FSRH CEU clinical advice to support provision of effective contraception during the COVID-19 outbreak
20 March 2020

During Covid19-related restriction in face-to-face contact with healthcare professionals, FSRH CEU offers the following clinical advice to support ongoing provision of effective contraception. Provision of effective contraception (this may be a bridging method in the short term) and emergency contraception are considered priority services.

It is noted that UK SRH and primary care services vary widely in their current provision of contraception. No one model of provision can be applied to all services, but expansion of remote (online/telephone) prescribing of oral contraception/emergency contraception is likely to be key.

All services should ensure that there is clear, up to date signposting for patients and partner services as to what local contraceptive services are currently available, how these can be accessed, and to national online services. Patient information to support effective use of short-acting contraceptive methods must be made available in a choice of formats for all users.

Individuals already established on a contraceptive method:

1. **Combined hormonal contraception (CHC)**
   For existing CHC users it is reasonable at this time to allow further remote prescription to cover the next 6-12 months without rechecking BMI/blood pressure; risk associated with unplanned pregnancy likely to be greater than risk relating to continued use. If the provider documented all relevant medical history at the time of last CHC provision, and no contraindications were identified, provision of a further supply of CHC without review of medical history can be considered.

2. **Progestogen only pill (POP)**
   For existing POP users it is reasonable at this time to allow a further 12 month supply to be given without review. FSRH CEU suggests that local patient group direction for POP could be modified in the short term to allow remote provision by non-prescribing nursing/pharmacy staff.

3. **Depot medroxyprogesterone acetate (DMPA)**
   Depo Provera®: Switch to desogestrel POP is recommended (face-to-face assessment is not required: if an individual has no contraindications to DMPA, they are likely to have no contraindications to POP unless absorption or adherence to use are of significant concern. Note that concomitant use of an enzyme-inducing medication could reduce contraceptive effectiveness of the POP). If POP is started up to 14 weeks after the last DMPA injection, no additional contraceptive precautions are required.

   Sayana Press®: Self-administering users of Sayana Press (or previous self-administering users who have been using Depo Provera during Sayana Press shortage) can receive up to a 12 month supply of Sayana Press (if available) and required equipment to self-administer at home without a face-to-face review or blood pressure check.

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4. Etonogestrel implant (ENG-IMP)

Limited evidence suggests that the risk of pregnancy in the 4th year of use of an ENG-IMP is likely to be very low. See FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID restrictions.[1]

Replacement can be deferred for a year after expiry to avoid unnecessary face-to-face contact. Women should be made aware that contraceptive effectiveness cannot be guaranteed but is likely to be adequate; they can be offered POP to use in addition without face to face assessment (if an individual has no contraindications to the ENG-IMP, they are likely to have no contraindications to POP unless absorption or adherence to use are of significant concern).

Beyond 4 years of use of an ENG-IMP, additional desogestrel POP should be offered.

There is no indication to bring users in at this time to remove expired ENG-IMP unless they wish to become pregnant or have serious adverse side effects.

5. 52mg LNG-IUS (Mirena® and Levosert®)

Limited evidence suggests that the risk of pregnancy in the 6th year of use of the 52mg LNG-IUS is likely to be very low. See FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID restrictions.[1]

Replacement can be deferred for a year after expiry to avoid unnecessary face-to-face contact at this time. Women should be made aware that contraceptive effectiveness cannot be guaranteed but is likely to be adequate; they can be offered POP to use in addition without face to face assessment (if an individual has no contraindications to the LNG-IUS, they are likely to have no contraindications to POP unless absorption or adherence to use are of significant concern. Note that concomitant use of an enzyme-inducing medication could reduce contraceptive effectiveness of the POP).

All women over age 45 years at insertion can rely on the 52mg IUS ***for contraception*** until age 55. (Despite lack of definitive evidence, FSRH CEU suggests that Levosert can be used in this way in the short term to reduce unnecessary face-to-face contact). **INDIVIDUALS USING THE 52mg LNG-IUS FOR ENDOMETRIAL PROTECTION AS PART OF HRT MUST HAVE THE IUS CHANGED AT 5 YEARS (OR STOP ESTROGEN, OR SWITCH TO A COMBINED HRT PREPARATION).**

Beyond 6 years of use of a 52mg LNG-IUS for contraception, additional desogestrel POP should be offered.

Other LNG-IUS

Jaydess® and Kyleena® users should be advised to use condoms or add desogestrel POP as above at the end of the licensed duration of use. There is no indication to bring LNG-IUS users in at this time to remove expired LNG-IUS unless they wish to become pregnant, have significant signs of infection or have serious adverse side effects.

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6. **Copper IUD (Cu-IUD)**
   Additional use of condoms/desogestrel POP is advised from the time of expiry of Cu-IUDs licensed for 5 years (although any Cu-IUD inserted over age 40 years will provide effective contraception until age 55 years). Extremely limited evidence suggests that banded Cu-IUDs like the TCu380A with a 10 year licence could be effective for up to 12 years; given the if use is extended, women may wish to use condoms in addition.[2,3]

   There is no indication to bring users in at this time to remove expired Cu-IUD unless they wish to become pregnant, have significant signs of infection or have serious adverse side effects.

New contraception starters:

FSRH CEU suggests that, as standard, individuals requesting to start contraception can be assessed remotely and a 6-12 month supply of desogestrel POP provided. Note that 1. enzyme inducers can reduce contraceptive effectiveness of POP (DMPA, LNG-IUS and Cu-IUD are not affected) and 2. individuals using teratogens should ideally use LARC methods. Local patient group direction for POP could be modified in the short term to allow remote provision by non-prescribing nursing/pharmacy staff.

If POP is not suitable or not acceptable:-

- First CHC prescription would require complete remote assessment of medical eligibility and accurate self-reported blood pressure/BMI. A 6-12 month supply should be provided.
- Administration of DMPA or insertion of ENG-IMP or intrauterine contraceptive may be considered where concerns about adherence, individual intolerance of oral contraceptives or use of teratogens make longer-acting reversible contraception the only suitable option. Pre-procedure assessment and information-giving should be done remotely to minimise face-to-face contact time with healthcare professionals. Current local protocol regarding infection control should be followed at the time of the procedure.

Emergency contraception (EC):

FSRH CEU recommends that remote assessment of requirement for EC is prioritised so that it can be made as soon as possible after unprotected intercourse.

Insertion of a Cu-IUD for EC should continue to be offered first line, where this is possible, to qualifying individuals; if there is a delay prior to Cu-IUD insertion, immediate oral EC should be offered **in addition.**

Individuals who do not meet the criteria for emergency IUD insertion, or who decline an emergency IUD should be assessed remotely as to the most appropriate oral emergency contraception, receive both oral EC and a 3 month supply of POP and be given clear written/digital advice about additional contraceptive precautions, when to start the POP, and follow up pregnancy testing. Where possible delay associated with postal delivery of oral EC should be avoided by facilitating collection by the individual.

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References

1. Faculty of Sexual & Reproductive Healthcare. FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID restrictions. 20 March 2020. Available online here
2. Wu JP, Pickle S. Extended use of the intrauterine device: a literature review and recommendations for clinical practice. *Contraception*. 2014;89(6):495-503.
3. Ti AJ, Roe AH, Whitehouse KC, Smith RA, Gaffield ME and Curtis KM. Effectiveness and safety of extending intrauterine device duration: a systematic review. *American Journal of Obstetrics and* Gynecology 2020 Jan 15. Available online here

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