FSRH Guideline

Contraception After Pregnancy

FSRH | January 2017 (Amended October 2020)

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Abbreviations Used

APS	ant p osp o p d syndro e
CEU	C n ca Effect veness n t
CHC	co b ned or ona contracept on contracept ve
CI	conf dence nterva
COC	co b ned ora contracept on contracept ve
Cu-IUD	copper ntrauter ne dev ce
CVR	co b ned contracept ve va na r n
DMPA	depot edroxypro esterone acetate

Grading of Recommendations

Please refer to **Appendix 1** for a full explanation of the classification of evidence level and grading of recommendations.

A

At least one meta-analysis, systematic review or randomised controlled trial (RCT) rated as 1++, and directly applicable to the target population;

or

A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

B

A body of evidence including studies rated as 2++ directly applicable to the

Executive Summary of Recommendations

1. Introduction: Contraception after Pregnancy

Discussion and provision of contraception after pregnancy

What methods of contraception are available in the UK?

	Clinicians should refer to the relevant current FSRH guidelines including the UK Medical Eligibility Criteria for Contraceptive use, UKMEC when making clinical judgement on safe and appropriate methods of contraception for a woman after pregnancy.

Effectiveness of contraceptive method

	Women should be informed during pregnancy about the effectiveness of different contraceptives including the superior effectiveness of long acting reversible contraception LARC when choosing an appropriate method to use after pregnancy.

Information giving and counselling

	All clinicians involved in the care of pregnant women should provide the opportunity to discuss contraception.
	Whenever contraceptive counselling is provided care should be taken to ensure women do not feel under pressure to choose a method of contraception.
D	Clinicians should adopt a person centred approach when providing contraceptive counselling.
	Clinicians who are giving advice to women about contraception after pregnancy should ensure that information is kept up to date and accurate.
	Comprehensive unbiased and accurate information on [illegible] acceptable.

	o en s ou d be nfor ed about t e effect veness of t e d fferent contracept ve et ods nc ud n t e super or effect veness of on act n revers b e contracept on LA C w en c oos n an appropr ate et od to use after c db rt -
D	C n c ans s ou d adopt a person centred approac w en prov d n wo en w t contracept ve counse n -

Who should provide contraception to women after childbirth?

	Appropr ately tra ned c n c ans nc ud n sexua and reproduct ve ea t H doctors and nurses obstetr c ans dw ves nurses ener a pract t oners GPs and ea t v s tors s ou d be ab e to prov de wo en w t contracept on after c db rt -
	Matern ty serv ces s ou d be ab e to prov de C and pro esto en ony et ods nc ud n IMP n ectab e POI or p POP to wo en before t ey are d sc ar ed fro t e serv ce after c db rt -
	Matern ty serv ces s ou d ensure t at t ere are suff c ent nu bers of staff ab e to prov de C or IMP so t at wo en w o c oose t ese et ods and are ed ca y e b e can n t ate t e ed ate y after c db rt -
	o en w o are unab e to be prov ded w t t e r c osen et od of contracept on s ou d be n for ed about serv ces w ere t e r c osen et od can be accessed A te porary br d n et od s ou d be d ffe p e e can a f bern be

	Ora EC evonor estre LNG_EC and u pr sta acetate PA_EC are safe to use fro days after c db rt - e copper ntrauter ne dev ce Cu D s safe to use for EC fro days after c db rt -
C	o en w o breastfeed s ou d be nfor ed t at ava ab e ted ev dence nd cates t at LNG_EC as no adverse effects on breastfeed n or on t e r nfants
D	o en w o breastfeed s ou d be adv sed not to breastfeed and to express and d scard for a wee after t ey ave ta en PA_EC

Is additional contraception required after initiation of a method after childbirth?

	o en s ou d be adv sed t at add t ona contracept ve precaut ons e - barr er et od abst nence are requ red f or ona contracept on s started days or ore after c db rt - Add t ona contracept ve precaut on s not requ red f contracept on s n t ated ed ate y or w t n days after c db rt -

Breastfeeding and contraception

Does initiation of hormonal contraceptives affect breastfeeding outcomes or infant outcomes?

A	o en w o are breastfeed n s ou d be nfor ed t at t e ava ab e ev dence nd cates t at pro esto en on y et ods of contracept on LNG IMP POI and POP ave no adverse effects on actat on nfant rowt or deve op ent
B	o en w o are breastfeed n s ou d wa t unt wee s after c db rt before n t at n a CHC et od
B	o en w o are breastfeed n s ou d be nfor ed t at t ere s o 4 e

Method-specific considerations

Intrauterine contraception (IUC)

B	IUC can be safely inserted immediately after birth within 10 minutes of delivery of the placenta or within the first 48 hours after uncomplicated caesarean section or vaginal birth. After 48 hours insertion should be delayed until 4 weeks after childbirth.

Progestogen-only implants (IMP)

C	IMP can be safely started at any time after childbirth including immediately after delivery.

Progestogen-only injectable (POI)

C	POI can be started at any time after childbirth including immediately after delivery.

Progestogen-only pills (POP)

C	POP can be started at any time after childbirth including immediately after delivery.

Combined hormonal contraception (CHC)

C	All women should undergo risk assessment for VTE postnatally. CHC should not be used by women who have risk factors for venous thromboembolism (VTE within 6 weeks of childbirth. These include obesity transfusion at delivery body mass index (BMI) ≥30 kg/m² postpartum infection or a history of post-caesarean delivery pre-eclampsia or stillbirth. This applies to both women who are breastfeeding and not breastfeeding.
B	Women who are not breastfeeding and are without additional risk factors for VTE should wait until 21 days after childbirth before initiating a CHC method.

Female sterilisation

A	Female sterilisation is a safe option for permanent contraception after childbirth.
A	For sterilisation after childbirth both Filshie clips and modified Pomeroy technique are effective. Filshie clip application requires equipment to perform.
D	

C

When can contraception be initiated after abortion?

B	A woman's chosen method of contraception should be initiated immediately after abort on ed ca and sur ca-
B	C n c ans s ou d be aware t at nsert on of ntrauter ne contracept on C at t e t e of abort on s conven ent and y acceptab e to wo en s as been assoc ated w t cont nuat on rates and a reduced r s for anot er un ntended pre nancy t an w en prov s on of C s de ayed

Medical eligibility

Which methods of contraception are safe to use after abortion?

D	o en s ou d be adv sed t at any et od of contracept on can be safe y n t ated ed ate y after an unco p cated abort on
D	l C s ou d not be nserted n t e presence of postabort on seps s

Is emergency contraception (EC) safe to use after abortion?

	E er ency contracept on EC s nd cated for wo en w o ave ad unprotected sexua ntercourse P I fro days after abort on

Combined hormonal contraception (CHC)

B	Co b ned or ona contracept on CHC can be safe y started ed ate y at any t e after abort on

Female Sterilisation

D	Fe a e ster sat on s a safe opt on for per anent contracept on after abort on
	o en s ou d be adv sed t at so e LA C et ods are as or ore effect ve t an fe a e ster sat on and ay confer non contracept ve benef ts However wo en s ou d not fee pressured nto c oos n LA C over fe a e ster sat on
B	uba occ us on s ou d dea y be perfor ed after so e t e as e apsed after abort on o en w o request tuba occ us on to be perfor ed at t e t e of abort on s ou d be adv sed of t e poss b e ncreased fa ure rate and r s of re ret
	C n c ans s ou d ensure t at consent fro t e wo an to conduct fe a e ster sat on at t e sa e t e as sur ca abort on s ta en and docu ented n advance of t e abort on

Barrier methods

D	Condo s a e and fe a e can be used by wo en after abort on
D	o en c oos n to use a d ap ra s ou d be adv sed to wa t at east wee s after second tr ester abort on because t e s ze of d ap ra requ red ay c an e as t e uterus returns to nor a s ze

Fertility awareness methods (FAM)

D	Fert ty awareness et ods FAM can be used by wo en after abort on However wo en s ou d be adv sed t at because FAM re es on t e detect on of t e s ns and sy pto s of fert ty and ovu at on ts use ay be d ff cu t after abort on

4. Contraception After Ectopic Pregnancy or Miscarriage

Discussion and provision of contraception after ectopic pregnancy or miscarriage

When should contraception be discussed/provided?

	erv ces prov d n care to wo en w t ectop c pre nancy or scarr a e s ou d ve t e opportun t es to d scuss t e r fert ty ntent ons contracept on and preconcept on p ann n -
	enever contracept ve counse n s prov ded care s ou d be ta en to ensure wo en do not fee under pressure to c oose a et od of contracept on
D	If a wo an w s es to de ay or prevent a furt er pre nancy effect ve contracept on s ou d be n t ated as soon as poss b e as sexua act v ty and ovu at on ay resu e very soon after ectop c pre nancy or

	erv ces s ou d ave a reed pat ways of care to oca serv ces for wo en w o ay requ re add t ona non ed ca care and support

Record keeping and obtaining valid consent

D	C n c ans s ou d c ear y docu ent t e d scuss on and prov s on of contracept on a d consent ust be obta ned before prov d n wo en w t t e r c osen et od of contracept on

Medical eligibility

Which contraceptive methods are safe to use after ectopic pregnancy or miscarriage?

	C n c ans s ou d refer to t e et od spec f c reco endat ons for abort on w c ay be extrapo ated for use after ectop c pre nancy or scarr a e

o en s ouıd be adv sed t at add t ona contracept ve precaut ons e - barr er et ods abst nence are requ red f or ona contracept on s started days or ore

	erv ces s ou d ave a reed pat ways of care to oca serv ces for wo en w o ay requ re add t ona non ed ca care and support

Record keeping and obtaining valid consent

D	C n c ans s ou d c ear y docu ent t e d scuss on and prov s on of contracept on a d consent ust be obta ned before prov d n wo en w t t e r c osen et od of contracept on

Medical eligibility

Which contraceptive methods are safe to use after GTD?

D	o en s ou d be adv sed t at ost et ods of contracept on can be safe y used after treat ent for G D and can be started ed ate y after uter ne evacuat on w t t e except on of ntrauter ne contracept on C-
D	C s ou d not be nserted n wo en w t pers stent y e evated CG eve s or a nant d sease
D	C s ou d not nor a y be nserted unt CG eve s ave nor a sed but ay be cons dered on spec a d 444 a - 7 4 ad v 4 7 4

FSRH Guideline (January 2017, amended October 2020)

Contraception After Pregnancy

(Revision due by January 2022)

1. Introduction: Contraception After Pregnancy

1.1 Purpose and scope

This new guideline brings together evidence and expert opinion on the provision of contraception to women after childbirth abortion ectopic pregnancy miscarriage or ectopic pregnancy GTD. It replaces the Faculty of Sexual and Reproductive Healthcare FSRH clinical guideline ***Postnatal Sexual and Reproductive Health***.

This guideline is for use by UK clinicians including sexual and reproductive health clinicians obstetricians gynaecologists midwives general practitioners GPs nurses and health visitors involved in caring for women during and after pregnancy. Typical settings where the guideline would be relevant include maternity services abortion services early pregnancy assessment units general gynaecology services integrated sexual health clinics and general practice.

It is hoped that the guideline will be implemented across all relevant services in the UK and will promote a more collaborative and consistent approach to providing the best standard of contraceptive care to all women after pregnancy.

Key considerations of this guideline include

- When should contraception be discussed provided
- Who should provide contraception
- Which contraceptive methods are most effective
- Which methods of contraception are safe to use
- Are there method specific issues to consider
- Are there other issues to consider

This guideline was developed by the FSRH and endorsed by the Royal College of General Practitioners RCGP Royal College of Midwives RCM Royal College of Nursing RCN and Royal College of Obstetricians and Gynaecologists RCOG.

1.2 Introduction and background – Why it is important to address contraception after pregnancy

1.2.1 Prevention of unintended pregnancies: a national health priority

A s ort nterpre nancy nterva IPI of ess t an l ont s ncreases t e r s of co p cat ons nc ud n preter b rt ow b rt we t st b rt and neonata deat - Currenty t e ord Heat Or an zat on HO reco ends a 4 ont IPI after c db rt -.7

A nat ona H strate es across t e K - 11 t t e portance of contracept on for wo en after pre nancy espec ay for wo en dent f ed as be n fro vu nerab e roups e - youn peop e 11 w o are at r s of future un ntended pre nancy- Access n t e y contracept ve counse n and t e fu ran e of contracept ve et ods w enab e wo en to p an t e nu ber of c dren t ey wou d e to ave and t e opt u spac n between t e -

Pre nancy s a ey reproduct ve event w en wo en are n contact w t ea t care serv ces creat n an opportun ty to d scuss contracept ve c o ce and prov de contracept on to wo en ot vated to avo d a future un ntended pre nancy- s c n ca u de ne prov des a fra ewor l l 4f

1.4 Discussion and provision of contraception after pregnancy

Clinicians should ensure they are familiar with or refer to the current version of the UKMEC unless specifically stated. UKMEC does not take account of multiple each conditions. Clinical judgement is required when making an assessment of a woman's medical eligibility, which should take into consideration her personal characteristics and other coexisting medical conditions. These evidence based recommendations apply only to the safety of contraceptive use and do not indicate a best method for a woman nor do they take into account method efficacy which could be affected by drug interactions or malabsorption.

1.4.3 Effectiveness of contraceptive method

Women should be informed during pregnancy about the effectiveness of different contraceptives, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after

1.4.4 Information giving and counselling

	All clinicians involved in the care of pregnant women should provide the opportunity to discuss contraception.
	Whenever contraceptive counselling is provided, care should be taken to ensure

Infor at on about contracept on t at s eas y understood unb ased and accurate s ou d be ade ava abe to wo en n d fferent an ua es and for ats nc ud n aud o v sua s s portant as nat ona reports on adu t teracy ave est ated t at a s zeab e propor on of adu ts n t e K ave ow eves s of teracy s su ests t at any wo en ay not be abe

1.4.6 Discussing women's contraceptive needs

2. Contraception After Childbirth

2.1 Discussion and provision of contraception after childbirth

2.1.1 When should contraception after childbirth be discussed/provided?

	Maternity services (including services providing antenatal, intrapartum and postpartum care) should give women opportunities to discuss their fertility intentions, contraception and preconception planning.
	Whenever contraceptive counselling is provided, care should be taken to ensure women do not feel under pressure to choose a method of contraception.
D	**Effective contraception after childbirth should be initiated by both breastfeeding and non-breastfeeding women as soon as possible, as sexual activity and ovulation may resume very soon afterwards.**
	Maternity service providers should ensure that all women after pregnancy have access to the full range of contraceptives, including the most effective LARC methods, to start immediately after childbirth. This should not be limited to those women with conditions that may pose a significant health risk during pregnancy and vulnerable groups (including young people) at risk of a short interpregnancy interval (IPI) or an unintended pregnancy.

There is growing recognition in the UK that women's need for effective contracepț on

	Women should be informed about the effectiveness of the different contraceptive methods, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after childbirth.

ee **Section 1.4.3**

C c **here** to access a tab e w c co pares t e percenta e of wo en exper enc n an unintended pregnancy during the first year of contraceptive use when the method is used 'typically' (which includes both incorrect and inconsistent use) or 'perfectly' (correct and cons stent use-

D	**Clinicians should adopt a person-centred approach when providing women with contraceptive counselling.**
	Clinicians who are giving advice to women about contraception after childbirth should ensure that this information is timely, up-to-date and accurate.
	Comprehensive, unbiased and accurate information on contraceptive methods postpartum should be made available in different languages and in a range of formats including audio-visual.

ee **Section 1.4.4**

o n n on p o n n p o

	Contraceptive counselling should be made available to women in the antenatal period to enable them to choose the method they wish to use after childbirth.
	Any contraceptive counselling (general or specialist) needs to be given in conjunction with easy access to contraception in the immediate postpartum period.

A t ou a Nat ona Inst tute for Hea t and Care Exce ence NICE u de ne as prev ous y reco ended t at contracept on s ou d be d scussed w t n t e f rst wee after de very adv ce about contracept on after c db rt ay be better d scussed antenata y espec a y s nce any et ods can be prov ded at t e t e of de very e - ntrauter ne contracept on C or dur n t e osp ta stay[4] Pr or to v n b rt wo en ay ave ore t e to t n t rou t e r opt ons t an ed ate y after v n b rt w en t e requ re ents of car n for a baby and recover n fro de very ay ta e pr or ty over contracept ve dec s on a n -

Ev dence eve 4

e effect veness of postpartu contracept ve counse n as not yet been estab s ed[4 4.7] One Coc rane rev ew[4] w c dent f ed s x non rando sed contro ed tr a s C s of educat ona ntervent ons reported t at wo en n t e ntervent on roups were ore e y to use y effect ve et ods rat er t an et ods w c are east effect ve or no et od co pared to wo en w o rece ved standard counse n nfor at on v n - Anot er Coc rane rev ew[4.7] of ten C s t at eva uated t e effect veness of postpartu educat on on contracept ve use reported t at a of t ese ntervent ons ed to fewer pre nanc es or ore contracept ve use However t e stud es nc uded n bot rev ews were of ow to oderate qua ty t n t e re ab ty of t e r f nd n s Many of t e stud es are e t er fro t e A or ow nco e countr es w ere barr ers to contracept ve use are e y to be d fferent fro t e K

Ev dence eve I

One u t nat ona C [4] w c nc uded Ed nbur an a and Cape own s owed t at spec a st antenata contracept ve counse n s no better t an standard contracept ve adv ce In t s study wo en attend n antenata c n cs were rando sed to rece ve e t er spec a st *n* 7,7 I or standard contracept ve adv ce *n* - No s n f cant d fferences were found between t e two roups n t e preva ence of contracept ve use or un ntended pre nanc es based on abort on rates at I year However t s study was conducted before t e w despread ava ab ty of y effect ve LA C nc ud n t e s n e rod pro esto en ony p ant IMP or t e evonor estre reas n ntrauter ne syste LNG I and before wo en were offered ed ate nsert on of I C after c db rt -

Ev dence eve I

ecent ev dence fro t e A as s own t at an antenata d scuss on ay be benef c a as t ay dent fy wo en w o w s to opt for nsert on of LA C n t e ed ate postpartu per od before d sc ar e fro osp ta[4] Accord n to a K survey of postpartu ot ers[4 4] wou d c oose LA C ed ate y after de very f t s was ava ab e However n order to be ab e to c oose LA C at t s t e wo en need to ave ade t s dec s on before v n b rt and t erefore s ou d be ade aware of t e r contracept ve opt ons antenata y

Ev dence eve

It s t erefore portant t at any contracept ve counse n ener a or spec a st be ven n con unct on w t easy access to contracept on n t e ed ate postpartu per od

2.1.2 When can contraception after childbirth be initiated?

D	**The choice of contraceptive method should be initiated by 21 days after childbirth.**
D	**A woman's chosen method of contraception can be initiated immediately after childbirth if desired and she is medically eligible.**
C	**Women should be advised that intrauterine contraception (IUC) and progestogen-only implant (IMP) can be inserted immediately after delivery.**

o en w o w, s to conce, ve a a, n s oud wa, t at east l ont s after c , db, rt - A cott, s retrospect, ve co ort study

eferra s to spec a st contracept ve serv ces e - co un ty H s ou d dea y be ade antenata y f requ red so t at a p an for contracept on can be ade before de very and contracept on can be n t ated as soon as poss b e after c db rt -

2.1.5 Record keeping and obtaining valid consent

D	**Clinicians should clearly document the discussion and provision of contraception after childbirth. Valid consent must be obtained before providing women with their chosen method.**

ee **Section 1.4.7.** o en w o c oose to ave C or ster sat on s ou d ave t e r dec s on c ear y docu ented before t ey are ad tted for de very-

2.2 Medical eligibility

2.2.1 Which methods of contraception are safe to use after childbirth?

C	**Women should be advised that although contraception is not required in the first 21 days after childbirth, most methods can be safely initiated immediately, with the exception of combined hormonal contraception (CHC).**

e current ev dence based K Med ca E b ty Cr ter a KMEC t at app y to breastfeed n and non breastfeed n wo en after c db rt are out ned n **Table 3**

ere are so e restr ct ons on t e use of co b ned or ona contracept on CHC — nc ud n co b ned ora contracept ve p s COC co b ned contracept ve va na

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
History of blood pressure during pregnancy						

of Contraception

C	**Women who breastfeed should be informed that available limited evidence indicates that LNG-EC has no adverse effects on breastfeeding or on their infants.**
D	**Women who breastfeed should be advised not to breastfeed and to express and discard milk for a week after they have taken UPA-EC**

LNG-EC or UPA-EC can be used without restriction by women after childbirth whether they are breastfeeding or not. Women can be advised to continue to breastfeed after using LNG-EC as evidence shows no adverse effect of progestogen on breastfeeding or infant outcomes.	Evidence level I
One recently published systematic review reported that limited direct and indirect evidence did not suggest any specific safety concerns regarding the use of LNG-EC or UPA-EC in women who breastfeed.	Evidence level I
Ulipristal acetate (UPA) is excreted in breast milk but the effect on infants has not been studied. The GDG recommends that women who breastfeed should not breastfeed for 7 days after the use of UPA-EC as stated in the Summary of Product Characteristics (SPC) for ellaOne. Women who breastfeed are advised to express and discard the breast milk in order to maintain lactation.	Evidence level 4

2.2.4 Is additional contraception required after initiation of a method after childbirth?

	Women should be advised that additional contraceptive precautions (e.g. barrier method/abstinence) are required if hormonal contraception is started 21 days or more after childbirth. Additional contraceptive precaution is not required if contraception is initiated immediately or within 21 days after childbirth.

The GDG recommends no additional contraception is necessary if any contraceptive method is initiated before Day 1 after childbirth. However if oral contraception is started 1 days or

Table 5: Requirements for abstinence or additional contraception when a method of contraception (which the woman is medically eligible to use) is initiated after childbirth

Methods of contraception the woman is medically eligible to use	Initiation <21 days after childbirth	Initiation ≥21 days after childbirth
	Number of days of additional contraceptive precautions required	
Copper intrauterine device	None for insertion to 4 hours	None
Levonorgestrel IUS Etonogestrel implant	Insertion between 4 hours and 4 weeks may not be appropriate, see KMEC	

Furt er ore at wee s after c ,db rt t ere were no d fferences between t e two roups ,n ter s of ,nfant rowt as easured by we t en t and ead c rcu ference

Ev dence eve l

o en s ou d be ,nfor ed about t e fu ran e of safe a ternat ve contracept ve et ods t ey can use part cu ar y dur n t e f rst wee s after c ,db rt w en t e r s of E s est and t at use of CHC et ods ay exacerbate t s r s -

2.3.2 Can women who breastfeed effectively use lactational amenorrhoea method (LAM) as contraception?

C	**Women may be advised that, if they are less than 6 months postpartum, amenorrhoeic and fully breastfeeding, the lactational amenorrhoea method (LAM) is a highly effective method of contraception.**
C	**Women using LAM should be advised that the risk of pregnancy is increased if the frequency of breastfeeding decreases (e.g. through stopping night feeds, starting or increasing supplementary feeding, use of dummies/pacifiers, expressing milk), when menstruation returns or when more than 6 months after childbirth.**

e use of breastfeed n as contracept on s nown as t e actat ona a enorr oea et od LAM- uc n suppresses t e resu pt on of ovar an act v ty and t e return of enses after c ,db rt - [7] Fu breastfeed n ,nc udes exc us ve w en no ot er qu ds or so ds are ven or a ost exc us ve w en v ta ns water or u ce s ven nfrequent y n add t on to breastfeeds -

Ev dence eve

o en w o are fu y breastfeed n ave reduced fert ty and breastfeed n can be used to reduce r s of an un ntended pre nancy However w en t e frequency and durat on of suc n decreases ovar an act v ty ay be restored and t e e ood of restart n per ods ,ncreases

o en w o breastfeed and exper ence a b eed n t e f rst ont s after c ,db rt ave been s own to ave a er r s of pre nancy t an t ose w o re a n a enorr oe c [7] erefore for breastfeed n to be used as an effect ve contracept ve et od t s reco ended t at wo en ust fu f a t ree cr ter a be ow

- e¸nserț on of IUC can ta e p ace as soon as t e p acenta¸s de¸vered at caesarean

e nsert on of I C ed ately after c db rt s assoc ated w t er expu s on rates but a so er cont nuat on rates – I ont s postpartu re ard ess of I C type or ode of de very [17]

In anot er C

A retrospect ve co ort study found no d fference n re ova rates for IMP due to va na b eed n between wo en w o ad IMP nserted ed ate y after c db rt w t n ours of de very de ayed – wee s after c db rt or as an nterva et od after wee s fo ow n c db rt or unre ated to a pre nancy event- e

2.4.4 Progestogen-only pills (POP)

C	**POP can be started at any time after childbirth, including immediately after delivery.**

Ev dence as s own t at POP ave n a effects on coa u at on factors b ood pressure or p d eve s and t us represent an appropr ate contracept ve c o ce for wo en after c db rt w o ave no contra nd cat ons to t e r use

Ev dence eve

POP can be n t ated ed ate y after c db rt and before days w t out t e need for add t ona precaut ons If started on Day t en add t ona contracept on s necessary for days

2.4.5 Combined hormonal contraception (CHC)

C	**All women should undergo a risk assessment for VTE postnatally. CHC should not be used by women who have risk factors for venous thromboembolism (VTE) within 6 weeks of childbirth. These include immobility, transfusion at delivery, body mass index (BMI) ≥30 kg/m^2**

ter,sat,ons, ed,ate,y after c ,db,rt and as an ,nterva, procedure are co on,y perfor ed us,n part,a,sa,p,n ecto y and tuba, occ,us,on e - F,s ,e c,ps- e Co,aborat,ve ev,ew of ter,,zat,on C E tr,a,,, reported t at postpartu part,a, sa,p,n ecto y as one of t e ,owest fa,,ure rates of a, ster,,sat,on tec n,ques w,t a l,year fa,,ure rate of - per l procedures and a l,year fa,,ure rate of ,7 per

D ap ra s are unsu tab e unt wee s after c db rt w en uter ne nvo ut on s co p ete and d sco fort as been reso ved [17] A d fferent s ze of d ap ra ay be requ red for postpartu wo en w o ave used t s et od prev ous y Anot er et od of contracept on s ou d be used fro Day unt t e wo an s abe to nsert and re ove a correct y f tted d ap ra -

Ev dence eve 4

2.4.8 Fertility awareness methods (FAM)

D

Fertility awareness methods (FAM) can be used by women after childbirth. However, women should be advised that because FAM relies on the detection of the signs and symptoms of fertility and ovulation, its use may be difficult after childbirth and during breastfeeding.

o en s ou d be adv sed t at fert ty awareness et ods FAM s ou d be used carefu y n order to ensure ax u effect veness e effect veness of FAM can be proved w en a co b nat on of nd cators are used and are tau t by tra ned FAM pract t oners H fa ure rates are assoc ated w t typ ca use efer to t e F H u de ne ***Fertility Awareness Methods*** for furt er u dance

Ev dence eve 4

t n t e f rst 4 wee s after c db rt wo en w o are not breastfeed n are un ey to ave suff c ent ovar an funct on to produce detectab e fert ty s ns or requ re FAM At ou t e r s of pre nancy s ow dur n t e f rst 4 wee s fo ow n c db rt wo en w s n to use a et od of contracept on dur n t s t e s ou d be offered an a ternat ve et od ee **Section 2.3** o en w o are not breastfeed n can re y on FAM as contracept on fro 4 wee s after c db rt as t s s w en ovar an funct on resu es and t e fert ty s ns and or or ona c an es beco e detectab e

o en w o are pr ar y breastfeed n are un ey to ave suff c ent ovar an funct on to produce detectab e fert ty s ns and or ona c an es dur n t e f rst ont s fo ow n c db rt - o en w s n to use a et od of contracept on dur n t s t e s ou d be offered an a ternat ve et od ee **Section 2.3** -

2.5 Useful links and support group: Contraception after childbirth

- NH C o ces Contracept on u de
- NH C o ces Pre nancy and baby
- e Fa y P ann n Assoc at on FPA

3. Contraception After Abortion

3.1 Discussion and provision of contraception after abortion

e c,n,ca u,de,ne and t e reco endat,ons ,n t ,s sect,on focus on t e d,scuss,on and prov,s,on of contracept,on to wo en w o ave recent,y ad an abort,on and co p,e ents

B	**Clinicians should be aware that insertion of intrauterine contraception (IUC) at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IUC is delayed.**
B	**Clinicians should be aware that insertion of progestogen-only implants (IMP) at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IMP is delayed.**

ee **Section 3.2**

Prov s on of y effect ve contracept ve et ods at t e t e of abort on as d st nct advanta es

Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated.

- ee **Section 1.4.5**

Observat ona stud es ave a so found t at t e r s of av n anot er abort on was stat st ca y ower n wo en w o used C after abort on co pared to t ose w o used ora contracept ves OC- An odds rat o O of - conf dence nterva CI - - -4 was reported n one study and an O of - CI - 7- -77 was reported n anot er study- 4 7 In one study 4 w ere wo en us n C were co pared to wo en us n a ot er et ods t e azard rat o H was - 7 CI - - - Co pared to wo en us n s ort act n et ods of contracept on t e H of subsequent abort on for wo en us n t e Cu D and LNG were found to be -4 CI - - - and - CI - - -44 respect ve y-

Observat ona stud es 4 4 ave reported t at wo en w o c oose to use IMP after abort on ave a so been s own to ave a reduced e ood of subsequent abort on- One K study found t at co pared to wo en w o used OC t e O of wo en w o used IMP after abort on av n anot er abort on w t n years was - CI - - -

Observat ona stud es 4 4 7 ave y e ded ncons stent f nd n s re ard n t e n t at on of depot edroxypro esterone acetate DMPA ed ate y after abort on and t e r s of subsequent abort on- For exa p e one observat ona study n t e K

Table 6: UK Medical Eligibility Criteria for Contraceptive Use UKMEC) categories applicable to a woman after an abortion

Post-abortion	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
a F rst tr ester						
b econd tr ester						

Table 7: Requirements for abstinence or additional contraceptive precautions when a method of contraception (which the woman is medically eligible to use) is initiated after abortion

Methods of contraception the woman is medically eligible to use	Initiation <5 days after abortion	Initiation ≥5 day after abortion

Ev dence eve

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If wo en c oose to de ay t e nsert on of L C t e return v s t for nsert on s ou d be

Pro esto en_ony contracept on can be safe y n t ated at t e t e of ad n strat on of fepr stone ere as been a concern t at co enc n pro esto en_ony contracept on at t e sa e t e as fepr stone a pro esterone receptor odu ator t reduce t e eff cacy of ed ca abort on due to co pet t on at t e pro esterone receptor One C l fro Mex co and t e A w c nc uded 4 7 wo en under o n EMA ¢ wee s rando sed nto rece v n IMP e t er w t fepr stone u c start roup ***n*** or after t e abort on was co p ete Afterstart roup ***n*** 4 s owed no d fferences n success of t e ed ca abort on e study found t at - and - of wo en n t e u c start and Afterstart roups respect ve y ad sur ery to co p ete t e abort on e ed an days of b eed n was s t y but s n f cant y er n t e u c start roup t an n t e Afterstart roup l vs l ***p*** - - e nc dence of eavy b eed n was near y dent ca n bot roups e study a so found t at qu c start n IMP en anced pat ent sat sfact on but found no ev dence t at t decreased un ntended pre nanc es ont s ater

A furt er rando sed_contro ed equ va ence tr a 4 fro weden and t e K nc uded wo en under o n EMA ¢ wee s rando sed to nsert on of IMP l our after fepr stone ed ate roup ***n***

e study a so found t at qu c start n DMPA en anced pat ent sat sfact on and resu ted n ore wo en us n t e et od n t e s ort ter at l ont but no d fference n use at ont s

Ev dence eve l

e study was des ned and powered to exa ne needs for sur ca ntervent on rat er t an on o n pre nancy w c s ess co on- In add t on t s un nown w et er s ar f nd n s wou d be observed w t use of t e subcutaneous C for u at on ayana Press Ñ at fepr stone s nce ayana Press s a ower dose l 4 preparat on t an t e IM preparat on l - Nevert e ess t e GDG reco ends t at wo en s ou d be adv sed t at ad n strat on of DMPA IM or C at t e sa e t e as fepr stone ay be assoc ated w t a s a ncrease n t e r s of fa ure of EMA o en w o w s to start DMPA at t e of fepr stone s ou d be adv sed of t e portance of conf r n success of t e procedure accord n to oca c n c protoco s o en s ou d be re nded t at scant or absent b eed n ay be due to fa ed ed ca abort on rat er t an or ona et od used nder suc c rcu stances ur ent ed ca rev ew s ou d be sou t

ere s no ev dence of an adverse effect of fepr stone on t e eff cacy of on o n contracept on wo C s l 7 l t at ave exa ned t e pact of t e pro esterone receptor odu ator u pr sta acetate PA w c s censed for EC ave s own no effect on contracept ve act on nu ber of days of p ta n requ red to nduce ovar an qu escence or ost e cerv ca ucus of e t er a deso estre conta n n pro esto en–ony p POP or co b ned ora contracept ve COC p w en co enced t e day fo ow n ad n strat on of PA

Women should be advised that scant or absent bleeding should not be attributed to a hormonal method of contraception that has been initiated, but that it may be due to failed medical abortion. Under such circumstances, urgent medical review for

3.3.3 Combined hormonal contraception (CHC)

B	**Combined hormonal contraception (CHC) can be safely started immediately at any time after abortion.**

A syste at c rev ew ' w c nc uded t ree C s and four co ort stud es reported t at t e use of COC ed ate y after co p et on of sur ca or ed ca abort on s safe wo C s [7] [7] ave s own t at ed ate use of COC does not affect t e success rate of t e abort on procedure

L ted ev dence fro C and observat ona stud es su ests t at t e co b ned transva na r n C [7] and t e co b ned transder a patc patc [7] [7] are a so safe to co ence ed ate y after abort on

e syste at c rev ew ' a so reported t at ed ate COC use after f rst tr ester ed ca [7] [7] [7] or sur ca abort on [7] – [7] d d not nc rease s de effects or pro on va na b eed n co pared w t use of a p acebo Cu D non or ona contracept ve et od or de ayed COC use In t at n COC after f rst tr ester sur ca abort on s assoc ated w t a s a stat st ca y s n f cant nc rease n coa u at on para eters co pared w t ntrauter ne dev ce D use [7] owever t s s un ke y to be of c n ca re evance '

Ev dence eve '

3.3.4 Female sterilisation

D	**Female sterilisation is a safe option for permanent contraception after abortion.**
	Women should be advised that some LARC methods are as, or more, effective than female sterilisation and may confer non-contraceptive benefits. However,

o on

e ava abe ev dence re ard n r s s of co p cat on and fa ure assoc ated w t abort on at t e t e of ster sat on s conf ct n - e F H COG u de ne notes t at a t ou t e add t on of ster sat on to a procedure for abort on does not see to ncrease t e co p cat on rate a ready assoc ated w t abort on t as been ar ued t at t e co p cat on rate assoc ated w t a co b ned procedure s er t an t at assoc ated w t nterva ster sat on tud es co par n abort on co b ned w t aparoscop c ster sat on versus aparoscop c ster sat on a one found no s n f cant d fferences n t e co p cat on rate between t e two procedures G ven t at concurrent sur ca abort on and aparoscop c tuba at on are typ ca y perfor ed under enera anaest es a t ad been su ested t at anaest es a re ated r s can be n sed by perfor n t e two procedures to et er

An ear y casenote rev ew study t at co pared fa ure rates of aparoscop c ster sat on w t non aparoscop c et ods found t at t e pre nancy rate was dou e f ster sat on was co b ned w t abort on However a ar e case contro study fa ed to f nd any assoc at on between t n of t e procedure and fa ure rate e fo ow up t e was s ort and t ere were fewer su tab e contro s for t e postabort on cases

o e stud es reported no d fference n re ret rates between wo en w o underwent aparoscop c ster sat on at t e sa e t e as abort on predo nate y f rst tr ester and t ose w o underwent nterva ster sat on Converse y ot er stud es ave reported an ncreased rate of re ret w en ster sat on was perfor ed at t e sa e t e as t e abort on

Ev dence eve

One C n w c wo en were rando sed to e t er under o a co b ned abort on w t aparoscop c ster sat on or an abort on w t ster sat on as an nterva procedure at east wee s ater reported t at - of wo en d d not return for t e r nterva ster sat on It s portant to note t at non attendance does not necessar y nd cate re ret but does su est t at so e wo en ay ave c an ed t e r nds w en t ey were ab e to recons der t e r dec s on outs de t e stressfu c rcu stances of an un ntended pre nancy s furt er e p as ses t e need for carefu counse n w en ster sat on s requested n assoc at on w t pre nancy

Ev dence eve

n pp o

ere are no stud es eva uat n concurrent abort on and ysteroscop c tuba occ us on e Essure cro nsert anufacturer nstruct ons for use st bot c db rt and abort on of a second tr ester pre nancy w t n t e prev ous wee s as contra nd cat ons for nsert on A recent narrat ve rev ew on contracept on after abort on noted t at t e procedure cou d be reasonab y and safe y acco p s ed before wee s after t e procedure n a wo an w o s no on er b eed n and as ad adequate endo etr a preparat on w t POP DMPA or t e LNG -

Ev dence eve

Clinicians should ensure that consent from the woman to conduct female sterilisation at the same time as surgical abortion is taken and documented in advance of the abortion.

The GDG considered that consent to conduct a sterilisation at the same time as surgical abortion should be taken and documented in advance of the procedure. This requires careful consideration

o en s ou d be adv sed t at fert ty awareness et ods FAM s ou d be used carefu y n order to ensure ax u effect veness e effect veness of FAM can be proved w en a co b nat on of nd cators are used and are tau t by tra ned FAM pract t oners H fa ure rates are assoc ated w t typ ca use efer to F H u de ne ***Fertility Awareness Methods*** for furt er u dance

Ev dence eve 4

ort y after abort on s ns of fert ty ay be d srupted and extre e caut on s requ red Any ca endar based et od s ou d not be re ed upon unt one enstrua per od as occurred

3.4 Useful links and support group: Contraception after abortion

- NH C o ces Contracept on u de
- NH C o ces Pre nancy and baby
- e Fa y P ann n Assoc at on FPA
- Br t s Pre nancy Adv sory erv ce BPA
- Mar e topes K

4. Contraception After Ectopic Pregnancy or Miscarriage

4.1 Discussion and provision of contraception after ectopic pregnancy or miscarriage

For clinical guidance relating to the diagnosis and initial management of ectopic pregnancy and miscarriage please refer to the COG Green-top guideline ***Diagnosis and Management of Ectopic Pregnancy***[1] and the NICE guideline ***Ectopic Pregnancy and Miscarriage.***[4]

The recommendations covered in this section apply only to diagnosed confirmed ectopic pregnancy – the excludes pregnancy of unknown location and/or miscarriage.

4.1.1 When should contraception be discussed/provided?

	Services providing care to women with ectopic pregnancy or miscarriage should give them opportunities to discuss their fertility intentions, contraception and preconception planning.
	Whenever contraceptive counselling is provided, care should be taken to ensure

Table 8: Summary of UK Medical Eligibility Criteria for Contraceptive Use UKMEC)

A Cochrane review of RCTs and a systematic review of studies reported that the use of oral EC has not been associated with an increased risk of ectopic pregnancy after contraceptive failure. PAEC has been available in the UK since 2009. A recently published post-marketing surveillance data reported four ectopic pregnancies out of an estimated 14,000 users.	Evidence level I

4.2.3 Is additional contraception required after initiation of a method after ectopic pregnancy or miscarriage?

	Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after miscarriage. Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of miscarriage.
	Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after surgical treatment or administration of methotrexate for ectopic

4.3 Specific issues

4.3.1 Does hormonal contraception have an effect on bleeding after ectopic pregnancy or miscarriage?

ere s a ac of ev dence on t e effect of or ona et ods of contracept on on b eed n after ectop c pre nancy or scarr a e Extrapo at on of ev dence on nduced abort on wou d su est no adverse effect of co b ned or ona contracept on CHC use on uter ne b eed n see **Section 3.3.3**-

4.3.2 What are the implications of recurrent miscarriage on contraceptive choice?

D	**Women who have had recurrent early miscarriage (REM) should be investigated for any underlying causes. However, investigations should not lead to a delay in initiation of a contraceptive method if the woman does not wish to become pregnant.**
D	**Combined hormonal contraception (CHC) should be avoided by women with REM until antiphospholipid syndrome (APS) has been excluded.**

If a wo an as exper enced recurre re - 7 4- lad s r 7 l

Table 10: Summary of UK Medical Eligibility Criteria for Contraceptive Use UKMEC) categories applicable to a woman with positive antiphospholipid antibodies or known thrombogenic mutations

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Positive antiphospholipid antibodies						
Known thrombogenic mutations e - Factor Le den prot ro b n utat on Prote n Prote n C and ant t ro b n def c enc es						

CHC co b ned or ona contracept on Cu D copper ntrauter ne dev ce DMPA depot edroxypro esterone acetate pro esto en only n ectab e IMP pro esto en only p ant LNG evonor estre re eas n ntrauter ne syste POP pro esto en only p

Def n t on of t e KMEC cate or es can be found **here**.

Co n o on on p on C C

A rev ew ' of s x case contro stud es est ated t at t e abso ute r s of ectop c pre nancy n wo en us n co b ned ora contracept ve COC ran es fro -.7 to I- ectop c pre nanc es per I wo an years No study report n on ot er types of CHC e - t e co b ned va na r n C or t e patc was dent f ed

Ev dence eve

o o n on p

Concerns ave been ra sed t at wo en us n a ow dose pro esto en ony p POP t be at er r s of ectop c pre nancy t an wo en us n ot er et ods of contracept on s s be eved to be due to t e ncons stent n b t on of ovu at on I7 I and t e reduct on n c a act v ty n t e fa op an tubes t at s ows t e passa e of an ovu I ead n to an ncreased r s of tuba p antat on

Ev dence eve4

e abso ute r s of ectop c pre nancy n wo en us n POP s s n f cant y ower t an wo en us n condo s or no et od Ectop c pre nancy rates a on st POP users ave been reported to ran e fro about – ectop c pre nanc es per I wo an years I

o o n on p n n n

e abso ute r s of ectop c pre nancy w en us n t e pro esto en ony p ant IMP or pro esto en ony n-ectab e POI s very ow A syste at c rev ew I based on stud es of IMP and stud es of depot edroxypro esterone acetate DMPA reported a very s a nu ber of ectop c pre nanc es IA on 4 I stud es 4 of DMPA 4 pre nancy rates ran ed fro - I–

on

C	**Women should be informed that if pregnancy occurs after tubal occlusion, there is an increased risk of ectopic pregnancy and therefore the location of the pregnancy should be confirmed by ultrasound as soon as possible.**

5. Contraception After Gestational Trophoblastic Disease (GTD)

5.1 Discussion and provision of contraception after GTD

For c,n ca, u,dance re,at,n to t e presentat,on ana e ent treat ent and fo,ow up of estat,ona, trop ob,ast,c d,sease G D ,nc,ud,n estat,ona, trop ob,ast,c neop,as,a G N p,ease refer to t e COG Green top u,de,ne ***The Management of Gestational Trophoblastic Disease***

Women should be informed about the effectiveness of the different contraceptive methods, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after GTD.

D	**After partial molar pregnancy, women should be advised to avoid pregnancy until two consecutive monthly hCG levels are normal.**
D	**Women who have had chemotherapy for GTD should be advised to avoid pregnancy for 1 year after treatment is complete.**

After molar pregnancy hCG levels are monitored so that persistent GTD can be identified and treated. It is recommended that women avoid becoming pregnant during the period of hCG monitoring because it is not possible to distinguish between a hCG level that is persisting because of a new pregnancy and that associated with

	Services should have agreed pathways of care to local specialist contraceptive services [e.g. community sexual and reproductive health (SRH) services] for women with complex medical conditions or needs which may require specialist contraceptive advice.
	Services should have agreed pathways of care to local services for women who may require additional non-medical care and support.

ee **Section 1.4.8**

5.1.5 Record keeping and obtaining valid consent

D	**Clinicians should clearly document the discussion and provision of contraception. Valid consent must be obtained before providing women with their chosen method of contraception.**

ee **Section 1.4.7**

5.2 Medical eligibility

5.2.1 Which contraceptive methods are safe to use after GTD?

D	

Table 11: Summary of UK Medical Eligibility Criteria for Contraceptive Use UKMEC) categories for women who have/had gestational trophoblastic disease

Gestational trophoblastic disease (GTD)	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
a. ndetectab/e CG /eve/s	1	1	1	1	1	1
b Decreas n CG /eve/s			1	1	1	1
c Pers stent/y e/evated CG /eve/s or a/ nant d sease	4	4	1	1	1	1

CHC co b ned or ona/ contracept on Cu- D copper ntrauter ne dev ce DMPA depot edroxypro esterone acetate pro esto en only n.ectab/e. CG u an c or on c onadotrop n IMP pro esto en only p/ant LNG- /evonor estre/ re/eas n ntrauter ne syste . POP pro esto en only p/

Def n t on of t e KMEC cate or es can be found **here**

5.2.2 Is emergency contraception (EC) safe to use after GTD?

	Emergency contraception (EC) is indicated if unprotected sexual intercourse (UPSI) takes place from 5 days after treatment for GTD.
D	**Women should be advised that use of oral EC is safe after treatment for GTD. Insertion of copper intrauterine device (Cu-IUD) for EC may y(el)5.9852(386.398 r**

t e LNG L -

C n o n p C

IUC insertion at surgical evacuation where GTD is suspected but not confirmed should be made on an individual case basis based upon the individual woman's risk for GTD, clinical findings and her preference for IUC insertion at this time.

Ne t er KMEC[1] nor HOMEC[1,7] a es reco endat ons as to w et er a wo an w t suspected G D can ave L C nserted at t e t e of sur ca evacuat on eoret ca concerns are t at L C p ace ent at sur ca evacuat on ay be assoc ated w t a er r s of uter ne perforat on and or excess ve b eed n f G D s ndeed present

In t e absence of ev dence for safety t e GDG cons ders t at L C nsert on at sur ca evacuat on w ere G D s suspected but not conf r ed s ou d be ade on an nd v dua case bas s based upon clinical findings and the woman's preference for IUC insertion at this time.

5.3.2 Hormonal contraception

B **Hormonal contraception can be started immediately after uterine evacuation for GTD.**

In t e [1,7] s a retrospect ve co ort study [4] reported t at CG eves reverted to nor a ore s ow y and t at t ere was a s n f cant y ncreased r s of requ r n c e ot erapy for treat ent of post ar trop ob ast c d sease f COC was co enced w e CG eves re a ned e evated after evacuat on of ydat d for o e On t e bas s of t ese data t was reco ended t at or ona contracept on s ou d be avo ded unt CG eves returned to nor a [1]

Ev dence eve

wo syste at c rev ews concluded t at t ere was no c ear ev dence of an effect

o o f op n n o n n

ere s ep de o o ca ev dence su est n b atera sa p n ecto y ay protect a a nst deve op n rade serous ovar an cancer It s postu ated t at t s ay be because so e ep t e a cancers ay or nate n tuba ep t e u - e COG adv ses t at wo en s ou d be carefu y couns ed for re ova of fa op an tubes f t e r fa y s co p ete and t ey are under o n pe v c sur ery s ay be a so re evant to wo en be n ster sed after G D

5.3.4 Barrier methods

D	**Condoms (male and female) can be used by women after treatment for GTD.**
	Women who choose a diaphragm should be advised to wait at least 6 weeks after treatment for GTD because the required size of diaphragm may change as the uterus returns to normal size.

Condo s a e and fe a e can be used w t out restr ct on at any t e by wo en w o ave ad G D However ven t e r fa ure rates percenta e of wo en exper enc n an un ntended pre nancy w t n t e f rst year of use w t typ ca use t ey are cons dered one of t e east effect ve et ods

e GDG reco ends t at s nce t e s ze of d ap ra ay c an e as t e uterus nvo utes

5.4 Specific issues

5.4.1 Is there any method associated with a risk of GTD in subsequent pregnancies?

D	**Clinicians should inform women that there is no evidence that the use of any contraceptive method after an episode of GTD increases the risk of GTD in a subsequent pregnancy.**

e popu at on r s of o ar pre nancy s - L - - 4 It s ore co on n wo en under t e a e of l years and over t e a e of 4 years and var es accord n to et n c roup After one o ar pre nancy t e r s of a repeat ep sode s about

Recommendations for Future Research

4 oya Co e of Obstetr c ans and Gynaeco o sts COG- ***Female Genital Mutilation and its Management*** Green top Gu de ne No . -
ttps www- rco - or - u oba assets docu ents u de nes t f - pdf-
4 Nat ona Inst tute for Hea t and Care Exce ence NICE- ***Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance.*** ttp www- n ce or - u u dance CG -
4 Ca eron - Postaborta and postpartu contracept on- ***Best Pract Res Clin Obstet Gynaecol*** . **28** 7 -
44 A en A A A en CEM russe J ***et al.*** I ed ate postpartu prov s on of y effect ve revers b e contracept on- ***BJOG*** . **122** -
4 G as er AF Lo an J McG ew J o ves adv ce about postpartu contracept on ***Contraception*** . **53** 7 -
4 Lopez LM Grey C en M ***et al.*** trate es for prov n postpartu contracept ve use ev dence fro non rando zed stud es- ***Cochrane Database Syst Rev*** . **11** CD -
4 7 Lopez LM H er JE Gr es DA ***et al.*** Educat on for contracept ve use by wo en after c db rt - ***Cochrane Database Syst Rev*** . **8** CD -
4 t KB van der puy ZM C en L ***et al.*** Is postpartu contracept ve adv ce ven antenata y of va ue ***Contraception*** . **65** 7 4 -
4 O burn JA Espey E tone oc er J Barr ers to ntrauter ne dev ce nsert on n postpartu wo en- ***Contraception*** . **72** 4 4 -
Speroff L, Mishell DR. The postpartum visit: it's t e for a c an e n order to opt a y n t ate contracept on- ***Contraception*** . **78** -
Godt wa te LM aw KA- I ed ate postpartu prov s on of on act n revers b e contracept on- ***Curr Opin Obstet Gynecol*** . **27** 4 4 4-
Co en eeder J Aran o N ***et al.*** we ve ont contracept ve cont nuat on and repeat pre nancy a on youn ot ers c oos n postde very contracept ve pants or postp acenta ntrauter ne dev ces- ***Contraception*** . **93** 7 -
as n ton CI Ja s d un F ***et al.*** n of postpartu ntrauter ne dev ce p ace ent a cost effect veness ana ys s- ***Fertil Steril*** . **103** 7
4 Gurtc eff E uro DK toddard G ***et al.***

4 Goldstuck ND, Steyn P. Intrauterine contraception after cesarean section and during lactation: a systematic review. ***Int J Womens Health*** 2015;7:735–749.

Tepper NK, Phillips J, Kapp N, ***et al.*** Combined oral contraceptive use and breastfeeding women: an updated systematic review. ***Contraception*** 2014;89:179–194.

Espey E, Ogburn T, Leeman L, ***et al.***

Jac son E Curt s KM Gaff ed ME- , s of venous t ro boe bo s dur n t e postpartu per od a syste at c rev ew- ***Obstet Gynecol*** **117** -7 -

,7 ord Heat Or an zat on HO- ***WHO Medical Eligibility Criteria for Contraceptive Use*** t ed t on- - www- w o nt reproduct ve eat pub cat ons fa y p ann n MEC en-

Petersen JF Ber ot N esen AK ***et al.*** Co b ned or ona contracept on and r s of venous t ro boe bo s w t n t e f rst year fo ow n pre nancy- Dan s nat onw de stor ca co ort - ***Thromb Haemost*** **112** 7 –7 -

Lawr e A Ku er Nard n JM ec n ques for t e nterrupt on of tuba patency for fe a e ster sat on- ***Cochrane Database Syst Rev*** **9:**CD 4-

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Appendices

Appendix 1: FSRH Clinical Guideline Development Process

Who has developed the guideline?

This guideline is produced by the Clinical Effectiveness Unit (CEU) with support from the Clinical Effectiveness Committee (CEC) of the Faculty of Sexual and Reproductive Healthcare (FSRH). The FSRH is a registered charitable organisation which funds the development of its own clinical guidelines. NHS Lothian is contracted to host the CEU within the Chalmers Centre and to provide the CEU's services using ring-fenced funding from the FSRH. No other external funding is received. Chalmers Centre supports the CEU in terms of accommodation, facilities, education, training and clinical advice for the members' enquiry service. As an organisation, NHS Lothian has no editorial influence over CEU guidelines, although staff members may be invited to join the CEU's multidisciplinary guideline development groups (GDG) in an individual professional capacity.

Development of the guideline was led by the secretariat CEU staff and involved the intended users of the guidelines (contraception providers and patient service user representatives as part of a multidisciplinary group). The scope of the guideline was informed by a scoping survey conducted among members of the FSRH and the Royal College of Obstetricians and Gynaecologists (RCOG) and among service users from three sexual and reproductive health services across the UK (Cardiff, Wales; London, England and Edinburgh, Scotland).

The first draft of the guideline was produced based on the final scope of the guideline agreed by the GDG. The first draft of the guideline (version 1) was reviewed

Below is a list of contributors involved in the development of this clinical guideline

Guideline Development Group (GDG)

- Dr Aaron Cameron – Director Clinical Effectiveness Unit

used to identify relevant guidelines produced by other organisations these guidelines were checked to identify any new evidence No language restrictions were applied to the searches

Considerations when making recommendations

Appendix 2: Clinical Guidelines, Systematic Reviews and Meta-analyses Included in this Guideline

Clinical guideline

e fo ow n c n ca u de nes were dent f ed and used to nfor t e reco

Contraceptive method-specific		
K Med ca E b ty Cr ter a for Contracept ve se	I	F H
HO Med ca E b ty Cr ter a for Contracept ve se t ed t on	I	HO
Med ca E b ty Cr ter a for Contracept ve se MM	I	Centres for D sease Contro and Prevent on CDC
Intrauter ne Contracept on	I	F H
Pro esto en ony I p ants	4	F H
Pro esto en ony In.ectab e Contracept on	4	F H
Pro esto en ony P s	I	F H
Co b ned Hor ona Contracept on	I I	F H
E er ency Contracept on	I I	F H
Barr er Met ods Contracept on and I Prevent on	I	F H
Ma e and Fe a e ter sat on	4	F H
Fert ty Awareness Met ods	I	F H
u c tart n Contracept on	I	F H
Lon act n evers b e Contracept on pdate	4	NICE

Systematic review/ meta-analysis

e fo ow n syste at c rev ews and or eta ana yses were dent f ed and used to nfor t e reco endat ons ade n t s u de ne ey are presented be ow based on t e re evant pre nancy outco e sect ons to w c t ey re ate

Contraception after childbirth (postpartum)

Breastfeeding

Resources

Resource 1: Risk factors for venous thromboembolism in pregnancy and the puerperium

ab e reproduced fro oya Co e e of Obstetr c ans and

Questions for Continuing Professional Development

e fo ow n u t p e c o ce quest ons MC ave on y one correct answer and ave been deve oped for cont nu n profess ona deve op ent CPD- e answers to t e quest ons and nfor at on on c a n CPD po nts can be found in the 'CPD Questions and Answers' sect on of t e F H webs te www-fsr - or w c s access b e to a D p o ates Me bers Assoc ate Me bers and Fe ows of t e F H

1. **In the UK, an estimate of the number of pregnancies ending in abortion is:**
   a. n
   b. n
   c. n
   d. n

2. **In a UK survey, the number of women presenting for abortion within 1 year of a previous birth is:**
   a. n
   b. n
   c. n
   d. n

3. **To reduce the risk of preterm birth, low birthweight and small for gestational age, how long should a woman be advised to wait after delivery before conceiving again?**
   a. ont s
   b. ont s
   c. ont s
   d. ont s

4. **Wh**

6. **Emergency contraception is indicated for a woman who has had unprotected sexual intercourse after childbirth from:**
   a. 7 days
   b. 4 days
   c. l days
   d. days

7. **Which statement is false?**
   a. Intrauter ne contracept on can be nserted w t n l nutes of p acenta de very
   b. Intrauter ne contracept on can be nserted w t n 4 ours of an unco p cated caesarean sect on
   c. Intrauter ne contracept on cannot be nserted at t e t e of a caesarean sect on
   d. Intrauter ne contracept on s ou d not be nserted between 4 ours and 4 wee s post de very

8. **A woman has unprotected sexual intercourse 7 days after an abortion. Which of the following statements is false?**
   a. A et ods of e er ency contracept on are su tab e
   b. An e er ency ntrauter ne dev ce cannot be cons dered
   c. If a subder a p ant s qu c started w t evonor estre e er ency contracept on 7 days of add t ona contracept on s needed
   d. If u pr sta acetate s ven a wo an s ou d wa t days before qu c start n a or ona et od of contracept on

9. **Post-ectopic pregnancy, which statement is true?**
   a. o en s ou d be adv sed t at ntrauter ne contracept on s unsu tab e
   b. On y anovu atory et ods of contracept on s ou d be reco ended
   c. If et otrexate s used pre nancy s ou d be avo ded for at east ont s post treat ent
   d. Contracept on can be co enced on t e day of et otrexate ad n strat on

10. **With gestational trophoblastic disease (GTD), which statement is false?**
   a. After co p ete ydat d for o e l – wo en deve op G D need n c e ot erapy
   b. After part a ydat d for o e – wo en deve op G D need n c e ot erapy
   c. Intrauter ne contracept on s unsu tab e w e u an c or on c onadotrop n s st detectab e

Auditable Outcomes

e fo ow n aud tab e outco es ave been su ested by t e F H C n ca tandards Co ttee

Auditable outcome	Target
Postnatal contraception	
Percenta e of postnata wo en w o are ven nfor at on about and offered a c o ce of a appropr ate contracept ve et ods w t n 7 days of de very	7
Percenta e of postnata wo en w o ave c osen a LA C et od w o are offered a br d n et od w en ed ate access to t e r c osen et od s not poss b e	7
Percenta e of postnata wo en c oos n LA C w o are prov ded w t t e r c osen et od before d sc ar e fro osp ta	
Abortion	
Percenta e of wo en w o request an abort on w o d scuss contracept on w t a ea t care pract t oner and are offered a c o ce of a appropr ate contracept ve et ods before d sc ar e	7
Percenta e of wo en av n an abort on w o rece ve t e r c osen et od at t e t e of abort on	7
Ectopic pregnancy or miscarriage	
Percenta e of wo en w t ectop c pre nancy or scarr a e w o are ven an opportun ty to d scuss t e r fert ty ntent ons contracept on and preconceptua counse n by t e r prov der	7
Percenta e of wo en w t ectop c pre nancy or scarr a e w o w s to defer subsequent pre nancy w o are ven nfor at on about and offered a c o ce of a appropr ate contracept ve et ods w t n 7 days of treat ent	7
Gestational trophoblastic disease (GTD)	
Percenta e of wo en av n G D w o are adv sed to avo d subsequent pre nancy unt GD on tor n s co p ete	7
Percenta e of wo en av n G D w o are ven nfor at on about and offered a c o ce of a appropr ate contracept ve et ods w t n 7 days of uter ne evacuat on	7
Adapted fro NICE ***Contraception Quality Standards***	

Comments and Feedback on Published Guideline

Any comments on this published guideline can be sent directly to the Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Healthcare (FSRH) via the FSRH website www.fsrh.org.

The CEU may not respond individually to all feedback. However the CEU will review all comments and provide an anonymised summary of comments and responses which are reviewed by the Clinical Effectiveness Committee and any necessary amendments made subsequently.

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