Suffolk County Council

NHS Cambridgeshire Community Services NHS Trust

Dear Colleagues

Provision of contraception, including LARC during the COVID-19 pandemic:

The Suffolk Sexual & Reproductive Health Board considers that at all times during the COVID-19 pandemic and period of restoration the provision of effective contraception, management of LARC complications, emergency contraception and abortion care remains essential.

The prevalence of COVID-19 is changing over time and is not the same across the UK. During the pandemic, unnecessary face-to-face contact should always be avoided to minimise risk of COVID-19 transmission. Primary Care has already adapted their contraceptive services depending on local COVID-19 prevalence and the resulting risk of COVID-19 transmission associated with face-to-face procedures.

When the risk of COVID-19 transmission is highest, and lockdown restrictions are in place, face-to-face contact may only be appropriate for fitting emergency contraception intrauterine devices (IUDs) and urgent examination. At times of lower COVID-19 prevalence, when restrictions are eased, non-urgent face-to-face procedures can take place.

All services should ensure that there is clear, up-to-date signposting for patients requiring contraception care including what is being provided, how this can be accessed and pharmacy/online contraception provision.

1. Avoiding unnecessary face-to-face contact for contraceptive provision

It is recommended that much of the contraceptive consultation process is achieved remotely. This includes assessment of medical eligibility, support with choice of contraceptive method, information-giving prior to any procedure and provision of essential information to support ongoing use. Patient information to support contraceptive choice, effective use of short-acting contraceptive methods and long-acting reversible contraception (LARC) aftercare should be made available in a choice of formats e.g. texting links to leaflets, websites.

Providers should check FSRH guidance to ensure that only *necessary* examinations/ investigations are done. For example, *routine* STI testing is not a requirement prior to insertion of intrauterine contraception *and routine* thread checks by healthcare professionals are not required - users should be encouraged to check their own threads.

2. Provision of contraception at times of high local COVID-19 prevalence (when risk of COVID-19 transmission may outweigh the benefit of non- urgent face-to-face contact)

At times of highest local COVID-19 prevalence, when lockdown restrictions are in place, individuals requiring contraception should be offered an effective contraceptive method that does not require a face-to-face procedure. Clear supporting information must be provided. If this is not their contraceptive method of choice, it may be used as a bridging method to provide effective contraception until COVID-19 transmission risk allows commencement of their chosen method.

A desogestrel progestogen-only pill (POP) is an ideal bridging method. It can be used safely by most individuals and is over 99% effective for contraception if taken correctly. Note that the effectiveness of POP may be reduced if an individual is taking an enzyme- inducing drug. Assessment, information-giving and prescription can take place remotely (no physical examination is required). It is hoped that in the near future the desogestrel POP can be bought from pharmacies without the need for a prescription.

If the desogestrel POP is not suitable or not acceptable, alternative options for providing effective contraception without a face-to-face procedure are:

- **Combined hormonal contraception (CHC).** Prescription of CHC requires assessment of medical eligibility, blood pressure and BMI. This may be achieved remotely, with self-reported BP and BMI (existing CHC users with an accurate blood pressure and BMI measurement documented within the past year do not need these repeated during lockdown). A 12-month supply of combined oral contraception, Evra® or SyreniRing® may be provided remotely to eligible individuals. Note that other brands of combined vaginal ring (e.g. Nuvaring®) can only be dispensed three months at a time.

- **Sayana Press®.** Existing self-administering users of Sayana Press may be assessed remotely and provided with a further prescription for Sayana Press if eligible. New Sayana Press users may be taught to self-administer via video consultation.

- **Extended use of LARC methods.** Existing Nexplanon® users and users of Mirena®, Levosert® and copper IUDs with 10 year licence may consider extending use (see below).

In-clinic administration of depot medroxyprogesterone acetate (DMPA) or insertion of Nexplanon or intrauterine contraception may be considered in individual cases if concerns about, for example, adherence, individual intolerance of oral contraceptives or use of teratogens make longer-acting reversible contraception the only suitable option. DMPA and intrauterine contraception should be considered for individuals taking enzyme- inducing drugs.

Emergency contraception

It is recommended that remote assessment for emergency contraception (EC) is prioritised so that EC can be offered as soon as possible after unprotected intercourse (UPSI) to maximise effectiveness.

At all times during the COVID-19 pandemic, insertion of an IUD for EC should continue to be offered first line to qualifying individuals. If there is a delay prior to Cu-IUD insertion, immediate oral EC should be given **in addition.**

For individuals who do not meet the criteria for emergency IUD insertion, or who decline this option, remote assessment should be undertaken to identify the most appropriate oral emergency contraception. They should receive both oral EC and a 3-month supply of desogestrel POP plus clear written/digital advice about additional contraceptive precautions, when to start the POP, and follow up pregnancy testing.

3. Provision of contraception at times of lower COVID-19 prevalence (when benefit of face-to-face contact for non-urgent contraceptive procedures may outweigh COVID-19 transmission risk)

In addition to the services described in section 2, when COVID-19 prevalence is lower, services can reinstate provision of non-urgent contraception that requires a face-to-face procedure or blood pressure measurement. Contraceptive choice consultation, assessment of medical eligibility and information-giving should continue to be done remotely prior to attendance for the procedure.

Long-acting reversible contraceptive (LARC) methods offer the most effective contraception and should be prioritised. This includes quick-start of Nexplanon after oral emergency contraception.

4. **The following Faculty of Sexual and Reproductive Healthcare recommendations support contraceptive provision *at any time during the COVID-19 pandemic:***

Nexplanon®

- New Nexplanon users should start or quick start according to existing FSRH guidance. See FSRH Clinical Guideline Progestogen-only Implants.

- **Extended use of Nexplanon.** Risk of pregnancy during the fourth year of Nexplanon use appears to be very low, although evidence is limited. See FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID-19 restrictions.

To avoid unnecessary risk of coronavirus transmission, replacement can be deferred for up to a year after expiry. Women should be advised that contraceptive effectiveness is not guaranteed during the fourth year and they may wish to use additional contraceptive precautions (e.g. condoms or POP) until the implant can be replaced.

- D*uring the COVID-19 pandemic,* **when replacing* a Nexplanon** that has been *in situ* for:

  - **Up to 3 years** - there is no requirement for additional contraceptive precaution or pregnancy testing prior to or after replacement

  - **3 to 4 years** - there is no requirement for additional contraceptive precaution or pregnancy testing prior to replacement. Condoms should be advised for the first seven days after replacement and a urinary pregnancy test recommended at 21 days after the last UPSI.

  - **Over 4 years** - so long as pregnancy test is negative, replacement can proceed; condoms should be advised for the first seven days after replacement and a urinary pregnancy test taken at 21 days after the last UPSI.

  (*removal followed immediately by insertion of the same device type)

- *During the COVID-19 pandemic,* decisions about whether to undertake **deep or difficult implant removals** that require longer contact time with a healthcare professional should be made at a local level after a risk assessment. The existing implant can safely remain *in situ* in the short term. If the implant has expired and contraception is required, any effective contraceptive method can be started with the expired implant still in situ. If the individual opts for another Nexplanon, the new implant should be inserted in the other arm.

Levonorgestrel-releasing intrauterine systems (LNG-IUS) and copper intrauterine devices (Cu-IUD)

- **New LNG-IUS/Cu-IUD** users should have existing pregnancy or risk of pregnancy excluded prior to insertion (unless Cu-IUD is fitted for emergency contraception). See FSRH Clinical Guideline Intrauterine Contraception. Bridging contraception can be provided where pregnancy cannot be excluded.

- **52mg LNG-IUS (Mirena® or Levosert ®) Extended use of Mirena and Levosert)**

  Risk of pregnancy during the 6th year of use of a 52mg LNG-IUS appears to be very low, but evidence is limited. See FSRH CEU recommendation on extended use of the etonogestrel implant and 52mg levonorgestrel-releasing intrauterine system during COVID restrictions.

To avoid unnecessary risk of coronavirus transmission, Mirena or Levosert replacement maybe delayed for up to a year after expiry. Users should be advised that contraception effectiveness is not guaranteed during the sixth year and that they may wish to use additional contraception precautions (e.g condom or POP) until the IUS can be replaced.

It is standard practice that individuals aged over 45 years at the time of 52mg LNG-IUS fitting can rely on the device **FOR CONTRACEPTION** until age 55 years.[i] Note if a 52mg LNG-IUS is used for endometrial protection as part of HRT it must be either changed at 5 years or a combined HRT preparation commenced.

- **13.5mg and 19.5 LNG-IUS (Jaydess® and Kyleena ®)**
  Additional contraceptive precautions are required after 3 years for Jaydess and 5 years for Kyleena.

- **Cu-IUD**
  Individuals due for replacement of a banded Cu-IUD with a 10 year licence can be advised that the risk of pregnancy up to 12 years of use is likely to be low [ii],[iii], contraception cannot, however, be guaranteed and individuals may wish to use additional contraceptive precautions until it considered safe to attend for replacement. Additional contraceptive precautions are required after the licenced 5 years for all 5-year Cu-IUDs.

During the COVID-19 pandemic, when replacing*:

- Mirena, Leosert or Kyleena in situ for up to 5 years, Jaydess in situ for up to 3 years or Cu-IUD within its licence – pregnancy testing is not required, no additional contraceptive precautions are required after replacement.

- Mirena or Levosert in situ for up to 7 years or 10-year Cu-IUD that has been in situ for up to 12 years – so long as pregnancy test is negative, replacement can proceed, with advice to use condoms for 7 days and to take a follow up urinary pregnancy test at 21 days after the last UPSI.

- Mirena or Levosert in situ for over 7 years, Kyleena in situ for over 5 years, Jaydess in situ for over 3 years, 5year CU-IUD in situ for over 5 years or 10 year Cu-IUD in situ for over 12 years – a negative pregnancy test after 3 weeks of additional contraceptive precautions is required prior to replacement; condoms should be advised for 7 days after replacement of Mirena/Levosert/Kyleena/Jaydess.

  (*removal followed immediately by insertion of the same device type)

Depo Medroxyprogesterone acectate (Depo Provera® and Sayana Press ®)

- DPMA (IM or subcutaneous) can be repeated at 14-week intervals without requirement for additional contraceptive precautions or pregnancy testing.

- If the interval is >14 weeks but there has been nop UPSI since 14 weeks, DMPA may be given, with advice to use condoms for 7 days.

- If the interval is >14 weeks AND there has been UPSI since 14 weeks, IF a high sensitivity urinary preganancy test is negative, DMPA may be given, with advice to use condoms for 7 days. A follow up pregnancy test MUST be taken at 21 days after the last UPSI.

- Individual may be taught to self-administer Sayana Press®. Since the start of COVID-19 pandemic, some services have successfully designated, tested and delivered teaching via video link. Once the user is trained, a one year supply can be given, so that contact with healthcare professionals for repeat injections is avoided.

Combined hormonal contraception

During the COVID-19 pandemic, remote assessment of past medical and family history plus associated health risks can be undertaken as per the FSRH guidance. See FSRH Clinical Guideline Combined Hormonal Contraception .

An accurate blood pressure and BMI measurement should have been documented within the past year and can be self reported during COVID-19 restrictions. A one year supply of combined oral contraception, Evra or SyreniRing may be prescribed for eligible individuals. Note that Nuvaring can only be dispensed three months at a time.

Progestogen-only pill

The desogestrel POP is ideal for remote provision as no physical examination (e.g blood pressure) is required. A one year supply may be prescribed for eligible individuals. It is hoped that the desogestrel POP may be bought from pharmacies without prescription in the near future.

5. Attendance for face-to-face contraceptive procedures: practicalities

Current local protocols for minimising risk of transmission of COVID-19 must always be followed when undertaking contraception procedures.

- As much of the consultation process as possible should be done remotely prior to attendance

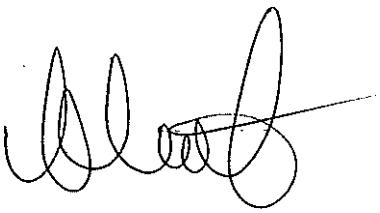
- Individuals are not required to self-isolate or undertake COVID-19 testing prior to attending contraceptive procedures. They should, however, be reminded of the importance of social distancing and hand hygiene measures to reduce transmission risk prior to their procedure date. They should be advised not to attend if they are diagnosed with COVID-19, develop COVID1-19 symptoms or are required to self isolate in the tend days prior to their procedure appointment. All individual must be assessed for symptoms of COVID-19 on the day of their procedure.

- By staggering appointment times, minimising the time that patients are waiting in the building and managing patient footfall and flow (ideally there should be separate entrance and exit), patient overlap can be kept to a minimum.

- The largest available clinic room with good ventilation should be used. Clinic rooms should be kept clutter free to facilitate cleaning and should be set up for the procedure prior to the patient entering. Appropriate PPE should be used. A chaperone should be offered in line with FSRH guidance, while maintaining a two metre distance between them and the patient. Where this cannot be maintained PPE should be worn by the chaperone. Conversation should be minimised, especially when within two metres.

We would be grateful if you would kindly share this information with colleagues within your organisation and should you require any further information please do not hesitate to contact us.

Yours faithfully



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[i] Faculty of Sexual and Reproductive Healthcare. Clinical Guideline Contraception for women aged over 40 years. August 2017, amended September 2019. Available online here (accessed 13/10/2020)

[ii] Wu JP, Pickle S. Extended use of the intrauterine device: a literature review and recommendations for clinical practice. Contraception. 2014;89:495-503

[iii] 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 Gynaecology 2020 Jan 15