Sex and contraception after childbirth

Supporting women's choices in the postnatal period

bpas
British Pregnancy Advisory Service

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Introduction

The World Health Organisation recognises the importance of pleasurable and safe sexual experiences, and the ability to control the number, timing and spacing of one's children.[1] In the UK, there has been much focus on developing sexual health policies and services for younger age groups which has led to a welcome fall in rates of unintended pregnancy. However the needs of other groups at other life stages have sometimes not received the attention they should, including women in the postnatal period. In 2012, the last year for which figures are available, around 800,000 women in the UK gave birth. There has been relatively little research on the sexual health needs of this group of women.

The British Pregnancy Advisory Service is a charity which counsels more than 60,000 women a year with unplanned pregnancy or a pregnancy they feel they cannot carry to term. We regularly see women experiencing an unplanned pregnancy in the year after giving birth. Our experience is mirrored elsewhere: recent research presented at the European Society of Contraception and Reproductive Health found that around 10% of women presenting with unplanned pregnancy at one NHS clinic had given birth in the last 12 months. In this study, unplanned pregnancy within a year of birth was significantly more prevalent than after abortion within the same space of time.[2]

After an initial shock, for many women the news that they are expecting again can be a source of real joy, but for others the discovery can cause considerable distress. Experiencing an unplanned pregnancy can be emotionally and physically challenging at any stage of a woman's life, but it may be particularly difficult while coping with a baby and the upheavals that in itself brings. While the risks of having 2 children close together should never be over-stated, shorter inter-pregnancy intervals are associated with an

increased risk of adverse outcomes for both mother and baby.[3] However it should be acknowledged that some women, particularly as more couples delay childbearing into their late 30s, may seek to become pregnant again relatively quickly before fertility further declines, while others may feel there are economic advantages associated with closer birth spacing. Their choices should absolutely be respected.

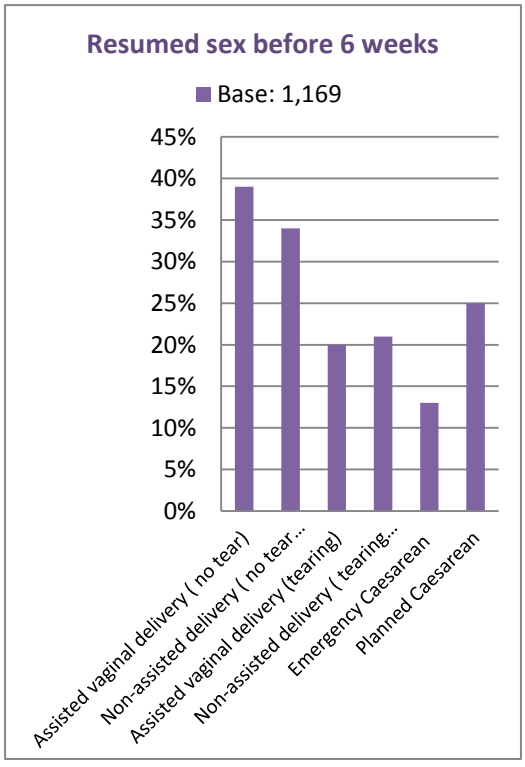
The reasons for unplanned pregnancy within a year of maternity may be diverse. More women are initiating breastfeeding than previously, and may believe that breastfeeding either provides full contraceptive cover or do not know what effective contraception can safely be used while breastfeeding. Live births increased by 22% between 2002 and 2012[4], and midwives say they do not always have the time and resources to provide the information and support about contraception they believe women need.[5] Women may not always know how rapidly fertility can return, but particularly if they have had a straightforward birth, may feel ready to start having sex again with their partner within a short period.

With the welcome support of Bounty, we are now able to ensure most new mothers in the country receive our guide to contraception after a baby, which provides information on the return of fertility, when breastfeeding protects against pregnancy, and which methods can safely be used whether a mum is breastfeeding or not. We have also undertaken research with Bounty's Word of Mum panel, surveying 1,323 women who had given birth at least once within the last 4 years, to better understand women's choices about resuming sex after childbirth, providing the first modern UK data in this area. The research also looked at their knowledge of contraception and ease of obtaining what they needed, when they needed it. This builds on research undertaken in conjunction with the parenting site Mumsnet in late 2012 and our guide has been produced in direct response to their calls for better written information on contraception choices after having a baby. Unless otherwise stated, all survey results in this report are from the Bounty panel and

exclude those who answered "prefer not to say" (the base is stated in each graph). Quotations, unless otherwise stated, are from users of Mumsnet who had given birth in the last 3 years.

Resuming sex

By 4 weeks postpartum, one in 5 women (20%) who have had a vaginal delivery without tearing or an episiotomy have started having sex again. By 6 weeks, a third of women (35%) who had deliveries without perineal trauma have resumed sex, and a quarter of women who have undergone planned caesarean sections (25%).



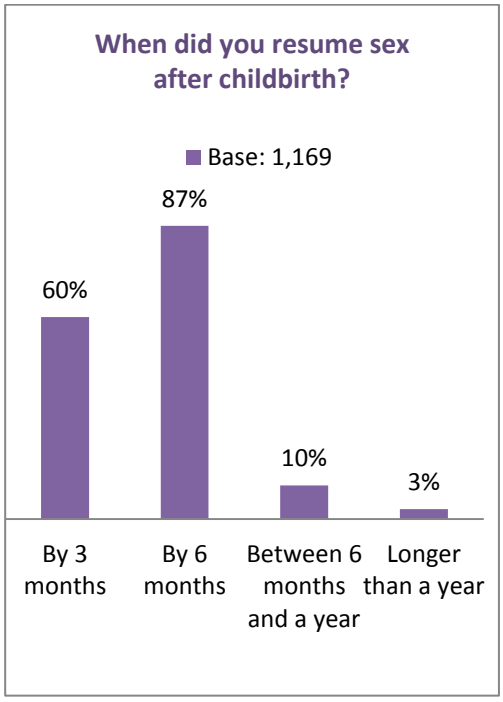
Those who are least likely to have started having sex again before 6 weeks are those who underwent an emergency caesarean (13% resumed before 6 weeks) followed by those who experienced tearing or an episiotomy, with little difference in whether the birth was assisted (forceps or ventouse) or non-assisted. (20% and 21% respectively). Contrary to previous studies, our survey suggests it is perineal trauma rather than whether the birth is assisted or not which leads to a differences in the timing of the resumption of sex.[6] In our survey around 85% of first time mothers delivering vaginally experienced tearing or an episiotomy, compared to 58% of women with subsequent vaginal deliveries.

Overall around a quarter of women (23%) will have started having sex again before 6 weeks, which is before a postnatal check is scheduled where contraception is generally discussed. There is absolutely no reason why women who wish to start having sex again should delay until this appointment, but they should be informed that in non-

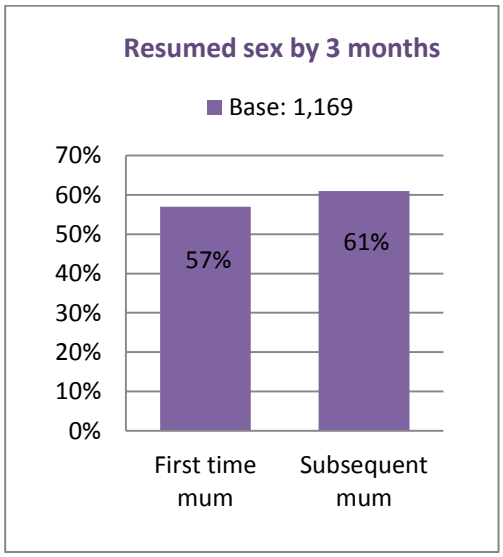
breastfeeding women contraception is needed from 3 weeks after the birth and offered their choice of contraception if they want to avoid pregnancy.

"I think being advised of how quickly you can fall pregnant again after the birth of a baby (I fell pregnant again when my eldest was 2 months old).[7]

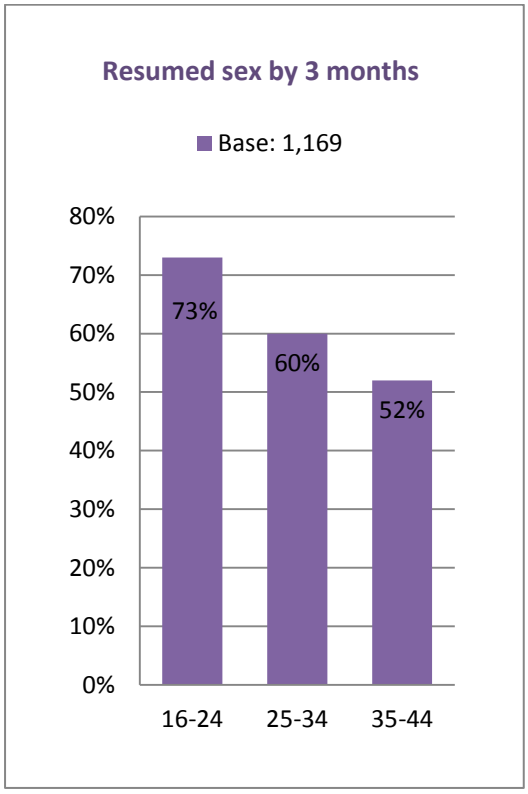
By 3 months, around 60% of women have resumed sex, but this ranges from 50% of women who underwent an emergency caesarean section to 73% of women with a vaginal delivery with no tearing or episiotomy. By 6 months 87% of women had resumed sex, with very little variation by mode of delivery. 10% waited between 6 months and a year, and a further 3% longer than a year.



Our survey shows little difference in resumption of sex between first time and second time mothers, however it does show some difference by age.

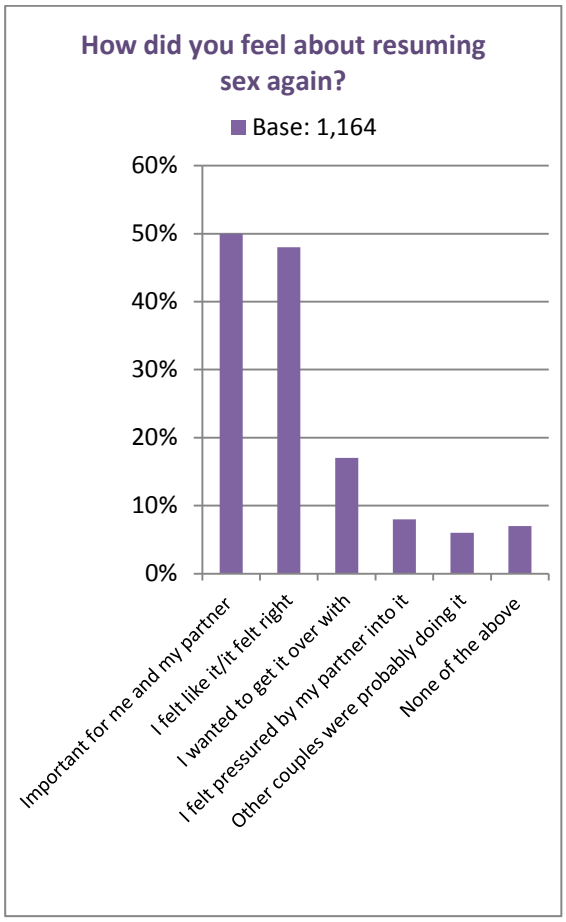


Nearly 3/4 of mothers (73%) under 25 have resumed sex by 3 months, compared to just over half of women aged 35-44.



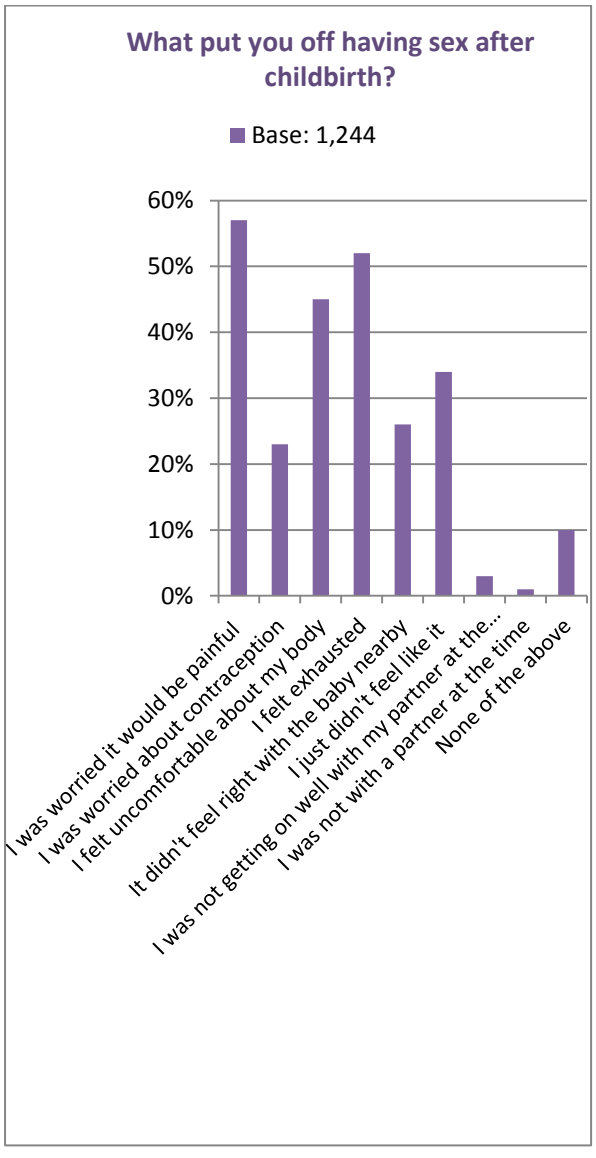
The survey shows therefore a wide timetable for resumption of sex, which means that sexual and reproductive health services need to be flexible to the individual needs of women in the postnatal period – needs which may well in the initial months at least be influenced by their mode of delivery.

When asked to describe how they felt about resuming sex, women were more likely to respond that it was "important for me and my partner" (50%) than "I felt like it/it felt right" (48%). Reassuringly relatively few women replied that they felt "pressured by my partner into it" (8%) or that they had felt they should do it because "other couples were probably doing it".



Pain and exhaustion were the principle barriers to women resuming sex, and worryingly nearly half of women (45%) women said feeling uncomfortable about their own body was a barrier. Research has shown that body image – and weight loss – are some of the most prevalent concerns for women in the postnatal period.[8] A survey conducted by the Royal College of

Midwives (RCM) and the parenting site Netmums in 2010 found 6 in 10 new mothers felt "celebrity culture" put more pressure on them to lose their pregnancy weight quickly. [9]

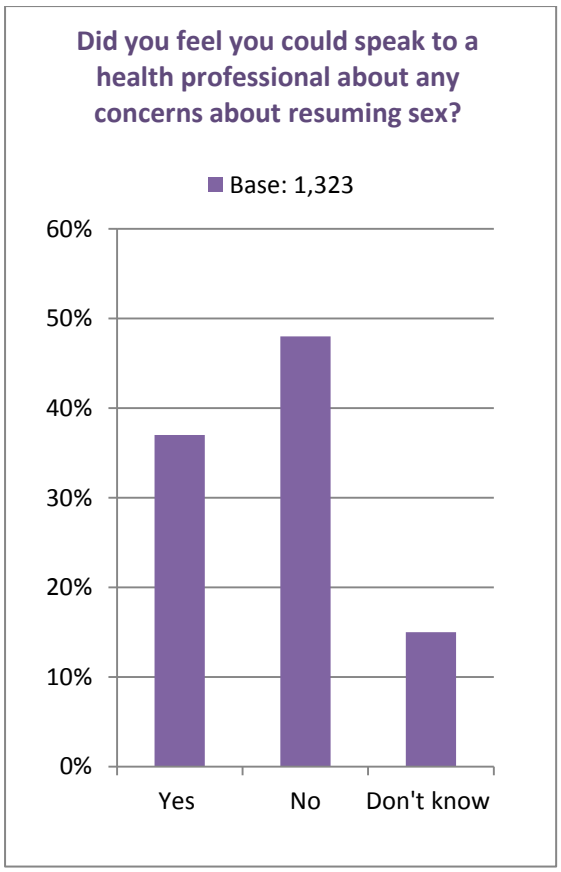


More than one in five also worried about contraception and getting pregnant again when they resumed sex, including a third of mothers under 25.

While guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH) says health professionals should create opportunities for women to raise issues relating to postnatal sexual health and body image,[10]nearly half of women (47%) in our survey did not feel they could speak to a health professional about any concerns they had with regards to resuming sex, if they needed to, compared to 37% who said they could, with the remainder unsure. A study published in 2000, found around 80% of women reported a postnatal sexual problem (eg pain, vaginal tightness, difficulty reaching orgasm), but only 15% of those said they discussed it with a healthcare professional.[11]

"What I would have liked was further discussion about sexual health in general, after I had a second degree tear – no-one asked about it save when I was getting my stitches checked, and it took such a long time to re-establish a sex life with my partner. I would really have appreciated someone talking that over with me, but never felt quite able to ask especially as

check-ups with baby are so focused on baby."[12]



"Sex was a difficult issue for us as a couple after pregnancy and birth and I felt embarrassed to speak to someone face-to-face" (mother who wished more help was available over the phone) [13]

Discussing contraception: providing women with information

"I know most women laugh when this comes up, but it would have been v helpful to have a fuller discussion of the options. DS 2 was conceived when I was breastfeeding and using condoms, no one ever suggested I use an implant."[14]

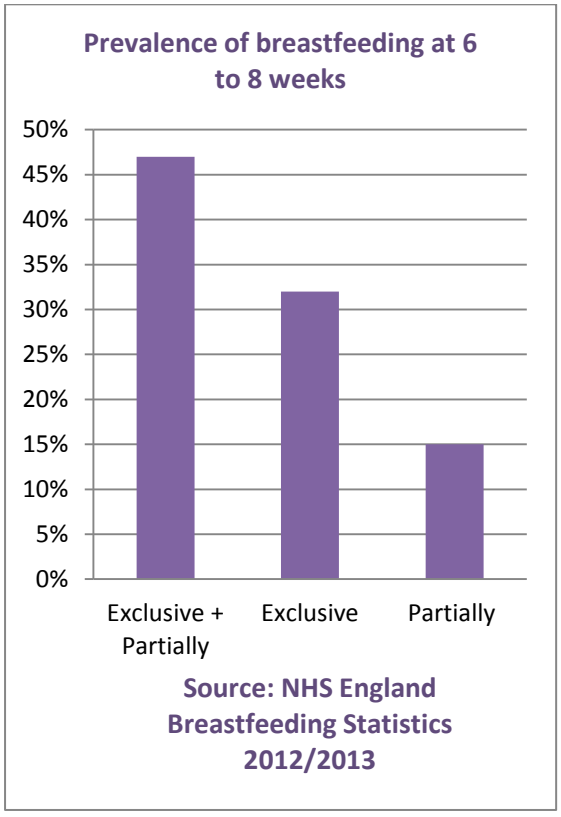
According to the RCM, there were 128,996 more births in 2012 than the service was designed to cope with. [15] Midwives, as is widely reported, are stretched. A recent report by the RCM found that fewer than half of these professionals believed they had the time and resources to provide the information they felt women needed on contraception. [16]

In addition, a qualitative study of midwives' experiences and views of giving postpartum contraceptive advice, published in 2014, found that while all discussed the return of fertility, most found it a job of lesser importance which they felt inadequately trained for.[17] In this study, no midwife made a firm contraceptive plan with women, the only plan being that they should see another healthcare professional to obtain further information and advice.

a) Breastfeeding as contraception

The proportion of women initiating breastfeeding has

increased steadily in recent years as a result of public health policies to promote this as the optimal form of infant feeding, with exclusive breastfeeding recommended for the first 6 months. In 2012/2013, the most recent year for which comprehensive figures are available, around 74% of mothers started breastfeeding their babies. By 6-8 weeks, just under half of babies are receiving some breast-milk.[18]



Exclusive, regular breastfeeding can act as an effective contraceptive as it supresses ovulation. This is known as the Lactational Amenorrhoea Method – or LAM. Fairly strict criteria need to be met for it to work effectively, including the baby not using a dummy, and like all contraception, it is not fail-safe. Research suggests relatively few healthcare professionals suggest it as a form of contraception in the knowledge that even if they intend to, few women exclusively breastfeed for long periods. Just under a third of women are exclusively breastfeeding by 6 weeks[19]but fewer than 1% of women follow official guidance to exclusively breastfeed for 6 months.[20]

"They shouldn't push breastfeeding as a safe contraceptive, it wasn't in my case and I had an unplanned pregnancy at 6 months followed by a miscarriage."[21]

However other women say they resent being told flat out that it will not work, and argue that women should be trusted with the information to assess their own levels of risk.

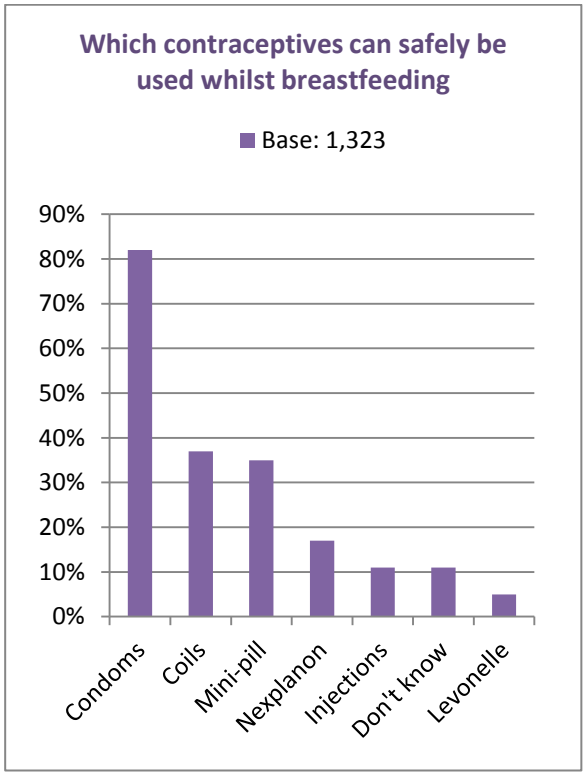
[referring to advice that breastfeeding could not be relied on as contraception] "It felt to me that women were not trusted

to assess whether the level of risk was acceptable to them and the blanket advice was that it could not be relied on."[22]

a) Contraception while breastfeeding

There are however several forms of contraception with can safely be used as a back-up to LAM or when a mother decides to introduce formula milk (mixed feeding), which do not impact upon either her milk supply or the growth of her baby. These include non-hormonal methods such as the copper coil, but also progestogen-only methods including the implant, mini-pill, injections and Mirena coils, as well as Levonelle emergency contraception (but not EllaOne).

Our work with Mumsnet suggested that only a third of mothers who were breastfeeding discussed safe forms of contraception with a healthcare professional.[23] The survey with the Bounty panel meanwhile found the majority of mums think that condoms are the only safe contraceptives which can be used while breastfeeding. Only around a third of those surveyed thought coils and the mini-pill could safely be used. Just 17% thought the contraceptive implant (Nexplanon) was safe while breastfeeding, and only one in 10 thought injections were safe. Worryingly, just 5% of mothers surveyed thought Levonelle emergency contraception could be used while breastfeeding. Infact the progestogen-only morning after pill can be used while breastfeeding without the need to express and discard the milk, and can be an extremely useful back up for women relying on condoms or who have not yet chosen a regular method of contraception.



"I have found the information on what hormonal contraception is suitable while breastfeeding extremely muddled."

"More advice on what to use while breastfeeding, and more info about using breastfeeding as a contraceptive."

"I raised the issue with my GP at my 6 week check. I specifically asked for contraception as I didn't want to rely on breastfeeding alone as it's not failsafe. I was then told that I didn't need it as I was breastfeeding and we just went round in circles. Needless to say other than condoms I have no birth control and am highly p** off."***[24]

b) Information about contraception for women who are not/no longer breastfeeding

All forms of contraception are suitable for a woman who decides breastfeeding is not the right feeding method for her and her baby.

It should be remembered that it may be considerably more than nine months since a woman last used contraception if the pregnancy was planned, as it may have taken some time to conceive.

In addition, it is estimated that only half of pregnancies are formally planned, with the rest either classed as ambivalent or unplanned.[25] Whatever the case, her contraception may have let her down or she may have abandoned it after deciding she was not suited to it, in which case information about the range of options now available could help her find a more suitable method.

"An overview of all contraceptive types might have been helpful as [it was a] a long time since I last chose new contraception."[26]

Life with a new baby disrupts women's normal routine, and a woman who has previously and successfully relied on the pill may find remembering to take her contraception daily no longer feasible now that her life has changed.

"Although I'm 37, I'm actually pretty ignorant about most forms of contraception. The pill no longer suits me, but I don't really know enough about other

forms and haven't the time or energy to find out."

"More options should be offered and discussed. Nobody spoke to me about contraception, I suspect because it was my second baby and they assumed I knew what I was doing. I asked for the mini-pill but I've since found out about other methods that I would have preferred if someone had taken the time to discuss them with me."

"It would have been nice to have been given more options, the approach did seem to be 'you were on the pill before and got on ok with it, so we'll prescribe that again'. I was on the pill for over 10 years, and I do wonder whether there would be anything better suited to me."[27]

Timing of discussion

"I wanted to say to them that there is no risk of sex soon, let alone pregnancy!"[28]

Discussions in the immediate aftermath of giving birth about resuming sex and contraception are understandably viewed as inappropriate by many women and their caregivers. As one midwife noted:

"You are in a four-bedded bay and you don't want to get too personal with people…because here obviously everyone listens through the curtains."[29]

But many women are happy not just with the information they received but the time it was delivered, and speak in glowing terms about their caregivers.

"My midwife was excellent, she raised the question early and in an informed way."

"I had amazing contraceptive advice. They were very thorough and discussed in detail."[30]

It is also clear that some women find the discussion, both content and timing, inappropriate and intrusive, whenever it is delivered.

"Every single health professional I talked to in the hours, days and weeks after my children were born mentioned contraception. This was true for all my three children. I probably had contraception mentioned to me more than I had sex in the six months following the birth of my kids."

"Don't go on and on about contraception to a woman who

had trouble conceiving and who lost one baby by miscarriage." [31]

Yet equally for another woman who had experienced problems conceiving, the opposite was true:

"As someone who has 2 children 51 weeks apart it would have been helpful if someone could have pointed out that a first pregnancy achieved via clomiphene does not mean that infertility would continue."[32]

Clearly, setting the right tone with the level of information and getting the timing right, is challenging for those providing women's care, something which mothers themselves recognise.

"It's a hard balance between too early and not soon enough!"[33]

Many women suggested that it would be more useful to have a discussion before the baby was born, and indeed this is in keeping with guidance from the Faculty of Sexual and Reproductive Healthcare,[34] although our research with Mumsnet found less than a third of mothers were offered this.

"***I would have preferred to have discussed it towards the end of pregnancy, I had to ring my GP when my daughter was 4 weeks, when I stopped breastfeeding and wanted to begin taking contraception as had no idea what to do about starting – I'd not discussed it with anyone up until this point."***

"***Perhaps if more information given DURING pregnancy, not immediately after birth."***

"It should be discussed before the birth so that something is in place more quickly."[35]

This would have the advantage of giving women more time to think about their options so they know what they want when the time comes.

"***Having time, I felt very rushed. It was assumed I'd go on the mini-pill."***[36]

Many women also commented on how "baby-focused"[37] postnatal care could be, and how they would have appreciated an appointment, preferably with a midwife, entirely devoted to their needs and concerns – including contraception.

"Very quickly post birth everything becomes about the

baby, weight gain, jabs etc and a bit more time after the newborn euphoria fades could be dedicated to mums."[38]

And many mothers commented on wanting written information that they could take away and read at a time that suited them about contraception choices, and in particular what methods can be used while breastfeeding.

Obtaining chosen contraception

Even if a woman has the information she needs to choose her contraceptive, fewer than a quarter of women said they found it easy to obtain it. This was highest for younger women (32%) and lowest for older women (17%).

More than one in ten women would have preferred to have left hospital with contraception

"***Would help if hospitals could provide an initial supply of contraception on leaving rather than women having to make GP or family planning clinic appointment in the early weeks of having a baby."***[39]

Some hospitals do provide this, and research suggests that there would be midwives who would be interested in being trained to directly provide contraceptives including long acting reversible forms.[40]

In addition many women commented that they wished they could have organised what they needed through their midwife or health visitor without needing to make an appointment with their GP.

"It would be handy if you could arrange the fitting of a coil through the midwife/health visitor rather than having to go to the GP."

"I feel that contraception could be more easily available after having a baby. Making an appointment at my GP isn't easy and the local family planning clinic is full of teenagers getting free condoms."

"Personally I would like to go on the pill or coil now but I have to go to a clinic between 5 and 7 once a week to do this. With a toddler and a newborn baby, this is not really possible right now!"[41]

Conclusions and policy implications

The postnatal period is a busy and sometimes difficult time. As previously noted, midwives are stretched and say they do not always have the time to provide the information and support they feel women need across a number of issues - maternal emotional wellbeing, normal infant behaviour, and how to prepare bottle feeds, as well as contraception.[42]

Also for women, particularly those who are struggling to breastfeed and/or who have had a traumatic birth, contraception is unlikely to be high on their list of priorities.

"Wasn't the main thing on my mind. (problems breastfeeding, wound healing, pnd/ptsd* [postnatal depression, post traumatic stress disorder], *would have been annoyed if it was made a big issue of."

"Annoying that it was one thing consistently mentioned when I felt I had so many other pressing concerns with a newborn - eg lack of help with breastfeeding."[43]

However while healthcare professionals need to respond to the individual needs of each mother, postnatal sexual health and contraception is an important component of care that feeds into broader issues of maternal wellbeing. For many women, the midwife is the one best placed to provide advice in a way that takes into account how she may be feeling post-birth.

"I think the midwives often have a better manner and approach to such discussions and have a better understanding of how you might be feeling about having sex and considering contraception so soon after your body has given birth."[44]

Resuming sex

Our data shows there is a wide timetable among women when it comes to resuming sex, and that mode of delivery may well affect timing. Women may well appreciate knowing that there is no set time to resume sex, and that it will vary widely from couple to couple.

"I felt it would have been nice for them to say you might be

gagging for it or don't worry if you don't get there yet."[45]

It is troubling that for many women body image was a barrier to doing so. Those involved in women's postnatal care could consider how reassurance could be provided about post-pregnancy body shape, and provide opportunities for women to discuss their concerns about issues relating to body image, and sexual health and wellbeing.

Information about contraceptives

Women should be informed that if they are not breastfeeding contraceptive protection is required from day 21 after the birth if pregnancy is to be avoided and provided with information about all contraceptive options available, including when breastfeeding provides contraceptive cover and the criteria that should be met for it to work effectively, as well as what contraception can be used while breastfeeding.

It should be recalled that it may be more than a year since a woman last used contraception, that the method she was using may have let her down, and that a method which may have suited her then may not suit her with a new baby. This means it is important that she has access to comprehensive information about all the methods available – including rings and patches, which could be a good option for women in between babies who do not want a daily pill but are reluctant for take on a long acting form.

Timing of advice about contraceptives

Discussion and provision of information in the antenatal period when women have more time to think about their options may be useful.

Greater understanding of how mode of delivery influences resumption of sex may enable healthcare professionals to time the provision of contraception information and support more effectively, while recognising that every woman will have her own personal needs.

The last midwife home visit at 10 days, when the health visitor takes over care, may be a particularly opportune moment, but it also appears many women would value

the offer of a discussion during various interactions with healthcare professionals in the first year.

Access to contraceptives

If women have made their mind up about their contraception in the antenatal period, it would be ideal if these could be provided before she leaves hospital.

Midwives who wish to take on a role in the provision of contraception, and in particular long acting reversible forms, would require on going training and support. This would necessitate closer links between maternity services and sexual and reproductive health services, which at the very least might also make it easier for midwives to refer women directly for contraception appointments, which many women would appreciate.

Attention could also be paid to providing more specific contraception clinic sessions for mothers.

Emergency Hormonal Contraception (EHC) is a safe and effective back-up for women when their regular contraception fails or has not been to hand. The Levonelle morning-after-pill can, as noted, be safely used by breastfeeding women up to 72 hours after an episode of unprotected sex. While young women can often obtain it free of charge from their local pharmacy, older women either have to pay in the region of £30 or visit their GP, local sexual health service or A&E, with all the inconvenience that entails. Consideration should be given to the advance provision of EHC to new mothers in order that women have it at home if and when they should need it.

July 2014

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