

Postnatal contraception



This Good Practice Point aligns to the NMC 2022 Standards of Proficiency for SCPHN Health Visitors, in particular Sphere of Influence D: Population health: enabling, supporting and improving health outcomes of people across the life course. See the [Nursing and Midwifery Council website](#) for more details.

Why is it important? The health visitor's universal reach in the postnatal and interpregnancy period provides an ideal opportunity to influence preconception care, including using contraception for pregnancy spacing and promoting ways to maximise health in this time.

The interval between childbirth and subsequent conception is known as the interpregnancy interval. Optimal pregnancy spacing and pregnancy planning are important because:

- Short interpregnancy intervals (< 12 months) are linked to an increased risk of subsequent maternal and neonatal complications including preterm labour, low birthweight infants and stillbirth (Bigelow et al, 2015; Smith et al, 2003).
- Pregnancy intent is an important determinant of both short- and long-term maternal and child health outcomes (Gipson et al, 2008) [an unintended pregnancy may be an unwanted pregnancy, or a mistimed pregnancy].
- Unintended pregnancies may affect parenting attitudes and behaviours, with wider psychological impact on the parent(s) and eventually have an impact on child development and child outcomes.
- Preventing unintended pregnancy by providing contraceptive advice and signposting to contraceptive services or sexual and reproductive health services is therefore a cost-effective preventive public health intervention.
- Health visitors are well placed to support parents with advice on contraception and signposting to appropriate resources in alignment with the NHS guidance on contraception.

A planned pregnancy is likely to be a healthier one. Since fertility and sexual activity can resume quickly after childbirth, there is a need for effective contraception if unintended pregnancy is to be avoided. Around 50% of couples will resume sexual intercourse by 6 weeks postpartum (McDonald et al, 2013). In non-breastfeeding individuals, fertility can return from as early as 3 to 4 weeks (Faculty of Sexual and Reproductive Health, 2017).

Healthy sexual relationships are part of all adult lives, it is important that new parents are able to discuss this with health visitors as part of a holistic approach to health and wellbeing. Contraception is important for all women of reproductive age, regardless of whether they are planning

a pregnancy, as it enables them to effectively control if and when they desire to conceive.

When should this be discussed?

It is best practice to start this conversation in the antenatal period. Individuals should be provided with opportunities to discuss their future fertility intentions and contraceptive needs, both during and after pregnancy, to give them time to ask questions, consider their options and plan ahead. Once these conversations have been started, they can be revisited at regular points giving women opportunities and permission to discuss new or ongoing fertility and contraceptive needs.

[More information on page 2](#)

For additional resources see www.ihv.org.uk

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Postnatal contraception

What do you need to know?

There are many methods of contraception and, dependent on the circumstances, some methods of contraception will be more effective than others. Individuals should be supported to find out about the different methods available to support their choice.

Many methods of contraception are safe to start immediately after birth, but the timing of initiation and suitability of some contraceptive methods can be affected by postpartum and breastfeeding status as shown below.

Long-acting reversible contraception (LARC)			
LARCs are forms of contraception which the user does not have to remember to take, they work for between different periods of time depending on form of delivery and product.			
Type of contraception	When can it be initiated?	Breastfeeding*	Other considerations
Progestogen subdermal implant i.e. Nexplanon	Immediately following birth, regardless of breastfeeding status.	No effect on breastfeeding.	
Progestogen injection , e.g. DepoProvera or Sayana Press	Immediately following birth, regardless of breastfeeding status.	No effect on breastfeeding.	
Levonorgestrel intrauterine device (LNG-IUD), e.g. Mirena, Kyleena, Levosert 'coils' And Copper intra-uterine device (CU-IUD), i.e. Copper 'coil'	Either within the 1st 48 hours immediately following birth or if not within this timeframe, then any time after 4 weeks.	No effect on breastfeeding. Perforation, i.e. damage to the uterus during vaginal insertion, is slightly more common in breastfeeding women as the uterus is softer but this risk is still very low (approx. up to 12 in 1000).	Some hospitals offer immediate insertion either during caesarean section or following vaginal delivery, check your local services for more information about what is currently being offered.

Other hormonal contraception			
Hormonal contraception are contraceptives which contain oestrogen and/or progesterone, although some LARCs may also contain hormones. The ones listed below need the user to remember to take them, this can be daily, weekly or monthly.			
Type of contraception	When can it be initiated?	Breastfeeding*	Other considerations
Progestogen only pill (POP)	Immediately following birth, regardless of breastfeeding status.	No effect on breastfeeding.	
Combined hormonal contraception, i.e. Combined pill, patch or vaginal ring containing the hormones progestogen and oestrogen	Breastfeeding women, safe to start 6 weeks after birth. Non-breastfeeding women, with no pregnancy-related venous thromboembolism (VTE) risk factors, can safely start 3 weeks after birth. Non-breastfeeding women with pregnancy-related VTE risk factors should wait until 6 weeks after birth to start. In all cases, a woman's medical eligibility for combined hormonal contraception must be assessed. These are the methods with the most contraindications.	No effect on breastfeeding.	It is recommended that an alternative 'bridging' method of contraception is considered in the meantime, until this method is started. Pregnancy-specific risk factors for VTE: Smoking, BMI >30, pre-eclampsia, immobility, caesarean section, postpartum haemorrhage, blood transfusion.

* We refer to breastfeeding and breastmilk but recognise terms such as chestfeeding, bodyfeeding, nursing, lactation, or providing human milk may be more preferable for and accurate to some of the families we support.

[More information on page 3](#)

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Lactational Amenorrhoea Method (LAM) (FSRH, 2017)

For some individuals, breastfeeding can suppress ovulation and provide contraception. This is known as the Lactational Amenorrhoea Method (LAM), and can be effective but only if the following three criteria are all present:

- Exclusively breastfeeding
Not having anything other than breastmilk, solid foods have not been introduced and breastfeeds are regular day and night, i.e. gaps of no longer than 3-4 hours between feeds including during the night.
It is also important to note that the effect of expressing breastmilk on LAM is unknown and therefore should not be included when thinking about the frequency of the breastfeeds.
- Amenorrhoeic, i.e. No bleeding/periods haven't resumed, this includes spotting.
- Less than 6 months' postpartum i.e. Less than 6 months since birth.

Individuals should be advised that if bleeding returns or breastfeeding frequency declines, the method cannot be relied upon. To ensure contraceptive efficacy, individuals may choose to use an additional method of contraception alongside breastfeeding.

N.B. If unprotected sex takes place at any time beyond the first 3 weeks' postpartum (and criteria for LAM are not met), emergency contraception may be indicated. This can be obtained from GPs, local sexual and reproductive health services, and pharmacies. It is important that women inform the healthcare professional if they are breastfeeding, as it will affect the advice given about the emergency contraception and what is prescribed.

Other methods

Sterilisation: If counselled in advance (at least 2 weeks), some individuals may choose to be sterilised during a planned elective caesarean section. There is an increased risk of regret when the procedure is performed in close proximity to pregnancy.

Male and female condoms: Can be used any time postpartum.

Female barrier methods, e.g. cap or diaphragm: Delay use until at least 6 weeks after childbirth, as by this time the uterus should have returned to its 'normal' size. If a diaphragm was used prior to pregnancy, reassessment for size of the device is essential prior to recommencing.

Fertility awareness methods: Rely on physiological indicators of ovulation which are unreliable after birth, therefore use of this method for contraception should be delayed until regular menstruation resumes. Individual choice should be respected but the woman should be advised that this method is not supported by clinical bodies such as the CoRSH, the RCOG, or Fertility UK.

Good Practice Points for health visitors

- Make sure families know that you can offer advice on contraception by starting a conversation at the antenatal contact and revisiting it at subsequent contacts.
- Reproductive health needs to be part of everyday business but remember that some people will find this an embarrassing topic to discuss. Respect their choice and ensure that each individual is aware that they have "permission" to discuss this and that it can be revisited whenever they would like.
- Provide families with evidence-based information, using a non-judgemental approach, to support their informed choices. Families should also be advised that an interpregnancy interval of less than 12 months between childbirth and conceiving again is associated with an increased risk of preterm birth, low birthweight and small babies for their gestational age.
- Care should be taken to ensure people do not feel under pressure to choose a method of contraception, including sensitive exploration of the family's cultural and religious beliefs which may affect individual choice and understanding.

[More information on page 4](#)

Good Practice Points Cont'd.

- Have accurate, up-to-date knowledge of the timeframes in which various methods can be safely started and their efficacy, including the superior effectiveness of LARC and the advantages and disadvantages of the available methods.
- Women at higher risk of poor outcomes (e.g. long-term conditions or mental illness) can be signposted to more specialist support. Refer to the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), which offers guidance to providers of contraception regarding who can use contraceptive methods safely, to check if an individual is medically eligible for a method, and for further information.
- Ensure you are familiar with your local services, what they offer, and how to access them - this may include, GP provision, specialist support for those with long-term conditions like diabetes, and local sexual and reproductive health services. You can find your local sexual health services by searching on the NHS website: <http://bit.ly/3q5yG3j>. It is also important to note that some hospitals offer contraception to women on discharge – usually a supply of POPs. Check with your local midwives if this is happening and discuss with women if they want to continue this form of contraception.
- Although conversations on contraceptive choices will predominantly be with women, it is important to offer a personalised approach that recognises the diversity of relationships and individual needs and preferences. Some women may want their partner to be included in conversations as they see this as a joint decision-making process.

Further information and resources

- **Contraception Choices:** Contraception after having a baby - <http://bit.ly/3umM86h>
- **CoRSH Clinical Guideline:** Contraception After Pregnancy - <https://bit.ly/3sjzpzp>
- **NHS:** Sexual Health Services near you - <http://bit.ly/3q5yG3j>
- **NHS:** Sex and contraception after birth - <https://bit.ly/4cFw6te>
- **CoRSH UK Medical Eligibility Criteria for Contraceptive Use (UK MEC)** - <http://bit.ly/2ZGXKTx>
- **FPA - The sexual health company:** Contraception Patient Information Guides - <https://bit.ly/3Za4U2R>

The Institute of Health Visiting has adopted an additive approach to the language that we use. This approach aims to add and not take away. It preserves women/men-centred language as well as including language for those who identify in other ways. Families are diverse and we will strive to ensure that everyone is represented and feels included. To ensure that we achieve both clarity and inclusivity, we will use sex-specific terms when referencing research which relates to biological sex.



References

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