

Contraception after pregnancy



Target audience	Staff in NHSL caring for pregnant or recently-pregnant women/birthing people.
Patient group	Pregnant or recently-pregnant women/birthing people. The term 'women/birthing people' is used within this document to include women, girls, trans men, and non-binary and intersex people, who are pregnant or have recently been pregnant.

Summary

- Women/birthing people should receive comprehensive, unbiased and accurate information about contraception.
- This should be made available in languages and formats that are suited to them.
- Women/birthing people should be informed about the effectiveness of different contraception, including the superior effectiveness of long-acting reversible contraception (LARC).
- Any appropriately trained member of medical, nursing or midwifery staff should be able to provide women/birthing people with all appropriate methods of contraception, including LARC before they are discharged home. If their chosen method cannot be provided, they should be informed which other services can provide it, such as Sexual Health Services. A 'bridging' method, such as the progesterone only pill (POP) should be offered until the chosen method has started.
- Maternity, Early Pregnancy, and Women's Health services should have agreed pathways to refer women/birthing people to specialist services e.g. community Sexual Health services for women/birthing people with complex medical, surgical or social needs which may require specialist advice.
- Any pre-existing medical conditions, or those which have developed during pregnancy which may influence eligibility for contraception should be discussed.
- The insertion of a progesterone containing implant (IMP), progesterone containing coil (IUS), or a copper containing coil (Cu-IUD) following the end of a pregnancy, is convenient and acceptable to women/birthing people. It has also been associated with high continuation rates and a reduced risk of unintended pregnancy.
- Women/birthing people should not feel pressured into choosing one type of contraception over another.
- Clinicians giving advice on and commencing any form of contraception should factor in guidance from The College of Sexual and Reproductive Healthcare's document entitled 'UK Medical Eligibility Criteria for Contraceptive Use (UKMEC). The woman/birthing person's individual risk of venous thromboembolism should be assessed and factored into contraceptive choice. Up-to-date guidance can be found here: <https://www.cosrh.org/Public/Public/Standards-and-Guidance/uk-medical-eligibility-criteria-for-contraceptive-use-ukmec.aspx>

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Abbreviations

APS	antiphospholipid syndrome
CHC	combined hormonal contraceptive
Cu-IUD	copper-containing intra-uterine device
DMA	depot medroxyprogesterone acetate
EC	emergency contraception
EP	ectopic pregnancy
FAM	fertility-awareness methods
GTD	gestational trophoblastic disease
hCG	human chorionic gonadotrophin
IMP	implanon (progesterone-containing implant)
IUC	intra-uterine contraception
IUS	intra-uterine system
LAM	lactational amenorrhoea
LARC	long-acting reversible contraception
LNG-EC	levonorgestrel emergency contraception
NHSL	National Health Service Lanarkshire
POI	progesterone-only injectable
POP	progestogen-only pill
SGA	small for gestational age
UKMEC	United Kingdom Medical Eligibility Criteria for Contraceptive Use
UPA-EC	ulipristal acetate emergency contraception
UPSI	unprotected sexual intercourse
VTE	venous thromboembolism

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Introduction

Fertility and sexual activity can resume shortly after any pregnancy. Effective contraception is therefore important to prevent an unintended pregnancy, to help plan any subsequent pregnancy and to avoid short interpregnancy intervals, particularly in those who have had a pregnancy lasting to 24 weeks of gestation or more.

An interpregnancy interval of at least 12 months is recommended to reduce the risk of obstetric and neonatal complications such as preterm delivery, small-for-gestational-age (SGA) birthweights, infant mortality and to reduce intrapartum complications such as uterine rupture in those with scarred uteri.

Most methods of contraception, including long-acting reversible contraception (LARC), can be safely initiated immediately after a pregnancy, irrespective of the pregnancy outcome and whether or not the woman/birthing person is intending to breastfeed.

Provision of contraception within all settings where women/birthing people with any pregnancy are cared for reduces health inequalities by offering contraception to women/birthing people who may not otherwise access sexual health services.

Aim/purpose

The purpose of this guideline is to provide comprehensive advice on contraception provision, including emergency contraception, after any pregnancy. This includes childbirth, miscarriage, ectopic pregnancy, termination of pregnancy and gestational trophoblastic disease.

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Chapter 1 – contraception after childbirth

Although contraception is not needed in the first 21 days after childbirth, most methods can be started safely immediately after childbirth, with the exception of combined hormonal contraception.

Women/birthing people should be advised that additional contraceptive precautions (e.g. barrier method/abstinence) are required if hormonal contraception is started 21 days or more after childbirth.

Contraceptive options

- **Intrauterine contraception (IUC):**
 - IUC such as the intra-uterine system (IUS) or the copper intrauterine device (Cu-IUD) can be safely inserted immediately after birth (within 10 minutes of delivery of the placenta) or within the first 48 hours after uncomplicated caesarean or vaginal birth.
 - After 48 hours, insertion should be delayed until 28 days after childbirth.
 - This would require prebirth discussion and consent.

- **Progesterone only contraception:**
 - Progesterone-only injectable (POI), progestogen-only implant (IMP) or the progestogen-only pill (POP) can be started at any time after childbirth, including immediately after delivery.

- **Combined hormonal contraception (CHC):**
 - All women/birthing people should be risk-assessed for venous thromboembolism (VTE) postnatally.
 - Any woman/birthing person with risk factors for VTE should not receive CHC of any sort within 6 weeks of childbirth (please see VTE assessment for further information)
 - This applies to both breastfeeding and non-breastfeeding women/birthing people.
 - Non-breastfeeding women/birthing people, who have no risk factors for VTE, can commence CHC from 21 days after childbirth.

- **Sterilisation:**
 - Sterilisation may be an option for those women/birthing people undergoing an elective caesarean birth.
 - Written consent should be obtained and documented at least 2 weeks in advance of an elective caesarean birth.
 - Sterilisation is not generally performed at the time of emergency caesarean birth and should only be done at the discretion of the consultant obstetrician.
 - Women/birthing people should be informed that some LARC methods are as, or more, effective than sterilisation and may have other benefits such as using the IUS to manage heavy menstrual bleeding.

- **Barrier methods:**
 - Condoms may be used safely after birth.

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- Women/birthing people choosing to use a diaphragm should have this fitted at least 6 weeks after childbirth as the required size may change as the uterus returns to its normal size.
- **Fertility-awareness methods (FAM):**
 - FAM relies on detecting the signs and symptoms of the 'fertile window' and ovulation.
 - It may be difficult to use accurately to prevent conception after childbirth or whilst breastfeeding.

Breastfeeding

- Progesterone-only methods of contraception are safe and have no adverse effects on lactation or the baby.
- If breastfeeding, women/birthing people should wait 6 weeks before commencing any oestrogen-containing contraception methods. This included the combined contraceptive pill, patch and ring.
- For a woman/birthing person to use Lactational Amenorrhoea (LAM) as contraception, they must be:
 - less than 6 months postpartum
 - fully breastfeeding and
 - amenorrhoeic.
- Women/birthing people should be advised that LAM is not an effective method of preventing pregnancy if anything reduces the frequency of breastfeeding such as stopping night feeds, using supplementary feeds or through the use of dummies or pacifiers.
- LAM is also not considered an effective contraceptive method if > 6months postnatal or if menstruation has returned.

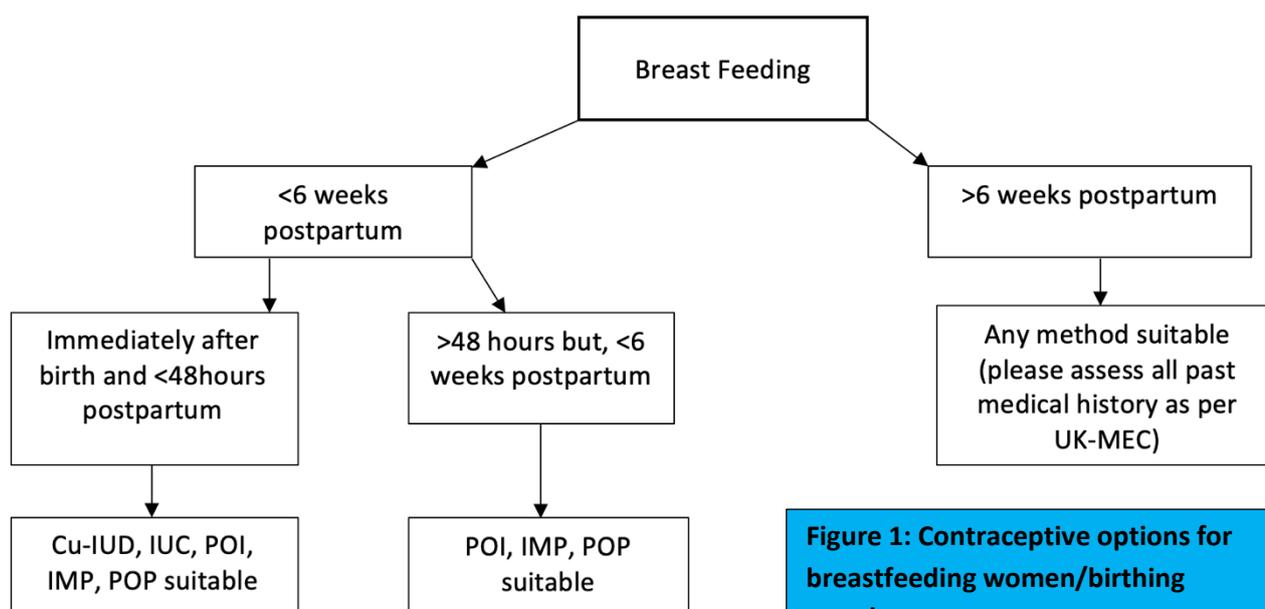
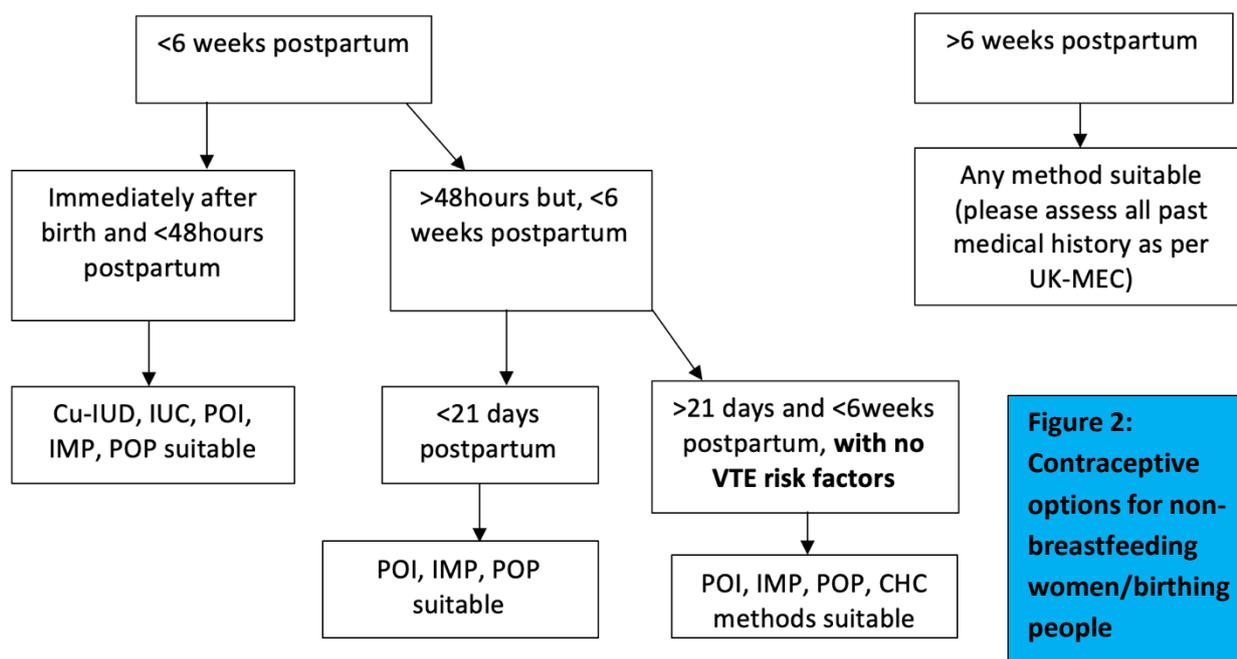


Figure 1: Contraceptive options for breastfeeding women/birthing people

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Emergency contraception (EC) after childbirth

- EC is required for women/birthing people who have had unprotected sexual intercourse (UPSI) from 21 days after childbirth.
- It is not required within 21 days of childbirth.
- Oral EC levonorgestrel 1.5 mg (LNG-EC) and Ulipristal Acetate 30 mg (UPA-EC) are safe to use from 21 days after childbirth.
- Women/birthing people who breastfeed should be advised not to do so and to express and discard milk for a week after they have taken UPA-EC.
- Cu-IUD is safe to use for EC from 28 days after childbirth.

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Chapter 2 – contraception after ectopic pregnancy or miscarriage

- Conception does not need to be delayed after most types of miscarriage or ectopic pregnancy (EP).
- Those treated with methotrexate should be advised that contraception is recommended for at least 3 months after the last dose due concerns regarding teratogenicity.
- Contraception can be started on the day that medical and surgical management methods for both EP and miscarriage management commence.
- EC is required if UPSI takes place more than 5 days after the day that medical and surgical methods for both EP and miscarriage management commence.
- Any method of EC can be used after EP or miscarriage.
- Additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after the day that medical and surgical management methods for both EP and miscarriage management commence.
- Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days.
- The absolute risk of EP whilst using contraception is very small – it is lowest when using LARC (including Cu-IUD and IUC).
- Women/birthing people should be advised to seek medical advice if they suspect they are pregnant or have symptoms of EP whilst using contraception.
- In the rare occasion that a pregnancy occurs with an IUC in situ, there is an increased risk of EP. The location of the pregnancy should be confirmed by ultrasound as soon as possible.

Contraceptive options

- **Intra-uterine contraception (IUC):**
 - The IUS and the Cu-IUD can be inserted safely after EP, regardless of how this it managed.
 - The IUS and the Cu-IUD can be inserted safely after expulsion or evacuation of the pregnancy following miscarriage.
 - The IUS and the Cu-IUD should not be inserted in the presence of sepsis.
 - This would require pre-procedure discussion and consent.
- **Progesterone only contraception:**
 - All forms of progesterone-only contraception can be started safely at any time following miscarriage or EP.
 - There may be a slightly higher risk of failed medical management of miscarriage if the depot medroxyprogesterone acetate (DMA) injection is started where mifepristone has been used for management.
- **Combined hormonal contraception (CHC):**
 - In the majority of women/birthing people, CHC can be started safely following EP or miscarriage.
 - CHC should be avoided in women/birthing people with recurrent miscarriage until antiphospholipid syndrome (APS) has been excluded.
- **Sterilisation:**

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- Sterilisation is a safe option for permanent contraception after miscarriage or EP.
- Women/birthing people should be informed that some LARC method are as, or more, effective than sterilisation and may have other benefits i.e. management of heavy menstrual bleeding in the context of IUC insertion.
- Written consent should be obtained in advance of sterilisation if it is to be performed at the time of surgical management of EP or miscarriage
- **Barrier methods:**
 - Condoms may be used safely after miscarriage.
 - Women/birthing people choosing to use a diaphragm should have this fitted at least 6 weeks after miscarriage or ectopic as the required size may change as the uterus returns to its normal size.
- **Fertility Awareness Methods (FAM):**
 - Women/birthing people may choose to use FAM after miscarriage or ectopic pregnancy.
 - As FAM relies on detection of the signs and symptoms of the 'fertile window' and ovulation, it may be difficult to use accurately to prevent conception after miscarriage or EP.

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Chapter 3 – contraception after abortion

- Those who choose to commence LARC immediately after abortion have a significantly reduced likelihood of undergoing another abortion within 2 years, compared with those provided with medium-acting, short-acting or no contraceptive methods.
- Choice of contraception should be initiated at the time of abortion or soon after, as sexual activity and ovulation can resume very soon after.
- Any method of contraception can be safely started immediately after an uncomplicated abortion.
- Women/birthing people should be advised that additional contraception (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after abortion.
- Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of abortion.
- Any form of emergency contraception can be used following uncomplicated abortion.

Contraceptive options

- **Intra-uterine contraception:**
 - The IUS and the Cu-IUD can be safely used after uncomplicated abortion, either after expulsion of the pregnancy with medical management, or inserted immediately after evacuation of the cavity following surgical management.
 - The IUS and the Cu-IUD should not be inserted if there are any signs/symptoms of sepsis or intrauterine infection.
 - This would require pre-treatment discussion and consent.
- **Progestogen-only contraception:**
 - These can be safely started at any time, including immediately, after medical or surgical abortion.
 - IMP can be inserted at the time of mifepristone administration in medical abortion.
 - Women/birthing people should be informed that there may be a slightly higher risk of failed abortion if the DMA injection is given at the time of mifepristone administration.
- **Combined hormonal contraction (CHC):**
 - Can be started safely immediately after medical or surgical abortion in women/birthing people with no other contraindications.
- **Sterilisation:**
 - Sterilisation is a safe option for permanent contraception following abortion.
 - Women/birthing people should be informed that some LARC methods are as, or more, effective than sterilisation and may have other benefits i.e. management of heavy menstrual bleeding in the context of IUS insertion.
 - Consent to perform sterilisation at the time of abortion should be taken and documented in advance of the procedure.
- **Barrier methods:**
 - Condoms can be used after abortion. Following a second trimester abortion, women/birthing people should wait at least 6 weeks, as the size of a diaphragm may change as the uterus returns to normal size.

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- **Fertility awareness methods (FAM):**
 - Women/birthing people may choose to use FAM after termination of pregnancy. As FAM relies on detecting the signs and symptoms of the 'fertile window' and ovulation it may be difficult to use accurately to prevent conception after abortion.

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Chapter 4 – contraception after gestational trophoblastic disease (GTD)

- Women/birthing people should be advised to avoid further pregnancy until GTD monitoring is complete. Therefore, effective contraception should be started as soon as possible.
- Women/birthing people with GTD should be reassured that fertility and pregnancy outcomes are favourable after GTD, including after chemotherapy.
- There is an increased risk of GTD in subsequent pregnancy.
- After a complete molar pregnancy, women/birthing people should be advised to avoid subsequent pregnancy for at least 6 months to allow hCG monitoring for ongoing GTD.
- After a partial molar pregnancy, women/birthing people should be advised to avoid pregnancy until two consecutive monthly hCG levels are normal.
- Women/birthing people who have had chemotherapy for GTD should be advised to avoid pregnancy for 1 year after treatment is complete.
- Most methods of contraception can be safely used after treatment for GTD and can be started immediately after uterine evacuation, with the exception of intrauterine contraception.
- EC is required if UPSI takes place from 5 days after treatment for GTD. Oral EC is safe. Insertion of a copper intra-uterine device (Cu-IUD) may be considered following advice from a specialist in a GTD centre for those with decreasing hCG levels.
- There is no evidence that the use of any contraceptive method after an episode of GTD increases the risk in a subsequent pregnancy

Contraceptive options

- **Intra-uterine contraception (IUC):**
 - Intrauterine contraception should not be inserted in women/birthing people with persistently elevated hCG levels or malignant disease.
 - IUC should not normally be inserted until hCG levels have normalised but may be considered following advice from a specialist in a GTD centre for those with decreasing hCG levels.
 - Insertion at surgical evacuation where GTD is suspected but not confirmed should be made on an individual case-by-case basis based upon risk factors for GTD, clinical findings and the woman/birthing person's preferences.
 - This would require pre-procedure discussion and consent.
- **Progesterone-only contraction:**
 - All forms of progesterone-only medication can be started immediately after uterine evacuation for GTD.
- **Combined hormonal contraception (CHC):**
 - Can be started immediately after uterine evacuation for GTD.
- **Sterilisation:**
 - Sterilisation is a safe option for permanent contraception following GTD.
 - Women/birthing people should be informed that some LARC methods are as, or more, effective than sterilisation and may have other benefits i.e. management of heavy menstrual bleeding in the context of IUC insertion.
 - Sterilisation should ideally be performed some time after surgical evacuation for GTD.

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- Women/birthing people who request sterilisation should be advised of the possible increased risk of failed treatment and risk of regret.
- **Barrier methods:**
 - Condoms can be used by women/birthing people after treatment for GTD.
 - Women/birthing people who choose a diaphragm should be advised to wait at least 6 weeks after treatment for GTD because the required size of diaphragm may change as the uterus returns to normal size.
- **Fertility awareness methods (FAM):**
 - Women/birthing people may choose to use FAM after termination of pregnancy. As FAM relies on detection of the signs and symptoms of the 'fertile window' and ovulation it may be difficult to use accurately to prevent conception after GTD.

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