

PERINATAL EDUCATION PROGRAMME

FAMILY PLANNING AFTER PREGNANCY

UNIT 14

OBJECTIVES

When you have completed this unit you should be able to:

1. Explain the wider meaning of family planning.
2. Give contraceptive counselling.
3. List the efficiency, contra-indications and side effects of the various contraceptive methods.
4. List the important health benefits of contraception.
5. Advise a postpartum patient on the most appropriate method of contraception.

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ISBN 0 7992 1362 4

14-1 WHAT IS FAMILY PLANNING?

Family planning is far more than simply birth control, and aims at improving the quality of life for everybody. Family planning is an important part of primary health care and includes:

1. Promoting a caring and responsible attitude to sexual behaviour.
2. Ensuring that every child is wanted.
3. Encouraging the planning and spacing of the number of children according to a family's home conditions and financial income.
4. Providing the highest quality of maternal and child care.
5. Educating the community with regard to the disastrous effects of unchecked population growth on the environment.

It is essential to obtain prior community acceptance of, and promote community participation in, any family planning programme if the programme is to succeed in that community.

14-2 WHO REQUIRES FAMILY PLANNING EDUCATION?

Because family planning aims at improving the quality of life for everybody, every person, female or male, requires family planning education. Such education should ideally start during childhood and be given in the home by the parents. It is then continued at school and throughout the rest of the individual's life.

14-3 WHO NEEDS CONTRACEPTIVE COUNSELLING?

Every person who is sexually active, or who probably will soon become sexually active, needs contraceptive counselling (i.e. information and advice about birth control). While the best time to advise a woman on contraception is before the first coitus, the antenatal and postdelivery periods provide an excellent opportunity to provide contraceptive counselling. Some patients will ask you for contraceptive advice. However, you will often have to first motivate a patient to accept contraception before you can advise her about an appropriate method of contraception.

14-4 HOW SHOULD YOU MOTIVATE A PATIENT TO ACCEPT CONTRACEPTION AFTER DELIVERY?

A good way to motivate a patient to accept contraception is to discuss with her, or preferably with both her and her partner, the health and socio-economic effects further children could have on her and the rest of the family. Explain the immediate benefits of a smaller, well spaced family.

It is generally hopeless to try and promote contraception by itself. To gain individual and community support, family planning must be seen as part of total primary health care. A high perinatal or infant mortality rate in a community is likely to result in a rejection of contraception.

14-5 HOW SHOULD YOU GIVE CONTRACEPTIVE ADVICE AFTER DELIVERY?

There are 5 important steps which should be followed:

STEP 1: DISCUSSION OF THE PATIENT'S FUTURE REPRODUCTIVE CAREER.

Ideally a woman should consider and plan her family before her first pregnancy, just as she would have considered her professional career. Unfortunately in practice this hardly ever happens and many women only discuss their reproductive careers for the first time when they are already pregnant or after the birth of the infant.

When planning her family the woman (or preferably the couple) should decide on:

1. The number of children wanted.
2. The time intervals between pregnancies as this will influence the method of contraception used.
3. The contraceptive method of choice when the family is complete.

Very often the patient will be unable or unwilling to make these decisions immediately after delivery. However, it is essential to discuss contraception with the patient so that she can plan her family. This should be done together with her husband and, where appropriate, other members of her family or friends.

STEP 2: THE PATIENT'S CHOICE OF A CONTRACEPTIVE METHOD.

The patient should always be asked which contraceptive method she would prefer as this will obviously be the method with which she is most likely to continue.

STEP 3: CONSIDERATION OF CONTRA-INDICATIONS TO THE PATIENT'S PREFERRED METHOD.

You must decide whether the patient's choice of a contraceptive method is suitable, taking into consideration:

1. The effectiveness of each contraceptive method.
2. The contra-indications to each contraceptive method.
3. The side effects of each contraceptive method.
4. The general health benefits of each contraceptive method.

If the contraceptive efficiency of the preferred method is appropriate, if there are no contra-indications to it, and if the patient is prepared to accept the possible side effects, then the method chosen by the patient should be used. Otherwise proceed to step 4.

STEP 4: SELECTION OF THE MOST APPROPRIATE ALTERNATIVE METHOD OF CONTRACEPTION.

The selection of the most suitable alternative method of contraception after delivery will depend on a number of factors including the patient's wishes, her age, the risk of side-effects and whether or not a very effective method of contraception is required.

STEP 5: COUNSELLING THE PATIENT ONCE THE CONTRACEPTIVE METHOD HAS BEEN CHOSEN.

Virtually every contraceptive method has its own side-effects. It is a most important part of contraceptive counselling to explain the possible side-effects to the patient. Expert family planning advice must be sought if the local clinic is unable to deal satisfactorily with the patient's problem. If family planning method problems are not satisfactorily solved, the patient will probably stop using any form of contraception.

AFTER DELIVERY THE REPRODUCTIVE CAREER OF EACH PATIENT MUST BE DISCUSSED WITH HER IN ORDER TO DECIDE ON THE MOST APPROPRIATE METHOD OF FAMILY PLANNING TO BE USED

14-6 WHAT CONTRACEPTIVE METHODS CAN BE OFFERED AFTER DELIVERY?

1. Sterilization. Either tubal ligation (tubal occlusion) or vasectomy.
2. Injectables (i.e. an intramuscular injection of depot progestogen).
3. Oral contraceptives. Either the combined pill (containing both oestrogen and progestogen) or a progestogen-only pill (the "minipill").
4. An intra-uterine contraceptive device (IUCD).
5. The condom.

Breast feeding, spermicides alone, coitus interruptus and the "safe period" are all very unreliable. All women should know about postcoital contraception.

BREAST FEEDING CANNOT BE RELIED UPON TO PROVIDE POSTPARTUM CONTRACEPTION

14-7 HOW EFFECTIVE ARE THE VARIOUS CONTRACEPTIVE METHODS?

Contraceptive methods for use after delivery may be divided into very effective and less effective ones. Sterilization, injectables, oral contraceptives and intra-uterine contraceptive devices are very effective. Condoms are less effective contraceptives.

*** *The effectiveness of a contraceptive method is given as an index which indicates the number of women who would be expected to fall pregnant if 100 women used that method for 1 year. The ideal efficacy index is 0. The higher the index, the less effective is the method of contraception. The efficacy of the various contraceptive methods for use after delivery is as follows:*

	CONTRACEPTIVE METHOD	EFFICACY INDEX
Sterilization:	Vasectomy	0,05
	Tubal ligation	0,5
Injectables:	Depo-Provera/Petogen	0,2
	Nur-Isterate	0,6
Oral contraceptives:	Combined pill	0,3
	Minipill	1,2
IUCD:	Copper	0,5
Condom:	Male	2-15
	Female (Reality female condom)	5-15

The safety of condoms depends on the reliability with which they are used.

14-8 HOW EFFECTIVE IS POSTCOITAL CONTRACEPTION?

1. Norlevo, E Gen-C or Ovral are effective within 5 days of unprotected sexual intercourse, but are more reliable the earlier they are used.
2. A copper intra-uterine contraceptive device can be inserted within 6 days of unprotected intercourse.
3. Postcoital methods should only be used in an emergency and not as a regular method of contraception.
4. If Norlevo is used, one tablet should be taken as soon as possible after intercourse, followed by another one tablet after exactly 12 hours.
5. If Ovral or E-Gen-C is used, two tablets are taken as soon as possible after intercourse, followed by another two tablets exactly 12 hours later.

*** *The tablets for postcoital contraception often cause nausea and vomiting reduce their effectiveness. These side effects are less with Norlevo which contains no oestrogen. Therefore Norlevo is a more reliable method and should be used if available. Norlevo as a single dose method will soon be available in South Africa.*

14-9 WHAT ARE THE CONTRA-INDICATIONS TO THE VARIOUS CONTRACEPTIVE METHODS?

The following are the common or important conditions where the various contraceptive methods should NOT be used:

1. STERILIZATION:
 - (i) Marital disharmony.
 - (ii) Psychological problems.
 - (iii) Forced or hasty decision.
 - (iv) Gynaecological problem requiring hysterectomy.
2. INJECTABLES:
 - (i) Depression.
 - (ii) Pregnancy planned within 1 year.

3. COMBINED PILLS:

- (i) A history of venous thrombo-embolism.
- (ii) Age 35 years or more with risk factors for cardiovascular disease.
- (iii) Anyone of 45 or more years.
- (iv) Oestrogen dependent malignancies such as breast or uterine cancer.

4. PROGESTOGEN-ONLY PILL (minipill):

- (i) None.

5. INTRA-UTERINE CONTRACEPTIVE DEVICE:

- (i) A history of excessive menstruation.
- (ii) Anaemia.
- (iii) Multiple sex partners when the risk of genital infection is high.
- (iv) Pelvic inflammatory disease.

A menstrual abnormality is a contra-indication to any of the hormonal contraceptive methods (injectables, combined pill or progestogen-only pill) until the cause of the menstrual irregularity has been diagnosed. Thereafter, hormonal contraception may often be used to correct the menstrual irregularity. However, during the puerperium a previous history of menstrual irregularity before the pregnancy is NOT a contra-indication to hormonal contraception.

**** If a woman has a medical complication, then a more detailed list of contra-indications may be obtained from the standard reference books such as J Guillebaud: Your questions answered. Fourth edition. London: Churchill Livingstone 2004.*

14-10 WHAT ARE THE MAJOR SIDE-EFFECTS OF THE VARIOUS CONTRACEPTIVE METHODS?

Most contraceptive methods have side-effects. Some side-effects are unacceptable to a patient and will cause her to discontinue the particular method. However, in many instances side-effects are mild or disappear with time. It is, therefore, very important to counsel a patient carefully about the side-effects of the various contraceptive methods, and to determine whether she would find any of them unacceptable. At the same time the patient may be reassured that some other side-effects will most likely become less or disappear after a few months' use.

The major side-effects of the various contraceptive methods used after delivery are:

1. STERILIZATION:

Tubal ligation and vasectomy have no medical side-effects and, therefore, should be highly recommended during counselling of patients who have completed their families. Menstrual irregularities are NOT a problem. However, about 5% of women later regret sterilization.

2. INJECTABLES:

- (i) Menstrual abnormalities, e.g. amenorrhoea, irregular menstruation or spotting.
- (ii) Weight gain.
- (iii) Headaches.
- (iv) Delayed return to fertility within a year of stopping the method. There is no evidence that fertility is reduced thereafter.

**** With Nur-Isterate there is a quicker return to fertility, slightly less weight gain and a lower incidence of headaches and amenorrhoea than with Depo-Provera or Petogen.*

3. COMBINED PILL:

- (i) Reduction of lactation.
- (ii) Menstrual abnormalities, e.g. spotting between periods.
- (iii) Nausea and vomiting.
- (iv) Depression.
- (v) Fluid retention and breast tenderness.
- (vi) Chloasma (a brown mark on the face).
- (vii) Headaches and migraine.

4. PROGESTOGEN-ONLY PILL:

- (i) Menstrual abnormalities, e.g. irregular menstruation.
- (ii) Headaches.
- (iii) Weight gain.

5. INTRA-UTERINE CONTRACEPTIVE DEVICE.

- (i) Expulsion in 3-15 cases per 100 women who use the device for one year.
- (ii) Pain at insertion.
- (iii) Dysmenorrhoea.
- (iv) Menorrhagia (excessive and/or prolonged bleeding).
- (v) Increase in pelvic inflammatory disease.
- (vi) Perforation of the uterus is uncommon.
- (vii) Ectopic pregnancy is not prevented.

6. CONDOM:

- (i) Decreased sensation for both partners.
- (ii) Not socially acceptable to everyone.

IF A COUPLE HAVE COMPLETED THEIR FAMILY THE CONTRACEPTIVE METHOD OF CHOICE IS TUBAL LIGATION OR VASECTOMY

Additional contraceptive precautions must be taken when the contraceptive effectiveness of an oral contraceptive may be impaired, e.g. diarrhoea or when taking antibiotics. There is no medical reason for stopping a hormonal method periodically to "give the body a rest".

14-11 WHAT ARE THE IMPORTANT HEALTH BENEFITS OF CONTRACEPTIVES?

The main objective of all contraceptive methods is to prevent pregnancy. In developing countries pregnancy is a major cause of mortality and morbidity in women. Therefore, the prevention of pregnancy is a very important general health benefit of all contraceptives.

Various methods of contraception have a number of additional health benefits. Although these benefits are often important, they are not generally appreciated by many patients and health care workers:

1. INJECTABLES:

- (i) Decrease in dysmenorrhoea.
- (ii) Less premenstrual tension.
- (iii) Less iron deficiency anaemia due to decreased menstrual flow.
- (iv) No effect on lactation.

2. COMBINED PILL:

- (i) Decrease in dysmenorrhoea.
- (ii) Decrease in menorrhagia (heavy and/or prolonged menstruation).
- (iii) Less iron-deficiency anaemia.
- (iv) Less premenstrual tension.
- (v) Fewer ovarian cysts.
- (vi) Less benign breast disease.
- (vii) Less endometrial and ovarian carcinoma.

3. PROGESTOGEN-ONLY PILL:

- (i) No effect on lactation.

4. CONDOM:

- (i) Less risk of HIV infection and other sexually transmitted diseases.
- (ii) Less pelvic inflammatory disease.
- (iii) Less cervical intra-epithelial neoplasia.

THE CONDOM IS THE ONLY CONTRACEPTIVE METHOD THAT PROVIDES PROTECTION AGAINST HIV INFECTION

14-12 WHAT IS THE MOST APPROPRIATE METHOD OF CONTRACEPTION FOR A PATIENT AFTER DELIVERY?

The most suitable methods for the following groups of patients are:

1. LACTATING PATIENTS:

- (i) An injectable, but not if a further pregnancy is planned within the next year.
- (ii) A progestogen-only pill (minipill) for 3 months, then the combined pill.
- (iii) An intra-uterine contraceptive device.

2. TEENAGERS AND PATIENTS WITH MULTIPLE SEXUAL PARTNERS.

- (i) An injectable, as this is a reliable method even with unreliable patients who might forget to use another method.
- (ii) Additional protection against HIV infection by using a condom is essential. It is important to stress that the patient should only have intercourse with a partner who is willing to use a condom.

3. PATIENTS WHOSE FAMILIES ARE COMPLETE:

- (i) Tubal ligation or vasectomy is the logical choice.
- (ii) An injectable, e.g. Depo-Provera or Petogen (12 weekly) or Nur-Isterate (8 weekly).
- (iii) A combined pill until 35 years of age if there are risk factors for cardiovascular disease, or until 50 years if these risk factors are absent.

4. PATIENTS OF 35 YEARS OR OVER WITHOUT RISK FACTORS FOR CARDIOVASCULAR DISEASE:

- (i) Tubal ligation or vasectomy is the logical method.
- (ii) A combined pill until 50 years.
- (iii) An injectable until 50 years of age.
- (iv) A progestogen-only pill until 50 years of age.
- (v) An intra-uterine contraceptive device until 1 year after the periods have stopped, i.e. when there is no further risk of pregnancy.

5. PATIENTS OF 35 YEARS OR OVER WITH RISK FACTORS FOR CARDIOVASCULAR DISEASE:
- (i) As above but NO combination pill.

THE PUERPERIUM IS THE MOST CONVENIENT TIME FOR THE PATIENT TO HAVE A BILATERAL TUBAL LIGATION PERFORMED

Every effort should be made to provide facilities for tubal ligation during the puerperium for all patients who request sterilization after delivery.

**** Remember that sperms may be present in the ejaculate for up to 3 months following vasectomy. Therefore, an additional contraceptive method must be used during this time.*

14-13 WHAT ARE THE RISK FACTORS FOR CARDIOVASCULAR DISEASE IN WOMEN TAKING THE COMBINED PILL?

The risk of cardiovascular disease increases markedly in women of 35 or more years of age who have 1 or more of the following risk factors:

1. Smoking.
2. Hypertension.
3. Diabetes.
4. Hypercholesterolaemia.
5. A personal history of cardiovascular disease.

SMOKING IS A RISK FACTOR FOR CARDIOVASCULAR DISEASE

14-14 WHEN SHOULD AN INTRA-UTERINE CONTRACEPTIVE DEVICE BE INSERTED AFTER DELIVERY?

It should not be inserted before 6 weeks as the uterine cavity would not yet have returned to its normal size. At 6 weeks or more after delivery there is the lowest risk of:

1. Pregnancy.
2. Expulsion.

Postpartum patients choosing this method must be discharged on an injectable contraceptive or progestogen-only pill until an intra-uterine contraceptive device has been inserted.

**** Insertion of an intra-uterine contraceptive device immediately after delivery may be considered if it is thought likely that a patient will not use another contraceptive methods and where sterilization is not appropriate. However, the expulsion rate will be as high as 20%.*

CASE PROBLEMS

CASE 1

You have delivered the fourth child of an unbooked 36 year old patient. All her children are alive and well. She is a smoker but is otherwise healthy. She has never used contraception.

1. Should you counsel this patient about contraception?

Yes. Every sexually active person needs contraceptive counselling. This patient in particular needs counselling as she is at an increased risk of maternal and perinatal complications, should she fall pregnant again, because of her age and parity.

2. Which contraceptive methods would be appropriate for this patient?

Tubal ligation or vasectomy would be the most appropriate method of contraception if she does not want further children. Should she not want sterilization, either an injectable contraceptive or an intra-uterine contraceptive device would be the next best choice.

3. If the patient accepts tubal ligation, when should this be done?

The most convenient time for the patient and her family is shortly after delivery (postpartum sterilization). Every effort should be made to provide facilities for postpartum sterilization for all patients who request it.

4. If the couple decides not to have a tubal ligation or vasectomy, how will you determine whether an injectable or an intra-uterine contraceptive device would be the best choice?

Assessing the risk for pelvic inflammatory disease will determine which of the 2 methods to use. If the patient has a stable relationship, an intra-uterine contraceptive device may be more appropriate. However, if she or her husband (or boyfriend) has other sexual partners, an injectable contraceptive would be indicated.

5. What other advice must be given to a patient at risk of sexually transmitted infections?

The patient must insist that her partner wears a condom during sexual intercourse. This will reduce the risk of HIV infection.

CASE 2

A 15 year old primigravida is attending the antenatal clinic. She has never used contraception. Her mother asks you for contraceptive advice for her daughter after delivery. The patient's boyfriend has deserted her.

1. Does this young teenager require contraceptive advice after delivery?

Yes, she will certainly need contraceptive counselling. She needs to learn sexual responsibility and must be told to attend a family planning clinic. She also needs to know about postcoital contraception.

2. Which contraceptive method would be most the appropriate for this patient?

An injectable contraceptive would probable be the best method for her as she needs reliable contraception for a long time.

3. Why would she need a long term contraceptive?

Because she should only have her next child when she is much older and has a stable relationship.

4. If the patient prefers to use an oral contraceptive, would you regard this as an appropriate method of contraception for her?

No. A method which she is more likely to use correctly and reliably would be more appropriate. Oral contraceptives are only reliable if taken every day.

5. The patient and her mother are worried that the long term effect of injectable contraception could be harmful to a girl of 15 years. What would be your advice?

Injectable contraception is extremely safe and, therefore, is an appropriate method for long term use. This method will not reduce her future fertility.

CASE 3

You have just delivered the first infant of a healthy 32 year old patient. In discussing contraception with her, she mentions that she is planning to fall pregnant again within a year after she stops breast feeding. She is a school teacher and would like to continue her career after having 2 children.

- 1. The patient says that she has used an injectable contraceptive for 5 years before this pregnancy and would like to continue with this method. What would your advice be?**

Injectable contraception would not be appropriate as she plans her next pregnancy within a year, and there may be a delayed return to fertility.

- 2. If the patient insists on using an injectable contraceptive, which drug would you advise her to use?**

Nur-Isterate should be used as there is a more rapid return to fertility than with Depo-Provera or Petogen.

- 3. Following further counselling, the patient decides on oral contraception and is given a combined pill. Do you agree with this management?**

No. As she plans to breast feed, she should be given a progestogen-only pill. Combined oral contraceptive pills may reduce milk production while breast feeding is being established. Progestogen-only pills have no effect on breast feeding.

CASE 4

A married primipara from a rural area has just been delivered in hospital. She has a stable relationship with her husband and they decide to have their next infant in 5 years time. The patient would like to have an intra-uterine contraceptive device inserted.

- 1. Is this an appropriate method for this patient?**

Yes, as the risk of developing pelvic inflammatory disease is low.

- 2. When should the device be inserted?**

Six weeks or more after delivery as there is an increased risk of expulsion if the device is inserted earlier.

- 3. Could the patient, in the meantime, rely on breast feeding as a contraceptive method?**

No. The risk of pregnancy is too high. She should use reliable contraception, such as injectable contraception or the progestogen-only pill, until the device is inserted.

- 4. The patient asks if the intra-uterine contraceptive device could be inserted before she is discharged from hospital. Would this be appropriate management?**

The expulsion rate and, therefore, the risk of contraceptive failure is much higher if the device is inserted soon after delivery. Therefore, it would be far better if she were to return 6 weeks later for insertion of the device.