Reproductive Health
in Nursing

Patient Situation 1

Postpartum Contraception in Unintended Pregnancy and Prevention Care

Amelia's Contraception
(Patient Situation #1)

The Patient

Amelia is 29 years old and gave birth two months ago to a baby girl, Isabella. Life slowly settled into a routine with regular daytime and nighttime breastfeeding. Amelia is breastfeeding exclusively. When she is away from Isabella, Amelia will pump and leave a bottle of breast milk with the caregiver. Amelia assumes she is protected from pregnancy while nursing so she is not using any additional method of contraception.

Amelia hasn't been using a method of contraception yet because she assumes she is protected while nursing (lactational amenorrhea).

The Setting

A Family Planning Department in a large federally qualified community health center (FQHC) that provides comprehensive reproductive health services. A full range of FDA-approved contraceptives are available on site. Registered nurses conduct the initial intake session, which focuses on the patient's reproductive life plan as well as providing counseling on various contraceptive methods.

What Happened

Two months after giving birth, Amelia resumes sexual activity. Amelia missed her postpartum appointment and wants to re-schedule the visit, but life events keep getting in the way. Finally, at three months postpartum, Amelia is able to schedule an appointment and she wants to discuss her contraceptive options.

During the intake portion of the visit, the nurse conducts a sexual history. Amelia wants to breastfeed and pump for at least six months, however, due to working full time she has decided to use formula during the day. Amelia and her husband

continue to use lactational amenorrhea as a contraceptive method. Given Amelia's history and based on office protocol, the nurse runs a pregnancy test.

The pregnancy test result is negative. Relieved, Amelia asks the nurse to provide information on birth control methods because she and her husband do not want another child right away. Amelia states that she has successfully used birth control pills in the past. When the nurse gently explores Amelia's strategies for consistent, daily use of the pill without gaps, Amelia says that this aspect of pill use was sometimes challenging. She had missed pills but, from her perspective, was lucky because she had never experienced an unintended pregnancy.

Risk of pregnancy in the postpartum period while breastfeeding

The timing of the six-week postpartum visit is largely based on historical practices and long-time beliefs that the uterus will return to a state by then conducive to a pelvic exam. It is also based on the outdated view that women do not resume sexual intercourse prior to six weeks. Speroff and Mishnell (2008) argue that it is time to change the timing of the postpartum visit to three weeks postpartum in order to appropriately assess women's physical and social well-being and to provide contraception in a timely fashion prior to women resuming sexual intercourse.

In Speroff and Darney's book *A Clinical Guide for Contraception*, the "Rule of Threes" states that with full breastfeeding, a contraceptive method should be used beginning in the third month and if not breastfeeding or partially breastfeeding, a contraceptive method should be used beginning in the third week. This is because the range of return to menses while breastfeeding varies widely from 2-18 months postpartum. Exclusive or continuous breastfeeding generally delays the resumption of ovulation and menses. Hormonal shifts that sustain lactation prevent ovulation if the mother is breastfeeding exclusively, is not gone for long periods of day or night between feedings, menses have not returned, and the baby is less than 6 months old. Ovulation usually occurs about two weeks before the onset of the first menses postpartum and there is no certainty when menses and ovulation will begin.

According to the *CDC's U.S. Selected Practice Recommendations for Contraceptive Use, 2016* breastfeeding can be a highly effective form of contraception for women who are within 6 months postpartum, are fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [greater than 85%] of feeds are breasfeeds), and are amenorrheic; the risk for pregnancy is less than 2%. A Cochrane review also concluded that women who are fully breastfeeding and remain amenorrheic, have a very small risk of pregnancy in the first six months postpartum. However, LAM is a temporary form of birth control, which means that once menses return, breastfeeding is no longer an effective contraceptive method.

If Amelia wants to space her pregnancies, she will want to consider another contraceptive method.

What are Amelia's contraceptive options?

BOX A1. Categories for classifying hormonal contraceptives and intrauterine devices.

1 = A condition for which there is no restriction for the use of the contraceptive method.
2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
4 = A condition that represents an unacceptable.

a. <21 days postpartum rates implants, injections, and progestin only pills are rated as a two. Combined hormonal contraceptives are rated as a four (do not prescribe).

b. 21 to <30 days postpartum

i. With other or without risk factors for VTE (e.g., age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, peripartum cardiomyopathy, BMI ≥30 kg/m2, postpartum hemorrhage, postcesarean delivery, preeclampsia, or smoking) implants, injections, and progestin only pills are rates as a two with combined hormonal contraceptives rated as a three.

c. 30–42 days postpartum

i. With other risk factors for VTE (e.g., age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, peripartum cardiomyopathy, BMI ≥30 kg/m2, postpartum hemorrhage, postcesarean delivery, preeclampsia, or smoking) implants, injections, and progestin only pills are rated as one and combined hormonal contraceptives are rated as a three.

ii. Without other risk factors for VTE implants, injections, and progestin only pills are rated as one and combined hormonal contraceptives are rated as a two.

d. >42 days postpartum, implants, injections, and progestin only pills are rated as one and combined hormonal contraceptives are rated as a two.

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What happened (continued)

After Amelia chooses a contraceptive method that she is comfortable and confident in using, she will continue to use daily prenatal vitmains. At some point when Amelia no longer is nursing, she can transition to a multivitamin with at least 400mcg of folic acid.

What if...

This section offers a twist or a different perspective on "What Happened" to guide and encourage learners to tease apart various aspects of the Patient Situation.

Amelia wanted an IUD?

Many clinics will insert IUDs on the same day without scheduling another appointment. The advantage of this scheduling is that the IUD begins acting immediately to prevent unintended pregnancy. Amelia's options for intrauterine devices in the U.S. include a copper IUD the FDA has approved for up to 10 years and levonorgesterel releasing hormonal IUDs which has been approved for up to 5 years. However, based on recent research findings, many clinicians are using copper IUDs for 12 years, and hormonal IUDs for 7 years (off-label).

The *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016* (MEC) provides detailed guidance in the use of IUDs in the immediate postpartum period and throughout the postpartum period for both breastfeeding and nonbreastfeeding mothers. The MEC states that if there is no evidence of puerperal sepsis, the copper IUD can be inserted at any time postpartum, including immediately postpartum. The hormonal IUD (levonorgesterel) can be inserted at any time, including immediately postpartum if it is reasonably certain that the woman is not pregnant. IUD expulsion rates are somewhat higher when inserted within 28 days

of birth compared to waiting until 4 weeks or later.

The presentation *IUD's – Dispelling the Myths* from the Reproductive Health Access Project, uses case studies to present factual information about intrauterine devices and their mechanisms, compares different types, and side effects including non-contraceptive advantages.

LARC FIRST is a comprehensive website that not only provides information on long-acting reversible contraceptive methods, but also includes videos, counseling tips, training and preceptoring information, quality management, and patient resources.

Amelia were not breastfeeding?

According to Speroff and Darney's "Rule of Threes" women who are not breastfeeding can begin using a contraceptive method in the third week postpartum. Jackson and Glasier (2011) examined evidence regarding the return to fertility among non-breastfeeding postpartum women and indicated that ovulation can occur as early as 25 days postpartum, although fertile ovulation likely will not occur until at least 42 days postpartum. In terms of hormonal contraception, the current evidence (MEC, 2016) generally recommends waiting until 42 days postpartum to begin hormonal pills, patches or rings. In women who are less than 21 days postpartum, use of combined hormonal contraceptives represents an unacceptable health risk and should not be used (Category 4). In women who are 21 – 42 days postpartum and have risk factors for venous thromboemolism (VTE) in addition to being postpartum, the risks for combined hormonal contraceptives usually outweigh the advantages and should not be used (Category 3). In the absence of other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks and can be used (Category 2 or Category 3 if breastfeeding). In women who are more than 42 days postpartum, no restriction applies for combined hormonal contraceptives (Category 1 or Category 2 if breastfeeding).

Providing evidence-based contraception counseling and care to women with specific medical conditions can be challenging. In 1996, the WHO published the first edition of the MEC to give evidence-based guidelines on the safety of contraceptive method use for women with specific medical conditions. The U.S. did not adopt the document until 2010 when the CDC adapted the MEC for use with the U.S. population. An easy-to-read, one page double sided, color coded summary chart is available in English and Spanish to download on portable devices.

References

Speroff and Mishnell. (2008). The postpartum visit: it's time for a change in order to optimally initiate contraception. http://www.contraceptionjournal.org/article/S0010-7824(08)00162-5/abstract

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