In the postpartum setting:

- Implants can be inserted immediately postpartum, including before a woman leaves the birthing facility. If inserted before 3 weeks after delivery, there is no need to check for pregnancy.
- Postpartum implant use does not interfere with lactation.

Permanent contraception

Female sterilisation

- Failure rates of female sterilisation are around 2 per 1000 women but the method is considered permanent.
- Female sterilisation does not protect against STIs, including HIV.

In the postpartum setting:

- Female sterilisation can be performed within the first 7 days postpartum or at any time after the baby is 6 weeks old. Between 7 days and 6 weeks there is an increased risk of complications as the uterus has not fully involuted.
- If a woman is scheduled for sterilisation at a later date, she should be provided with an effective interim method of contraception (e.g. a hormonal method) that will protect her from pregnancy until she undergoes sterilisation.
- It may be convenient to perform female sterilisation at the time of elective caesarean section.

Male sterilisation (vasectomy)

- Failure rates of male sterilisation (vasectomy) are around 1 per 1000 men but the method is considered permanent.
- Vasectomy does not protect against STIs, including HIV.

In the postpartum setting:

- Vasectomy can be performed at any time, including during the antenatal or postpartum period. Newborn survival rates should be discussed if considering vasectomy during the antenatal period.
- A woman whose partner is planning to have a vasectomy should be provided with an effective interim method of contraception (e.g. a hormonal method) that will protect her from pregnancy until the vasectomy has been performed and is deemed to be effective.

Effective methods

These methods are generally associated with failure rates of more than 3 per 100 users.

Progestogen-only injectable (POI) contraceptives

- Progestogen-only injectable (POI) contraceptives (Depo-Provera® and norethisterone enanthate (NET-EN)) last 8–12 weeks and so repeat injections must be given four or more times each year, requiring the woman to return to a provider or be in contact with a community-based distributor.
- Failure rates are around 3 per 100 users largely because of failure to get a repeat injection.
- Amenorrhoea is common with these methods and the return of fertility can take some months after the method is stopped.
- POI contraceptives do not protect against STIs, including HIV.

In the postpartum setting:

- POI contraceptives can be started immediately postpartum in both breastfeeding and non-breastfeeding women.
- Postpartum POI contraceptives do not interfere with lactation.

The lactational amenorrhoea method (LAM)

Although an effective method of birth spacing when used correctly, the lactational amenorrhoea method (LAM) is time-limited as it cannot be used after the first 6 months postpartum and it requires women to be fully or nearly fully breastfeeding.

- Failure rates of LAM are around 2 per 100 women.
- Women who are breastfeeding their infants can rely on the contraceptive effects of lactation to prevent unintended pregnancy provided that they are: (1) experiencing amenorrhoea; (2) fully or nearly fully breastfeeding; and (3) less than 6 months postpartum.
- Once menstruation returns, breastfeeding frequency decreases or the baby is 6 months old, another method of contraception should be started and all available methods are suitable for use.
- LAM does not protect against STIs, including HIV.

Hormonal contraceptive pills

Progestogen-only (POP, mini) pills

- Progestogen-only (POP, mini) pills are taken continuously every day without a break. Some brands must be taken at the same time every day or they will not prevent pregnancy.
- The failure rate is around 9 per 100 users.
- POPs do not protect against STIs, including HIV.

In the postpartum setting:

- POPs can be started immediately postpartum.
- Postpartum POP use does not interfere with lactation.

Combined oral contraceptive (COC) pills

- Combined oral contraceptive (COC) pills are usually taken daily for 21 days followed by a 7 day break when withdrawal bleeding (menstruation) occurs.
- The failure rate is around 9 per 100 users.
- COCs do not protect against STIs, including HIV. They are safe for use by women with HIV/AIDS.

In the postpartum setting:

- COCs should not be used by breastfeeding women until the baby is 6 months old because they may interfere with breastfeeding.
- Women who are not breastfeeding may start COCs at 3 weeks postpartum unless they have additional risk factors for venous thromboembolism (VTE), in which case they should not start COCs until 6 weeks after childbirth.

Less effective methods

These methods are generally associated with failure rates of more than 12 per **100** users.

Male condoms

- The failure rate of male condoms is relatively high, at least 12 per 100 couples.
- Male condoms **do** protect against STIs, including HIV.

In the postpartum setting:

- Male condoms can be used at any time after childbirth.
- Male condoms do not interfere with breastfeeding.

Female condoms

- The failure rate of female condoms is relatively high, at least 12 per 100 couples.
- Female condoms may give some protection against STIs.

In the postpartum setting:

- Female condoms can be used at any time after childbirth.
- Female condoms do not interfere with breastfeeding.

The least effective methods

These methods are generally associated with failure rates of more than 18 per **100** users.

Withdrawal (coitus interruptus)

- Withdrawal failure rates are high at around 18 per 100 couples.
- Withdrawal does not protect against STIs, including HIV.

In the postpartum setting:

- Withdrawal can be used at any time after childbirth.
- Withdrawal does not interfere with breastfeeding.

Fertility awareness based (FAB) methods

- All fertility awareness based (FAB) methods have relatively high failure rates of around 24 per 100 women.
- No FAB method protects against STIs, including HIV.

In the postpartum setting:

- The ability to rely on use of FAB methods postpartum differs with respect to whether the woman is breastfeeding or not.
- Breastfeeding women cannot rely on FAB methods until they have completed three to four menstrual cycles after childbirth and so these methods are not recommended for use postpartum.
- FAB methods do not interfere with breastfeeding.

Emergency contraception

Emergency contraception can be safely used in the postpartum period even if a woman is breastfeeding. It can be used to prevent unintended pregnancy after intercourse has already occurred.

- Levonorgestrel (LNG) emergency contraception can be used at any time postpartum regardless of whether or not a woman is breastfeeding.
- High doses of ethinyl estradiol either alone or in combination with a progestogen (e.g. combined oral contraceptive pills used as emergency contraception) should not be used in the postpartum period because of the theoretical increase in risk of VTE.
- Emergency IUD insertion is the most effective method of emergency contraception and can be retained for ongoing contraception. See the above section on IUDs for more detail.

Contraception for women on antiretroviral therapy for HIV

There are potential drug interactions between some antiretroviral drugs and hormonal contraception. However, WHO has reviewed the data and concluded that the benefits of using hormonal contraception outweigh the risks (2015 MEC, Category 2).

Giving information about postpartum family planning

General points

It is important to reach women *before* they are at risk of an unintended pregnancy with information about return of fertility, their options to space or limit future pregnancies, and the benefits to their own and their baby's health of doing so.

Contraception should preferably be discussed with all women while they are still pregnant since this allows them to choose immediate postpartum contraception without the need to make a hurried choice. Patient information leaflets about PPFP options should be given at the antenatal visit. Since interbirth intervals of at least 2 years are recommended by WHO for the health of both mother and infant, long-acting methods such as post-placental IUD insertion should be encouraged. When discussing the range of contraceptive methods available to women after childbirth, the importance of choosing the most effective method that is acceptable to the woman should be emphasised. IUDs and implants are the most effective reversible methods of contraception.

It is important to listen to what the woman has to say about her experience with contraceptive methods in the past and to try to dispel any misconceptions she may have about particular methods.

Women should be invited to discuss their choice of contraceptive method with their partner or other family members if desired or appropriate. Women who have not decided on their chosen method should be given every opportunity to discuss contraception including during very early labour, if appropriate, or else immediately postpartum. If a woman brings her baby to a clinic for immunisation or if she attends a clinic for any other reason and she is not yet using contraception, available methods should be discussed and provided for her or she should be referred to a service where her chosen method can be provided. If she chooses a method such as sterilisation that cannot be provided there and then, ensure that an interim method is provided in order to prevent unintended pregnancy. In settings that have strong community health systems, the community health workers should also be engaged to disseminate information (both antenatally and postnatally) and to encourage women to seek PPFP services.

Whenever contraceptive counselling is provided, care should be taken to avoid putting undue pressure on the woman to choose a particular method as she is more likely to continue a method if it is acceptable to her. Reminder systems can be developed in antenatal records or client charts to offer family planning counselling at every client contact, in an effort to reduce missed opportunities.

Women at risk of HIV infection should be advised to use condoms in addition to their chosen method of contraception.

What do you need to know about a woman thinking about PPFP?

Women should be asked about infant feeding and, if they are breastfeeding, for how long they plan to continue. Women planning to breastfeed should not use combined hormonal methods of contraception until the baby is 6 months old or until breastfeeding stops, whichever is sooner. Women planning to use LAM should be told when they need to start using another method of contraception, and their chosen method should be provided *before* they need to start using it.

A medical history should be taken from all women and medical eligibility checked. This will need to be checked again if labour or delivery is complicated (e.g. puerperal sepsis). There should be no restrictions on provision of any method based on age, parity or the number of children a woman

has had, unless there is a medical reason. The Appendix on page 16 lists common and/or important side effects and circumstances in which a method should not be used.

What do women need to know about PPFP?

Effectiveness and correct use	• Women should be told that the most effective methods of postpartum contraception are IUDs and implants and that either of these can be provided as soon as the baby is born. • Women should be informed about the importance of using their chosen method correctly and consistently. If a woman is likely to find it difficult to remember to take a pill every day, or if her partner is reluctant to use condoms, the benefits of IUDs and implants, which are independent of compliance, should be emphasised.
Side effects	• Women should be given information about common side effects associated with the chosen method (see the Appendix) and which of these are serious (e.g. symptoms suggestive of VTE in a woman using the combined oral contraceptive pill), and reassured about those that are not serious. They must know where they can go for advice and help if problems arise. • Women should be told that if they are experiencing unwanted side effects or problems with their chosen method they should seek advice about changing to an alternative method *rather than simply stop using contraception.*
Follow-up care and re-supply	• Women using an IUD or contraceptive implant should be told how long it lasts, when they need to have it replaced or removed, and where this can be done. • Women choosing to have an IUD inserted should be followed up at around 6 weeks postpartum to check for expulsion – a convenient opportunity for this may be when she takes her baby to be immunised. • Women choosing POI contraceptives (Depo-Provera or NET-EN) should receive clear information about when their next injection is due and where they can get it.
Stopping a method	• All women should know what to do if they want to stop using a method of contraception, including where to get implants or IUDs removed.
STI prevention	• All women should be told that the only method of contraception that protects against STIs, including HIV, is the male condom. If they are at risk of STIs, they should be advised to tell their partner to use a condom, as well as continuing with their chosen method of contraception.

Providing supplies

Since opportunities to obtain further supplies of oral contraceptive pills or condoms may be limited, women should be given an adequate supply of their chosen method. It is best practice to ensure that every woman goes home with a method of contraception and, if appropriate, with instructions about when and how to start using the method. If provision of the chosen method is postponed for any reason, such as interval sterilisation, an effective interim method should be provided.

Recommendations for services managers

It is not enough for doctors, nurses and other healthcare workers to be well trained to provide postpartum contraception safely and appropriately. Service managers and other staff responsible for health facilities, including procurement, need to play their part in ensuring that no opportunity for providing PPFP is missed.

All healthcare staff should be adequately trained to talk to women about postpartum contraception and, where appropriate, to provide the full range of methods. Staff should be aware that adolescents have a high risk of repeat pregnancy with short birth-to-pregnancy intervals. While all contraceptive methods can be provided to adolescents, long-acting reversible contraception (LARC) methods have been shown to reduce rapid repeat pregnancy in young women.

Avoiding missed opportunities for PPFP

Antenatally

- Healthcare providers who provide antenatal care should be given the time and opportunities to be trained to give contraceptive advice.
- Discussion of contraception can become part of any antenatal visit but becomes more important for method selection as the woman approaches term. To ensure that it is being discussed, 'Contraceptive advice' can be added to maternity checklists.
- Women can be provided with information (in a variety of forms) about the importance of PPFP and the range of methods available.
- The method of contraception chosen should be documented, e.g. in the Maternity Case Record.
- DVDs or brief talks about PPFP can be provided in clinic waiting rooms. Posters emphasising the importance and advantages of PPFP should be available and visible.
- The woman's choice should be communicated to the local community-based distribution (CBD) network, if available, so that a CBD worker can provide follow-up care as needed.
- Reminders should be placed in the antenatal record for providers to structure their discussion of PPFP options with women.

In the labour ward

- Ensure that healthcare professionals (HCPs) who provide intrapartum care are trained to give contraceptive advice and to provide all methods, including IUD and implant insertion.
- Ensure that contraceptive implants and IUDs and the necessary equipment for their insertion are available at all times.

In the postnatal ward

- When women come in to the delivery suite too late in labour to discuss contraception, HCPs should raise the issue on the postnatal ward.
- HCPs on the postnatal ward should be competent to discuss all methods of contraception and to insert implants and IUDs.
- Ensure that all methods of contraception are available in the postnatal ward, including contraceptive implants and IUDs, and that the necessary equipment for insertion (including long forceps and a supply of IUDs) is available at all times.

In baby immunisation and postnatal clinics

- Ensure that HCPs at baby immunisation clinics are trained to give contraceptive advice and to provide all methods, including implants and IUDs, or are able to refer appropriately.

In all settings

- Ensure the involvement of all appropriate partners including CBD workers, midwives and peer educators.

- Facilitate training of all relevant staff in PPFP and particularly in IUD and implant insertion and follow-up care.
- Make every effort to avoid stock-outs of both contraceptives and the instruments required for IUD and implant insertion.
- Ensure that emergency contraception is available in all settings.
- Ensure that there are arrangements in place to facilitate timely access to vasectomy and interval female sterilisation.

Evidence sources

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Appendix: Common and/or important side effects of contraceptive methods and which women should not use the method

Intrauterine devices (IUDs)

Side effects

There are two types of IUD, copper IUDs and the hormone-releasing LNG-IUD (levonorgestrel-IUD, Mirena®). The important things that women considering an IUD should know are the following:

- *Perforation*: 1–2 per 1000 insertions.
- *Expulsion*: 1 in 20 women with interval insertion, up to 1 in 7 after immediate postpartum insertion.
- *Infection*: IUD insertion does not increase the risk of pelvic infection.
- *Ectopic pregnancy*: IUD use does not increase the risk of ectopic pregnancy when compared with women using no contraception.
- *Bleeding patterns*: Copper IUDs can be associated with heavier periods; mostly this settles after the first 3 months of use. Complaints of bleeding problems are less common in breastfeeding women.
  LNG-IUDs are usually associated with irregular spotting and bleeding (perhaps daily) for the first 6 weeks after insertion. This usually settles with time and many women have very light infrequent vaginal bleeding or amenorrhoea that increases the longer the method is used.
  In the first few months after childbirth, bleeding patterns are in any case likely to be different. Women who are breastfeeding may have amenorrhoea and when vaginal bleeding does occur it is often light.

When can an IUD not be inserted immediately postpartum?

- if a woman has had ruptured membranes for 24 hours or longer
- if a woman has had a postpartum haemorrhage
- when there is sepsis present.

Who should not use an IUD?

- women with active or current tubal infection or pelvic TB
- women with unexplained abnormal vaginal bleeding
- women with abnormal anatomy of the uterus, e.g. due to fibroids.

Contraceptive implants

Common or severe side effects

- *Bleeding patterns*: Depending on the type of implant, women should be advised that they are likely to experience irregular bleeding (perhaps for the full 3 years of Implanon®/Nexplanon® use). Some women (perhaps 1 in 20) will have amenorrhoea. Heavy bleeding is uncommon with implant use.
  In the first few months after childbirth, bleeding patterns are in any case likely to be different. Women who are breastfeeding may have amenorrhoea and when vaginal bleeding does occur it is often light.

Who should not use an implant?

- women with breast cancer

Progestogen-only injectable (POI) contraceptives (Depo-Provera and NET-EN)

Common or severe side effects

- *Bleeding patterns*: Use of POI contraceptives is often associated with amenorrhoea, much less often with irregular or, rarely, heavy bleeding.

Who should not use POI contraceptives?

- women with breast cancer.

Oral progestogen-only pills (POPs)

Common or severe side effects

- *Bleeding patterns*: Women should be advised that they are likely to experience irregular bleeding. Some women (perhaps 1 in 10) will have amenorrhoea. Heavy bleeding is uncommon with POP use.

Who should not use a POP?

- women with breast cancer.

Combined hormonal contraceptive pills

Common or severe side effects

- *Venous thromboembolism (VTE)*: Women who use combined hormonal contraception are at increased risk of VTE (deep venous thrombosis, commonly in the thigh or lower leg – or pulmonary embolism). Women who experience a swollen or painful calf or shortness of breath should be advised to consult a healthcare provider as soon as possible.

Who should not use combined hormonal contraceptive pills?

- women who are breastfeeding before the baby is 6 months old
- women who are not breastfeeding before the baby is 3 weeks old
- women who are not breastfeeding and who have additional risk factors for VTE before the baby is 6 weeks old
- women with a history of VTE
- women who smoke more than 15 cigarettes a day
- women with heart disease (severe hypertension, stroke, myocardial infarction, valvular disease)
- women with migraine with aura
- women with breast cancer
- women with diabetes with complications
- women with severe liver disease.

Contraception for women on antiretroviral therapy for HIV

There are potential drug interactions between some antiretroviral drugs and hormonal contraception. However, WHO has reviewed the data and concluded that the benefits of using hormonal contraception outweigh the risks (2015 MEC, Category 2).