POSTPARTUM CONTRACEPTION

NEED FOR POSTPARTUM CONTRACEPTION

- A person can ovulate as soon as 25 days after delivery if they are not exclusively breastfeeding.
- 50% of people have sex prior to their 6-week postpartum visit.
- Unplanned rapid repeat pregnancies can increase risk of adverse outcomes for both parent and baby.

Postpartum contraception provision prior to hospital discharge after delivery is a best practice that should be promoted as routine care. Because postpartum visits may be delayed, cancelled, or converted to telemedicine, the inpatient stay after delivery may be the last opportunity to engage patients on their plan for contraception during the postpartum period.

The best time to talk about postpartum contraception is during prenatal visits in the third trimester, which allows for signing of consent forms for sterilization and inpatient IUD and implant insertions. If counseling about IUD/implant did not happen during prenatal care, avoid counseling during labor, due to concerns about informed consent and possible coercion. Instead, counsel on postpartum day 1 or 2 to provide a method or set a contraception plan prior to discharge.

BEST PRACTICES FOR PROVIDING POSTPARTUM CONTRACEPTION

- For all pregnant patients, counsel about when fertility returns postpartum and the benefits of birth spacing to both parent and infant.
- Counsel about postpartum contraception during a prenatal visit, ideally during the third trimester.
- Emphasize the need for a plan at the time of delivery, as postpartum visits may take place via telemedicine.
- Counsel that the only method that affects return to fertility is the injection (Depo-Provera); all other methods have immediate return to fertility when discontinued.
- Within your hospital's capacity, try to fulfill all requests for postpartum sterilization.
- Start provision of inpatient contraceptive implants on the postpartum unit.*
- If you have providers who are comfortable placing inpatient postpartum IUDs, ask the inpatient pharmacy to stock devices on labor and delivery to facilitate placement.*
- Provide prescriptions for all methods a patient plans to use in the first six months postpartum prior to discharge – i.e. If a patient wants to use emergency contraception in the first six weeks postpartum and then switch to the patch, you can provide prescriptions for both methods with clear instructions for use.
- Provide prescriptions for emergency contraception, the contraceptive monthly ring or patch with 11 refills (12 month supply).
- If a patient chooses oral contraceptives, offer them a prescription to receive 13 packs of pills at a single time.
- Remind patients that only condoms prevent STIs, and offer a prescription for condoms to decrease out-of-pocket costs.
- If a patient chooses not to select a postpartum contraceptive method, offer a prescription for emergency contraception with the maximum refills (11), so that if they do become sexually active and want to prevent pregnancy they will have a way to rapidly access a method.

**PICCK can provide insertion training and technical assistance to operationalize an inpatient IUD and implant protocol.*

Partners in Contraceptive Choice and Knowledge (PICCK) is a five-year program funded by the Executive Office of Health and Human Services, Commonwealth of Massachusetts and housed at Boston Medical Center/Boston University School of Medicine.
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POSTPARTUM CONTRACEPTION

GO

METHODS THAT ARE SAFE FOR IMMEDIATE POSTPARTUM USE

- **Sterilization**
- **Copper IUD** (inserted during delivery or on postpartum floor)
- **Hormonal IUD** (inserted during delivery or on postpartum floor)
- **Implant**
- **Injectable**
- **Progestin-only pills**
- **Lactational amenorrhea method**--must be followed strictly *(see box)*
- **Plan B**
- **Ella**
- **Condoms**--internal and external
- **Spermicide**
- **Phexxi**
- **Withdrawal**

WAIT

METHODS THAT BECOME SAFE FOR USE AFTER 6 WEEKS POSTPARTUM

- **Combined estrogen/progestin pills**
- **Patch**
- **Vaginal ring**
- **Diaphragm** and **cervical cap**
- **Sponge**

STOP

METHOD THAT IS NOT RECOMMENDED FOR POSTPARTUM USE

- **Fertility awareness methods**--menstrual cycles may be too unpredictable in the 3-6 months after delivery to rely on one's body signals to predict fertility

PLAN B OR ELLA EFFICACY AND BMI

Plan B becomes less effective with BMIs greater than 26 kg/m^2, and Ella becomes less effective with BMIs greater than 35 kg/m^2

LACTATIONAL AMENORRHEA METHOD (LAM)

- Exclusively nursing (feeding pumped breast milk does not provide the same protection)
- Be within six months of delivery
- Have not had menses return
- No more than 4 hours between feeds during day (and 6 hours at night)

CONTRACEPTION AND LACTATION

All methods are safe for breastfeeding and have not been found to affect milk supply, quality, duration of breastfeeding, or infant growth and development.

Consistent with the recommendation of the InfantRisk Center, PICCK recommends that breastmilk does not need to be discarded after taking Ella. This recommendation is based on the limited infant safety data available. Out of caution with the limited evidence-base, the CDC recommends that breastfeeding persons discard pumped milk for 24 hours after taking Ella. (InfantRisk Center, https://www.infantrisk.com/category/breastfeeding)

IMMEDIATE POSTPARTUM IUD AND IMPLANT INSERTION

The immediate postpartum period is an excellent opportunity to provide effective contraception. The contraceptive implant may be placed at any time after delivery prior to hospital discharge. Intrauterine devices can also be placed at any time during a patient's postpartum hospital stay. Immediate postplacental IUD insertion has the lowest expulsion rates and may be the most technically straightforward time to place the device. Further, reimbursement for IUDs and implants is unbundled from the global delivery fee in Massachusetts.

PICCK can support hospitals to improve postpartum contraception access, including educational trainings and technical assistance to begin immediate postpartum provision of IUDs and implants.

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