Contraception and the Postpartum Woman

Summary:
• The most up-to-date evidence and expert driven guidelines for postpartum contraception are provided by the CDC MEC. These guidelines can easily be accessed through the CDC MEC app which is available for android and apple devices, or online at https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf

• Contraception plans should be discussed during the prenatal and postpartum course, and plans should be documented in both the prenatal problem list and in the postpartum progress notes.

• Patients should have the opportunity to begin any non-hormonal or progestin-only method prior to leaving the hospital. It is appropriate to begin combination estrogen/progestin methods after 30 days postpartum if desired, or between 21 to 30 days, as the risk for thromboembolism decreases, with appropriate risk-benefit counseling. See CDC MEC for more details.

• Patients should be provided with consistent messages in regard to contraception options by all members of her care team. Differences of opinion between team members should be discussed with the ordering physician and recommendations should not be made to the patient without such a discussion.

Specific recommendations:
Medically appropriate options based on: CDC U.S. Medical Eligibility Criteria for Contraceptive Use in Breastfeeding Women, 2016. Please review guidelines as they provide much more information than can be covered here.

<21 days postpartum options:
Implant, Depo Provera, and Progestin Only Pill are category 2, a condition for which the advantages of using the method generally outweigh the theoretical or proven risks

Combined Hormonal Contraception is category 4, a condition that represents an unacceptable health risk, due to risk of venous thromboembolism
21-30 days postpartum options:
  Implant, Depo Provera, and Progestin Only Pill are category 2, a condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
  Combined Hormonal Contraception is category 3, a condition for which the theoretical or proven risks usually outweigh the advantages of using the method.

>30 days postpartum:
  Implant, Depo Provera, and Progestin Only Pill are category 1, a condition for which there is no restriction for the use of the contraceptive method.
  Combined Hormonal Contraception is category 2, a condition for which the advantages of using the method generally outweigh the theoretical or proven risks.

Immediate post placental IUD:
  Copper (Paragard) is category 1, a condition for which there is no restriction for the use of the contraceptive method.
  Levonorgestrel (Mirena) is category 2, a condition for which the advantages of using the method generally outweigh the theoretical or proven risks.

Other options include at anytime postpartum (see CDC MEC):
  Lactation amenorrhea (LAM)
  Condoms
  Diaphragm

Rationale:
It is advantageous to mothers and their babies (present and future) to prevent unintended pregnancy and for women to have opportunity to plan intervals between pregnancy with an evidence based understanding of risks and benefits of options.

Unintended pregnancy may lead to an increased risk of abortion, and in the case of carrying pregnancy to term – may lead to INCREASE in risk of relationship instability, preterm delivery, low birth weight, later entry to prenatal care, lower cognitive scores compared to children from planned pregnancies, and postpartum depression; and a DECREASE in neural tube defect prevention, and chance of subsequent child being breastfed.² 45 % of pregnancies overall are unintended.¹²

Postpartum women are at risk of unintended pregnancy. High numbers of postpartum women do have intercourse prior to their postpartum visit,³ and as many as 40% of women do not attend a postpartum visit.⁴ Ovulation can occur as early as 25 days postpartum.¹² Women who consider themselves to be exclusively breastfeeding may not be aware that sleep training, pumping, supplementation of any kind, vaginal bleeding, or time from delivery >6 months can increase pregnancy risk. Therefore education regarding “exclusive breastfeeding” should be provided, and women should
be provided with the opportunity to make an autonomous and informed decision regarding contraception options prior to or soon after delivery.

**Short inter-pregnancy interval** may lead to decreased milk production, poor nutritional status and consequences for the new pregnancy such as preterm birth, small for gestational age and low birth weight and more than 30% of women experience short inter-pregnancy intervals in the US. Spacing of pregnancies by 18 months to 5 years may be beneficial for outcomes. Evidence regarding the effect of contraception on breast milk supply is inconsistent, with most studies being of poor to medium quality. Studies indicate possibly improved, no difference, or possibly decreased lactation with various methods. Providers have at times counseled patients based on opinion and anecdotal rather than scientific evidence regarding contraception and breastfeeding and efforts should be made to avoid that.

National recommendations state that “Obstetric care providers should discuss these limitations and concerns within the context of each woman’s desire to breastfeed prior and her risk of unplanned pregnancy, so that she can make an autonomous and informed decision.”

Therefore it is important to resolve that at MMC we access and present evidence and consensus-based guidelines for contraception care to the postpartum woman so that she may make the individual, personal decision that best meets her needs and encompasses her goals and values.

Family planning, infant feeding and postpartum recovery should be discussed during prenatal care, and the woman’s contraception plan should be documented in both the prenatal problem list and in the postpartum progress notes. The patient should have the opportunity to begin any non-hormonal or progestin only method prior to leaving the hospital or to start an estrogen containing method after 21-30 days postpartum if she is not at increased risk of venous thromboembolism.

If there are concerns about an individual woman’s breast milk supply and her contraception plan, providers of nursing or lactation care are encouraged to discuss these concerns with the ordering provider. If the contraception plan is not altered after this discussion, the patient should receive education on ways to increase milk supply (such as pumping regimen, natural remedies, hydration, etc.) and be offered an outpatient lactation appointment for close follow up.

**Resources:**
Link to CDC MEC website: https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf

Download the 2016 US MEC and US SPR app, an easy to use reference that combines information from the both CDC family planning guidance. It features a streamlined interface so any provider can access the guidance quickly and easily. It is available for iOS and Android operating systems.
Attached are two patient handouts:
1. What You Need to Know About Birth Control Options while Breastfeeding
2. What You Need to Know About Depo-Provera and Breastfeeding

References:
3. The postpartum visit: it's time for a change in order to optimally initiate contraception. Contraception. Leon Speroff a, Daniel R. Mishell Jr. b, Received 22 February 2008; accepted 27 February 2008
4. ACOG Committee Opinion # 666, Optimizing Postpartum Care
9. Postpartum Contraception: A exploratory Study of lactation consultants' knowledge and practices Contraception. 2016 July; 94 (1) 87-92
10. ACOG Committee Opinion #658, Optimizing Support for Breastfeeding as Part of Obstetric Practice
11. ACOG Committee Opinion #570,Breastfeeding in Underserved Women: Increasing Initiation and Continuation of Breastfeeding
12. ACOG Committee Opinion #670, Immediate Postpartum Long-Acting Reversible Contraception
Family Birth Center
at Maine Medical Center

What You Need to Know About Birth Control Options while Breastfeeding

It is important to think about how you will prevent pregnancy after having a baby. This handout will tell you more about the birth control options that are safe for you to use while you are breastfeeding. It is suggested that you do not use birth control that has estrogen in it during the first 6 weeks after your baby is born. This is because estrogen might reduce your breast milk supply.

These birth control options are at least 99% effective at preventing pregnancy when used correctly. This means that 1 out of 100 women who use one of these birth control options may still become pregnant:

Intrauterine contraception or IUD
- An IUD is a device that is placed inside your uterus. This can happen either in the delivery room right after you have your baby, or at your 6 week follow-up visit.
- There are two main types of IUD:
  → Paragard® is an IUD made out of copper. Once in place, it works for up to 10 years.
  → Mirena® is an IUD containing a drug called progestin. Once in place, it works for up to 5 years.
- You will need to have the IUD replaced, depending on how long it works
- It is very rare for an IUD to fall out of the uterus. It is more likely to fall out if placed in the delivery room. It is less likely to fall out if placed at least 6 weeks after you have your baby.

Birth control implant
- Nexplanon® is a birth control implant that contains progestin and does not contain estrogen.
- It is placed under the skin in the arm
- It may cause periods to be very irregular. This means it may be hard to know what days you will bleed.

Tubal ligation
- Tubal ligation is a surgery that may also be called “having your tubes tied”.
- It is permanent. This means you will not be able to get pregnant again.

These birth control options are 91–99% effective at preventing pregnancy when used correctly. This means that up to 9 out of 100 women who use one of them may still become pregnant:

Progestin-only oral contraceptives
- There are oral contraceptives (birth control pills) that contain only progestin and no estrogen.
- They may cause periods to be irregular. This means it may be hard to know what days you will bleed.
- They work best if taken at the same time every day.

Birth control shot
- Birth control shot or Depo Provera® contains progestin. You must get a new shot every 12 weeks.
- It may cause periods to be irregular. This means it may be hard to know what days you will bleed.
- It may also cause weight gain.
- It may take longer for you to get pregnant after using the birth control shot compared to other forms of birth control.
Lactational Amenorrhea
- Lactational amenorrhea or LAM is natural birth control. There is no pill, shot, or other medicine to take.
- It works well in the first 6 months after the birth of your baby if you:
  → Are breastfeeding at least every 3 to 4 hours.
  → Are not giving your baby any bottles of breast milk or formula or food.
  → Have no vaginal bleeding.

Diaphragm with spermicide
- A diaphragm is another barrier method. It is a silicone or latex device that is placed inside the vagina against your cervix and keeps sperm from reaching the egg.
- It should always be used with spermicide. Spermicide is a chemical that destroys sperm.
- You will need to be refitted after having a baby and at least every 2 years after.
- They may increase your risk of a bladder infection

These birth control options are 81-90% effective at preventing pregnancy when used correctly. This means that up to 19 out of 100 women who use one of them may still become pregnant.

Male or Female Condoms
- Condoms are a barrier method of preventing pregnancy. This means they block the semen that contains sperm from entering the vagina.
- They also protect against some sexually transmitted diseases.
- Condoms may tear or break and semen may get into the vagina.
- Most condoms are made of latex or plastic. If you or your partner is allergic to latex, you should only use latex free condoms.

Please note that this is a brief handout about birth control methods. Please talk to your doctor or nurse if you have other questions.

Other Resources:

Bedsider: www.bedsider.org

Association of Reproductive Health Professionals-Method Match: www.arhp.org/methodmatch/
What You Need to Know About Depo-Provera and Breastfeeding

What is Depo-Provera?

- Depo-Provera is the brand name of a drug called medroxyprogesterone acetate. It contains progestin which is similar to progesterone. Progesterone is a hormone made by your ovaries.
- It is given as a shot and prevents pregnancy by stopping the release of an egg from the ovary.
- You need a new shot every 12 weeks.

Does it work?

- Yes. It is 99% effective at preventing pregnancy, when used correctly. This means that 1 woman out of 100 who use it will still become pregnant.
- It does not protect against HIV infection or any other sexually transmitted infections.

Is it permanent?

- No. Depo-Provera only works for 12 weeks. Then you will need to get a new shot.
- You will start ovulating again, or releasing eggs from your ovaries, a short time after stopping Depo-Provera. Sometimes it can take up to 10 months to get pregnant after stopping.

Are there benefits besides preventing pregnancy?

- Yes. It contains no estrogen, so it may be used in women who have migraines or history of deep vein thrombosis (DVT) or clotting disorders.
- Reduces sickling crises in women with sickle cell disease.
- Helps periods to be less heavy and less painful.
- Reduces the risk of uterine cancer.

Are there side effects?

- Yes. Using Depo-Provera can cause you to lose some of the calcium that is stored in your bones. The longer you use it, the more calcium your bones may lose. This does not mean that your bones will break more easily. Your bone calcium will increase after stopping Depo-Provera.
- Most women have some changes in their periods while using Depo-Provera such as:
Irregular bleeding or spotting. This means it may be hard to know what days you will bleed or not.

An increase or decrease in menstrual bleeding.

No bleeding at all. After 1 year of use, up to 75% of women stop getting their periods.

Weight gain of less than 10 pounds.

Headaches.

Mood changes.

Can I use it if I am breastfeeding?

- Yes. Most women are able to use Depo-Provera without it affecting their milk supply.
- If you are worried about your milk supply, consider waiting to get Depo-Provera until breastfeeding is established.
- If you do choose to wait, you should schedule a visit with your doctor to have it given 3 weeks after your baby is born. You can get pregnant as early as 25 days after your baby is born.

Who should not use Depo-Provera?

- You should not use Depo-Provera if you:
  - Have vaginal bleeding without a known reason
  - Have cancer of the breast or reproductive organs
  - Are pregnant or could be pregnant
  - Are allergic to the drug in Depo-Provera

Other Resources:
Besider - www.bedsider.org
Association of Reproductive Health Professionals-Method Match- www.arhp.org/methodmatch/