



Best practice in postpartum family planning

Best Practice Paper No. 1
June 2015

Published by the Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London NW1 4RG

www.rcog.org.uk

Registered charity no. 213280

First published 2015

© 2015 The Royal College of Obstetricians and Gynaecologists

No part of this publication may be reproduced, stored or transmitted in any form or by any means, without the prior written permission of the publisher or, in the case of reprographic reproduction, in accordance with the terms of licences issued by the Copyright Licensing Agency in the UK [www.cla.co.uk]. Enquiries concerning reproduction outside the terms stated here should be sent to the publisher at the UK address printed on this page.

Copy-editing and typesetting: Andrew Welsh (www.andrew-welsh.com)

Contents

Introduction to the <i>Best Practice Papers</i>	ii
Why is PPFp important?	I
When should contraception be provided?	I
What can be done to make sure opportunities for providing PPFp are not missed?	2
Which methods can be provided and when can they be started?	3
Giving information about postpartum family planning	8
General points	8
What do you need to know about a woman thinking about PPFp?	8
What do women need to know about PPFp?	9
Providing supplies	9
Recommendations for services managers	9
Avoiding missed opportunities for PPFp	10
Evidence sources	11
Other publications reviewed	11
Appendix: Common and/or important side effects of contraceptive methods and which women should <u>not</u> use the method	12

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 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, Projectine 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 PFP important?

Postpartum family planning (PFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth. PFP 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 PFP 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.
- PFP can save mothers' lives – family planning can prevent more than one-third of maternal deaths. PFP 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 PFP 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 PFP are not missed?

PFP should be discussed at every opportunity. If you can, you should start to discuss PFP 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 PFP options. Women should be told about the particular benefits of PFP, 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.

	48 hours	4 days	7 days	3 weeks	4 weeks	6 weeks	6 months	12 months and beyond
All women	IUD							
	Contraceptive implants							
	Female sterilisation							
	Male sterilisation							
Breastfeeding women	Progestogen-only injectable (POI) contraceptives (Depo-Provera/NET-EN)							
	Progestogen-only pills (POP)							
	Male and female condoms							
Non-breast-feeding women	Lactational amenorrhoea method (LAM)							
	Combined oral contraceptive (COC) pills*							Combined oral contraceptive (COC) pills

*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 PFP 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 PFP 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 PFP?

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 PFP?

Effectiveness and correct use	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <i>rather than simply stop using contraception</i>.
Follow-up care and re-supply	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 PFP 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 PFP

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 PFP 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 PFP can be provided in clinic waiting rooms. Posters emphasising the importance and advantages of PFP 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 PFP 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

World Health Organization. *Medical Eligibility Criteria for Contraceptive Use*. 5th ed. Geneva: WHO; 2015.

World Health Organization. *Selected Practice Recommendations for Contraceptive Use*. 2nd ed. Geneva: WHO; 2004 [www.who.int/reproductivehealth/publications/family_planning/9241562846index/en/].

World Health Organization. *Programming Strategies for Postpartum Family Planning*. Geneva: WHO; 2013 [www.who.int/reproductivehealth/publications/family_planning/ppfp_strategies/en/].

Faculty of Sexual and Reproductive Healthcare. *UK Medical Eligibility Criteria for Contraceptive Use*. London: FSRH; 2009 [www.fsrh.org/pages/Clinical_Guidance_1.asp].

Other publications reviewed

Lopez LM, Grey TW, Chen M, Hiller JE. Strategies for improving postpartum contraceptive use: evidence from non-randomized studies. *Cochrane Database Syst Rev* 2014; (11):CD011298.

Sonalkar S, Kapp N. Intrauterine device insertion in the postpartum period: a systematic review. *Eur J Contracept Reprod Health Care* 2015; 20:4–18.

Zapata LB, Murtaza S, Whiteman MK, Jamieson DJ, Robbins CL, Marchbanks PA, et al. Contraceptive counseling and postpartum contraceptive use. *Am J Obstet Gynecol* 2015; 212:171.e1–8.

Kapp N, Curtis K, Nanda K. Progestogen-only contraceptive use among breastfeeding women: a systematic review. *Contraception* 2010; 82:17–37.

Kapp N, Curtis KM. Combined oral contraceptive use among breastfeeding women: a systematic review. *Contraception* 2010; 82(1):10–16.

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).