CLINICAL PRACTICE ALERT
POST-PREGNANCY CONTRACEPTION

Introduction

The term ***post-pregnancy*** refers to the time interval after which an individual has had an abortion whether by procedure or medication, miscarriage, or has delivered a newborn. The term ***post-partum*** refers to the time interval after which an individual has delivered a newborn, whether by a vaginal delivery or a cesarean section (c-section). For those who recently delivered, initiation of post-partum contraception is important so that the individual can time the interval until the next pregnancy if more children are desired[1].

Key Points:

- An optimal interpregnancy interval is at least 18 months between the prior delivery and the onset of the next pregnancy, resulting in a birth interval of at least 27 months. Individuals who choose highly effective methods (implants and intrauterine devices (IUDs)) are more likely to have optimal interpregnancy intervals than those using moderately or less effective methods.
- Two unique factors in contraceptive management include supporting successful breastfeeding and minimizing the risk of venous thromboembolic events (VTE) in those using combined hormonal contraceptives (CHCs).
- The earliest that a post-partum person will ovulate is 25 days after the delivery; therefore, contraception is not necessary before the end of post-partum week 3.

Questions and Answers

When should the initiation of post-partum contraception take place?

Most individuals (60-70%) are sexually active by six weeks post-partum; only 4% are abstinent

by the end of the 12th post-partum week. Non-lactating individuals ovulate in 6-7 weeks on average, but none ovulate before 25 days from the delivery. Resumption of ovulation in lactating individuals depends on the intensity, frequency, and duration of suckling; the time since delivery; maternal nutritional state; the rate of weaning (rapid weaning permits ovulation more than gradual weaning), and the introduction of supplementary feeding.

How is the Lactational Amenorrhea Method (LAM) used?

LAM works well when practiced correctly but is unforgiving of imperfect use. LAM pregnancy rates are 2% by 6 months, 7% by 12 months, and 13% by 24 months post-partum[2]. Another contraceptive method must be used by 6 months, or sooner if menstrual bleeding occurs.

The Bellagio Conference Consensus Statement[2] defined conditions for effective use of the LAM.

- The infant nurses "on-demand" (more than 5 feedings/day; greater than 65 minutes).
- "Exclusive breast-feeding" occurs; breast milk is the only nutrition to the newborn with no formula feedings or other foods.
- There is no vaginal bleeding episode beyond 56 days from the time of delivery.
- The newborn has nursed for up to 6 months.

How does the use of combined hormonal contraceptives (combined oral contraceptive (COC) pill, patch, and ring) affect lactation?

- As long as low estrogen dose products are started after the establishment of lactation (usually by 4 weeks), the effect on the quantity of breast milk produced is minimal. The quality of breast milk is not affected by estrogen or progestins.
- Certain individuals may be at risk for breast-feeding difficulties, such as those with previous breast-feeding problems, certain medical conditions, perinatal complications, or those who experienced preterm delivery. Discussions should include information about risks, benefits, and alternatives to hormonal contraceptives[3].
- The effect of estrogen secreted in breast milk and ingested by the newborn is inconsequential. The amount of estradiol secreted in breast milk is similar to that seen in ovulating post-partum women.
- Studies are mixed regarding the length of time that COC users breast-feed their infants compared to non-users. A recent study showed no difference in breast-feeding duration between those who used COCs compared to progestin-only pills[4].

Why is there concern regarding increased risk of post-partum VTE in those using combined hormonal methods?

Pregnancy induces hypercoagulability throughout pregnancy and for up to 6 weeks post-partum. There is concern that adding exogenous estrogen will increase the tendency to clot to an even greater degree, resulting in an increased risk of VTE. This risk is even greater in those with other risk factors for VTE including age of 35 or older, a body mass index of 30 or greater, immobility, having had a post-partum hemorrhage, transfusion at delivery, post-cesarean delivery, preeclampsia, or smoking. Having a history of a prior VTE or an inherited clotting disorder, such as the factor V Leiden mutation, also are major risk factors for VTE.

Given these considerations, how should combined hormonal methods be used in the post-partum period?

The 2016 Centers for Disease Control and Prevention (CDC) Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)[3] recommend initiation of CHC methods at:

- 21 days post-partum in non-lactating individuals with no VTE risk factors
- 30 days post-partum in lactating individuals with no VTE risk factors
- 42 days in those with pregnancy specific VTE risk factors. For those with other VTE risk factors, refer to the 2016 U.S. MEC.[3]

Are progestin-only pills (POPs) considered to be a better option in the post-partum period?

POPs are a safe and effective choice, as they have no effect on either lactation or coagulation and VTE risk. However, they are slightly less effective than COCs, less forgiving of missed or late doses, and their use will require a switch from POPs to another product if the individual intends to use OCs or other methods in the longer term.

When can contraceptive implants be used in the post-partum period?

The U.S. Food and Drug Administration (FDA)-approved package insert states that an implant can be inserted at 4 weeks post-partum. However, the U.S. MEC states that implant placement can be performed at any time in a non-lactating individual. In those who are breast-feeding, implant placement is U.S. MEC Category 2 until 30 days post-partum and Category 1 thereafter.

What about depot medroxyprogesterone acetate (DMPA) use in post-partum individuals?

DMPA is a safe and effective choice and sometimes is initiated after delivery before hospital discharge because of concerns that the individual may not return for a post-partum visit.

- If more than 21 days post-partum and menstrual cycles have not returned, an individual can have the first injection at any time if it is reasonably certain that they are not pregnant. Those who are not lactating will need to abstain from sex or use additional contraceptive protection for 7 days after the first post-partum injection. If the individual is fully or nearly fully breast-feeding, no additional contraceptive protection is needed.

Are there special considerations for post-partum contraception in those who had gestational diabetes?

- The 2016 CDC U.S. MEC state that all methods are Category 1 in women with a history of gestational diabetes.
- Note that gestational diabetics have a >50% chance of developing Type 2 diabetes mellitus in the next 10 years. The American Diabetes Association (ADA) Guidelines recommend follow-up with a 2-hour post-glucose load test (75 gm) at 6 weeks, then screen annually (*not a Family PACT benefit*).
- Gestational diabetics who become frankly diabetic usually can continue CHCs (see 2016 CDC U.S. MEC).[3]

When should IUDs be placed in the post-partum interval?

IUDs can be inserted within 10 minutes of a vaginal or cesarean delivery or should be delayed until 4 weeks post-partum.[5] If placed longer than 10 minutes after the delivery or earlier than 4 weeks, there is a relatively high expulsion rate. IUDs must not be placed in individuals who have post-partum or post-abortion endometritis until the condition is fully resolved.

What are the advantages of post-abortion IUD placement?

Immediate post-abortal IUD placement is a safe, effective, practical, and underutilized intervention that can reduce by two-thirds repeat unintended pregnancy and repeat abortion in the first year after the procedure.

- There is no difference in complication rates for immediate versus delayed placement of an IUD after abortion.
- The advantages of post-abortion IUD placement are: one invasive procedure rather than two; less or no pain with insertion, since the cervix already is dilated; and immediate contraceptive protection, which is important, since 40% of people scheduled for delayed IUD placement do not return for the insertion.
- The main disadvantage is a slightly higher expulsion rate, which is 8-10% after second trimester abortion and 7% after a first trimester abortion, compared to a 2-4% expulsion rate when placements are not done at the time of abortion or delivery.

What is the Medi-Cal Presumptive Eligibility for Pregnant Women (PE4PW) Program?

PE4PW provides immediate, temporary coverage for ambulatory pregnancy services based on preliminary information pending the state's determination of the person's regular Medi-Cal eligibility. The Program covers prenatal care, delivery, and post-partum care; care for miscarriage; and surgical and medication abortion services.

An individual can apply for PE4PW through a qualified provider (QP) based on family income, family size, and county of residence. If there is a determination of eligibility, they can receive Medi-Cal pregnancy services starting the same day. Once the person has enrolled in PE4PW, they may seek services from any Medi-Cal provider for pregnancy or abortion care. By the end of the following month, the individual must begin a full Medi-Cal application.

Application of Family PACT Policies

When can individuals who have been pregnant resume Family PACT services?

Family PACT eligibility begins (or may be reinstated) when an individual no longer has other health care coverage or is no longer eligible for Medi-Cal "pregnancy-related" services, which lasts up to one full year after the delivery.

When can individuals who have had an abortion resume Family PACT services?

- Abortions and services ancillary to abortions are not benefits of Family PACT. However,

contraceptive supplies and IUD and implant placements are Family PACT benefits when provided immediately after a procedural abortion and are not considered services ancillary to abortion. Contraceptives are reimbursed by Family PACT as long as all eligibility criteria are met and the client is certified as eligible after the abortion. Office visits (billed with an Evaluation and Management (E&M) or Education and Counseling (E&C) code) are not reimbursable during the 21-day post-operative period (*Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual, Family PACT Program Overview section).

- Individuals who have undergone medication abortion are considered to be no longer pregnant either by the findings of an empty uterus on pelvic ultrasound, by falling human chorionic gonadotropin (hCG) levels, or by a negative pregnancy test.

For the complete text of the *Family PACT Standards*, official administrative practices, and billing information, please refer to the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual.

References

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5. Kapp N, Curtis KM. Intrauterine device insertion during the postpartum period: a systematic review. *Contraception*. 2009 Oct;80(4):327-36. https://www.sciencedirect.com/science/article/pii/S0010782409001280?via%3Dihub.

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