



Royal College of
Obstetricians &
Gynaecologists

Guidance on the provision of contraception by maternity services after childbirth during the COVID-19 pandemic

Information for healthcare professionals

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Summary of recommendations

- Information about contraception after childbirth should be offered in the antenatal period to support informed decision-making and facilitate provision of contraception by maternity services.
- After childbirth, effective contraception should be discussed and offered prior to discharge from maternity services.
- Maternity services with staff trained in postpartum insertion of intrauterine contraception and an etonogestrel implant (ENG-IMP) should offer insertion of a long-acting reversible contraception (LARC) device to all medically eligible women prior to discharge from maternity services.
- Women for whom LARC is unavailable, unacceptable or unsuitable should be offered a supply (at least 6 months) of the desogestrel progestogen-only pill (POP) prior to discharge (so long as they are medically eligible).
- If women cannot be provided with their preferred method of contraception prior to discharge from maternity services, they should be offered effective bridging contraception and information about accessing local contraceptive services.
- Women should receive clear information about how to use their contraception and when to seek medical advice.
- Protocols for timely offer and provision of contraception should be put in place to prevent delay in discharge from maternity services.

Why is it important to provide contraception after childbirth?

Fertility returns rapidly after childbirth. Faculty of Sexual and Reproductive Healthcare (FSRH) guidance¹ recommends that effective contraception is commenced as soon as possible after birth by both breastfeeding and non-breastfeeding mothers. This enables women to plan any subsequent pregnancy and avoid short inter-pregnancy intervals, which are associated with poorer pregnancy outcomes. Provision within maternity services offers an opportunity to reduce health inequalities by offering contraception to women who may otherwise not normally engage with sexual health services.

When should counselling about contraception be provided?

Discussion, information-giving and decision-making during the antenatal period about contraception after childbirth supports informed postnatal decision-making, and facilitates provision of contraceptive methods at the time of birth or prior to discharge from maternity services. Discussions during pregnancy about elective caesarean birth can be a particularly useful time to plan contraception. Prior to the birth, women may have more time to consider their options than they have immediately after giving birth, when the requirements of caring for a baby and recovering may take priority over contraceptive decision-making.¹

Clinical recommendation

Information about contraception after childbirth should be offered in the antenatal period to support informed decision-making and facilitate provision of contraception by maternity services.

When and where should contraception be provided after childbirth?

During the COVID-19 pandemic, access to sexual health and primary care contraceptive services has been significantly reduced. Maternity services are ideally placed to provide effective postpartum contraception before discharge.

Clinical recommendation

After childbirth, effective contraception should be discussed and offered prior to discharge from maternity services.

Which contraceptive methods are suitable after childbirth?

Most contraceptive methods (except combined hormonal contraception) can be started safely by most women (both breastfeeding and non-breastfeeding) immediately after birth.¹ The UK Medical Eligibility Criteria (UKMEC) 2016² should be used to support assessment of suitability of contraceptive methods (see also Appendix I).

Long-acting reversible contraception

The most effective long-acting reversible contraception (LARC) methods, including the copper intrauterine device (Cu-IUD), the levonorgestrel-releasing intrauterine system (LNG-IUS) and the etonogestrel implant (ENG-IMP) can be inserted at, or immediately after birth, in the

maternity setting by appropriately trained maternity staff. LARC methods have the advantage of providing immediate, user-independent contraception that is effective for several years without a requirement for routine follow-up. See Appendix I when assessing suitability and providing information to the woman.

A [National Reproductive Health Patient Group Direction \(PGD\) template](#) for supply of an ENG-IMP and the required local anaesthetic is available for reference.

Clinical recommendation

Maternity services with staff trained in postpartum insertion of intrauterine contraception and an ENG-IMP should offer insertion of a LARC device to all medically eligible women prior to discharge from maternity services.

Progestogen-only pill

The desogestrel progestogen-only pill (POP) is extremely safe and there are few contraindications to its use. Women can be reassured that it does not affect their breast milk supply. It can be started immediately after birth (or by day 21) without any requirement for additional contraceptive precautions. The POP is highly user-dependent and may not be suitable where the woman (or carer if required) is concerned about adherence to pill-taking. See Appendix I when assessing suitability and providing information to the woman. A [National Reproductive Health PGD template](#) for supply of the desogestrel POP is available for reference.

Clinical recommendation

Women for whom LARC is unavailable, unacceptable or unsuitable should be offered a supply (at least 6 months) of the desogestrel POP prior to discharge (so long as they are medically eligible).

Depot medroxyprogesterone acetate

Depot medroxyprogesterone acetate (DMPA) can be administered immediately after childbirth and could be administered prior to discharge if other methods are unsuitable, unacceptable or unavailable. Women can be reassured that it does not affect their breast milk supply. Both intramuscular and subcutaneous DMPA preparations are now available. DMPA is effective for contraception for 13 weeks; the woman may then need to access ongoing contraception as long as in-person services are limited.¹ Women can be taught to self-administer subcutaneous DMPA at home to avoid additional in-person contact with healthcare professionals.

Combined hormonal contraception

Contraception is recommended from day 21 after childbirth unless the woman is fully breastfeeding and amenorrhoeic. Combined hormonal contraception (CHC) should not be

started until 6 weeks after birth in breastfeeding women or in non-breastfeeding women with additional risk factors for venous thromboembolism (VTE). Postnatal risk factors for VTE are discussed in RCOG Green-top Guideline 37a *Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium*.³ Women who are not breastfeeding and have no additional VTE risk factors may consider the use of CHC from 3 weeks after childbirth.¹

There are significant potential health risks associated with the use of CHC in the immediate postnatal period, therefore prior to provision, medical eligibility must be carefully assessed, blood pressure and body-mass index measured, and users advised about CHC-associated health risks. Such requirements could be a barrier to provision of CHC by maternity services. CHC may be offered to eligible women where other methods are unsuitable, unacceptable or unavailable. In these circumstances, a 6-month supply of CHC could be provided prior to discharge, with clear instructions as to when to start and the interim requirement for alternative contraception.

Lactational amenorrhoea

It is recognised that fully breastfeeding women can rely on lactational amenorrhoea for contraception for the first 6 months after birth, so long as they remain amenorrhoeic AND continue to breastfeed fully. A woman may, however, reduce breastfeeding or have their first period at any time, with resulting loss of contraceptive effect; this could come at a time when access to contraception services is still restricted by COVID-19. It is recommended, therefore, that breastfeeding women commence additional contraception as soon as possible after birth.¹

Female sterilisation

FSRH guidance recommends that, because of concern about potential regret, written consent to female sterilisation for women undergoing elective caesarean section should be obtained at least 2 weeks prior to the birth.¹

Clinical recommendation

If women cannot be provided with their preferred method of contraception prior to discharge from maternity services, they should be offered effective bridging contraception and information about accessing local contraceptive services.

What follow-up is required after postpartum provision of contraception?

Etonogestrel implant and progestogen-only pill

No routine follow-up is required after postpartum initiation of the ENG-IMP or desogestrel POP. See Appendix I for information that should be provided to the user.

Intrauterine contraception

Women who have undergone insertion of intrauterine contraception after childbirth may require follow-up for pain, bleeding, or expulsion, or if threads are very long or cannot be felt. Clear local pathways must be established to manage these relatively common problems and advice must be provided to women about accessing these pathways. The following models are suggested during the COVID-19 outbreak:

Problem: Unable to feel threads

Advice to user, and pathway: use condoms; contact local contraceptive provider for supply of POP; contact local Sexual and Reproductive Healthcare (SRH) service or GP to arrange an ultrasound scan.

Problem: Very long threads

Advice to user, and pathway: do not pull threads; trim threads to vaginal entrance; use condoms; contact local contraceptive provider for supply of POP; contact local SRH service to arrange review and further trimming of threads (may be deferred depending on circumstances).

Problem: Expulsion

Advice to user, and pathway: use condoms; contact local contraceptive provider for supply of POP; if local services are unable to offer insertion of intrauterine contraception because of COVID-19 restrictions, advise the woman to contact her local contraceptive provider for a supply of bridging POP.

See Appendix I for standard information that should be provided to women.

Clinical recommendation

Women should receive clear information about how to use their contraception and when to seek medical advice.

Administering and dispensing of contraception should not disrupt the timely discharge of women from maternity services. Community pharmacies and other options may need to be explored, where delays are expected to occur.

Clinical recommendation

Protocols for timely offer and provision of contraception should be put in place to prevent delay in discharge from maternity services.

References

1. Faculty of Sexual and Reproductive Healthcare. FSRH Clinical Guideline: Contraception After Pregnancy. London: FSRH; 2017 [<https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/>]. Accessed 19 January 2021.
2. Faculty of Sexual and Reproductive Healthcare. UK Medical Eligibility Criteria for Contraceptive Use (UK MEC). London: FSRH; 2016 (Updated 2019) [<https://www.fsrh.org/ukmec/>]. Accessed 19 January 2021.
3. Royal College of Obstetricians and Gynaecologists. Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. Green-top Guideline 37a. London: RCOG; 2015.
4. Family Planning Association [<https://www.fpa.org.uk/professionals/resources/leaflet-and-booklet-downloads>]. Accessed 19 January 2021.
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6. Faculty of Sexual and Reproductive Healthcare. FSRH Clinical Guideline: Progestogen-only Implant. London: FSRH; 2014 [<https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-implants-feb-2014/>]. Accessed 19 January 2021.
7. Faculty of Sexual and Reproductive Healthcare. FSRH Clinical Guideline: Progestogen-only Pills. London: FSRH; 2015 (Updated 2019) [<https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-pop-mar-2015/>]. Accessed 19 January 2021.
8. Faculty of Sexual and Reproductive Healthcare. FSRH Clinical Guideline: Progestogen-only Injectable. London: FSRH; 2014 (Updated 2020) [<https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-injectables-dec-2014/>]. Accessed 19 January 2021.

Appendix I: Fast facts to support safe provision of long-acting reversible contraception, the desogestrel progestogen-only pill and depot medroxyprogesterone acetate by maternity services

Long-Acting Reversible Contraception Fast Facts

Copper intrauterine device

The copper intrauterine device (Cu-IUD) can be inserted at the time of caesarean section, immediately after vaginal birth or at any time up to 48 hours postpartum by maternity staff trained in the technique.

Contraindications	Postpartum sepsis, history of sexually transmitted infection (STI) during the current pregnancy, current pelvic tuberculosis (TB), current gestational trophoblastic disease (GTD), diagnosis of cervical or endometrial cancer in the current pregnancy, copper allergy, Wilson disease
Potential contraindications	Previous heavy menstrual bleeding, anaemia, complications after organ transplant, long QT syndrome, previous trachelectomy, uterine cavity significantly distorted by fibroids or structural abnormality, HIV infection with CD4 count < 200 cells/ μ l
Contraceptive effectiveness	0.6–0.8% first year contraceptive failure (effective immediately); enzyme-inducing drugs do not affect contraceptive effectiveness
Duration of use	Device-dependent, 5 or 10 years
Bleeding	Often heavier, longer, more painful; pattern usually unchanged
Follow-up information required by user	How to check for threads, possibility of long threads, how to access review of pain/bleeding/very long or missing threads, replacement date (5 or 10 years)

For further information see FSRH Clinical Guidelines Contraception After Pregnancy¹ and Intrauterine Contraception.³ See the Family Planning Association (FPA) website for access to patient information.⁴

Levonorgestrel intrauterine system

The 52 mg levonorgestrel intrauterine system (LNG-IUS) can be inserted at the time of caesarean birth or immediately after vaginal birth or at any time up to 48 hours postpartum by maternity staff trained in the technique.

Contraindications	Allergy to content; postpartum sepsis, history of STI during the current pregnancy, current pelvic TB, diagnosis of breast, endometrial or cervical cancer in the current pregnancy, current GTD
Potential contraindications	Previous breast cancer diagnosis, previous arterial thromboembolic event during use, decompensated cirrhosis, hepatocellular adenoma or carcinoma, complications after organ transplant, long QT syndrome, HIV infection with CD4 count < 200 cells/ μ l, uterine cavity significantly distorted by fibroids or structural abnormality, previous trachelectomy
Contraceptive effectiveness	0.2% first year contraceptive failure rate (effective immediately if inserted postpartum); enzyme-inducing drugs do not affect contraceptive effectiveness
Duration of use	5 years (for 52 mg LNG-IUS)
Bleeding	Initially erratic, likely to become light over first year of use, may become amenorrhoeic
Follow-up information required by user	How to check for threads, possibility of long threads, how to access review of pain/bleeding/very long or missing threads, replacement date

For further information see FSRH Clinical Guidelines Contraception After Pregnancy¹ and Intrauterine Contraception.⁴ See FPA website for access to patient information.⁵

Etonogestrel implant

The etonogestrel implant (ENG-IMP) can be inserted immediately after birth or at any time prior to discharge from maternity services by maternity staff trained in the technique. If inserted by day 21 after childbirth, no additional contraceptive precautions are required.

Potential contraindications	Previous arterial thromboembolic event during use, previous breast cancer, decompensated cirrhosis, hepatic adenoma or adenocarcinoma
Contraceptive effectiveness	0.05% first year contraceptive failure rate (effective immediately if inserted by day 21 after childbirth); enzyme-inducing drugs may affect contraceptive effectiveness
Duration of use	3 years
Bleeding	Unpredictable
Follow-up information required by user	How to feel for implant, how to access review of bleeding/non-palpable implant, potential for drug interaction, replacement date

For further information see FSRH Clinical Guidelines Contraception After Pregnancy¹ and Progestogen-only Implants.⁶ See FPA website for access to patient information.⁵

Desogestrel Progestogen-Only Pill Fast Facts

The desogestrel progestogen-only pill (POP) can be started immediately after birth. If started by day 21 after childbirth, no additional contraceptive precautions are required. One pill is

taken at the same time every day. The pill can be taken up to 12 hours late without affecting contraceptive effectiveness; subsequent pills should be taken at the intended time.

Contraindications	Allergy to content; current breast cancer
Potential contraindications	Previous arterial thromboembolic event during use, previous breast cancer; decompensated cirrhosis, hepatic adenoma or adenocarcinoma
Contraceptive effectiveness	0.3% first year contraceptive failure rate if taken perfectly; 9% with typical use (effective immediately if started by day 21 postpartum); enzyme-inducing drugs and conditions that affect gastrointestinal absorption may affect contraceptive effectiveness
Bleeding	Unpredictable
Follow-up information required by user	How to take, missed pill rules (including after vomiting), possibility of drug interaction, how to access further supplies (including direction to local and online services)

For further information see FSRH Clinical Guidelines Contraception After Pregnancy¹ and Progestogen-only Pills.⁷ See FPA website for access to patient information.⁵

Depot Medroxyprogesterone Acetate Fast Facts

The depot medroxyprogesterone acetate (DMPA) injection (both intramuscular and subcutaneous preparations) can be administered immediately after birth. If started by day 21 after childbirth, no additional contraceptive precautions are required. DMPA should be repeated at 13-week intervals to maintain contraceptive effectiveness. Users may be taught to self-administer subcutaneous DMPA at home; teaching can be done virtually via video link.

Contraindications	Allergy to content; current breast cancer
Potential contraindications	Multiple risk factors for cardiovascular disease, established cardiovascular/cerebrovascular disease, previous breast cancer; decompensated cirrhosis, hepatic adenoma or adenocarcinoma
Contraceptive effectiveness	0.2% first year contraceptive failure rate if used perfectly; 6% with typical use (effective immediately if started by day 21 postpartum); enzyme-inducing drugs do not affect contraceptive effectiveness
Duration of use	13 weeks
Bleeding	Initially erratic, likely to become light over first year of use, may become amenorrhoeic
Follow-up information required by user	When next injection is required, how to access services for subsequent injections or to be taught to self-administer subcutaneous DMPA

For further information see FSRH Clinical Guidelines Contraception After Pregnancy¹ and Progestogen-only Injectable.⁸ See FPA website for access to patient information.⁵

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