New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

National Contraception Draft Guidelines

Feedback from: New Zealand College of Midwives
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The New Zealand College of Midwives is the professional organisation for midwifery. Members are employed and self-employed and collectively represent more than 90% of the practising midwives in this country. The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and well-being.

Aotearoa New Zealand's guidance on contraception

Thank you for providing the opportunity to give feedback on the draft guidance on contraception for Aotearoa New Zealand. The College of Midwives supports the aims of the guidance and agree that increasing effective contraception options and supporting informed choice is important for all New Zealand women.

The College has consulted with members to ensure a comprehensive response. We have focused on the 'Contraception after Pregnancy' section of the guidance because this is more pertinent to the midwifery role.

Overall feedback

This is a comprehensive and helpful guideline which should support clarity and consistency of practice for all health practitioners. On the whole we are supportive of the draft guidelines but would like to make the following specific points related to the contraception after pregnancy guidance.

Gender neutral language

The document refers to 'people' throughout yet the contraception options discussed are pertinent mostly for women. The College is concerned that the use of gender neutral language is eliminating the term 'woman' from the vocabulary. We respect the human rights of all people and are committed to gender affirming conceptualisations and descriptions. However, we are also aware that the rights of pregnant and birthing women continue to be threatened and that there has been historical and traditional bias against women's rights in favour of men. Now it would appear that these rights are being superseded by the imperative to support gender neutrality. The College supports an additive approach in which gender diverse terms are added to the sentence but the words woman/wāhine is retained. We believe that because this guidance is identifying contraception options for women specifically relating to the postpartum period, the term 'woman/women' not 'people/individuals' should be used throughout this section.

Abbreviations

The College recommends that words are written in full throughout the guideline and that abbreviations such as LNG, Cu-IUC, POI, IMP, POP, CHC and others are not used alone, without being written in full. The use of these abbreviations reduces the accessibility of the guideline.

Consultation questions and College responses

Consultation questions:

1. Do you agree that this guideline should form the basis of NZ guidance on contraception after pregnancy?

   Response: The College supports the use of the use of this guidance as the basis of contraception advice after pregnancy in New Zealand.

2. Do you agree that the Faculty of Sexual & Reproductive Healthcare (FRSH) of the RCOG UK Medical Eligibility Criterial for Contraceptive Use (UK MEC) form the basis of the NZ guidance on who can use contraception after pregnancy?

   Response: The College considers it important that any guideline for NZ practitioners is context specific. Using the FRSH guidance as a basis would appear to be acceptable as long as the adaption supports the NZ context of care.

Do you agree with the following recommendations?

3. Contraception counselling is **part of routine antenatal care**. The relationship between the lead maternity carer and the individual will determine the appropriate opportunities for these discussions, prior to the birth (Draft practice point for New Zealand).

   Response: The College would prefer the following wording:

   It is beneficial to discuss contraception during pregnancy with women and other pregnant individuals. The relationship between the lead maternity carer and the woman/individual will determine the appropriate opportunities for these discussions, prior to the birth (Draft practice point for New Zealand).

Rationale: The FSRH summary of recommendations state: A*ll clinicians involved in the care of pregnant women should provide the* ***opportunity to discuss*** *contraception*. And that: *Women should be informed during pregnancy about the effectiveness of different contraceptives…* this appears to have been translated for the NZ context to *contraception counselling* ***should be a routine part*** *of antenatal care with a plan in place prior to birth.* It is unclear why this recommendation has been altered to become a directive.

4. Every person should have a contraception plan in place prior to giving birth (including the option to not use contraception). Revision of this plan may be required after the birth depending on clinical outcomes and ongoing choice (Draft practice point for NZ).

   Response: The College would prefer the following wording: *Every pregnant woman/person should be given* ***an opportunity to discuss contraception*** *and make a plan prior to giving birth* (*including the option to not use contraception). Revision of this plan may be required after the birth depending on clinical outcomes and ongoing choice (Draft practice point for NZ).*

   Rationale: Some women are ready to engage in meaningful discussion about contraception during pregnancy but others are not. It is important that the midwife provides an opportunity to discuss contraception so that the woman determines if she is ready to have that discussion.

5. **Individuals** should be advised that long acting reversible contraception (LARC) (e.g Jadelle and Mirena) can be safely inserted immediately after birth (Draft practice point for NZ).

   Response: The College would prefer a change to: ***Women/individuals*** *should be advised that long acting reversible contraception (LARC) (e.g Jadelle and Mirena) can be inserted immediately after birth. Women who may have a compromised milk supply should be informed that the impact on milk production of hormonal LARC insertion prior to lactogenesis II is currently unknown.*

   Rationale: The FSRH guidelines for contraception after pregnancy identify the need to provide comprehensive, unbiased and accurate information. The College has concerns about the risk to lactogenesis II (which is the onset of

copious milk production usually between 48 hrs and 72 hours following birth) with early insertion and are particularly concerned for women who may be at risk of delayed lactogenesis ll – for instance if their baby is in the Neonatal unit or they have diabetes. The evidence to date does not clearly identify differences for women in potential delay risk groups. We believe that women should be informed of the gaps in the evidence to support decision making and so that they can seek appropriate support for breastfeeding following the birth if they choose to have LARC.

6. IUC can be safely inserted immediately after birth (within 10 minutes of delivery of the placenta) or within the first 48 hours after uncomplicated caesarean section or vaginal birth. After 48 hours, insertion should be delayed until 28 days after birth. (Draft practice point for NZ, based on FSRH guidance evidence grade B).2"

   Response: The College would prefer a change to: *Women/individuals should be advised that IUC can be inserted immediately after birth (within 10 minutes of delivery of the placenta) or within the first 48 hours after uncomplicated caesarean section or vaginal birth. IUC expulsion rates are 10% at this time. After 48 hours, insertion should be delayed until 28 days after birth due to the high expulsion rate (28.7%). When inserted after 28 days the expulsion rate is 1.9%. Women should also be informed that the risk of uterine perforation is not increased when performed during the postpartum period (World Health Organization 2015, p. 190). For insertion up to 36 weeks post-birth the rate of uterine perforation is approximately 1 per 1,000 insertions for non-breastfeeding women and 6 per 1,000 for breastfeeding women. This risk reduces to 1.6 per 1,000 insertions for breastfeeding women after 36 weeks post-birth (Heinemann et al 2015, p. 277)..*

   Rationale: The FSRH guidelines for contraception after pregnancy identify the need to provide comprehensive, unbiased and accurate information. We consider it important that women are aware of the risks of expulsion and uterine perforation, when IUC is inserted following birth.

7. Individuals should be made aware of the safety of immediate postpartum IUC insertions; individual choice should drive service provision (Draft practice point for NZ).

   Response: The College would prefer a change to Change to: *Wome**n/individuals** should be fully informed of the benefits and risks of immediate postpartum IUC insertions; individual choice should drive service provision.*

   Rationale: The FSRH guidelines for contraception after pregnancy identify the need to provide comprehensive, unbiased and accurate information. We believe that making this change will support improved information sharing for women.

8. Individuals having immediate postpartum IUC insertion should be informed of the signs and symptoms of expulsion (Draft practice point for NZ).

   Response: The College would prefer a change from *individuals* to *women/individuals.*

9. Individuals who have an IUC inserted immediately after birth should have a string check/shortening at 6 weeks postpartum (Draft practice point for NZ)."

   Response: The College would prefer a change from *individuals* to *women/individuals.*

10. Progestogen-only implants can be safely started at any time after birth including immediately after delivery (Evidence Grade C).2"

    Response: The College would prefer a change to: Progestogen-only implants can be started at any time after birth (including immediately following the birth). *Women/individuals who may have a compromised milk supply should be informed that the impact on their milk production when commenced immediately following birth is unknown.*

11. Individuals who are breastfeeding should be informed that the available evidence indicates that progestogen-only methods of contraception (LNG-IUS, progestogen-only implants, the progestogen-only injectable and POP) have no adverse effects on lactation, infant growth or development (Evidence Grade A)."

Response: The College would like to suggest also adding: *Women/individuals who may have a compromised milk supply should be informed that the impact on their milk production when commenced immediately following birth is unknown.*

We note that the other tables include advice related to female sterilisation, barrier methods and fertility awareness methods. We consider these should also be included in the recommendations above.

We fully support the need for hospital services to be available and appropriately staffed to support women in their contraceptive choice. However, we are also concerned that these services are sometimes opportunistic which can result in women feeling under pressure. We note that the FRSH recommends that: *care should be taken to ensure women do not feel under pressure to choose a method of contraception*. We consider that it is important that all clinicians ensure a woman-centred approach when discussing contraception and ensure that women are fully informed and have sufficient time to consider their options following birth (without pressure). In addition this guideline provides an opportunity to improve equity by suggesting/recommending that contraception services for both men and women be more widely available within the community with the potential to have services set up within (or travelling to) differing communities to support more widespread availability and reduce the need for opportunistic contraceptive services within the hospitals.

We would like to thank the National Contraception Guidelines Steering Group for the work they have undertaken on this guideline. We hope that our feedback is helpful and look forward to future communication.

Appendix 1:

Tables of recommendations and evidence levels below – changes suggested in red/purple (track change)

11.6.1 Table contraception counselling during pregnancy –suggested changes to recommendations

DRAFT RECOMMENDATIONS + GOOD PRACTICE POINTS	**EVIDENCE LEVEL**
Women/individuals should have access to the contraceptive option of their choice at the time of their choosing, or when clinically appropriate.	Draft NZ practice point
Timing	
Opportunities for c~~C~~ontraceptive counselling should be made available to ~~individuals~~ women/individuals during pregnancy~~in the antenatal period~~ to enable them to choose the method they wish to use after birth.	Good practice
I~~ndividuals~~Women/individuals should be informed ~~during pregnancy~~ about the effectiveness of different contraceptives, including the superior effectiveness of LARC, when choosing an appropriate method to use after birth.	Good practice
Information giving and counselling *NB additional proposals regarding the antenatal contraception counselling are noted above*	
All health practitioners involved in the care of pregnant ~~individual~~ women/people ~~should~~ are able to provide the opportunity to discuss contraception.	Good practice
Maternity services (including services providing antenatal, intrapartum, and postpartum care) should give ~~individuals~~ women/individuals opportunities to discuss their fertility	Good practice

intentions, contraception, and preconception planning.	
Health practitioners should refer to the relevant current FSRH guidelines, including the UKMEC, when making a clinical judgement on safe and appropriate methods of contraception for a woma/individual n~~n individual~~ after pregnancy.	Good practice
I~~ndividuals~~Women/individuals should be advised that although contraception is not required in the first 21 days after birth, most methods can be safely initiated within this time ~~immediately~~, with the exception of Combined Hormonal Contraception. Where possible, it is recommended that contraception initiation should be deferred until after 48-72 hours postpartum to allow for lactogenesis II.	C
Health practitioners should discuss with the ~~individual~~ woman/individual any personal characteristics or existing medical conditions, including those that have developed during pregnancy, which may affect medical ~~eligibility~~ appropriateness for any given contraceptive ~~use~~method.	D
If tubal occlusion is performed at the same time as a caesarean section, counselling and agreement should be given at least 2 weeks in advance of the procedure.	C

11.6.2 Contraception after birth – suggested changes

DRAFT RECOMMENDATIONS + GOOD PRACTICE POINTS	**EVIDENCE LEVEL**
When should contraception be provided after birth *NB additional proposals regarding the immediate insertion of LARC is provided above*	

~~E~~ffective contraception after birth should be initiated by both breastfeeding and non-breastfeeding ~~individuals~~women/individuals within 21 days of birth to prevent unwanted pregnancy ~~as soon as possible, as sexual activity and ovulation may resume very soon afterwards.~~	D
DHB Maternity service providers should ensure that all ~~individuals~~ women/individuals after pregnancy have access to the full range of contraceptives, including the most effective LARC methods, following ~~to start immediately after~~ birth. This should not be limited to those~~-~~ ~~individuals~~women/individuals with conditions that may pose a significant health risk during pregnancy and vulnerable groups (including young people) at risk of a short interpregnancy interval or an unintended pregnancy.	Good practice
Services providing care to pregnant women/individuals should be able to offer all appropriate methods of contraception or a referral for an appropriate future date to receive the woman's/individual's chosen method of contraception, including LARC, to women before they are discharged from the service.	Good practice
DHB Maternity services should be able to provide IUC and progestogen-only methods, including IMP, injectable (POI) or POP, before women/people ~~people~~ are discharged from the service after birth if the woman/person identifies she/they requires this services.	Good practice
A woman's//individual's ~~n individual's~~ chosen method of contraception can be initiated immediately after birth if desired and ~~they are~~it is medically ~~eligible~~appropriate.	D
Health practitioners should discuss with the ~~individual~~ woman/individual any personal characteristics or existing medical conditions, including those that have developed during pregnancy, which may affect medical ~~eligibility~~ appropriateness for any given contraceptive ~~use~~method.	D

The choice of contraceptive method should be initiated by 21 days after birth.	D
Women/individuals should be advised that IUC and progestogen-only implants can be inserted immediately after birth but ~~delivery~~ there is limited evidence on the impact of breastfeeding for women (with a compromised milk supply) with progesterone implants and higher expulsion rates for IUCs.	C
Health practitioners should be aware that insertion of IUC at the time of either vaginal or caesarean delivery is convenient and highly acceptable to many ~~W~~women/individuals. This has been associated with high continuation rates and a reduced risk of unintended pregnancy. There is a higher risk of expulsion at this time and increased risk of uterine perforation for women who are breastfeeding	B
Health practitioners should be aware that insertion of a progestogen-only implant soon after birth is convenient and highly acceptable to many women/people. This has been associated with high continuation rates and a reduced risk of unintended pregnancy.	B
Inpatient ~~M~~maternity services should ensure that there are sufficient numbers of staff able to provide IUC or a progestogen-only implant so that women who choose these methods and ~~are~~ for whom they are medically ~~eligible~~ appropriate can initiate them immediately after birth.	Good practice
DRAFT RECOMMENDATIONS + GOOD PRACTICE POINTS	**EVIDENCE LEVEL**
Women/individuals who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated if there is expected to be a delay beyond	Good practice

21 days postpartum.	
Any contraceptive counselling (general or specialist) needs to be given in conjunction with easy access to contraception in the immediate postpartum period.	Good practice
DHB Maternity services should have agreed pathways of care to local specialist contraceptive services for women with complex medical conditions or needs which may require specialist contraceptive advice.	Good practice
DHB Maternity services should have agreed pathways of care to local services for women who may require additional non-medical care and support.	Good practice
Record keeping and obtaining valid consent	
Health practitioners should clearly document the discussion and provision of contraception after birth. Informed consent must be obtained before providing women with their chosen method.	D
How long should an individual wait before trying to conceive again?	
Women/individuals should be advised that an interpregnancy interval of less than 12 months between birth and conceiving again is associated with an increased risk of preterm birth, low birthweight, and SGA babies.	B
Is emergency contraception safe to use after birth?	
Emergency contraception is indicated for women who have had ~~UPSI~~ unprotected sexual intercourse from 21 days after birth but is not required before this.	Good practice
Oral ~~LNG~~ levonorgestrel is safe to use from 21 days after birth. The Copper IUCD (Cu-IUCD) is safe to use for emergency contraception from 28 days after birth.	Good practice
Women/individuals who breastfeed should be informed that available limited evidence indicates that oral levonorgestrel ~~LNG~~	C

has no adverse effects on breastfeeding or on their infants.	
Is additional contraception required after initiation of a method after birth?	
Women/individuals should be advised that additional contraceptive precautions (eg, barrier method/abstinence) are required if hormonal contraception is started 21 days or more after birth. Additional contraceptive precaution is not required if contraception is initiated immediately or within 21 days after birth.	Good practice
Does initiation of hormonal contraceptives affect breastfeeding outcomes or infant outcomes? *NB see above for further discussion*	
Women/individuals who are breastfeeding should be informed that the available evidence indicates that progestogen-only methods of contraception levonorgestrel intrauterine system (LNG-IUS), implant (IMP), POI and progesterone only pill (POP) have no adverse effects on lactation, infant growth, or development.	A
Women/individuals who are breastfeeding should wait until 6 weeks after birth before initiating a combined hormonal contraceptive (CHC) method.	B
Female sterilisation is a safe option for permanent contraception but there is a potential for increased regret. Women/individuals should be advised that some LARC methods are as, or more, effective than female sterilisation and may confer non-contraceptive benefits. However, ~~individuals~~people should not feel pressured into choosing LARC over female sterilisation. Condoms (male and female) can be used by women following birth Women/individuals should be advised that, if they are less than 6	

months postpartum, amenorrhoeic and fully breastfeeding, the lactational amenorrhoea method (LAM) is a highly effective method of contraception.	
Contraception discussions should include the option of male vasectomy	

References:

Ministry of Health. (2019). *Report on Maternity 2017*. Retrieved from Wellington: https://www.health.govt.nz/publication/report-maternity-2017

Morton, S., Atato Carr, P., Bandara, D., Grant, C., Ivory, V., Schmidt, J., & Waldie, K. (2010). *Growing up in New Zealand: a longitudinal study of New Zealand children and their families.* Retrieved from Auckland: