Special Population:

CONTRACEPTION FOR POSTPARTUM WOMEN

The postpartum period may provide a good opportunity for a woman to start contraception for several reasons. The woman is likely to access healthcare, and she may be motivated to avoid an unplanned pregnancy soon after giving birth. If the woman is not breastfeeding, ovulation may resume approximately 25 days after she has given birth. Short intervals of less than three years between pregnancies are associated with greater risks for adverse outcomes, such as maternal death, third trimester bleeding, premature rupture of membranes, uterine infection, maternal anemia, abortion, and low birth weight.(107) Thus, the importance of initiating the use of a contraceptive method at postpartum should be highlighted.

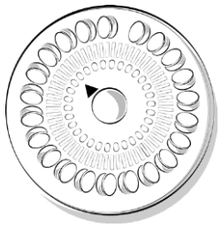
RECOMMENDED METHODS

Lactation amenorrhea method

- This temporary contraceptive method is a good option because it provides an ongoing and safe contraceptive that a fully breastfeeding woman can employ up to six months after giving birth.
- The LAM is based on the natural effect of breastfeeding against ovulation. It is reliable and effective provided that three conditions are met:
  - The woman's menses has not yet resumed after giving birth.
  - Breastfeeding is exclusive (full), and the baby is fed often both day and night ("exclusive" means that no other source of food or water is employed).
  - The baby is under six months old.

- While the Medical Eligibility Criteria (MEC) state that NO medical conditions preclude breastfeeding, other options may be preferred in certain cases. Among these cases are the following:
  - Women with human immunodeficiency virus (HIV). These women can transmit HIV to their offspring via infected breast milk. However, current evidence supports breastfeeding if the mother and/or her exposed infant has already been administered with antiretroviral drugs, as these agents significantly lower risk of transmission (see Chapter 12).
  - Women on certain medications, such as the following: mood-altering agents, reserpine, antimetabolites, cyclosporine, bromocriptine, radioactive drugs, high doses of corticosteroids, lithium, ergots, and anticoagulants.
  - Conditions in the newborn that impede effective breastfeeding, such as the following: congenital anomalies affecting the mouth, jaw, or palate; low birth weight babies or premature infants that require intensive or critical neonatal care; and metabolic disorders that hinder normal food digestion and processing. Edmond and Bahl (108) recommend feeding with expressed breast milk through nasogastric or orogastric tubes, spoons, or small cups when babies have poor sucking ability for its nutritional benefits to infants.

Progestin-only contraceptives: progesterone-only pill, depot medroxyprogesterone acetate (DMPA) or norethisterone enantate injectables, and levonorgestrel and etonogestrel implants



- Breastfeeding women who are
  - more than six weeks postpartum can use progestin-only contraceptives.
  - between six weeks and six months postpartum with no monthly bleeding may use progestin-only contraceptives. A backup method is not necessary.
  - less than six months postpartum with monthly bleeding can use progestin-only contraceptives.
  - more than six months postpartum can use progestin-only contraceptives provided that she is reasonably certain that she is not pregnant. She will need to use a backup method for the first two days of taking pills.

- Postpartum non-breastfeeding women who are
  - less than four weeks postpartum can start on progestin-only contraceptives any time. A backup method is not necessary.
  - more than four weeks postpartum can use progestin-only contraceptives provided that she is reasonably certain that she is not pregnant. She will need to use a backup method for the first two days of taking pills.
- No restrictions exist for the use of these agents as birth control methods (MEC 1) because these agents provide effective contraception without adversely affecting breastfeeding unless the client has risks of thrombosis.

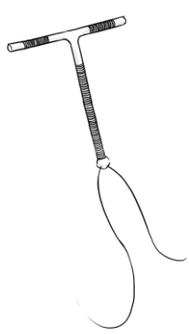
Female sterilization: tubal ligation

- Surgical sterilization can be performed less than seven days after giving birth or during the time of a cesarean section procedure.
- Only the client's (not the husband's) consent is required to perform this procedure.
- Performing this procedure is acceptable (MEC A) even if the woman is breastfeeding, has mild (but not severe) preeclampsia, and at 42 days and beyond postpartum (see Methods to Avoid below).

Male sterilization: vasectomy

- The woman's partner or husband can undergo vasectomy any time during the woman's postpartum period.

Intrauterine devices (IUDs)



- The copper-bearing IUD is a good option, as evidence points to a lower incidence of expulsion if insertion is performed immediately postpartum, especially after delivery of the placenta.
- No restrictions exist for copper-bearing IUD insertion within 48 hours postpartum in both breastfeeding and non-breastfeeding women (MEC 1).
- Levonorgestrel-releasing IUD is also a good option if the woman is NOT breastfeeding. This approach is NOT recommended if the woman is breastfeeding because of concerns about early neonatal exposure to hormonal agents at less than six weeks of age (MEC 3).

- Both types of IUDs are also recommended contraceptive choices (MEC 1) for women four weeks postpartum or beyond (see also Methods to Avoid below).

Barriers

- Male condoms are recommended options any time postpartum (MEC 1).
- Diaphragms and cervical caps are recommended at six weeks postpartum and beyond.

METHODS TO AVOID

Combined pills and combined injectables: combined oral contraceptives (COCs) and combined injectable contraceptives (CICs)

- Women breastfeeding for at least six weeks (MEC 4), women breastfeeding for six weeks to six months (MEC 3), and women not breastfeeding but are less than 42 days postpartum (MEC 2–4) should not use combined hormonal contraceptives (CHCs) because of a high risk for venous thromboembolism (VTE).
- Women 42 days postpartum have a 22- to 84-fold increased risk for VTE compared with controls. The use of COCs or CICs during this period also affects the quality and quantity of milk production in breastfeeding women.

Progestin-only contraceptives: progesterone-only pill, DMPA or norethisterone enantate injectables, and levonorgestrel and etonogestrel implants

- For breastfeeding women who are less than six weeks postpartum, the use of progestin-only methods is not recommended unless contraceptive options are limited despite high pregnancy morbidity and mortality rates (MEC 3).
  This recommendation stems from a concern about early neonatal exposure to hormonal agents in breast milk. Current studies do not demonstrate any harmful effects of this exposure on infants less than six weeks of age. However, the investigational designs are not enough to provide convincing data regarding issues on serious or long-term subtle effects. The adverse findings on animal studies with regard to neurologic effects have not yet been established in humans.

Female sterilization: tubal ligation

- The procedure is delayed (MEC D) in the following conditions until such time that these conditions have been resolved or have been addressed appropriately:
  - For women 7 to 42 days postpartum because of the increased risk of complications from an incompletely involuted uterus
  - Severe preeclampsia or eclampsia because of increased risk from elevated blood pressure
  - Prolonged rupture of membranes for 24 hours or more, as well as puerperal sepsis or intrapartum or puerperal fever because of the greater risk of infections
  - Severe antepartum or postpartum bleeding, as well as severe trauma to birth canal because of dangers posed by additional blood loss and aggravation of anemia
  - Uterine rupture or perforation because of additional blood loss or damage to abdominal organs

IUDs

- Insertion of IUDs at 48 hours to less than 4 weeks postpartum must be avoided because of increased chances of expulsion at a time of uterine involution (MEC 3).
- The procedure is contraindicated in postpartum women (MEC 4) who have puerperal sepsis and those with more than 18 hours of premature ruptured membranes.

Barriers: diaphragm and cervical cap

- The diaphragm and cervical cap are inappropriate for use prior to complete uterine involution.
- These devices may also prove difficult to apply and uncomfortable at this time, especially for those who have episiotomies.

Fertility awareness-based methods

- Most fertility awareness-based methods are best delayed or used with caution until the postpartum period has ended or until regular menstruation has resumed.
- Such options may be less effective in a breastfeeding woman than in a non-breastfeeding woman. At less than six weeks postpartum, the fully breastfeeding mother is likely to be amenorrheic and usually does not experience fertility and hormonal changes. However, chances of ovulation increase over time, especially if breastfeeding is non-exclusive. Alternative options should be given.
- After menses resume and fertility signs can be detected, the woman may use symptoms-based methods (e.g., cervical secretions or Billings). Calendar- based methods are best reserved for when the woman has had at least three consecutive menstrual cycles. The Standard Days Method can be used if she has already achieved four consecutive menstrual cycles, with the most recent having an interval of 26 to 32 days. However, before these times, a barrier contraceptive is advised.
- As for the non-breastfeeding woman, she does not have adequate ovarian function to produce obvious evidence of fertility or hormonal changes at four weeks postpartum. Thus, an appropriate contraceptive method is needed at this time. However, beyond four weeks, the non-breastfeeding woman will most probably begin to exhibit detectable fertility signs and hormonal changes. Calendar-based methods can then be used after at least three consecutive menstrual cycles. The Standard Days Method can be used after at least four consecutive menstrual cycles, with the most recent having an interval of 26 to 32 days.

Figure 6 presents the recommended family planning methods that may be used during the first year postpartum and beyond based on the MEC for Contraceptive Use.(59) For postpartum women, the following contraceptives are recommended:

- From delivery up to six months postpartum, a woman who is exclusively breastfeeding and has no menstrual period yet can use the LAM safely. When the client uses the LAM and decides to change to another method or when the client no longer fits the criteria for the LAM, other contraceptive methods should be provided in a timely manner.
- Intrauterine devices (Cu-IUD) can be inserted immediately up to 48 hours after birth or at any time after four weeks postpartum.
- Female sterilization can also be performed immediately up to seven days after birth or at any time after six weeks postpartum.
- For non-breastfeeding women, IUDs and progestin-only methods can be initiated immediately following birth. COCs can be initiated three weeks after birth.
- For breastfeeding women, all progestin-only methods can be initiated at six weeks following birth, as per WHO MEC. CHCs cannot be initiated until six months after birth.
- All women, breastfeeding or not, can initiate use of condoms immediately after birth and diaphragms or cervical caps after six weeks.

Figure 6. Postpartum family planning methods