Contraception after Delivery

Unique Identifier	NMP200/SSM/100 - v02.00
Document Type	Clinical Guideline
Risk of non-compliance	may result in significant harm to the patient/DHB
Function	Clinical Practice, Patient Care
User Group(s)	Auckland DHB only
• Organisation(s)	Auckland District Health Board
• Directorate(s)	Women's Health
• Department(s)	Maternity
• Used for which patients?	All maternity women
• Used by which staff?	All clinicians in maternity including access holder lead maternity carers (LMCs)
• Excluded	
Keywords	n/a
Author	Clinician
Authorisation	
• Owner	Service Clinical Director - Regional Maternity Services
• Delegate / Issuer	Service Clinical Director - Secondary Maternity Services
Edited by	Document Control
First issued	08 March 2019
This version issued	28 March 2022 - reviewed
Review frequency	3 yearly

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1. Purpose of guideline

The purpose of this guideline is to present the evidence on the provision of contraception after childbirth and to promote a more collaborative and consistent approach to providing the highest standard of contraceptive care to all women after delivery.

2. Guideline management principles and goals

Women should be informed during pregnancy about the effectiveness of different contraceptives and which methods can be initiated immediately after delivery. Services should ensure that there are sufficient numbers of staff able to provide these methods prior to discharge, including the more effective long-acting reversible contraceptions (LARCs) (IUD and implant). If women are unable to be provided with their chosen method before discharge, a temporary (bridging) method should be offered along with information about where they may access contraceptive services.

3. Indications

To provide effective and appropriate contraception after delivery to enable a decrease in unintended pregnancies and short pregnancy intervals.

4. Patient information

Women should be informed of their contraceptive options antenatally and advised that fertility may return quickly after childbirth. Fifty percent of first menstruations are preceded by ovulation and at least 70% of pregnancies in the first year postpartum are unintended. Women should 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 birth weight and small for gestational age babies. Non-use of any contraceptive method means that 85% will have a pregnancy in the next year. This compares to 18% with typical condom use, 9% with contraceptive pill use, 6% with the contraceptive injection and <1 % with IUD and contraceptive implant use. Apart from combined hormonal contraception, the choice of method should be initiated by 21 days after childbirth and can be initiated immediately after delivery for all women, including those who are breastfeeding. Research suggests that, apart from combined hormonal methods, the timing of initiation of progestogen only methods, including the implant, does not affect lactation, infant growth or development. Women should be provided with evidence based information about contraception that is easily understood and available in different languages such as Family Planning pamphlets and the Family Planning website (see Supporting evidence).

5. Staff training

Improving women's access to contraception after delivery will need an integrated and collaborative approach. All staff involved with the care of women in pregnancy should provide the opportunity to discuss contraception in the antenatal period and clearly document the woman's decision in the chart. They should refer to the relevant current Faculty of Sexual and Reproductive

Health (FSRH) guidelines; including the UK Medical Eligibility Criteria for Contraceptive use (UKMEC) when making a clinical judgement on safe and appropriate contraceptive methods after delivery. Clinicians should be aware that the insertion of a contraceptive implant soon after childbirth is convenient and highly acceptable to women, as is insertion of an IUD at time of vaginal or caesarean delivery. Both of these have been associated with high continuation rates and a reduced risk of unintended pregnancy. The provision of the contraceptive method should be clearly documented in the chart.

Services should ensure that there are appropriately trained clinicians able to provide contraceptive methods to women before they are discharged including IUD and contraceptive implants.

6. Supporting evidence

- Aiken, A. R., Aiken, C. E., Trussell, J., & Guthrie, K. A. (2015). Immediate postpartum provision of highly effective reversible contraception. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(8), 1050-1051.
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- Heller, R., Cameron, S., Briggs, R., Forson, N., & Glasier, A. (2016). Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. *Journal of Family Planning and Reproductive Health Care*, *42*(2), 93-98.
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- New Zealand Family Planning. (2022). *Contraception Methods*. http://www.familyplann ing.org.nz/advice/contraception/contraception-methods
- National Institute for Health and Care Excellence. (2019). *Long-acting reversible contraception* (Clinical Guideline CG30). https://www.nice.org.uk/guidance/cg30
- Tepper, N. K., Phillips, S. J., Kapp, N., Gaffield, M. E., & Curtis, K. M. (2016). Combined hormonal contraceptive use among breastfeeding women: an updated systematic review. *Contraception*, *94*(3), 262-274.
- White, K., Teal, S. B., & Potter, J. E. (2015). Contraception after delivery and short interpregnancy intervals among women in the United States. *Obstetrics and Gynecology*, *125*(6), 1471.
- World Health Organization. (2007). *Report of a WHO technical consultation on birth spacing: Geneva, Switzerland 13-15 June 2005* (No. WHO/RHR/07.1). Geneva: World Health Organization.

7. Associated documents

- Breastfeeding Policy
- Informed Consent
- Sub-dermal contraceptive (Jadelle®) Insertion by Gynaecology Nurses and Midwives
- Medications - Allergies & Adverse Drug Reactions (ADRs) Identification, Documentation & Recording
- Medications - Prescribing

8. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

9. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.