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Appendix two

LARC guidance

Taken from NICE Clinical Guideline 30

Long-acting reversible contraception. Quick Reference Guide 2005. National Institute for Health and Clinical Excellence. Developed by the National Collaborating Centre for Women's and Children's Health.

Available at: www.nice.org.uk

RCOG Guidelines on Induced Abortion

The Care of Women Requesting Induced Abortion. Evidence-based Guideline 7, 2004. Available at: www.rcog.org.uk.

LARC general points

- Women requesting contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods.
- All healthcare professionals providing LARC methods need training in the relevant skills.
- Practices and services that do not offer LARC methods should have an agreed mechanism for referring women

LARC and cost-effectiveness

- NICE guidance states that all currently available LARC methods (IUDs, IUS, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- IUDs, the IUS and implants are more cost effective than injectable contraceptives

All LARC methods are suitable for

- Nulliparous women
- Women who are breastfeeding
- Women who have had an abortion – at the time of the abortion or later
- Women with BMI >30
- Women with HIV – encourage safer sex
- Women with diabetes
- Women with migraine – with or without aura – all progestogen-only methods may be used
- Women with a contraindication to oestrogen

LARC and adolescents

- There are no specific restrictions for the use of the IUD, IUS or implants
- Care is needed with the use of the injectable contraception, DMPA (Depot Medroxyprogesterone Acetate), by adolescents. It should only be used if other methods are unacceptable or unsuitable (go to www.mhra.gov.uk and search for Depo Provera for more information).

LARC post-partum, including for women who are breastfeeding

- The IUD and IUS can be inserted from 4* weeks after childbirth
- The injectable contraceptive, DMPA and implants can be given at any time after childbirth
- use of the IUS before 6 weeks post-partum is outside the UK Marketing Authorisation. Where it is used in this way the Summary of Product Characteristics should be checked for current licensed indications; if it is to be used outside licensed indications, this should be discussed with the client, and their informed consent obtained. This should be documented in the client's notes.

LARC post-abortion

- The RCOG state that "the initiation of contraception immediately following induced abortion has its advantages. The woman is known not to be pregnant, her motivation for effective contraception is high and she is already accessing

health care. In addition, it has been shown that ovulation occurs within a month of first-trimester abortion in over 90% of women."

- Before she is discharged following abortion, future contraception should have been discussed and the chosen method should be initiated immediately following abortion
- Injectable contraceptives can be given immediately after first or second trimester abortion, or at any time afterwards;
- Implants can be inserted immediately after abortion in any trimester.
- WHOMEAC (The World Health Organisation's Medical Eligibility Criteria for Contraceptive Use) states that ideally both injectables and implants should be commenced at the time of termination, when contraceptive protection is immediate. If they are started after this time, additional barrier contraception is required.
- The IUD and IUS can be fit immediately after first or second trimester abortion
- WHOMEAC recommends that there are benefits of intrauterine contraception immediately following first trimester termination (unrestricted use) or second trimester termination (benefits generally outweigh any risks).
- There are few data specifically relating to IUD insertion following medical termination of pregnancy. The RCOG suggest that an IUD may be inserted immediately (within 48 hours) following first or second trimester medical abortion. Otherwise insertion should be delayed until 4 weeks following medical abortion (as for post-partum insertions)

Post abortion check from the RCOG guidelines

- A follow-up appointment within 2 weeks of the procedure is a requirement of early medical abortion (although it becomes optional if complete abortion is confirmed on the day of the procedure).
- The Birth Control Trust has advocated early follow-up as a routine for all women following abortion.
- The first 2 weeks is when immediate complications of abortion will present and when any problems with contraception should be resolved.

LARC and sexually transmitted infections (STIs)

- All women at risk of STIs should be provided with advice on safer sex
- All women at risk of STIs should be tested for Chlamydia trachomatis prior to IUD or IUS insertion.
- Women should be additionally tested for Neisseria Gonorrhoeae in areas where it is prevalent. If women request testing for other STIs, testing should be provided.
- If testing has not been completed, prophylactic antibiotics should be given prior to IUD or IUS insertion.
- Investigations should be arranged for women with identified risks associated with uterine or systemic infection, and they should be given appropriate prophylaxis or treatment before IUD or IUS insertion.
- There are no specific contraindications in relation to STIs and injectable contraception (DMPA) or implants

LARC by type: injectable contraceptives

- Provided it is reasonably certain that the woman is not pregnant, this method of LARC can be started:
- Up to and including the 5th day of her menstrual cycle, without the need for additional contraceptives
- At any other time in her cycle, barrier methods of contraception should be used for five days after the injection is given
- Immediately after first or second trimester abortion, or any time afterwards. See notes above for more information about contraceptive use post-abortion.
- At any time post-partum
- Repeat injections can be given up to two weeks late without the need for additional contraceptives.

LARC by type: implants

- Provided it is reasonably certain that the woman is not pregnant, implants may be inserted:
- At any time in her menstrual cycle (though barrier methods should be used for the first 7 days after the implant is inserted if the woman is amenorrhoeic (ie there is a suppression or lack of menstrual bleeding), or it is more than 5 days since her period started)
- Immediately after abortion in any trimester. See notes above for more information about contraceptive use post-abortion
- At any time post-partum
- It is important to remove the implant if the woman becomes pregnant whilst using the implant, and she chooses to continue with the pregnancy.

LARC by type: IUDs and the IUS

Provided it is reasonably certain that the woman is not pregnant an IUD or IUS can be fit:

- At any time in her menstrual cycle (although for the IUS if the woman is amenorrhoeic) or it is more than 5 days since her period started, she should be advised to use barrier contraception for the first five days following IUS insertion)
- Immediately after first or second trimester abortion (or at any time afterwards). See notes above for more information about contraceptive use post-abortion
- From 4 weeks post-partum, irrespective of the mode of delivery (note however that use of the IUS before 6 weeks postpartum is outside the UK Marketing Authorisation – see notes above for more information about the use of the IUS post-partum).
- If a woman becomes pregnant with an intrauterine pregnancy, she should be advised to have the IUD or IUS removed before 12 weeks gestation, whether or not she intends to continue the pregnancy
- The risk of uterine perforation when fitting an IUD or IUS is related to the skill of the professional inserting it

Appendix three

LARC Care Pathway

Page 4 of NICE Quick Reference guide

Available at:

<http://guidance.nice.org.uk/CG30/quickrefguide/pdf/English>

Appendix four

Features of LARC methods to discuss with women

Page 6 of NICE Quick Reference guide

Available at:

<http://guidance.nice.org.uk/CG30/quickrefguide/pdf/English>

Appendix five

Postnatal contraception planning for young women

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Abstract

The Young Women's Pregnancy Service (YWPS) in South Tyneside is a dedicated specialist maternity service for young women under 20 years of age. Since its establishment in 1986 the YWPS has developed a multidisciplinary, multi-agency team approach to care, aimed at supporting young parents throughout pregnancy and into parenthood. The value of this integrated approach was cited as a model of innovative practice in May 2005.²

In 2004, the YWPS further developed its service provision to include a dedicated postnatal contraception service, which ensures that contraception planning is integral to young women's antenatal and postnatal care. Collaboration between key service providers from the Primary Care and Acute Hospital Trust supports the efficient and effective delivery of the contraception plan. This article will describe the background, development and implementation of the contraception planning service and describe how it supports young women to make informed decisions in relation to choice and use of contraception after their baby is born.

Background

The Young Women's Pregnancy Service in South Tyneside began in 1986 as a dedicated teenage pregnancy clinic. Over the years it has been responsive to changing client and service needs and has developed into a specialist maternity service with Young Women's care being provided by a dedicated teenage pregnancy team. The team comprises specialist midwives, a Sure Start midwife, Sure Start Plus Advisors, a dedicated Young Women's Health Visitor and a Young Women's Pregnancy Options Advisor. Some 85% of pregnant young women under 20 years of age in South Tyneside opt to receive their care from the service.

In November 2004 the Teenage Pregnancy Unit suggested that about 20% of births conceived to under 18's were second pregnancies and identified the need to support those who were already teenage mothers to avoid second unplanned pregnancies.¹ However, in South Tyneside, as early

as September 2003 anecdotal evidence from the Young Women's Pregnancy Service suggested an increasing number of unintended repeat conceptions within the first postnatal year. By November 2003 discussion had taken place at the Teenage Pregnancy Partnership Board and agreement reached for the YWPS lead specialist midwife and the Pregnancy Options Advisor to develop and implement contraception planning within the YWPS. It was agreed that the Pregnancy Options Advisor, who works within the Contraception and Sexual Health Service and holds the Family Planning Certificate, would attend the weekly YWPS clinic and that contraception planning would become an integral part of the ante and postnatal care offered to young women and their partners. Previous studies had suggested that women were more receptive to and welcomed information about contraception in the antenatal period.^{3,4} A later study by Smith et al (2002)⁵ suggested that this appeared to have no impact on the postnatal pattern of contraceptive use. The contraception planning service for young women in the antenatal period was developed to ensure young women had easy access to information and discussion about all methods of contraception available in order to give them the opportunity to make an informed choice based on their personal needs in relation to contraception in the postnatal period and beyond. This is in accordance with the evidence-based FFPRHC Guidance (October 2004) "Contraceptive choices for young people."⁶

Development and Implementation

Although comprehensive information leaflets about postnatal contraception are readily available, a number of young women expressed the view that too much information and irrelevant information acted as a deterrent to them reading the leaflets. The young women largely saw information about sterilisation, caps and diaphragms as unnecessary and irrelevant. This led to the development of a user friendly, easy to read leaflet which was specific to the needs of young women, giving a brief overview of each method and including information about postnatal ovulation, menstruation and condom use. (Fig 1) This introductory leaflet is supplemented by providing the Family Planning Association method specific leaflets as appropriate.

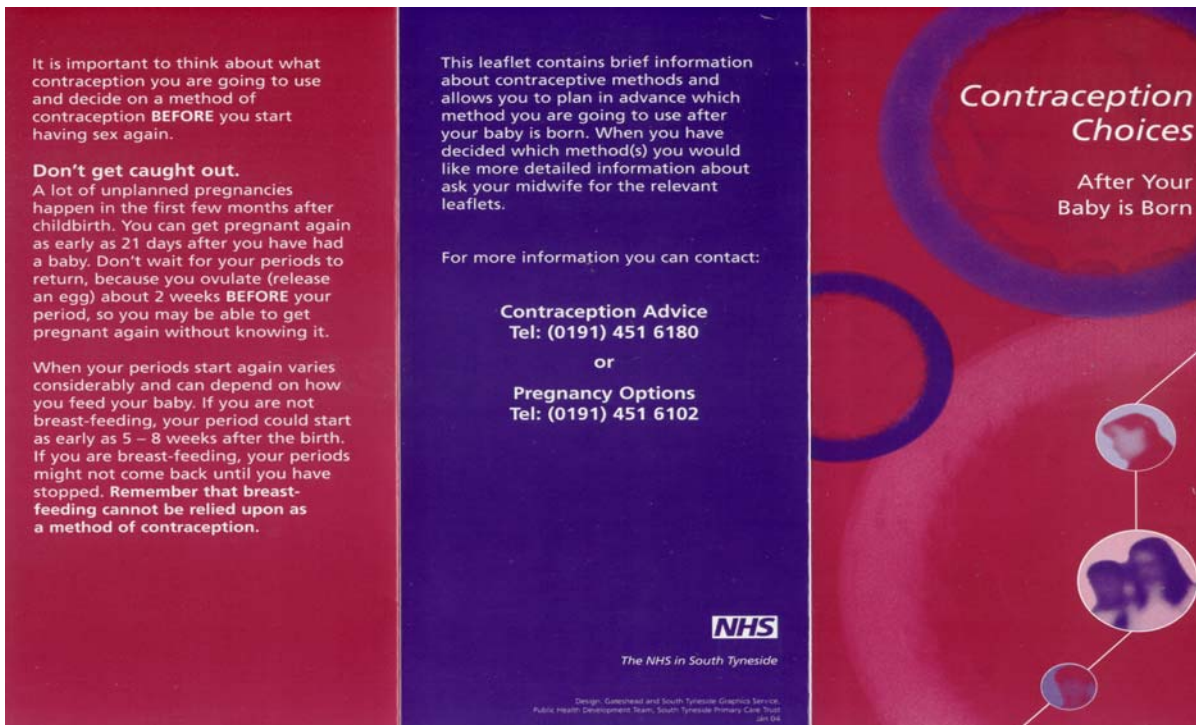


Figure 1: Information leaflet

Key intervention and information points for discussion about contraception were identified to correspond with the young women’s attendance at the antenatal clinic. A pre printed contraception plan is generated as part of the case note documentation and updated at each intervention/discussion point. (Fig 2)

<u>Under 20's Contraceptive Plan</u>	
Name: _____	Age: _____
Address: _____	
Tel. No. _____	Parity: _____
	Hospital No. _____
Named Midwife _____	
At Booking	
Previous contraception	Y N
If Yes: OCP POP Depo IUCD Implant Condoms Other _____	
Planned pregnancy?	Y N
Did contraception fail?	Y N
Comment _____	
At 28 weeks	
Give contraceptive advice pack and Grapevine info.	
Possible choices discussed _____	
Further information/advice required	Y N
At 34 weeks	
Possible choices discussed _____	
Method chosen	Y N
Support appointment	Y N
Contraceptive plan at 38 weeks:	
Ward 22	
Advice given: _____	
Method of contraception provided:	
OCP POP Depo IUCD Implant Condoms Other	

Discussion first takes place at the antenatal booking appointment to explore any previous contraceptive use, whether the pregnancy was planned or unplanned and whether contraceptive method/user failure was a factor. The introductory contraception leaflet “Contraception Choices” can be given at this point. The next planned discussion takes place at 28 weeks and begins with helping young women identify the factors that they feel influence their choice and sustained use of contraception. Stevens-Simon et al (1998)⁷ suggested that one of the deterrents to continued contraceptive use by young women in the postnatal period was concerns about side effects and, therefore, discussion in the YWPS clinic includes

exploration of the factors, which might influence the young woman's choice of postnatal contraception. Issues such as likes and dislikes, perceived advantages and disadvantages in relation to previously used contraception, preferred time interval before next pregnancy, reliability of chosen method, ease of use, any concerns about side effects e.g. altered body image due to weight gain, possible effects on menstrual cycle e.g. irregular cycle/ amenorrhoea are all explored.

Further discussion and information giving takes place at 34 weeks and 38 weeks with the aim of supporting young women to plan a contraceptive method choice prior to delivery, which can then be implemented post delivery. As the written contraception plan remains within the case notes, it is readily available for the midwives to refer to when the young woman has delivered. The Pregnancy Options Advisor also visits the postnatal ward twice a week to see young women who have had their babies and to take details for further contact about those young women who have been discharged.

Figure 2: Contraception plan

The essential key to the service is the collaboration between service providers; the Acute and Primary Care Trusts, Contraception and Sexual Health Service, hospital and community midwives and Obstetric and Gynaecology Consultants. It is this that supports the effective and efficient delivery of young women's individual contraception plan and ensures that method choice is implemented at the optimal postnatal interval and within the most appropriate service.

Whichever method is chosen, the service aims to ensure that the young woman feels she has made a well-informed choice about her chosen method and that she has enough information, knowledge and understanding to take ownership of her choice and allow her to confidently use that method. If oral contraception has been chosen young women are offered in depth discussion in the antenatal period about reliable pill taking, when to start pill taking in the postnatal period and information is given about use of and access to emergency contraception. There is also an opportunity to re-discuss pill taking routine prior to commencing pill use on the 21st day after delivery and this can take place either prior to discharge from the postnatal ward or as a home visit, whichever the young woman prefers. Aids to remembering pill taking are also explored and, as many young people are familiar with and more aware of modern technology, such things as using the mobile phone reminder setting until daily pill taking routine is established are used. Young women are offered the option of having a text message reminder sent by the Options

Advisor to their mobile phones the day before the 21st postnatal day to remind them to begin their pill next day.

Although South Tyneside has a policy for 28 day supply of drugs dispensed on discharge from hospital, early discussion lead to an agreement for 3 months supply of oral contraception to young women under 20 years of age on discharge from hospital as it was felt that this would support sustained use of the chosen method, especially in the early postnatal period.

For those who wish to consider using the contraceptive patch, placebos are made available in the antenatal period to allow the young woman to assess adhesion of the patch and use of routine and to make an informed decision at a time when she is not exposed to risk of user failure if adherence or compliance proves to be a problem. If the patch is chosen as a method of contraception encouragement is given to access the manufacturer's automated text message service, which delivers reminders in relation to patch use and patch free interval as an aid to method compliance.

Discussion about intra-uterine devices (IUD) are supported by the availability of devices which the young women can see and handle, as this often serves to dispel any myths and misconceptions that may be held about the size, appearance and weight of an IUD. Should she choose to have an intra-uterine device (coil) or intra-uterine system (Mirena^R), interim short term oral contraception to take from 21st day postnatal is made available and arrangements made for insertion of the IUD/IUS at the optimal postnatal time.

Young women who choose to have the implant (e.g. Implanon^R) have preparatory method counselling undertaken in the antenatal period ensuring thorough discussion and understanding of the method and when they have had their baby an appointment is made for Implanon insertion within the contraception and sexual health service during the optimal 21st to 28th postnatal day. Again, the Options Advisor sends text message reminders about IUD, IUS or Implanon^R appointment details.

Those who choose to have the contraceptive injection have the opportunity to discuss optimal postnatal timing and if they wish to wait until 6 weeks after giving birth to commence the injection, are offered interim short-term oral contraception to take from 21st postnatal day.

All young women, regardless of choice of method, have the option of being sent text reminder messages to support the use of their chosen contraception. Additionally, in line with the Sexual Health Strategy ⁸ the use of condoms are encouraged as a primary means of preventing sexually transmitted infections and an adjuvant to contraception. Condoms are freely available from the Options Advisor at the antenatal sessions and their use is promoted as an integral part of young women's sexual health. Young women are also provided with a supply of condoms on discharge from the postnatal ward.

The provision of the contraceptive planning both in the antenatal and postnatal period has encouraged both service providers and service users to see contraception as a natural part of antenatal and postnatal care. Feedback from young women about the service has been very positive.

In the postnatal period ongoing care by the community midwife incorporates discussion about contraception and the YWPS dedicated Health Visitor discusses contraception as part of the young woman's postnatal visit. A study on postnatal home visits in teenage mothers in 2003⁹ suggested that home visits, at which contraception continued to be discussed, increased mother's

use of contraception at six month follow-up.

A brief questionnaire has recently been developed within the YWPS to record information in relation to sustained use of contraception at the 9 months postnatal Health Visitor review (Fig 3)

The questionnaire seeks information about maintenance of chosen method, factors influencing any change of method and source of ongoing contraception. It is anticipated that this will provide information that can be used to further tailor the service to meet the

Postnatal contraception review

Name.....

Age.....

1) How old is your baby?.....mths

2) Have you used a method of contraception since you had baby? Yes / No

3) If Yes, when did you start the contraception?

within first 3 weeks 3 to 6 weeks

2 to 3 months 3 to 6 months later than 6mths

4) What method of contraception did you first use after having baby?

Combined pill Progestogen only pill

Injection Implant

IUD (coil) IUS (Mirena coil)

Evra patch Condoms

5) Are you still using the same method? Yes / No

6) If you are using a different method, or have stopped using contraception, what made you change?

.....

.....

7) When did you change your method of contraception?

.....

8) What method did you change to?

Combined pill Progestogen only pill

Injection Implant

IUD (coil) IUS (Mirena coil)

Evra patch Condoms

9) Where do you get your contraception from?

Contraception clinic G.P.

Please return to: Elaine Doherty, Contraception Service @ Stanhope Parade H C

needs of the young women and provide essential service user feedback on any developments, which could be considered and incorporated in the future.

Figure 3: Postnatal questionnaire

South Tyneside District Hospital has now expanded contraception planning to all pregnant women and an adapted service has been taken forward within mainstream the maternity service by Community Midwives. Contraception information updates are now incorporated in the community and hospital midwives' annual in-house training programme. Information about the

development of the service has also proved attractive to other maternity service providers both locally and nationally and was identified as an area of innovative practice in 2005.²

References

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Appendix six

Annotated bibliography of published research on repeat abortion. Page 45, Repeat Abortion in the United States published by Guttmacher Institute

Available at:

<http://www.guttmacher.org/pubs/2006/11/21/or29.pdf>