Take Home Messages

- Oestrogen-containing contraceptives are not recommended in the first three weeks postpartum because of the significantly higher risk of venous thromboembolism.

- After six weeks, the benefits of low dose combined contraception appear to outweigh any proven or theoretical risks for the breastfeeding woman and her infant and there are no restrictions at all beyond six months.

- The assumption that couples will not have resumed sexual activity by six weeks is erroneous, as Australian research suggests that at least 41% have done so.

Introduction

Initiation of contraception in the immediate post-partum period is a safe and cost-effective way of reducing the rates of both unintended pregnancy and early repeat deliveries. However, contraception is often neglected in the hospital setting, given the understandable immediate focus on pregnancy and delivery. Traditionally, the discussion of contraception has been deferred until the six-week check, but this neglects the fact that ovulation can occur within twenty-five days of delivery in women who are not breastfeeding. The assumption that couples will not have resumed sexual activity by six weeks is also erroneous, as Australian research suggests that at least 41% have done so.

The Natural Approach: Breastfeeding, Fertility Awareness and Barrier Methods

Women who exclusively breastfeed, have not yet resumed menstruating and who are within six months of delivery have around a 2% risk of pregnancy. However, should any one of these conditions alter, the contraceptive effect of breastfeeding plummets...
Ovulation can occur within twenty-five days of delivery in women who are not breastfeeding

Barrier contraception appeals to many couples, as it avoids the use of any exogenous hormones. Condoms have a typical failure rate of 15%, but with careful use and the decreased fertility associated with breastfeeding, most couples will have more success than this postpartum. The use of a diaphragm should be delayed until uterine involution has ended. The ‘one-size-fits-most’ CAYA® is now the only diaphragm now available in Australia. It has a typical failure rate of around 18%, but again, this rate is likely to be decreased during lactation. It is recommended that for maximum efficacy the CAYA® is always be used with its companion cellulose-based gel. If artificial lubricants are used, it is important to ensure that they are compatible with the barrier method chosen. This means only water-based lubricant can be used with latex condoms, though plastic condoms can be used with either oil-based or water-based products.

What about Combined Contraceptive Methods in the Postpartum Period?

Oestrogen-containing contraceptives are not recommended in the first three weeks postpartum because of the significantly higher risk of venous thromboembolism at this time. For breastfeeding women, this proviso against combined contraception extends until the infant is six weeks of age since oestrogen may impact on milk supply while feeding is being established. After six weeks, the benefits of low dose combined contraception appear to outweigh any proven or theoretical risks for the breastfeeding woman and her infant and there are no restrictions at all beyond six months. Mothers should be aware that with all hormonal methods of contraception, small amounts of hormone will be present in the breast milk. One recent systematic review found that no studies indicated an effect on infant growth or other infant health outcomes with the initiation of combined contraception beyond six weeks’ postpartum.

What about Progestogen-only Methods in the Postpartum Period?

Systematic reviews of studies examining the effect of progestogen-only contraception on breastfeeding parameters (such as milk quality and infant development) have never found any significant adverse impact. Progestogen-only pills (POPs), also known as minipills, have traditionally been the first choice for contraception during lactation but it is no longer recommended that their initiation be delayed until six weeks. One problem with POPs is the requirement that they be taken within three hours of the usual administration time. This can be difficult given the demands of new motherhood.

Contraceptive implants may be easier to manage and may certainly be used by all women in the immediate post-partum period, whether they are breastfeeding or not. The Faculty of Sexual and Reproductive Health Care in the United Kingdom also deems the depo-medroxyprogesterone acetate contraceptive injection broadly usable for most women immediately after delivery. The World Health Organisation, however, suggests that the contraceptive injection be delayed until six weeks’ postpartum, because of the higher initial doses likely to be excreted in breast milk. In some countries, though not Australia, breastfeeding women have access to a progesterone-only vaginal ring which delivers 10mg of progesterone per day. Each ring provides contraceptive cover for three months and is 98.5% effective (provided the women breastfeeds more than four times daily).

What about Intrauterine Methods?

Intrauterine devices (IUDs), both copper and hormonal, offer effective, immediate, long-term contraception and are rapidly reversible. The copper IUD has the advantage of being not only very effective but completely non-hormonal; this can be an important consideration for some mothers. Placement of an IUD within forty-eight hours of delivery (or at Caesarian) is associated with an increase in risk of expulsion (12% to 24% as opposed to approximately 4%). However, the risk of expulsion significantly increases in the period from forty-eight hours to four weeks’ postpartum; one study gave the rate of this complication as 70%. For that reason it is usually recommended that insertion be delayed until four weeks’ postpartum.

What about Emergencies?

Emergency contraception is considered unnecessary if unprotected intercourse occurs in the in the first twenty-one days postpartum. Until four weeks after the birth, complications such as an increased risk of perforation and expulsion generally outweigh the benefits of a copper IUD insertion as a means of emergency contraception. Both levonorgestrel and ulipristal emergency contraception can be used by mothers safely from three weeks’ postpartum. However, since breastmilk must be discarded for one week after taking ulipristal, levonorgestrel emergency contraception is preferred in breastfeeding mothers.
What about Something More Permanent?

It is usually recommended that female tubal sterilisation be performed more than six weeks’ post-vaginal delivery, since tubal occlusion devices are more reliably placed at that time. However, if the woman has had an elective Caesarian, the procedure may be performed directly afterwards. One issue to be considered is that tubal occlusion failure rates rise over time. Although the failure rate in first year after surgery is one in two hundred and fifty, this rises to one in fifty-four by ten years’ postpartum. At best, sterilisation can only offer a younger woman a one in three hundred lifetime failure rate. Vasectomy is technically a much easier procedure, can be performed under twilight sedation only and has a much lower rate of serious complications when compared to tubal occlusion. The failure rate usually quoted for male sterilisation is around one to two per thousand.

Starting the Discussion about Postpartum Contraception

The ideal time to initiate the discussion of postpartum contraceptive needs is while the patient is still pregnant. It is important to provide the women or the couple with an evidence-based discussion of their various options and to provide prescriptions in advance, if appropriate. On a practical note, if her choice is an implant or an IUD, taking this to the hospital prior to the birth maximises the chances of insertion before discharge. Lastly, extol the virtues of ‘bridging’ – a pill or contraceptive injection might not be the ultimate contraceptive choice, but can provide an excellent stop-gap measure until a woman’s long-term method can be arranged.

Further reading


