

## Contraception in the immediate postnatal period

### Key Points

- Fertility can return by day 21 after delivery.
- Effective contraception should be commenced as soon as possible after delivery.
- Prompt contraception allows individuals to avoid unplanned short inter-pregnancy intervals with their associated poorer pregnancy outcomes.

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### Abbreviations

Cu-IUD	Copper intrauterine device
CHC	Combined hormone contraceptive
ENG-IMP	Etonogestrel implant
FSRH	Faculty of sexual and reproductive healthcare
IUD	Intrauterine device
IUS	Intrauterine system
LARC	Long-acting reversible contraceptive
LNG-IUS	Levonorgestrel intrauterine system
POP	Progesterone only pill
TB	Tuberculosis
TTO	To take out

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## 1. PURPOSE OF THE GUIDELINE

Effective contraception should be started as soon as possible after childbirth as fertility returns rapidly (within 21 days in some cases). The Faculty of Sexual and Reproductive Healthcare (FSRH) guidance recommends that effective contraception is commenced as soon as possible after delivery by both breastfeeding and non-breastfeeding mothers. This allows individuals to plan any subsequent pregnancy and avoid unplanned short inter-pregnancy intervals with their associated poorer pregnancy outcomes.

The most effective long-acting reversible contraceptive (LARC) methods, including the non-hormonal copper coil (IUD), the levonorgestrel-releasing hormone coil (IUS), the contraceptive injection (Depo-Provera) and the hormonal implant can be inserted at, or immediately after delivery in the maternity setting, by appropriately trained clinical staff. LARC methods have the significant advantage of providing immediate, user-independent contraception that is effective for several months or years without requirement for routine follow up.

## 2. FORMS OF CONTRACEPTION AVAILABLE WITHIN THE MATERNITY DEPARTMENT

### Copper IUD (Cu-IUD)

The Cu-IUD can be inserted by a clinician *already trained in the technique* at the time of caesarean section, immediately after vaginal delivery or at any time up to 48 hours post-partum. If the IUD is not inserted within 48 hours, insertion should be delayed until 4 weeks after the birth to reduce the risk of uterine perforation.

<b>Contraindications</b>	Postpartum sepsis, current symptomatic pelvic chlamydia or gonorrhoea infection, current pelvic TB, current gestational trophoblastic disease, current cervical or endometrial cancer, copper allergy, Wilson's disease. Should not be inserted immediately post-partum if a woman has ruptured membranes for 24 hours or longer, postpartum haemorrhage or chorioamnionitis.
<b>Potential contraindications include</b>	Previous heavy menstrual bleeding, anaemia (thalassemia, sickle cell disease or iron deficiency); current asymptomatic chlamydia or gonorrhoea infection, complications after organ transplant, long QT syndrome, previous trachelectomy, uterine cavity significantly distorted by fibroids or structural abnormality, HIV infection with CD4 count <200.
<b>Contraceptive effectiveness</b>	0.6-0.8% first year contraceptive failure (effective immediately). Enzyme-inducing drugs do not affect contraceptive effectiveness.
<b>Duration of use</b>	Device-dependent, 5 or 10 years.
<b>Bleeding</b>	Often heavier, longer, more painful; pattern usually unchanged
<b>Follow up information required by user</b>	How to check for threads, possibility of long threads, how to access review of pain/bleeding/very long or missing threads, replacement date (5 or 10 years).

### Levonorgestrel intrauterine system (LNG-IUS)

The 52mg LNG-IUS can be inserted by a clinician *already trained in the technique* at the time of caesarean section or immediately after vaginal delivery or at any time up to 48 hours post-partum. If the IUD is not inserted within 48 hours, insertion should be delayed until 4 weeks after the birth to reduce the risk of uterine perforation.

<b>Contraindications</b>	Allergy to content; postpartum sepsis, current symptomatic chlamydia or gonorrhoea infection, current pelvic TB, current breast, endometrial or cervical cancer, current gestational trophoblastic disease. Should not be inserted immediately postpartum if the woman has had ruptured membranes for 24 hours or longer, chorioamnionitis or postpartum haemorrhage.
<b>Potential contraindications include</b>	Current asymptomatic chlamydia or gonorrhoea infection, previous breast cancer, previous arterial thromboembolic event during use, decompensated cirrhosis, hepatocellular adenoma or carcinoma, complications after organ transplant, long QT syndrome, HIV infection with CD4 count <200, uterine cavity significantly distorted by fibroids or structural abnormality, previous trachelectomy.
<b>Contraceptive effectiveness</b>	0.2% first year contraceptive failure rate (effective immediately if inserted post-partum). Enzyme-inducing drugs do not affect contraceptive effectiveness.
<b>Duration of use</b>	5 years (for 52mg LNG-IUS)
<b>Bleeding</b>	Initially erratic, likely to become light over first year of use, may become amenorrhoeic.
<b>Follow up information required by user</b>	How to check for threads, possibility of long threads, how to access review of pain/bleeding/very long or missing threads, replacement date.

### Medroxyprogesterone Acetate Depot injection (DMPA)

The DMPA is extremely safe and there are few contraindications to its use. After taking the appropriate history, it may be prescribed by a doctor and administered by a midwife, nurse or doctor trained in the administration of intramuscular injections.

The DMPA can be started immediately after delivery (or by Day 21) without any requirement for additional contraceptive precautions. If started more than 21 days postpartum, additional contraceptive precautions are required for 7 days.

<b>Contraindications</b>	Allergy to content; current breast cancer
<b>Potential contraindications include</b>	Previous arterial thromboembolic event during use, previous breast cancer (in the last 5 years), decompensated cirrhosis, hepatic adenoma or adenocarcinoma, multiple risk factors for cardiovascular disease
<b>Contraceptive effectiveness</b>	0.2% first year contraceptive failure rate if taken perfectly; 6% with typical use (effective immediately if started by Day 21 post-partum). If the Emergency Contraceptive is required, then DMPA may reduce its effectiveness.
<b>Bleeding</b>	Unpredictable, but generally less bleeding overall.
<b>Follow up information required by user</b>	How and when to access further doses (including direction to local and online services).

**Etonogestrel implant (ENG-IMP)**

The ENG-IMP can be inserted anytime post-delivery. No routine follow up is required after post-partum initiation of the ENG-IMP. There is a risk of neurovascular injury and migration therefore women should be advised on how to locate the implant, informed to check this occasionally and report any concerns. If inserted by Day 21 after childbirth, no additional contraceptive precautions are required.

This is currently only provided by certain clinicians within the maternity department who will assess suitability on an individual basis. If an appropriate clinician is not available, then women considering ENG-IMP should be provided with a three-month supply of the POP or a single dose of Depo-Provera and referred to their GP or local family planning services.

<b>Contraindications</b>	Current or past history of thrombosis, liver tumours or active liver disease, undiagnosed abnormal bleeding, known or suspected breast cancer or progestin-sensitive cancer, allergy to any components
<b>Contraceptive effectiveness</b>	0.05% contraceptive failure rate (effective immediately if inserted by day 21 post-partum)
<b>Duration of use</b>	3 years (for 68mg etonogestrel)
<b>Bleeding</b>	Initially erratic, likely to become light over first year of use, may become amenorrhoeic.
<b>Follow up information required by user</b>	How to identify the implant. When the implant will need replacement.

**Individuals for whom LARC methods cannot be provided, those that decline LARC and those for whom LARC is unsuitable can be given a 3-month supply of the desogestrel progestogen-only pill (POP) prior to discharge.**

**Desogestrel Progesterone only pill (POP)**

The POP is extremely safe and there are few contraindications to its use.

The desogestrel POP can be started immediately after delivery (or by Day 21) without any requirement for additional contraceptive precautions. If started more than 21 days postpartum, additional contraceptive precautions are required for 2 days. The POP is highly user-dependent and may not be suitable where there is concern about adherence to pill-taking.

One pill is taken at the same time every day. The pill can be taken up to 12 hours late without affecting contraceptive effectiveness; subsequent pills should be taken at the intended time. If the pill was more than 12 hours overdue, additional contraceptive precautions must be used for 2 days.

<b>Contraindications</b>	Allergy to content; current breast cancer
<b>Potential contraindications include</b>	Previous arterial thromboembolic event during use, previous breast cancer (in the last 5 years), decompensated cirrhosis, hepatic adenoma or adenocarcinoma
<b>Contraceptive effectiveness</b>	0.3% first year contraceptive failure rate if taken perfectly; 9% with typical use. Effective immediately if started by Day 21 post-partum. Enzyme-inducing drugs and conditions that affect GI absorption may affect contraceptive effectiveness.
<b>Bleeding</b>	Unpredictable.

<b>Follow up information required by user</b>	How to take, missed pill rules (including after vomiting), possibility of drug interaction, how to access further supplies (including direction to local and online services).
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### 3. FOLLOW UP

#### Intrauterine contraception

Women who have had insertion of intrauterine contraception after childbirth require follow up with their GP or family planning clinic to check for and trim threads. **If threads are not visible, the woman will require an ultrasound scan to confirm the placement of the device. Additional contraception will be required until the device location is confirmed. Please see Appendix 2 for more details.** They may also require follow up for pain, bleeding, or expulsion. Women are advised to contact their GP to manage these relatively common problems. Clear advice must be provided to users as to how to follow these pathways.

#### Progestogen-only pill

No routine follow up is required after post-partum initiation of the desogestrel progestogen-only pill.

### 4. OTHER FORMS OF CONTRACEPTION

#### Combined hormonal contraception (CHC)

Contraception is required from Day 21 after childbirth unless the woman is fully breastfeeding and amenorrhoeic. CHC should not be started until 6 weeks after delivery in either breastfeeding women or non-breastfeeding women with additional risk factors for venous thromboembolism (VTE).

Please note: caesarean section is a VTE risk factor. Individuals who are not breastfeeding and have no additional VTE risk factors may consider use of CHC from 3 weeks after childbirth. There are, however, significant potential health risks associated with use of CHC, therefore prior to provision, medical eligibility must be carefully assessed, blood pressure and BMI measured, and users advised about CHC-associated health risks. CHC will not be offered for immediate postnatal contraception within the maternity department.

#### Lactational amenorrhoea

It is recognised that breastfeeding individuals can rely on lactational amenorrhoea for contraception for the first six months after delivery, so long as they remain amenorrhoeic **AND** continue to breastfeed exclusively. An individual may, however, reduce breastfeeding or have their first period at any time, with resulting loss of contraceptive effect. It is recommended, therefore, that breastfeeding individuals commence additional contraception as soon as possible after delivery.

#### Female sterilisation

Existing guidance recommends that, because of concern about potential regret, written consent to female sterilisation at the time of caesarean section should be obtained at least two weeks prior to delivery. Additional guidance recommends that this should have been discussed on more than one occasion during the antenatal period.

## 5. PROVISION OF CONTRACEPTION IN THE IMMEDIATE POSTNATAL PERIOD

Community Midwives should discuss contraception with women during their 28 week antenatal appointment. This information should be given in a range of formats including providing women with the Frimley Health contraception leaflet and sign posting women to the Frimley Health Maternity website and FSRH guidance.

Women who are having an elective caesarean should be offered the insertion of an IUS/IUD when the caesarean is requested. Consent should be taken for the insertion of the IUS/IUD when women are consented for the caesarean section.

Midwives should discuss contraception as part of the discharge process and women who have not had an IUS/IUD inserted should be offered the Depo Injection or a 3-month supply of the progesterone only pill.

The obstetric team covering the relevant area of discharge should prescribe a 3-month supply of the POP with a TTO letter. The supply from pharmacy should be provided and explained to the woman prior to discharge and she must be informed to contact her GP for further prescriptions. The woman's GP should be informed of the method of contraception provided as part of the discharge process.

## REFERENCES

Faculty of Sexual and Reproductive Healthcare (2017) Clinical Guideline Contraception After Pregnancy. Available at: <https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/>

Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit (2020) Provision of contraception by maternity services after childbirth during the Covid-19 outbreak. Available at: <https://www.fsrh.org/documents/fsrh-rcog-rcm-statement-postpartum-contraception-covid19/>

## Appendix 1: Patient information leaflet

### How effective are these methods?

This is the percentage of women who have an unplanned pregnancy with perfect and typical use of each method over one year:

• Progesterone pill	0.3-9%
• Copper coil	0.6-0.8%
• Hormonal coil	0.2%
• Progesterone implant	0.05%
• Progesterone injection	0.2-6%
• Combined pill	0.3-9%
• Lactational amenorrhea	2%
• Condoms	2-18%

### How do I access postnatal contraception?

- If you would like the progesterone only pill please talk to your midwife or doctor on the postnatal ward. This can be started in hospital.
- If you would like a coil inserted at the time of your caesarean, please discuss this with your doctor who can add this to your consent form.
- If you would like a coil inserted after a vaginal delivery, please discuss this with your doctor on the postnatal ward.
- If you would like the progesterone injection, please talk to your midwife or doctor on the postnatal ward as this can be given before discharge.
- If you would like the progesterone implant, we may need to refer you to a family planning clinic.
- You can also access through your GP or a family planning clinic at a later time.

For a translation of this leaflet or for accessing this information in another format:

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Please contact (PALS) the Patient Advice and Liaison Service on:

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Please remember that this leaflet is intended as general information only. We aim to make the information as up to date and accurate as possible. Please therefore always check specific advice or any concerns you may have with your doctor.

**Frimley Health** 

NHS Foundation Trust

Obstetrics and Gynaecology  
Frimley Health

Contraception after having your baby



Information for patients,  
relatives and carers

## Introduction

Contraception may be the last thing on your mind right now, but did you know that you can get pregnant as early as 3 weeks after giving birth?

A short gap between pregnancies is not only exhausting for you but can also increase your risks of complications in pregnancy and the risk of the baby not growing well.

We have put together this information leaflet to give you an idea of the contraceptive options available to you (all offered methods are reversible).

If you are interested, please ask your midwife or doctor for further information.

## What are your options?

- Progesterone only pill
- Hormonal or copper coil
- Progesterone implant
- Progesterone injection
- Combined oral contraceptive pill

## You can also use:

- Barrier methods (condoms, caps and diaphragms)
- Natural family planning: tracking your cycle to work out fertile times or lactation amenorrhoea if breastfeeding.

## Desogestrel progesterone only pill (Mini-pill)

One pill taken at the same time each day. It is suitable for most women and can be started straight after birth. It works by thickening the cervical mucus and sometimes prevents ovulation. It can be associated with irregular bleeding although this usually settles with time. Many women have no periods at all when taking this pill. Breastfeeding is not affected.

## Copper intrauterine device (Copper coil)

The copper coil can provide contraception for 5-10 years. The copper causes an immune reaction within the womb which is toxic to sperm. It is not toxic to anything else in your body. It is a good option for women wanting to avoid hormones, although it can make your periods heavier and more painful. It can be inserted at the time of caesarean section or within 2 days / after 4 weeks of a vaginal delivery. Breastfeeding is not affected.

## Hormonal intrauterine system (Hormonal coil)

The hormonal coil can provide contraception for up to 5 years. It slowly releases a form of progesterone that thins the lining of the womb. The most common side effect is irregular bleeding although this usually settles with time. Many women report their periods being lighter or stopping whilst they have a hormonal coil. It can be inserted at the time of caesarean section or within 2 days / after 4 weeks of a vaginal delivery. Breastfeeding is not affected.

## Progesterone implant

The implant is a small rod inserted under the skin of your upper arm and provides contraception for up to 3 years. It slowly releases small amounts of progesterone which thins the lining of the womb and may stop ovulation. It can be inserted any time after birth. It can be associated with irregular bleeding although this usually settles with time, and many women stop having periods at all. Breastfeeding is not affected.

## Progestogen injections

This is a single injection into the buttock area every 10-12 weeks. It works by thinning the lining of the womb and stopping ovulation. It can be given any time after birth. It can be associated with irregular bleeding although this usually settles with time and many women stop having periods at all. Breastfeeding is not affected.

## Combined Oral Contraceptive pill

One pill taken at the same time each day for 3 weeks, followed by a week break. It works by preventing ovulation. Periods are usual regular and light. Not suitable for women who are breastfeeding (other contraindications also apply). Can be started 3 weeks after delivery if suitable.

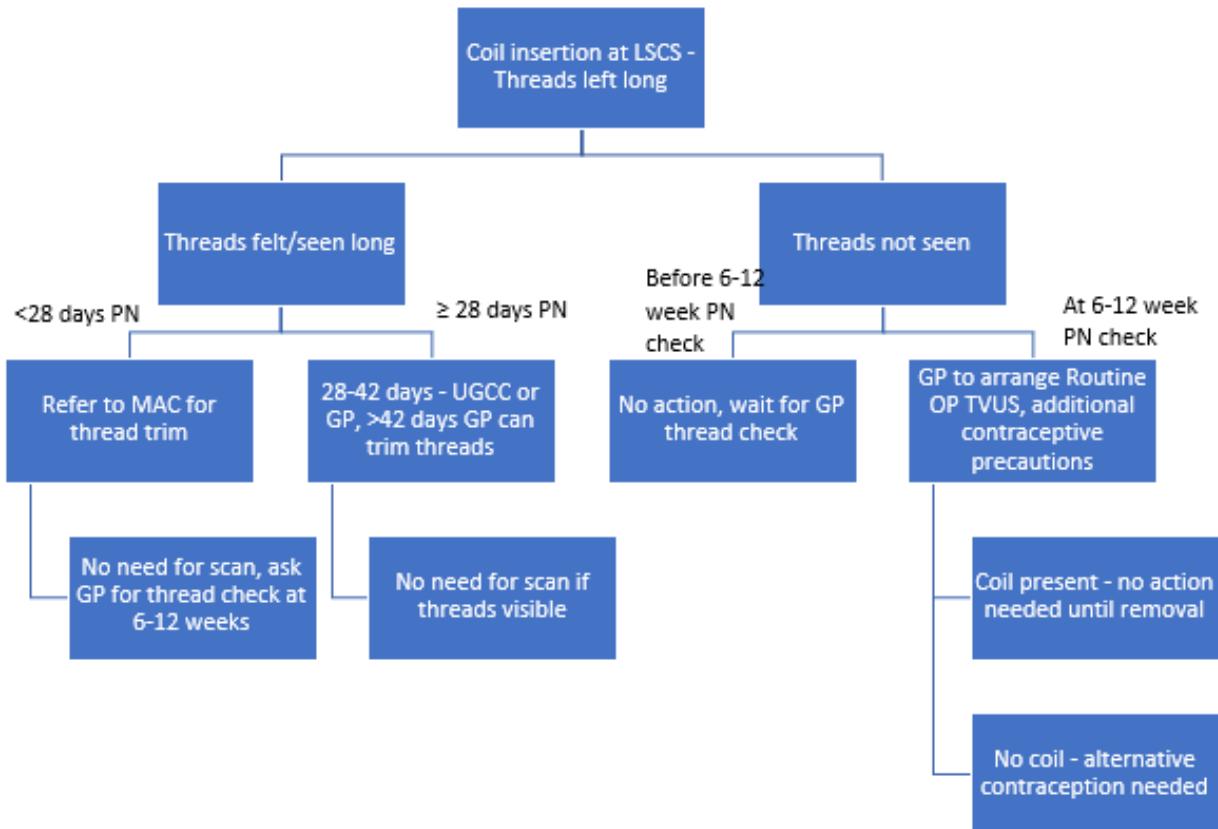
## Can you rely on breastfeeding as contraception?

Lactational amenorrhoea can provide a level of contraception but only if the following conditions are all met:

- It has been six months or less since the birth of your baby
- You are exclusively breastfeeding (no formula)
- Time between feeds not more than 4 hours in the day and 6 hours at night
- Your periods have not returned

Giving your baby expressed breast milk may reduce the effectiveness of lactational amenorrhoea as contraception.

## Appendix 2: Intrauterine contraception thread check



## Full version control record

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<b>Guidelines Lead(s):</b>	Helen Walker (O&G Consultant, FPH)
<b>Contributor(s):</b>	Dipika Aggarwal (O&G Consultant, WPH) Nicola Rose-Stone (Consultant Midwife, WPH)
<b>Lead Director / Chief of Service:</b>	Anne Deans (Chief of Service for Obstetrics and Gynaecology)
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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

## Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	September 2020	Nicola Rose-Stone (Consultant Midwife – secondment)	Final	First cross site version
1.1	July 2022	Nicola Rose-Stone (Consultant Midwife)	Amendment	Contraception leaflet added as appendix 1
1.2	July 2022	Clinical Guidelines Administrator	Interim	Transferred to new Clinical Guidelines Template
2.0	December 2024	Helen Walker (O&G Consultant, FPH)	Final	Approved at Cross Site Obstetrics Clinical Governance meeting, 16 December 2024

## Related Documents

Document Type	Document Name
Policy	Medicines Policy
Patient Leaflet	Contraception after Having your Baby