



Best Practice Paper of Royal College of Obstetricians and Gynaecologists Modified for Pakistan

Postpartum Family Planning (PPFP) in Pakistan

Comment [AF1]: What's the title about?
Should be BPP?

Introduction to the Best Practice Papers

Professionals providing reproductive health care have a responsibility to ensure that the couples they treat benefit from the latest evidence-based clinical practices. In support of these, and in line with their mandate of improving health care for women everywhere, by setting standards for clinical practice, the UK Royal College of Obstetricians and Gynaecologists sets out the essential elements of a high-quality postpartum family planning (PPFP) service in this Best Practice Paper. The paper has been adapted to the local context for use in Pakistan by Professor Rubina Hussain, Professor Al Fareed Zafar, Dr. Rafat Jan, Dr. Azmat Waseem, Professor Sadiqua N Jafarey, Professor Shahnaz Baloch, Professor Sadaqat Jabeen, Dr. Sumbul Sohail and Miss Aliya Nasir.

Comment [AF2]: Be consistent over abbreviations and punctuation

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.

The original Best Practice Paper on Postpartum Family Planning was developed as part of the RCOG Leading Safe Choices programme and can be accessed at:
<https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-1---postpartum-family-planning.pdf>.

More information about the Leading Safe Choices programme is available at www.rcog.org.uk/leadingsafechoices.

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 has been omitted but can be found in the original source documents. Recently published evidence at the time of writing the RCOG BPP, was assessed to determine whether any of the recommendations from current guidelines should be amended.

The use of the clinical recommendations should be individualized 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.

Why is post partum family planning important ?

Pakistan is the sixth most populous country in the world (Government of Pakistan, 2013).

The population increased approximately 5.5-fold since 1951 reaching 184.5 million in 2012-13.

The current population growth rate is 2 percent. According to estimates, Pakistan will become the fifth most populous country in 2050 at its current rate of population growth (Government of Pakistan).

According to Pakistan Demographic Health Survey (PDHS) 2012-2013

- Only 45% of women deliver in health facilities
- 52% of deliveries are conducted by a skilled birth attendant (SBA)

- 46% of pregnancies are unattended
- 25% of unintended pregnancies end in induced abortions (Pop council 2012).

It is hoped that adoption and use of this guideline may help to prevent unintended pregnancies, a national health priority.

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

It is clear from the statistics below that PPFP saves lives:

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

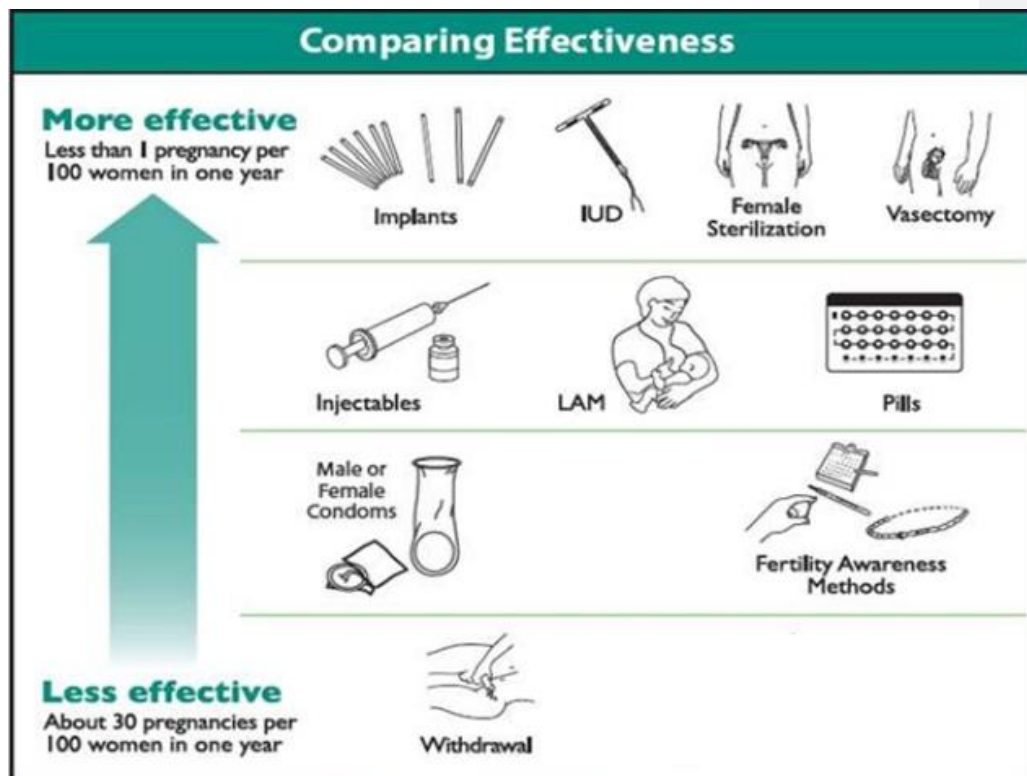
The purpose of a comprehensive PPFP service is to help women to choose the contraceptive method they want to use, to start that method, and to continue to use it for 2 years or longer, depending on their reproductive plans. It is best practice when talking to women about using contraception postpartum to be helpful and respectful and to listen to what they have to say. Women should be given the opportunity to make an informed choice about their contraceptive method.

Pregnancy is a time when women are in contact with healthcare services, creating an opportunity to discuss contraceptive choices and provide contraception to women motivated to avoid a future unintended pregnancy. In Pakistan 55% of women (PDHS2012-2013) do not deliver in hospital and do not deliver there. There is therefore a need for community midwives to provide information and counseling on PPFP. The development of this clinical guideline will provide an opportunity to bring together different health care providers to develop approach to the provision of contraception to women after pregnancy. It will contribute to improve the quality of care received by women after childbirth in the community .

Comment [AF3]: This doesn't quite make sense and I'm not sure what is meant? How about 'There is therefore a need for community midwives to provide information and counselling on PPFP'?

Comment [AF4]: Not sure quite what this means.

Contraceptive Methods available in Pakistan



The methods of contraception available in Pakistan are:

- Intrauterine contraception (IUD)
- Progestogen-only implant
- Progestogen-only injectable contraception (POI)
- Combined hormonal contraception (CHC)
- Barrier methods available for males only
- Fertility awareness based methods (FAB)(2)
- Emergency contraception (EC)
- Male and female sterilization

Effectiveness of methods

Couples should be informed about the effectiveness of different contraceptive choices, including the superior effectiveness of long-acting reversible Contraception (LARC), when choosing an appropriate method to use after pregnancy(FSRH2017).(3)

When should contraception be provided?

Some couples start having sex again before 6 weeks after the baby is born. Conception 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 amenorrhea 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 amenorrhea 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.

Women in Pakistan are not aware of and do not follow the three criteria for LAM contraception: (1) experiencing amenorrhea; (2) fully or nearly fully breastfeeding; and (3) less than 6 months postpartum. It is highly user dependent method and we observe high failure rate. Therefore LAM is theoretically effective in preventing 98% of pregnancies but in Pakistan women are unaware of the criteria for using LAM and failure rates are high. Best practice aims to ensure that women have a method of contraception that they can start before the risk of pregnancy returns after childbirth. 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.

Best practice in postpartum family planning

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⁽²⁾

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

In the antenatal clinic

- Women should be given verbal and written information about all PFP (breast feeding and non-breast feeding 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 sterilization 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.

In the labor ward

Contraception should not be discussed with a woman who is in active labor.

However the early stages of labour offer an opportunity to raise the topic of PFP especially if this is the first time that the woman has been in contact with health services.

Women should be asked whether they have received antenatal contraceptive antenatally.

There should be a suitable private place where the contraceptive method can be provided.

Ideally, a minimum of four methods (pills/injectable/IUCD/implants) should be available not only in labor room but in operating theatre as well.

- 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 Period

- 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

- 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.

In the baby immunisation clinic

- Women bringing their babies for immunization 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?

Maternity services should be able to provide IUDs and progestogen-only methods, including progesterone implants, injectable (POI) or pill (POP).

Maternity services should ensure that there are sufficient numbers of staff able to provide IUCD or IMP so that women who choose these methods and are medically eligible can initiate them immediately after childbirth.

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 method should be offered until the chosen method can be initiated.

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). Women who are breastfeeding should be informed that the available evidence indicates that progestogen-only methods of contraception (LNG-IUS, IMP, POI and POP) have no adverse effects on lactation, infant growth or development.

Women who are breastfeeding should wait until 6 weeks after childbirth before initiating a CHC method. There are theoretical concerns that use of DMPA may be associated with an increased risk of venous thromboembolism (VTE) compared to other progestogen-only methods. For WHO medical eligibility criteria for contraceptive use classification is higher for DMPA(MEC 3) than IMP and POP (MEC 1).

Women choosing DMPA should be informed of the potential for problematic bleeding; however, use of DMPA in the period after childbirth should not be restricted for this reason. (Evidence level 2+)

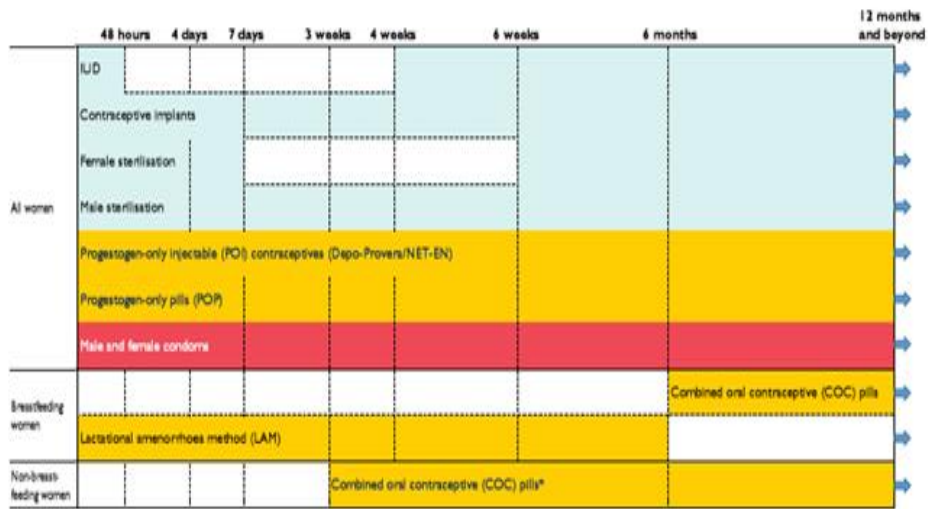
POI including DMPA administered intramuscularly (IM) or subcutaneously (SC) can be initiated immediately to inhibit the first ovulation after childbirth without the need for additional contraceptive precautions.

Women may find the initiation of the method before discharge from maternity services to be convenient as it avoids the need for a follow-up appointment.(2)

Comment [AF5]: Suggest Pakistan should decide which to follow and then stick to it a otherwise HCPs will get confused.

Comment [AF6]:

Comment [AF7]: If Pakistan go with WHO MEC for POI as MEC 3 until 6 weeks post partum this diagram will need to be change



*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

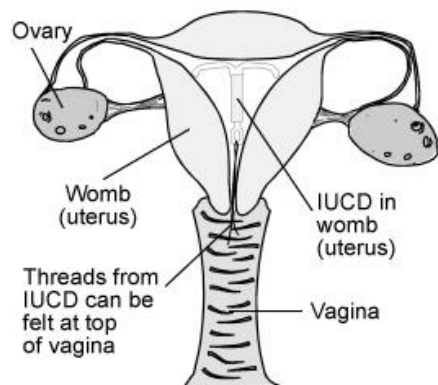
*Unless there are other risk factors for venous thromboembolism (VTE), in which case only from 6 weeks onwards.

Postpartum contraception options: timing of method initiation for all women, for breastfeeding women and for non-breastfeeding women.(2)

adapted from WHO (2013) Programming Strategies for Postpartum Family Planning
The most effective methods

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 (12yrs)(depending on the type) and the levonorgestrel-releasing IUD (LNG-IUS, 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,
- **IUDs** are safe for women who have HIV/AIDS.

In the postpartum setting:

- IUDs can be inserted following expulsion of the placenta which 10 min. 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 **labor** ward and before 48 hours post partum
- An IUD can be inserted up to 48 hours after the baby is born.
- If the IUD is not inserted within 48 hours, insertions 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.

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

Comment [AF8]: Suggest use diagram with IUD rather than IUS as copper IUDs are more common than IUS.

<ul style="list-style-type: none"> • There is some evidence that women who use LNG-IUDs may breastfeed for a shorter time. 	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.
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Effective methods
These methods are generally associated with failure rates of more than 3 per 100 users.

<p>Progestogen-only injectable (POI) contraceptives</p> <ul style="list-style-type: none"> • 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. • Amenorrhea 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. <p>In the postpartum setting:</p> <ul style="list-style-type: none"> • POI contraceptives can be started immediately postpartum in both breastfeeding and non-breastfeeding women. • Postpartum, POI contraceptives do not interfere with lactation. <p>Hormonal contraceptive pills Progestogen-only (POP mini) pills</p> <ul style="list-style-type: none"> • 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. <p>In the postpartum setting:</p> <ul style="list-style-type: none"> • POPs can be started immediately postpartum. Postpartum POPs used does not interfere with lactation. 	<p>Combined oral contraceptive (COC) pills</p> <ul style="list-style-type: none"> • 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 <p>In the postpartum setting</p> <ul style="list-style-type: none"> • 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. • • •
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Less effective method

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 – n/a in Pakistan

The lactational amenorrhoea method (LAM) Less effective in Pakistan.

- 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.

Comment [AF9]: Suggest move this into less effective space above.
Under female condoms.

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 ethanol 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

- Prior to prescribing any form of contraception for use after pregnancy, clinicians should take in to consideration a woman's:
- Contraceptive needs (e.g. degree of efficacy required)
- Personal beliefs, attitudes and preferences
- Sociocultural practices that may impact on choice of method including the views of her husband.
- Sexual activity and sexual problems.
- Social factors (e.g. return to work, ability to access services for initiation/follow-up)
- Medical history [e.g. hypertension, migraine, venous thromboembolism (VTE), obesity, cholestasis, trophoblastic disease] and status [e.g. HIV/Hepatitis B & C status]
- Risk of acquiring or transmitting STIs.

Further, an assessment should be made to determine whether:

- The woman plans to breastfeed
- Ovulation is likely to have resumed
- The woman could be pregnant.

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

While the focus of this clinical guideline is mainly on the safe and appropriate use of contraception by women after pregnancy, clinicians should also be aware of other issues that may be relevant when ensuring that women (and, if appropriate, their baby, partner and family) receive the care they need after pregnancy.

Issues that should be considered include:

- Domestic violence/gender-based violence (GBV)
- Emotional well-being and mental health
- Any sexual problems
- Substance misuse and sexual risk-taking
- Body recovery, nutrition and physical health
- Social and financial support (including safe housing).

What do women need to know about PFP?

Comment [AF10]: The spacing has gone wrong from here onwards with no spaces between words. I don't know if copy editor can sort this out?

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
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 rather than simply stop using contraception.
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 maybe 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 PPF 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 PPF

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 PPF 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 PPF can be provided in clinic waiting rooms. Posters emphasising the importance and advantages of PPF 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 PPF 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 immunization and postnatal clinics

- Ensure that HCPs at baby immunization 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 PFP 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.

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.

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-

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

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 anti-retroviral 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).

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