The selection of contraceptives is a personal choice, but the physician should provide information to the patient regarding the optimal contraception. The postpartum period is an ideal time to initiate contraception as women are continuing to follow up with their healthcare providers and are likely to be more motivated to avoid the next pregnancy soon. Postpartum contraception should consider factors like a resumption of ovulation, its effects on lactation, and the woman’s health. Ideally, all women requesting postpartum contraception should be advised not to wait until the resumption of their menstrual cycle but instead start their contraceptive use before resuming sexual activity. Physicians should also provide emergency contraception, if requested, to all women.

Resumption of ovulation

Resumption of ovulation is unpredictable and can occur even before the onset of menstrual cycles in breastfeeding women; therefore, a return of the menstrual cycle is not a good indicator to initiate contraception. Typically, ovulation can occur between 25 to 40 days postpartum in non-lactating women and, of this, 60% are fertile.

This interval varies from women to women. Ovulation in women who are lactating or breastfeeding depends on the frequency and duration of breastfeeding, the maternal nutritional status and her body mass index (BMI). Ovulation in
breastfeeding women is typically delayed due to the inhibition of hypothalamic gonadotropin-releasing hormone by prolactin. Both Puerperium and lactation bring about hormonal alterations in the body demanding the need of safe choice of contraception.

The Center for Disease Control (CDC) updated their guidelines in 2011 which states that hormonal contraceptives should be avoided in the first three weeks postpartum due to the high risk of venous thromboembolism (VTE) in that period. **Combined hormonal contraceptives can be prescribed between three to six weeks postpartum** if there are no risk factors for VTE. In the presence of risk factors for VTE, e.g., a past history of VTE or a recent cesarean section delivery, hormonal contraceptives are contraindicated.

Postpartum contraception methods

Reversible Postpartum Contraception

<table>
<thead>
<tr>
<th>Natural family planning</th>
<th>Barrier method</th>
<th>Progestin-only oral contraceptive</th>
<th>Long-acting reversible contraceptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prolactin increasing cause ovulation diminishing • Reliability = 98%, if used correctly</td>
<td>• Use of condoms and/or spermicides • Effective rate = 82%</td>
<td>• Progestin-only or the mini-pill • Most reliable when taken at the same time everyday</td>
<td>• LARC provide contraception for an extended period of time • There are several options</td>
</tr>
</tbody>
</table>

**Long-acting reversible contraceptives (LARCs) are:**
- Copper IUC
- Progestin IUC
- Progestin Implant
- Progestin Injection

**Non-reversible contraceptives:**
- Postpartum Tubal ligation
- Hysteroscopic Tubal ligation
- Vasectomy

The Lactational Amenorrhea Method (LAM)

This is an economical and temporary form of the contraceptive method in women who have amenorrhea and are breastfeeding at frequent, regular intervals, demand feeding and not expressing milk or bottle feeding. However, one should caution the mother that if she is separated from her infant for several hours, she is at risk of conceiving. However, this method can be only practiced up to 6 months after child’s birth or next menstrual flow.

Hormonal contraception

As mentioned above, hormonal contraceptives can only be made available if there are no risk factors for VTE. They can ideally be started safely only after 42 weeks postpartum. It is also important to remember that **estrogen can reduce the quality and amount of breast milk.** Non-lactating women can be offered hormonal contraception with estrogen four weeks postpartum, while breastfeeding women can be offered a progesterone-only
pill or medroxyprogesterone depot injection (DMPA; Depo-Provera) or levonorgestrel intrauterine system. This pills not interfere with sexual activity and may reduce menstrual bleeding.

DMPA should not be recommended for long-term use (more than two years) in older women as it is associated with a higher incidence of a decrease in bone density unless no other contraceptive alternatives are acceptable. It is also not recommended in women who have breast cancer or history of breast cancer.

Barrier devices

Barrier devices such as diaphragms, and cervical caps, should ideally be fitted six weeks postpartum as pregnancy and delivery tend to alter the cervical and vaginal size and tone as uterus and cervix return back to its normal size after delivery in this period. Condoms, and spermicides, on the other hand, can be offered in the immediate postpartum period. The use of contraceptive sponges should be postponed until at least 42 days postpartum to avoid toxic shock syndrome.

Intrauterine devices

Both breastfeeding, as well as non-lactating women, can be offered intrauterine devices like the Copper T or intrauterine systems like the levonorgestrel (LNG IUS). The Copper T is an ideal long-term contraceptive option and can be kept in situ for up to ten years. If inserted in the immediate postpartum period, they are likely to be extruded and should ideally be inserted 30 to 42 days postpartum when the uterus has involuted completely. Three types of levonorgestrel systems are currently available. Each of these is effective for different durations ranging from three to five years.

Sterilization

Tubal sterilization is an effective and permanent contraceptive solution for women who have completed their childbearing. It should be offered with caution to women in unstable relationships, or young women or those desirous of having children later. This surgical procedure can ideally be performed in the immediate postpartum period as it is associated with lower failure rates compared to when it is performed later. When it is requested later, it can be done either laparoscopically or transcervically.

A transcervical sterilization method (Essure) is another method for sterilization if it is desired after a long time of delivery or postpartum. In this method, scars tissues are formed in the fallopian tubes by microinserts via uterus that result in permanent closing of the tubes in the span of 3 to 6 months. The woman should be informed that the tubes can take three to six months to close completely after the procedure, so she should use another form of contraception until then. Confirmation about successful occlusion of the tubes requires a hysterosalpingogram.

References

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Postpartum: First 6 Weeks After Childbirth – Recovery At Home via webmd.com
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