Postpartum Contraception

Darrah Berck, PGY2
Grand Rounds
December 6, 2017
Overview

- Unintended Pregnancy
- Short Interval
- Postpartum Period
- Contraception Specifics
- Barriers to Care
Unintended Pregnancy

- 45% all pregnancies in United States
  - Cost $21 billion in 2010 for prenatal, L&D, PP, infant to 1 year care

- Risk Factors
  - Low socioeconomic status, Younger age (18-24), Lower education level
  - Cohabitation, Minority race (African American, Hispanic)

- **Negative Outcomes**
  - Delayed initiation of prenatal care
  - ↓ Likelihood of breastfeeding
  - ↑ Risk of maternal depression
  - ↑ Risk of physical violence during pregnancy
  - Child – poor mental & physical health, lower educational attainment
Postpartum Problem

- 40-57% of women report unprotected intercourse before 6 weeks
- Ovulation: 25-39 days postpartum in non-lactating women
- Within first year, 70% of all pregnancies are unintended
- Up 40 to 50% women will not attend postpartum visit
- *Adolescents*
  - 12 – 49% of postpartum teens experience short-interval pregnancy
  - Less likely to graduate or attain GED
  - Earn $3,500 less than those who delay childbearing into late 20s
  - Receive 2x federal aid for twice as long
Short Interval Pregnancy

**Definition**
- “Interval” = birth to conception
- No standard, anywhere up to 18mths
- Greatest risk at ≤ 6 mths

**Complications**
- Maternal anemia (30% increase)
- pPROM and preterm birth (< 6 mths = 3.6x increase)
- Placental abruption (< 6 mths = 1.8x increase)
- Congenital anomalies (folate specific)
- Low birth weight and SGA
Short Interval Pregnancy

- **Optimum Counseling**
  - Ideally 18mths, range 12-24 mths
  - 12mths is “acceptable” for women > 35 yrs, balance fertility
  - “When ready” after miscarriage
    - 2016 meta-analysis showed no increase adverse outcomes
  - 18 – 24 mths for CS, especially desiring TOLAC
Gold Standard: LARC?

**Benefits**
- Among most effective methods overall
- Require no “ongoing effort” on part of patient
- Generally rapid return to fertility with removal
THE CONTRACEPTIVE CHOICE PROJECT:

Positive Impacts of Expanding Access to LARCs

Increasing counseling and removing cost barriers result in higher use of LARCs and lowered rates of abortion and unintended pregnancy.

The Contraceptive CHOICE Project in St. Louis, Missouri, provided counseling and no-cost reversible contraception to more than 9,200 diverse women and adolescents wanting to prevent pregnancy for at least 12 months.5,10

> After standardized counseling on contraceptive methods, 75% of women chose a LARC.
> 86% of women who chose a LARC method were still using that method one year later, compared to 55% of women who chose a non-LARC method.
> Rates of unintended pregnancy were 20 times higher among women using a non-LARC method (birth control pill, patch, or ring).
> The abortion rate among the CHOICE participants was less than half the national and regional rates.
> The teen birth rate among the CHOICE participants was 6.3 births per 1,000, compared to the national rate of 34.3 births per 1,000.10
Postpartum LARC

**Benefits**
- Among most effective methods, highest continuation rate
- Women known not to be pregnant
- Motivated to commit to contraception
  - 80% women desire no pregnancy for 2 years
- No additional visit, insurance coverage
- 4x more likely to have optimum pregnancy interval

**Barriers**
- Low postpartum visit rate follow-up, 10-50% do not attend
- 40-75% of those who intend IUD postpartum do not receive
- Inability to pay, not offered, need for repeat visit/abstinence
Implant

- **Use**
  - May be inserted in delivery room or throughout PP stay
  - No + contraindications in postpartum period
  - Same technique

![Implant Image]
Intrauterine Device

- **Use**
  - Best placed within 10 minute of placental delivery
  - Requires altered technique and training
  - Contraindications – chorio, endometritis, sepsis, PPH
  - Not been associated with increased pain, infection, or bleeding

- **Expulsion**
  - Higher rate than interval placement
  - NSVD: 20-30%, CS 8-12%, Interval 3-5%
  - Cost-benefit: reduce unintended pregnancy > expulsion

- **Comparison at 6 mths**
  - Immediate vs. interval placement, 83% vs. 64%
  - Interval – 39% did not obtain (25% DKNA, 14% declined)
Depo Provera

- **Use**
  - May be given during postpartum stay

- **Benefits**
  - Greater effectiveness than OCPs
  - 3-mth interval dosing

- **Drawbacks**
  - Irregular bleeding, prolonged anovulation
  - Requires more regular follow-up
Oral Contraceptives

- **Micronor**
  - May be given at discharge
  - Does not reliably inhibit ovulation
  - Effects of mucous thickening only last 24 hrs

- **Combined OCPs**
  - Given at 3-4wks PP, pending VTE risks
  - May have effect on milk production
Postpartum LARC1 vs Non-LARC2

Breastfeeding

- **Lactogenesis** – progesterone withdrawal trigger
  - Theoretical concern that exogenous progesterone limits effect

- **Limited Data**
  - Implant 3 days PP vs. 4-8 wks – no difference in ability
  - Copper vs. Mirena IUD at 6-8 wks PP – duration, growth
  - Mirena immed vs. delayed – more continued BF at 6 mths
  - Implant vs. copper 4-6 wks – no diff milk content, growth

- Women should be counseled about theoretical risk
### Postabortion Use

#### Benefits
- Safe and effective, may ovulate within 10 days
- 3x more likely to choose IUD immediately vs interval

#### Use
- IUD may be inserted immediately after D&C or D&E
- No difference in 6mth expulsion for 1st trimester
- Place within 1 to 6 weeks after medication-induced
- Same-day administration possible for implant
Barriers

- **Knowledge**
  - Lack of patient interest, lack of provider training
  - Overly restrictive criteria for use
  - Convenience and time-constraints

- **Cost**
  - LARCs generally cost-effective even with use at 12-24mths
  - Most insurance cover contraception with little cost sharing
  - Issue of reimbursement separate from global delivery
Health Policy

- 2012 – SC first state to offer reimbursement PP
- Now more than half all states have guidelines
  - 7 states have complete separate coverage
- Kansas
  - $166 million spent on unplanned pregnancies (2010)
  - 34% of births are funded by Medicaid (2016)
  - **No Policy** for Medicaid postpartum LARC reimbursement
“Reproductive Life Planning”

- Set of personal goals on whether, when, and how to have children based on individual priorities, resources and values

- Every Woman, Every Time
  - “Would you like to become pregnant in the next year?”

- Counseling
  - Contraception - health status, sexual behavior, personal choice
  - Yes – lifestyle modifications to optimize health

- Support initiatives to improve access to care
Conclusion

- Ovulation can occur within 25 days PP
  - Women who are sexually active should initiate contraception
- LARCs reduce unintended, short interval pregnancy
- **Postpartum Access Initiative** – ACOG + LARC
  - “Ensure all women have access to the full range of postpartum contraceptive methods before leaving the hospital after delivery”
- Counseling
  - Both antepartum and postpartum
  - Phone calls to increase follow-up, Rx for clinic pts?
References

- ACOG.org. Immediate Postpartum LARC. https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC
- South Carolina Postpartum LARC Toolkit.
- UpToDate. “Interpregnancy Interval and Obstetrical Complications.”
- UpToDate. “Postpartum Contraception: Initiation and Methods.”