Postpartum Contraception & Breastfeeding
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Disclosures

- All health care providers who perform implant insertions and removals must receive training from the manufacturer. Therefore, the insertion process is deferred to the manufacturer and not covered in this presentation.
Topics covered in presentation

Section 1: Unmet need for postpartum contraception
Section 2: Clinical considerations of immediate postpartum (IPP) contraception
Section 3: Breastfeeding: clinical considerations
Section 4: Contraceptive counseling: shared decision-making and reproductive justice
Learning objectives

1. Understand the need for postpartum contraception
2. Describe postpartum contraceptive methods currently available
3. Describe ACOG and CDC recommendations for postpartum contraception, including IPP LARC
4. Discuss current evidence available on IPP LARC and breastfeeding
5. Understand key elements of patient-centered postpartum contraceptive counseling
UNMET NEED

for Postpartum Contraception
Nearly half of U.S. pregnancies were unintended in 2011.
Pregnancy spacing is important for healthy families

- **ACOG Committee Opinion #544, Over-the-Counter to Oral Contraceptives**, states that short interpregnancy intervals have been associated with adverse neonatal outcomes, including low birth weight and prematurity.

- **ACOG Committee Opinion #666, Optimizing Postpartum Care**, states that:
  - The optimal interval between delivery and subsequent pregnancy is 18 months to 5 years.
  - The greatest risk of low birth weight and preterm birth occurs when the interconception interval is less than 6 months.
The challenge with postpartum visits

- **ACOG Committee Opinion #666, Optimizing Postpartum Care**, states that:
  - As many as 40% of women do not return for the 6 week postpartum visit
  - Attendance rates are even lower in under resourced areas, further contributing to health disparities

- Women have difficulty returning for a postpartum visit because of:
  - Childcare obligations
  - Unable to get off work
  - Unstable housing
  - No transportation
  - Communication or language barrier
  - Lack of insurance coverage or potential expiration of Medicaid eligibility

- Non-breastfeeding women can ovulate as early as 25 days postpartum
  - 40% will ovulate by 6 weeks postpartum

- 57% women are sexually active by 6 weeks postpartum
Unfilled immediate postpartum sterilization requests

• At least 1/3 of women who want a postpartum sterilization will not have it done
  o Insurmountable systems barriers like lack of OR room, physician availability or uncompleted consent forms

• 47% of women who leave without having a desired postpartum sterilization done will be pregnant within 1 year

• Insurance Issues
  o Medicaid coverage may end postpartum
  o Uninsured – cost of sterilization can be prohibitive
What is LARC? ACOG Practice Bulletin #186 says:

- LARC stands for long-acting reversible contraception
- The intrauterine device and the contraceptive implant, also called LARC, are the most effective reversible forms of contraception
- 2 major advantages of LARC include:
  1. Compared with other methods, LARC does not require ongoing effort for long-term and effective use
  2. Rapid return to fertility after removal of the device

Contraceptive implant ➔
(about the size of a match stick)
What is immediate postpartum LARC?

When LARC methods are available to women in the hospital after a delivery before discharge

• ACOG, CDC, WHO, and Cochrane reviews all agree that immediate postpartum (IPP) LARC is safe and effective
• Can be an ideal time to provide LARC methods for many women
Definitions: timing of LARC placement

1. **Immediate postplacental** – placement while still in the delivery room and, when possible, within 10 minutes of placental delivery

2. **Immediate postpartum** – placement during hospital admission for delivery

3. **Postpartum** – placement within 6 weeks of delivery

4. **Interval placement** – placement 6 weeks or later following delivery
ACOG Committee Opinion #670, IPP LARC

- IPP LARC:
  - Should be offered as an effective option for postpartum contraception
  - Can reduce unintended pregnancy & lengthen interpregnancy intervals
  - Women should be counseled prenatally about IPP LARC, including:
    - Advantages
    - Risks of IUD expulsion
    - Contraindications & alternatives to allow for informed decision making

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**Immediate Postpartum Long-Acting Reversible Contraception**

**ABSTRACT:** Immediate postpartum long-acting reversible contraception (LARC) has the potential to reduce unintended and short-interval pregnancy. Women should be counseled about all forms of postpartum contraception in a contract that allows informed decision making. Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum intrauterine devices and implants. Obstetrician-gynecologists and other obstetric care providers should discuss LARC during the antenatal period and counsel all pregnant women about options for immediate postpartum initiation. Education and institutional protocols are needed to raise clinicians awareness and to improve access to immediate postpartum LARC insertion. Obstetrician-gynecologists and other obstetric care providers should incorporate immediate postpartum LARC into their practices, counsel women appropriately about advantages and risks, and advocate for institutional and payment policy changes to support provision.

**Recommendations**

The American College of Obstetricians and Gynecologists (the College) recommends the following strategies for immediate postpartum long-acting reversible contraception (LARC):

- Optimal women should be counseled prenatally about the option of immediate postpartum LARC. Counseling should include advantages, risks of intrauterine device (IUD) expulsion, contraindications, and alternatives to allow for informed decision making.
- Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum IUDs and implants. Obstetrician-gynecologists and other obstetric care providers should counsel women about the convenience and effectiveness of immediate postpartum LARC, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals.
- Obstetrician-gynecologists and other obstetric care providers should include in their contraceptive counseling the increased risk of expulsion, including unrecognized expulsion, with immediate postpartum IUD insertion compared with interval IUD insertion.
- Systems should be in place to ensure that women who desire LARC can receive it during the comprehensive postpartum visit if immediate postpartum placement was not undertaken.
- Obstetrician-gynecologists, other obstetric care providers, and institutions should develop the resources, processes, and infrastructure, including stocking LARC devices in the labor and delivery unit and coding and reimbursement strategies, to support immediate LARC placement after vaginal and cesarean births.
IPP LARC satisfaction & continuation rates

• Many women like and continue their LARC method received postpartum
  o 74% of women who had an IUD placed immediately postpartum did not experience an expulsion and still had their IUD in place at one year
  o 84% of women who had an implant placed immediately postpartum still had the implant at one year

• Elective discontinuation for IUDs and implants on par with interval placement
What are the benefits of IPP LARC?

1. Unintended pregnancy remains a significant issue in the U.S. and LARC methods can decrease unintended pregnancy and lengthen interpregnancy intervals
2. Patient is still in the midst of care and can be convenient for both woman and clinician
3. Time limit on postpartum insurance coverage for some women
4. Reasonable certainty that the patient is not pregnant
What are the benefits of IPP LARC? (continued)

5. Providing IUDs immediately postpartum is cost-effective despite higher expulsion rates

6. Provision of immediate postpartum contraception can extend interpregnancy intervals
   o 70% of pregnancies are unintended in the first year postpartum

7. Women using LARC methods have high satisfaction and continuation rates as compared to oral contraceptive pill users
IPP LARC can help meet women’s needs

• Safe
• Convenient
• Highly effective
• Reversible
• Forgettable
• High patient satisfaction
• High continuation rates
CLINICAL CONSIDERATIONS
of Immediate Postpartum Contraception
<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization (male &amp; female)</td>
<td>99%+</td>
<td>- Permanent</td>
</tr>
<tr>
<td>Etonogestrel (ENG) Implant</td>
<td>99%+</td>
<td>- Must be placed and removed by trained clinician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clinicians must attend manufacture training prior to placement</td>
</tr>
<tr>
<td>IUD: Copper</td>
<td>99%+</td>
<td>- Must be placed and removed by trained clinician</td>
</tr>
<tr>
<td>IUD: Levonorgestrel (LNG)</td>
<td>99%+</td>
<td>- Must be placed and removed by trained clinician</td>
</tr>
<tr>
<td>Injectable (Medroxyprogesterone acetate)</td>
<td>94%</td>
<td>- Must obtain injection every 3 months</td>
</tr>
<tr>
<td>Lactational amenorrhea method (LAM)</td>
<td>92-98%</td>
<td>May be impractical for many women; this effectiveness is reached when:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Infant frequently &amp; exclusively breastfed (no pumping or bottles; time between</td>
</tr>
<tr>
<td></td>
<td></td>
<td>feeding during day &lt;4 hours &amp; &lt;6 hours at night)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- &lt;6 months postpartum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Amenorrheic</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>91%</td>
<td>- Must take pill at same time every day with 3 hour late window</td>
</tr>
<tr>
<td>Estrogen/progestin combined pill, patch or</td>
<td>91%</td>
<td>- Cannot be used within 3 weeks of delivery due to increased risk of blood clots</td>
</tr>
<tr>
<td>ring</td>
<td></td>
<td>- Women with risk factors must wait until 6 weeks after delivery to use these methods</td>
</tr>
<tr>
<td></td>
<td></td>
<td>safely</td>
</tr>
</tbody>
</table>
# Current LARC methods on the market

<table>
<thead>
<tr>
<th>Description</th>
<th>Brand Name of Method</th>
<th>Type of Method</th>
<th>FDA-Approved Duration of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hormonal IUD</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Mirena®</td>
<td>52 mg LNG IUD</td>
<td>5 years</td>
</tr>
<tr>
<td></td>
<td>Skyla®</td>
<td>13.5 mg LNG IUD</td>
<td>3 years</td>
</tr>
<tr>
<td></td>
<td>Kyleena®</td>
<td>19.5 mg LNG IUD</td>
<td>5 years</td>
</tr>
<tr>
<td></td>
<td>Liletta®</td>
<td>52 mg LNG IUD</td>
<td>4 years</td>
</tr>
<tr>
<td><strong>Non-hormonal IUD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paragard®</td>
<td>Copper IUD</td>
<td>10 years</td>
</tr>
<tr>
<td><strong>Contraceptive Implant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nexplanon®</td>
<td>68 mg ENG implant</td>
<td>3 years</td>
</tr>
</tbody>
</table>
Levonorgestrel IUDs

- ACOG Committee Practice Bulletin #186, LARC: Implants and IUDs, provides information on clinical issues and candidate selection, including the following:
  - Mechanism of Action
    - Prevent fertilization by changing amount and viscosity of cervical mucus, making it impenetrable to sperm
    - Evidence supports that LNG IUDs do not disrupt pregnancy and are not abortifacients
  - Most women ovulate normally but experience diminished menstrual bleeding because of the local effect of levonorgestrel on the endometrium
- 99.8% effective; the one-year typical use failure rate is 0.2 per 100 women
Copper IUD

- **ACOG Committee Practice Bulletin #186, LARC: Implants and IUDs**, provides information on clinical issues and candidate selection, including the following:
  - Mechanism of Action – Prevents fertilization by:
    - Inhibition of sperm migration
    - Change in transport speed of ovum
    - Damage to or destruction of the ovum
  - Evidence supports that the Copper IUD does not disrupt pregnancy and is not an abortifacient
  - The most common adverse effects reported are abnormal bleeding and pain
- 99.2% effective; the one-year typical use failure rate is 0.8 per 100 women
Radiopaque 68 mg etonogestrel implant

- **ACOG Committee Practice Bulletin #186, LARC: Implants and IUDs**, provides information on clinical issues and candidate selection, including the following:
  - **Mechanism of Action:**
    - Primary: ovulation suppression
    - Additional: thickening of cervical mucus and alteration of the endometrial lining
  - After implant insertion, changes in bleeding patterns are common and include amenorrhea or infrequent, frequent, or prolonged bleeding
  - Placed subdermally in upper arm; size: 4cm x 2mm (comparable in size to a match stick)
- 99.9% effective; the one-year typical use failure rate is 0.05 per 100 women
# Three insertion methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ring forceps</td>
<td>・The ACOG LARC Work Group recognizes these three methods of insertion for IPP IUD placement, and leaves method selection up to provider discretion</td>
</tr>
<tr>
<td>2. Manual/hand</td>
<td>・No matter which method is used, the IUD should ALWAYS be placed at the fundus of the uterus for both vaginal &amp; cesarean births</td>
</tr>
<tr>
<td>3. Device inserter</td>
<td>• The ACOG LARC Work Group recognizes these three methods of insertion for IPP IUD placement, and leaves method selection up to provider discretion • No matter which method is used, the IUD should ALWAYS be placed at the fundus of the uterus for both vaginal &amp; cesarean births</td>
</tr>
</tbody>
</table>
BREASTFEEDING

Clinical Considerations
IPP LARC & breastfeeding: key takeaway

• The Copper IUD lacks hormones, which avoids any theoretical effect on breastfeeding

• For hormonal IPP LARC use, ACOG Practice Bulletin #186, LARC: Implants & IUDs, states that:

  “Given available evidence, women considering IPP hormonal LARC should be counseled about the theoretical risks of reduced duration of breastfeeding, but the preponderance of evidence has not shown a negative effect on actual breastfeeding outcomes”
What should you tell patients?

• When discussing IPP LARC & breastfeeding with patients:
  o Review future child-bearing intentions
  o Review safety and high user satisfaction with IPP LARC
  o Discuss the theoretical risk of hormonal LARC methods, but that this has not been observed in clinical practice
  o Review potential rapid return to fertility after delivery

• If patients desire IPP LARC, its provision should be supported in the hospital setting
CONTRACEPTIVE COUNSELING

Shared Decision-Making & Reproductive Justice Framework
Reproductive coercion

- Reproductive coercion is the act of forcing a woman to use a method of birth control that she did not choose
- The U.S. has history of reproductive coercion and forced sterilization
- Minority and socioeconomically disadvantaged women may have mistrust of health care system because of this history
Any counseling for postpartum contraception, especially sterilization or IPP LARC, must be sensitive to this history:

- Highlight the reliance provider for removal.
- LARC devices can give women a decreased sense of control or the feeling of being forced into a contraceptive method.
A reproductive justice framework for contraceptive counseling

ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity, states:

“The framework of reproductive justice connects family planning and other aspects of sexual and reproductive health with the disparities and complexities that affect patients’ lives. Furthermore, it encourages gynecologic health care providers to examine issues of bias and coercion and advocate for equitable access and change.”
A reproductive justice framework for contraceptive counseling

ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity, states:

• “A reproductive justice framework for contraceptive counseling and access is essential to providing equitable health care, accessing and having coverage for contraceptive methods, and resisting potential coercion by health care providers.”

• “When engaging in shared decision making regarding contraceptive use, [health care providers] should be aware of and address their own biases, work to empower patients, and strive for equitable outcomes for all patients regardless of age, race or ethnicity, class, or socioeconomic status.”
ACOG guidance on IPP LARC counseling

ACOG Committee Opinion #670, IPP LARC, states:

- “Women should be counseled about all forms of postpartum contraception in a context that allows informed decision making.”

- “Optimally, women should be counseled prenatally about IPP LARC. Counseling should include advantages, risk of IUD expulsion, contraindications, and alternatives to allow for informed decision making.”

- “Counsel women about the convenience and effectiveness of IPP LARC, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals.”
ACOG Guidance on IPP LARC counseling (cont.)

ACOG Committee Opinion #670, IPP LARC, states that:

• Counseling should include “the increased risk of expulsion, including unrecognized expulsion, with IPP IUD insertion compared with interval IUD insertion.”

• “Given available evidence, women considering IPP hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that the preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.”
Tools for contraceptive counseling

**HOW WELL DOES BIRTH CONTROL WORK?**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Method</th>
<th>Duration</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Really, really well</td>
<td>The Implant ( Nexplanon)</td>
<td>5 years</td>
<td>Very Low</td>
</tr>
<tr>
<td>Ok</td>
<td>IUD (Mirena)</td>
<td>5 years</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>IUD (ParaGard)</td>
<td>12 years</td>
<td>Very Low</td>
</tr>
<tr>
<td></td>
<td>Sterilization (men)</td>
<td>Forever</td>
<td>No chance</td>
</tr>
<tr>
<td>Not so well</td>
<td>The Pill</td>
<td>Every 3 months</td>
<td>6-8/100 women</td>
</tr>
<tr>
<td></td>
<td>The Patch</td>
<td>Every week</td>
<td>6-8/100 women</td>
</tr>
<tr>
<td></td>
<td>The Ring</td>
<td>Every month</td>
<td>6-8/100 women</td>
</tr>
<tr>
<td></td>
<td>The Shot (Depo-Provera)</td>
<td>Every 3 months</td>
<td>6-8/100 women</td>
</tr>
</tbody>
</table>

For each of these methods to work, you or your partner have to use it every single time you have sex.

**What is your chance of getting pregnant?**

- Loss than 1 in 100 women
- 6-8 in 100 women, depending on method
- 12-24 in 100 women, depending on method
More ACOG guidance on contraceptive counseling

ACOG has many contraceptive counseling resources, including, but not limited to:

1. ACOG Practice Bulletin #186, LARC: Implants and Intrauterine Devices
2. ACOG Committee Opinion #672, Clinical Challenges of LARC Methods
3. ACOG Committee Opinion #670, IPP LARC
4. ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity
5. ACOG Committee Opinion #490, Partnering With Patients to Improve Safety
6. ACOG Committee Opinion #587, Effective Patient-Physician Communication
7. ACOG Committee Opinion #666, Optimizing PP Care
8. ACOG LARC Program Contraceptive Counseling Resource Digest
What is the goal of contraceptive counseling?

A. To inform women about all postpartum contraceptive options
B. To have a woman leave the hospital after delivery with a plan for contraception that she feels comfortable with
C. To allow women to make the contraceptive choices that are best for them
D. To remind women that there is not one perfect method for everyone

E. All of the above!
KEY TAKEAWAYS

Things to Keep in Mind
Summary & key takeaways

1. Immediate postpartum LARC use can reduce unintended pregnancy
2. Many forms of contraception, including LARC, are safe immediately postpartum
3. Observational studies suggest that initiation and continuation of breastfeeding is not effected by the hormonal IUD or implant placement immediately postpartum
4. Given available evidence, women considering IPP hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes
5. All times are good times to talk about contraception!
6. Shared medical decision making can increase engagement and reduce risk resulting in improved outcomes, satisfaction, and treatment adherence
QUESTIONS?
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