



# Postnatal Contraception Guideline

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<b>Author:</b>	Elinore Macgillivray, Consultant Midwife Ms. Rajul Patel-Gadhia
<b>Executive Sponsor:</b>	Executive Nurse Director
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## Target Audience:

<b>People who need to know about this document in detail</b>	All staff working in maternity or integrated sexual health services
<b>People who need to have a broad understanding of this document</b>	<i>As above</i>
<b>People who need to know that this document exists</b>	<i>As above</i>

## Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	<b>Date: December 2025</b> <b>Outcome: No negative impact</b>
<b>Welsh Language Standard</b>	No
<b>Date of approval by Equality Team:</b>	(00/00/0000)
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Choose an item.



**Disclaimer:**

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or [CTM\\_Corporate\\_Governance@wales.nhs.uk](mailto:CTM_Corporate_Governance@wales.nhs.uk)

**Guidelines Definition**

Clinical guidelines are systematically developed statements that assist clinicians and women in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

**Minor Amendments**

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
Version 3	Updates to the service, including midwifery led postnatal contraception service.			1 to 2.0	Elinore Macgillivray Rajul patel-Gadhia

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## Introduction

At least 30% of pregnancies are unintended in the UK every year <sup>1</sup>. Unplanned pregnancies are known to have poorer obstetric outcomes and also result in an inevitable increase in women seeking termination of pregnancy. The immediate post-partum period is particularly high risk with a rapid return to fertility in most women.

A short inter- pregnancy interval (<1year) is associated with an increase in the risk of pre term labour, small for gestational age babies, stillbirth and the likelihood of caesarean birth. One in 13 women in the UK have a short inter-pregnancy interval or termination of pregnancy within the first year after childbirth. In 2021, the percentage of conceptions leading to termination of pregnancy reached 26.5%.

The routine six-week post-natal check is no longer routinely offered, and when offered has a low rate of acceptance. Additionally, there is a 50 per cent rate of non-attendance for appointments made in sexual health clinics during the immediate post-natal period<sup>4, 5</sup>. Most methods of contraception can be safely initiated in the immediate postnatal period whilst women are still under the care of maternity services, reducing barriers for women trying to access contraception.

In line with RCOG guidance, services providing maternity care should be able to offer all appropriate methods of contraception, including long-acting reversible contraception (LARC) to women before they are discharged from the service (Public Health Wales 2018).

All progestogen only contraceptives are safe for use by breast feeding women, and have no effect on milk production or infant outcome.

Progestogen only contraception is immediately effective if started before postnatal day 21. Immediate use of LARC is associated with a higher continuance at 1 year, and there is no increase in the rate of postpartum bleeding with the use of Depo Medroxyprogesterone Acetate (DMPA) postnatally<sup>6, 7</sup>.

This Guideline covers the use of Depo Medroxyprogesterone Acetate (DMPA, Depo-Provera®), the Progestogen only Pill (Desogestrel 75mcg), Intrauterine System (IUS) and the etonogestrel subdermal implant (SDI) in the immediate postnatal period.



## Aims and Standards

The aims of this guideline are to ensure:

- All women are provided with information on postnatal contraception during pregnancy, including the particular effectiveness of Long-Acting Reversible Contraceptives (LARCs). Information should always be offered in the woman's preferred language and cover all types of contraception available postnatally. This is available on the CTM Maternity webpage and can be printed if needed (appendix one).
- Contraception counselling is made available early in the pregnancy by either Midwives or Doctors to enable women the time to choose the method which is best for them. This discussion should be clearly documented.
- Women are advised that an inter-pregnancy interval of less than 12 months is associated with an increase in the incidence of pre term labour, low birthweight and small for gestational age babies.
- Contraception is initiated immediately after childbirth if accepted, taking into account medical suitability. Women 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. Additional contraceptive precaution is not required if contraception is initiated immediately or within 21 days after childbirth.
- Healthcare professionals providing postnatal contraception refer to the relevant UK Medical Eligibility Criteria for contraception Use (UKMEC) [www.fsrh.org/ukmec](http://www.fsrh.org/ukmec) when advising on safe and appropriate methods of contraception after pregnancy.
- Women are able to access their chosen method of contraception before being discharged from maternity care either in hospital or in the community setting. Or, if not available at that time, have the information to be able to access community based sexual health services.
- Women using the lactational amenorrhea method are advised that the risk of pregnancy increases if the frequency of breastfeeding decreases.
- Male and Female Condoms can be safely used after childbirth.
- Women wishing to use a diaphragm should be advised to wait 6 weeks until fitting one.



## Who May Prescribe and Administer Postnatal Contraception

Certain types of postnatal contraception may be provided under Patient Group Direction (PGD) by midwives who have undergone a relevant postnatal contraception training programme and have signed the appropriate PGD. These are shown below:

Type of Contraception	Who can administer it?
<b>PPUIC</b>	Doctors only.
<b>POP</b>	Any registered midwife once it has been prescribed by a doctor.  OR  Can be given under PGD without prescription by a registered midwife who has undertaken appropriate training.
<b>Depo-Provera</b>	Any registered midwife once it has been prescribed by a doctor.  OR  Can be given under PGD without prescription by a registered midwife who has undertaken appropriate training.
<b>SDI</b>	Doctors.  OR  A registered midwife who is working under PGD, has undertaken appropriate training and holds a valid FRSH Letter of Competence for the insertion of sub-dermal contraceptive implants.



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## General Principles

Prior to the prescription and/ or administration of any postnatal contraception:

- Appropriate counselling should be given in the woman's preferred language.
- A UK Medical Eligibility Criteria for contraception Use (UKMEC) [www.fsrh.org/ukmec](http://www.fsrh.org/ukmec) should be completed in order to identify any potential contraindications to use (appendix 1).
- A checklist for health professional providing contraception should be completed (appendix 2).

If a woman declines postnatal contraception, remind her of her likely return to fertility and that the RCOG advise against pregnancy within 12 months postpartum. Also, offer condoms.

Stocks of the progestogen only pill, Depo Medroxyprogesterone Acetate (DMPA, Depo-Provera injection) and The Sub Dermal Contraceptive Implant (SDI) are kept at Prince Charles and Princess of Wales Hospitals and Tirion Birth Centre to ensure availability 24/7.

## Progestogen Only Contraception

### i. Progestogen Only Pill (POP, 'Mini pill')

Where women request the progestogen only pill, a doctor should prescribe this.

Alternatively, midwives who have undergone an appropriate postnatal contraception training programme may administer the progestogen only pill under PGD.

### ii. Depo Medroxyprogesterone Acetate (DMPA, Depo-Provera injection)

Doctors may prescribe and fit a Sub-Dermal Contraceptive Implant.

Midwives who have undergone an appropriate postnatal contraception training programme may administer the Depo-Provera injection under PGD.

### iii. **Postpartum Intrauterine Contraception (PPIUC)**

Women should be informed that a PPIUC (coil) is one of the most effective methods of contraception and that they may have this fitted immediately after their baby is born. PPIUC can only be fitted by a doctor and may **not** be fitted by a midwife.

For women who have chosen this method of contraception, this may be done at the time of birth by Caesarean section or just after vaginal birth and up to 48hrs after birth (UKMEC1) with evidence to support efficacy and safety.

Women should be informed of the advantages of PPIUC to include:

- the convenience of onsite fitting;
- immediate contraceptive cover;
- less painful insertion;
- low risk of complications;
- and high continuation rate.

There are exceptions for suitability which may preclude PPIUC which include:

- signs of Sepsis;
- pre-labour premature rupture of the membranes (PPROM) of more than 36 hours;
- and ongoing Postpartum Haemorrhage (PPH).

For PPIUC, regardless of mode of birth there is no increased risk of uterine perforation and no increased risk of infection.

The use of PPIUC is associated with higher expulsion rates (between 8 and 20% at more than 4 weeks) but also higher continuation rates at 6 to 12 months regardless of type PPIUC or mode of birth.

Expulsion more likely within the first 3 months postnatally and may be slightly higher after vaginal birth than other modes of birth. Women should be advised that another form of contraception will be required if this occurs.

Women should complete a self-assessment checklist (appendix 4) which will be signed and filed in advance of birth in her maternity notes.

All women should have written information explaining the risk of expulsion and signs and symptoms of infection for which they should seek medical attention. This will be included in the post insertion advice leaflet along with advice to attend the 6-week IUS check with their GP or Integrated Sexual Health (ISH) service provider as agreed locally.

If threads are not visible at the 6-week check, the woman should be sent for ultrasound and alternative contraception advised including the need for emergency contraception. Threads should ideally be trimmed to between 2 to 3cm from the cervix. If the tip of the device is seen, consider partial expulsion and remove with consideration of further contraception including the need for emergency contraception.

#### **iv. The Sub Dermal Contraceptive Implant (SDI)**

Doctors may prescribe and fit a Sub-Dermal Contraceptive Implant.

Midwives who have undergone an appropriate training programme and have a valid Faculty of Sexual and Reproductive Health (FSRH) Letter of Competence for the insertion of sub-dermal contraceptive implants may also offer and fit SDIs under Patient Group Direction (PGD).

Please follow this hyperlink for Midwife led Subdermal contraceptive implant Standard Operating Procedure:

[wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/midwifery-led-subdermal-contraceptive-implant-clinic-sdi-sop/](https://wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/midwifery-led-subdermal-contraceptive-implant-clinic-sdi-sop/)

The Midwifery Led Sub-Dermal Contraceptive Implant (SDI) Clinic Checklists should (appendix 4) should be completed prior to insertion.

#### **Auditable Standards**

Rate of women who have a discussion documented regarding contraception during their antenatal period.

Rate of women whom are administered either POP, PPIUC, DMPA or SDI before leaving hospital.

Rate of women whom are administered either POP, PPUIC, DMPA or SDI before being discharged from community midwifery care.

Adherence to the checklist for administration of DMPA, PPIUC, SDI and POP.



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## References

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Kaye Wellings, Prof, FRCOG, Kyle G Jones et al. Lancet 2013 Nov 30; 382 (9907): 1807-1816. [www.fsrh.org](http://www.fsrh.org)
2. Heller R, Cameron S, Briggs R et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter pregnancy intervals.
3. J Fam Plann Reprod Health Care 2016;42:93-98.  
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4. Gurtcheff SE, Turok DK, Stoddard g et al. Lactogenesis after early postpartum use of the contraceptive implant: RCT Obstet/Gynecol 2011;117:1114-1121.
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7. Aiken ARA, Aiken CEM, Trussell J et al. Immediate postpartum provision of highly effective reversible contraception. BJOG 2015;122:1050-1051.
8. UK Medical Eligibility Criteria for Contraceptive use  
NHS Contraceptive guide [www.nhs.uk/conditions/contraception](http://www.nhs.uk/conditions/contraception)



### Appendix 1: Depo-Provera (DMPA) & Desogestrel (POP) Checklist

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_cm      Weight: \_\_\_\_Kg      BMI: \_\_\_\_\_

#### UKMEC 4

ABSOLUTE contraindications / if any of the below are present the medication **SHOULD NOT** be provided:

Condition:	Present	Absent	Details
Current / Possible Pregnancy			
Known Allergies – Consider Nut / Soya etc. (POP)			
Current Breast Cancer			

#### UKMEC 3

**RELATIVE contraindications** / please refer to medic to consider safety to give:

Condition:	Present	Absent	Details
Current/History of Ischaemic Heart Disease, CVA, TIA			
Multiple risk factors of Cardiovascular disease (obesity, smoking, diabetes, lipid abnormalities)			
Liver Tumour/ Severe Liver Cirrhosis			
Past History of Breast Cancer			
Hypertension (vascular complications)			
Vaginal bleeding problems, needing investigation			

**UKMEC / WHO 2 – Advantages generally outweigh the theoretical or proven risks. We would ask you to consider these conditions and if a patient has 2 or more of these please speak to a family planning doctor:**

Migraine with Aura	Diabetes	Age <18 or >45 DMPA	Rheumatoid Arthritis
Controlled hypertension	VTE	Thrombogenic mutations	Dyslipidaemias
Atrial fibrillation	BRCA1 gene	CIN awaiting treatment	Organ transplant
Ischaemic heart disease	Liver tumour	Unexplained heavy vaginal bleeding	Gall bladder disease.
Postpartum with cardiovascular risks.	Chronic systemic disease: Crohn’s & ulcerative colitis (POP) malabsorption		

## Appendix 2: Check List for Health Professionals

### Check list for health professional providing contraception:

<b>Progestogen Only Pill</b>	<b>Informed</b>	<b>DMPA</b>	<b>Informed</b>
Mode of Action.		Mode of Action.	
Administrative route: Take every day, within 3 hours (12 hours for Desogestrel).		Route of administration IM injection (deltoid, gluteal or thigh).	
When: Can be started immediately postpartum but before day 21.		When: Can be given immediately postpartum up until time of discharge.	
Failure rate: POP is 99% effective in perfect use, But 91% effective in typical use.		Depo is due every 12-14 weeks. The next dose (12 weeks) will be due: ____/____/_____ — Make sure date on woman's leaflet.	
48 hour rule. Vomiting, diarrhoea, missed pills. Concurrent use of other medication.		Failure Rate: Depo is over 99% effective if administered every 12 weeks.	
Side effects/ disadvantages: <ul style="list-style-type: none"> <li>• Irregular periods,</li> <li>• Breast tenderness,</li> <li>• Mood Changes.</li> </ul>		Side effects/ disadvantages: <ul style="list-style-type: none"> <li>• Irregular periods,</li> <li>• Amenorrhoea,</li> <li>• Small weight gain,</li> <li>• Mood changes,</li> <li>• Breast tenderness,</li> <li>• Can delay return of fertility up to 12 months,</li> <li>• Bone density effects: smokers/ poor diet/ anorexia/ steroid use.</li> </ul>	

Midwife Name and Designation: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



### Appendix 3

## Midwifery Led Sub-Dermal Contraceptive Implant (SDI) Clinic Checklist

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Body Mass Index (BMI): \_\_\_\_\_

### UK MEC 4/ WHO 4: Absolute Contraindications.

The presence of **ONE** risk factor contraindicates the usage of the implant.

CONDITION	PRESENT	ABSENT
Known or suspected pregnancy.		
Hypersensitivity to any component.		
Current breast cancer		

### UK MEC 3/ WHO 3: Relative contraindications

Conditions requiring careful consideration where risks generally outweigh advantages & where Implanon should not generally be used.

CONDITION	PRESENT	ABSENT
Severe Liver cirrhosis. Liver tumours		
Current & H/O ischaemic heart disease, H/O stroke ( <b>developed while on Implant</b> )		
Unexplained vaginal bleeding(suspicious underlying condition) before evaluation		
<b>Check Drug interaction - Liver enzyme inducers</b> ( Use condoms)		
Past history of breast cancer with no evidence of recurrence for 5 years		

### UK MEC 2/WHO 2:

Conditions requiring caution but where the advantages generally outweigh the theoretical or proven risks.

CONDITION	PRESENT	ABSENT
Multiple risk factors for arterial cardiovascular disease (smoking, diabetes, obesity hypertension)		
Past history of VTE, major surgery with prolonged immobilisation,		



Known thrombogenic mutation (e.g. Factor V Leiden),		
Current VTE on anticoagulants		
Current & H/O ischaemic heart disease, H/O stroke ( <b>before starting Implant</b> )		
Dyslipidaemia		
Hypertension with vascular disease		
SLE with or without Antibodies, Rheumatoid arthritis		
Migraine with or without aura (present or past history)		
Diabetes with or without complications		
Heavy or prolonged vaginal bleeding (regular or irregular patterns), irregular pattern without heavy bleeding. Unexplained heavy vaginal bleeding		
Cervical cancer (awaiting treatment)		
Breast disease – undiagnosed mass, carrier of known gene mutation associated with breast cancer (e.g. BRCA1)		
Cardiomyopathy with impaired function. Atrial fibrillation		
Mild liver cirrhosis, gall bladder disease, history of cholestasis (past COC-related)		
Organ transplant		

**CHECKLIST FOR 1<sup>ST</sup> COUNSELLING/CONSENT**

- |   |  |
|---|--|
| <input type="checkbox"/> Mode of action | <input type="checkbox"/> Option to discontinue       |
| <input type="checkbox"/> Safer sex      | <input type="checkbox"/> Perseverance for 3-6 months |

**ADVANTAGES**

- Effectiveness
- Non user dependent
- 3 year lifespan
- Easily reversible /Return of pre-existing fertility
- Decrease in painful periods

**DISADVANTAGES**

- Headaches 1 in 100
- Possible change acne 1 in 100
- Possible mood change 1 in 20
- Possible weight gain 1 in 20
- Changes in bleeding pattern 1 in 5/



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**INSERTION & REMOVAL TECHNIQUE EXPLAINED**

- Site
- Equipment / Local anaesthesia
- Possible problems: - pain, itching, bruising, tenderness at site, possible infection at site, scarring.
- Due date for removal (no reminder will be given)

**Date of baby's birth:**...../...../.....

**PATIENT DECLARATION**

**I confirm that I have been counselled prior the referral of the Nexplanon contraceptive implant and consent to the procedure.**

**Patient signature:** ..... **Date:** .....

**Midwife signature**.....

**Print Name:**..... **Date:**.....

Implant fitted in **Left / Right** arm (please circle as appropriate)

<b>IMPLANON BATCH STICKER</b>	
<b>Credit Card Issued:</b>	
<b>Date Inserted:</b>	
<b>Due date for removal:</b>	
<b>Implant felt in arm after insertion:</b> (please circle as appropriate)	
<b>Practitioner Yes/ No</b>	<b>Patient Yes /No</b>

Chaperone offered: accepted / declined (please circle as appropriate)

Local anaesthetic used:  Lidocaine 1% 1-2.mls

Pressure dressing:

Advise clean/dry 24hrs:

Expiry card:

Info leaflet:

Comments:

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Signed Midwife:.....

Print Name:.....

Date:.....

## Appendix 4 (English and Cymraeg): Service User Information Leaflet and Link to CTM Webpage to download

### Progestogen Only Pill (Mini Pill)

- 92% effective
- Must be taken every day at the same time
- Safe to use when breastfeeding
- Can be used from birth, we can give you a supply to go home with
- Periods may become irregular, lighter, more frequent or stop
- Missing pills, vomiting or severe diarrhoea can make it less effective
- Normal fertility returns as soon as you stop using it

### Combined Contraceptive Pill (The Pill)

- 92% effective
- Should not be used when breastfeeding
- Can be used from 6 weeks after delivery if you are not breastfeeding
- Periods are usually regular, lighter and less painful
- Missing pills, vomiting or severe diarrhoea can make it less effective
- Normal fertility returns as soon as you stop using it

### Female or Male Sterilisation

- 99.8% effective
- Permanent contraception and irreversible
- Only suitable if you are certain you have completed your family
- Female sterilisation can be performed at the same time as C-section – you can discuss this with your obstetrician in antenatal clinic

### Male and Female Condoms

- 85% effective
- Can be used from birth
- Protects against STIs

### Diaphragms and Caps

- 84% effective
- Can be used from 6 weeks
- Should be used with spermicide
- Will need refitting if you had one pre-pregnancy

### Emergency Contraception

If you have unprotected sex after your baby is 3 weeks old you can use emergency contraception.

**IUD (Copper Coil)**

- Most effective method of emergency contraception, prevents over 99% of pregnancies
- Can be inserted from 4 weeks after your baby is born and up to 5 days after unprotected sex.

**Emergency Contraceptive Pill (Levonelle) 'morning after pill'**

- Can be taken up to 120 hours (5 days) of having unprotected sex, but the sooner you take it, the more likely it is to work.

**Ulipristal Acetate (ellaOne)**

- Another form of morning-after pill
- Can be also used up to 120 hours (5 days) after unprotected sex
- May be more effective than Levonelle
- Breastfeeding not recommended for 36 hours after taking ellaOne

### The Coils (IUD / IUS)

There are 2 types of coil, both are devices that are inserted into the uterus and are over 99% effective. Coils can be inserted during a C-section – you can discuss this with your obstetrician in antenatal clinic or from 4 weeks after your baby is born. They are both safe when breastfeeding.

**The IUD (Copper Coil)**

- Contains no hormones
- Lasts up to 10 years, but can be removed earlier
- Periods may become more heavy or painful

**The IUS (Mirena Coil)**

- Contains progestogen
- Lasts up to 5 years, can be removed earlier
- Periods may be lighter or stop altogether

### The Implant (Nexplanon)

- 99.9% effective
- Small rod (about the size of a matchstick) inserted under the skin of the upper arm using local anaesthetic
- Can be inserted anytime after your baby is born
- Lasts up to 3 years, but can be removed at any time and fertility returns straight away
- Safe with breastfeeding
- Can cause unpredictable bleeding

### The Injection (Depo-Provera)

- 97% effective
- Can be used from birth, we can give it before you go home
- Lasts 12 weeks, then it must be given again
- Safe with breastfeeding
- If given in the 6 weeks after delivery may cause heavier bleeding
- It can cause unpredictable bleeding; however, periods in most women become lighter over time or stop altogether
- Can sometimes cause weight gain
- The injection takes 12 weeks to leave the body, and it can take up to 1 year for fertility to return to normal

### Lactation Amenorrhoea Method

Breastfeeding can be used as a contraceptive method known as the Lactation Amenorrhoea Method (LAM). This can be up to 98% effective if the following criteria are adhered to:

- You are fully breastfeeding (i.e. breastfeeding 100% of the time without any bottle or top up feeds) and you are breastfeeding regularly (at least every 4 hours during the day and every 6 hours at night)
- Your baby is less than 6 months old
- You have no periods

If any of the above criteria don't apply the risk of pregnancy increases and you should consider using another method of contraception if you don't want to get pregnant. You may also wish to use another method of contraception simply as a back up to LAM.

If you use a hormonal method of contraception, a small amount will enter the milk, but research has not shown this will harm your baby. Methods that contain the hormone oestrogen (the pill, the patch or the vaginal ring) may reduce the amount of milk you produce so are not recommended when breastfeeding. Methods that contain the hormone progestogen only (e.g. the mini pill, implant, injection and IUS) do not have any effect on the amount of milk you produce.

### Pilsen Progesteron yn unig (y bilsen fach)

- 99% yn effeithiol os cymwrch yn unol â chyfarwyddiadau
- Rhaid ei gymryd bob dydd ar yr un amser
- Yn ddiogel i'w ddefnyddio wrth fywdo ar y fron
- Gallwch ddefnyddio o enedigaeath.
- Gall eich misfil ddod yn afreolaidd, yn ysgafnach, yn amlach neu'n stopio
- Gall anghofio cymryd y bilsen, chwydu neu ddolur rhydd difrifol ei wneud yn llai effeithiol
- Mae ffwythlondeb arferol yn dychwelyd cyn gynted ag y byddwch yn rhoi gorau i'w ddefnyddio

### Y Bilsen Atal Cenhedu Cyfunol (Y Bilsen)

- 92% yn effeithiol os cymwrch yn unol â chyfarwyddiadau
- Gall anghofio cymryd y bilsen, chwydu neu ddolur rhydd difrifol ei wneud yn llai effeithiol
- Dydyn ni ddim yn argwneidi ei chymryd wrth fywdo ar y fron oherwydd gall effeithio ar gyflenwad llaeth
- Gallwch ddefnyddio o 6 wythnos ar ôl genedigaeath
- Mae eich misfil fel arfer yn rheolaidd, yn ysgafnach ac yn llai poenus na phan nad ydych chi'n cymryd pilsen atal cenhedu
- Mae ffwythlondeb arferol yn dychwelyd cyn gynted ag y byddwch yn rhoi gorau i'w ddefnyddio

### Difffwythloni i Fenywod neu Ddyinion

- 99.8% yn effeithiol
- Yn darparu atal cenhedu parhaol ac mae'n newid am byth
- Dim ond yn addas os ydych chi nad ydych chi eisau mwy o blant
- Gallwch berfformio difffwythloni i fenywod ar yr un pryd â thoriad cesaraidd wedi'i gynllunio — gallwch drafod hyn gyda'ch obstetriedd

### Condomau i Ddyinion neu Fenywod

- Mae condomau i ddyinion yn 98% effeithiol pan gânt eu defnyddio'n gywir
- Mae condomau i fenywod yn 95% effeithiol pan gânt eu defnyddio'n gywir
- Gallwch ddefnyddio o enedigaeath
- Yn amddiffyn yn erbyn STIs
- Ni allwch ddefnyddio condomau menywod a dyinion ar yr un pryd

### Diaphragm neu Gapiu

- Hyd at 96% yn effeithiol pan gaiff ei ddefnyddio'n gywir gyda sbermeiddiad
- Gallwch ddefnyddio o 6 wythnos
- Dylech ddefnyddio bob amser gyda sbermeiddiad
- Bydd angen gweithwr gofal iechyd proffesiynol ei osod cyn y defnydd cyntaf
- Bydd angen ail-osod os oedd gennyh yn cyn beichiogwydd

### Dulliau brys o atal cenhedu

**IUCD (Coil Copr)**

- Y dull mwyaf effeithiol o atal cenhedu brys, yn atal dros 99% o feichiogwydd
- Mae'n gallu cael ei fenyddio o 4 wythnos ar ôl i'ch babi gael ei eni a hyd at 5 diwrnod ar ôl rhyw heb ei ddiogelu.
- Gallwch ddefnyddio wrth fywdo ar y fron

**Y Bilsen Atal Cenhedu Brys (Lefongestrel)**

- Gallwch gymryd hyd at 96 awr (4 diwrnod) o gael rhyw heb ddiogelwch, ond po gyntaf y byddwch chi'n ei gymryd, y mwyaf tebygol yw hi o weithio
- Yn ddiogel i'w gymryd wrth fywdo ar y fron

**Asetadua Wilpristal (ellaOne)**

- Gallwch ddefnyddio hyd at 120 awr (5 diwrnod) ar ôl rhyw heb ddiogelwch
- Gall fod yn fwy effeithiol na Lefongestrel
- Nid oes digon o dystiolaeth ar gael ar hyn o bryd am ellaOne a byddo ar y fron

## Contraception Choices: After You Have Had A Baby

Information from the Faculty of Sexual and Reproductive Health, Fpa.org.uk and Cardiff and Vale UHB.

For more information on contraception services in Cwm Taf Morgannwg, please speak to your healthcare professional or visit...

Integrated Sexual and Reproductive Health Cwm Taf Morgannwg University Health Board (nhs.wales)

## Contraception Choices: After You Have Had A Baby

Contraception may be the last thing on your mind when you have just had a baby, but it is something you need to think about if you want to delay or avoid another pregnancy. Many unplanned pregnancies happen in the first few months after childbirth, so it is better to be prepared.

**How soon can I have sex again?**

You can have sex as soon as you and your partner want to. It may take some time before you want to have sex after having your baby, or it may take no time at all. Everyone is different so do not feel pressurised or worry that you are not normal if you don't feel ready. It can help to talk to your partner about any concerns you might have.

**When should I start using contraception?**

You need to start using contraception from **3 weeks (21 days)** after the birth. Don't wait for your periods to return or until you have your postnatal check before you use contraception as you could get pregnant again before then. You can start some methods before 3 weeks, or even immediately after delivery if this is more convenient.

We can provide some contraceptive methods in hospital after delivery - speak to your midwife or doctor about this. You can get other types of contraception from your GP or one of the Cwm Taf Morgannwg Integrated Sexual Health clinics.

## Dewisiadau Atal Cenhedu Ar ôl i Chi Gael Babi

Am ragor o wybodaeth am wasanaethau atal cenhedu yng Nghwm Taf Morgannwg, siaradwch â'ch gweithiwr gofal iechyd proffesiynol.

Am fwy o wybodaeth, sganwch y cod QR isod

## Dewisiadau atal cenhedlu ar ôl i chi gael babi

Efallai mai atal cenhedlu yw'r peth olaf ar eich meddwl pan fyddwch neswydd gael babi, ond mae'n rhywbeth y mae angen i chi feddwl amdano os ydych chi am oedi neu osgoi beichiogrwydd arall. Mae llawer o feichiogrwydd heb eu cynllunio yn digwydd yn ystod yr ychydig fisodd cyntaf ar ôl genedigaeth, felly mae'n well bod yn barod.

### Pa mor fuan y gallaf gael rhyw eto?

Gallwch gael rhyw cyn gynted ag y byddwch chi a'ch partner eisiau gwneud hynny. Efallai y bydd yn cymryd peth amser cyn i chi eisiau cael rhyw ar ôl cael eich babi, neu efallai na fydd yn cymryd unrhyw amser o gwbl. Mae pawb yn wahanol felly peidiwch â theimlo dan bwysau na phoeni nad ydych chi'n normal os nad ydych chi'n teimlo'n barod. Gall helpu i siarad â'ch partner am unrhyw bryderon a allai fod gennych.

### Pryd ddylwn i ddechrau defnyddio atal cenhedlu?

Mae angen i chi ddechrau defnyddio dulliau atal cenhedlu o **3 wythnos (21 diwrnod)** ar ôl yr enedigaeth os ydych chi'n bwriadu cael rhyw. Peidiwch ag aros i'ch mislif dychwelyd neu hyd nes y byddwch yn cael eich gwirddel ôl-enedigol cyn i chi ddefnyddio atal cenhedlu gan y gallech feichiogi eto cyn hynny. Gallwch ddechrau rhai dulliau yn syth ar ôl genedigaeth. Gallwn ddarparu rhai dulliau atal cenhedlu yn yr ysbtyr ar ôl genedigaeth - siaradwch â'ch bydwraig neu'ch meddyg am hyn. Gallwch gael mathrau eraill o atal cenhedlu gan eich meddyg teulu neu un o'ch clingau Iechyd Rhywiol Integredig Ieol.

### Y Coiliau (IUCD / IUS)

Mae yna 2 fath o coil, mae'r ddau yn ddyfeisiau sy'n cael eu mewnosod yn y groth ac sy'n dros 99% effeithiol. Gallwch fewnosod coiliau yn ystod toriad cesaraid. Gallwch trafod hyn gyda'ch obstetriedd. Hefyd yn addas ar gyfer menywod sydd wedi cael genedigaeth drwy'r wain. Mae'r ddau ohonyn nhw'n ddiogel wrth lwydo ar y fron.

#### Yr IUCD (Coil Copr)

- Nid yw'n cynnwys unrhyw hormonau
- Gall bara hyd at 6 mlynedd, ond gallwch dynnu yn gynharach
- Gall mislffau dddod yn fwy trwm neu'n boeus

#### Yr IUS (coil progestin)

- Yn cynnwys y hormon progestin
- Gall bara hyd at 6 mlynedd, neu gallwch dynnu'n gynharach
- Gall eich mislif fod yn ysgafnach neu'n stopio'n gyfan gwbl

### Y Mewnblianiad (Nexplanon)

- 99.9% yn effeithiol
- Rhodan fach (tua maint matsien) wedi fewnosod o dan groen y fraich uchaf gan ddefnyddio anesthetig lleol
- Gellir ei fewnosod unrhyw adeg ar ôl i'ch babi gael ei eni
- Yn para hyd at 3 blynedd, ond gallwch dynnu ar unrhyw adeg ac mae ffwythlondeb yn dychwelyd yn syth
- Yn ddiogel gyda bwydo ar y fron
- Gall achosi gwaedu anrhagwladwy

### Y Pigiad (Depo-Provera)

- 97% yn effeithiol
- Gallwch ddefnyddio o enedigaeth.
- Yn para 12 wythnos, yna rhaid ei roi eto
- Yn ddiogel o 6 wythnos ar ôl genedigaeth wrth lwydo ar y fron
- Os caiff ei roi yn ystod y 6 wythnos ar ôl genedigaeth, gall achosi gwaedu trwmach
- Mae mislffau y rhan fwyaf o fenywod yn dod yn ysgafnach dros amser neu'n stopio'n llwyr. Mewn rhai achosion, gall achosi gwaedu anrhagwladwy.
- Weithiau gall achosi i chi ennill pwysau
- Mae'r pigiad yn cymryd 12 wythnos i adael y corff, a gall gymryd hyd at ffwyddyn i ffwythlondeb dychwelyd i normal

### Dull Bwydo ar y Fron

Gallwch ddefnyddio bwydo ar y fron fel dull atal cenhedlu a elwir yn Dull Llaetha Amenorhea (LAM). Gall hyn fod hyd at 98% yn effeithiol os ydych chi'n dilyn y wybodaeth isod yn ofalus:

- Os ydych yn bwydo ar y fron yn llawn (h.y. bwydo ar y fron 100% o'r amser heb unrhyw botel neu fwyd ychwanegol) ac ydych yn bwydo ar y fron yn rheolaidd (o leiaf bob 4 awr yn ystod y dydd a phob 6 awr yn y nos)
- Mae eich babi yn llai na 6 mis oed
- Nid oes gennych unrhyw fislffau

Os nad yw unrhyw un o'r uchod yn berthnasol, mae'r risg o feichiogrwydd yn cynyddu a dylech ddefnyddio dull arall o atal cenhedlu os nad ydych chi eisiau dod yn beichiog.

Information Leaflets can be accessed and downloaded by accessing the following link:

[Contraception Choices: After You Have Had A Baby - Cwm Taf Morgannwg University Health Board](#)