POSTPARTUM COUNSELING
A Quick Reference Guide for Clinicians

Contents

This publication has been made possible by an unrestricted educational grant from GlaxoSmithKline Consumer Healthcare

POSTPARTUM COUNSELING
A Quick Reference Guide for Clinicians

Using This Guide

This *Quick Reference Guide for Clinicians* is designed to assist health care providers counsel women in the postpartum period. Three important areas of concern to these patients are addressed:

- Diet, nutrition, and exercise
- Mood disorders
- Sexuality and contraception

Each section includes a list of counseling points that the provider should cover in talking with the patient, as well as a discussion of the related health issues. Because appropriate counseling depends upon identification of the patient's needs and concerns, comprehensive screening and assessment must precede it. Key elements in postpartum screening and assessment are presented in a table on the following page.

This guide focuses on the postpartum follow-up visit—4 to 6 weeks after delivery—for women who had an uncomplicated pregnancy and a vaginal delivery. Much of the information it contains is relevant for other women in the postpartum period as well, but those who have had Cesarean deliveries, obstetrical complications, or other health problems will need counseling on additional topics not addressed here. Moreover, a number of the assessment and counseling points identified in the guide should also be addressed at earlier points in the perinatal period.

Health care providers have a clear responsibility to counsel their postpartum patients on the issues presented in this guide. But their time and opportunity to do so is limited. The Association of Reproductive Health Professionals (ARHP) hopes that presenting these issues together in a brief, easy-to-use format will facilitate their systematic incorporation into the care of patients at an important period of change and adjustment.

POSTPARTUM COUNSELING CHECKLIST

ASSESSMENT AND SCREENING

Physical exam

- ❑ Weight
- ❑ Height
- ❑ Body mass calculation (compare with pre-pregnancy)
- ❑ Lab work
- ❑ Perineal healing/vaginal discharge
- ❑ Condition of breasts
- ❑ Diastasis recti

Emotional adjustment

- ❑ Postpartum Depression Screening Scale (PDSS) or Edinburgh Postnatal Depression Scale (EPDS)
- ❑ Postpartum Depression Predictors Inventory (PDPI)
- ❑ Sleeping pattern; level of fatigue
- ❑ Availability of resources and support
- ❑ Relationship with spouse/partner

Diet, nutrition, and exercise

- ❑ Eating patterns, nutrition review
- ❑ Use of calcium supplement
- ❑ Continuing use/non-use of prenatal vitamin and mineral supplements
- ❑ Cultural conditions surrounding diet
- ❑ Status of breastfeeding
- ❑ Weight loss concerns and expectations
- ❑ Alcohol consumption
- ❑ Substance abuse
- ❑ Constipation
- ❑ Exercise level (current, pre-pregnancy)
- ❑ Readiness to return to work

Sexuality

- ❑ Sexual relations
- ❑ Contraceptive use
- ❑ Incontinence
- ❑ Pelvic and abdominal muscle exercise

Feel free to copy or visit www.arhp.org/guide/ for a printable version.

Diet, Nutrition, and Exercise

Good nutrition counseling for the postpartum woman should have its basis in accepted guidelines for a well-balanced nutritious diet. The US Dietary Guidelines published by the US Department of Agriculture and endorsed by the American Dietetic Association, are recommended.[1] Counseling must also be tailored to the individual woman and take into account risk factors for poor nutrition such as teenager status, restrictive dietary practices (e.g., vegan), excessive weight gain during pregnancy, deviation from ideal body weight, multiple gestations, history of eating disorders, and close interconceptional period. An additional 500 Kcal/day is recommended for women who breastfeed (2,700 Kcal versus 2,200 for non-pregnant, non-lactating women). Even higher intake may be recommended for lactating women who are underweight, exercise vigorously, or need to produce enough milk for more than one infant.[2]

POSTPARTUM COUNSELING CHECKLIST
DIET, NUTRITION, AND EXERCISE

- ❑ Importance of good nutrition and appropriate caloric intake
- ❑ Reasonable expectations for weight loss
- ❑ Importance of calcium, food sources, and value of calcium supplementation
- ❑ Continued use of prenatal vitamin and mineral supplement if proper nutrition is a concern
- ❑ If patient is anemic
  - ❑ Importance of iron, food sources, and supplementation
- ❑ Constipation
- ❑ Fluid consumption
- ❑ For breastfeeding mothers
  - ❑ Encouragement
  - ❑ Additional caloric requirements
  - ❑ Alcohol and caffeine consumption
- ❑ Exercise

Feel free to copy or visit www.arhp.org/guide/ for a printable version.

FOODS HIGH IN CALCIUM

Dairy Products

- Plain, 2% fat yogurt, 1 cup - 415 mg
- Nonfat dry milk, 1/2 cup - 377 mg
- Skim milk, 1 cup - 302 mg
- Buttermilk, 1 cup - 285 mg
- Part-skim mozzarella Cheese, 1 oz. - 207 mg
- Cheddar cheese, 1 oz. - 204 mg

Fish

- Sardines, 3 oz. - 372 mg
- Oysters, 1 cup - 226 mg
- Salmon in can, 3 oz. - 167 mg

Greens

- Collard, 1/2 cup - 179 mg
- Kale, 1 cup - 179 mg
- Beet, 1 cup - 165 mg

Other

- Waffle/pancake with milk/egg - 179 mg
- Dark molasses, 1 Tbsp - 137 mg
- Tofu, 1/2 cup - 130 mg
- English muffin - 96 mg

Calcium, magnesium, zinc, vitamin B_6 and folate are nutrients likely to be consumed in lower than recommended amounts.[3] If inadequate nutrition is suspected, continued use of prenatal vitamin-mineral supplementation may be appropriate. Since prenatal supplements generally do not include a significant amount of calcium, the patient should be apprised of the need for additional supplementation to meet the need for this key mineral.

Calcium. The RDA of calcium for lactating women, as for pregnant women, is 1,200 mg/day. Postpartum women are also

concerned with weight loss, and there is some evidence that diet-induced weight loss results in generalized bone loss.[4] Given the important functions of calcium in the body—aiding in muscle relaxation, blood coagulation, nerve impulse transmission, and enzyme reactions as well as promoting tooth and bone health and preventing osteoporosis[5]—and the fact that the postpartum period is a time when women tend to be receptive to health counseling, this is an excellent opportunity to promote lifelong habits to ensure adequate calcium intake.

There is evidence that, in comparison with a low calcium diet, a high calcium diet may increase weight loss,[6,7] and this fact may be an incentive for some women to boost their calcium intake. Most women do not obtain enough calcium from dietary sources and will benefit from calcium supplementation. Calcium carbonate (found in Tums®, Os-Cal® and certain other supplements) is readily absorbed by most people[8] and is the least costly form of calcium supplement. To improve absorption, suggest to patients that, they divide their daily calcium supplement into two or three doses, taken with meals.

Iron. Unless blood loss is higher than usual during vaginal delivery, dietary requirements for iron return to pre-pregnancy levels in the postpartum period—15mg/day. Postpartum iron supplementation may be indicated when the interval between pregnancies is short. In the presence of a low hemoglobin or hematocrit, and if other causes of anemia such as thalassemia have been ruled out, oral supplementation of 60-120 mg of iron should be prescribed. Fortified cereals like Total® or Product 19® provide significant amounts of iron. Oysters, beef liver, and lean beef are excellent sources of iron. Other good, non-meat food sources include tofu and, to a lesser extent, potato with skin, watermelon, figs, spinach, chard, and dried fruits such as apricots, raisins and prunes. Foods that inhibit iron absorption, such as whole-grain cereals, unleavened whole-grain breads, legumes, tea, and coffee, should be consumed separately from iron-fortified foods and iron supplements.[9] For

women taking a supplement of more than 30 mg of iron daily, 15 mg zinc and 2 mg of copper supplementation is recommended to counter iron's interference with absorption of these minerals.[10]

Fluid intake. Adequate fluid intake is an important element of good nutrition. Women, especially those lactating, should be encouraged to drink enough to satisfy thirst.[11] However, controlled studies provide no evidence that increased fluid intake results in improved lactation, and increasing fluids will increase diuresis, which could cause perineal and labial trauma discomfort to increase.[12]

Weight loss. Returning to their pre-pregnancy weight is a common concern among postpartum women. With proper diet and exercise, much of the weight they gained during pregnancy will be shed naturally during the postpartum period. The goal should be gradual weight loss. For all but those women with high or very high pre-pregnancies weights, the recommended weight loss after the first month postpartum is a maximum of 4.5 lbs/month.[13] Caloric intake should not fall below 1,800 kcal per day, and this figure may need to be revised upward based on such considerations as breastfeeding, nutritional status, and level of activity.[14] Weight loss should not be promoted as a benefit of breastfeeding. Some studies have suggested that lactation may actually impede weight loss.[15]

Alcohol and caffeine. Occasional consumption of small amounts of alcohol, and moderate ingestion of caffeine-containing products are not contraindicated during breastfeeding, according to guidelines of the Institute of Medicine (IOM).[16] The American Academy of Pediatrics (AAP), while noting that excessive maternal consumption may adversely affect the infant who is breastfeeding, also considers moderate consumption of alcohol and caffeine to be compatible with breastfeeding. Women should be cautioned that consuming large amounts of alcohol may interfere with their ability to breastfeed effectively and may adversely affect their infant in other ways as well.[17] Alcohol consumption may also impair a mother's ability to nurture and care for her infant.

Constipation. A common problem during pregnancy and afterwards, constipation may be caused by slack muscles following delivery, inadequate fluid intake, a diet low in fiber, iron or calcium supplementation, painful hemorrhoids or perineum, or fear of damaging episiotomy repair during a bowel movement. Suggestions for preventing constipation include eating foods high in fiber, drinking 8 to 10 large glasses of liquid (water, juice—including prune juice—or milk), and getting regular exercise. Encourage the use of ice packs or sitz baths to alleviate persistent hemorrhoid or perineal pain that may interfere with bowel movements.

Exercise. Published studies confirm the importance of regular exercise in the postpartum period, as in other times of life, although its effect on weight loss may not be significant without specific calorie restriction.[18] Women should be encouraged to exercise and reassured that exercise will not adversely affect their ability to breastfeed successfully. Even exhaustive exercise has been shown to increase lactic acid levels only minimally and to have no effect on infant acceptance of breast milk one hour after exercise.[19,20] Advise patients to breastfeed before exercising in order to minimize discomfort of engorged breasts, and to allow time for any transient post-exercise elevation of lactic acid to decline before another feeding time occurs.

Postpartum women should also be encouraged to perform exercises to strengthen pelvic floor and abdominal muscles. Kegel pelvic floor exercises can be effective in reducing the risk of stress incontinence.[21] If postpartum exercise programs are available in hospitals or other locations in your community, suggest them to patients as a good way to get needed exercise and meet other women with new infants. Appropriate exercise level will depend on the individual woman's level of fitness and recuperation from delivery. Some women may be able to engage in an exercise routine within days of delivery.[22] Gradual resumption of exercise is recommended to gauge effect and identify appropriate level of intensity.

References

[1]http://www.usda.gov/cnpp/Pubs/DG2000. [2]Institute of Medicine. *Nutrition Services in Perinatal Care: Second Edition.* 1992. [3]Institute of Medicine. *Nutrition Services in Perinatal Care: Second Edition* 1992. [4]Jensen LB, et al. *J Bone Miner Res* 2001. [5]American Dietetic Association. 2003; www.eatright.com/erm/erm090497.html. [6]Heaney RP, et al. *J Am Coll Nutr. 2002.* [7]Zemel MB. *J Amer Coll Nutr* 2002. [8]Heaney RP, et al. *Calcif Tissue Int* 1990. [9]American Dietetic Association 2002; www.eatright.com/adar1002b.html. [10]American Dietetic Association. 2002; www.eatright.com/adar1002b.html. [11]American Academy of Pediatrics & The American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care: Fifth Edition.* 2002. [12]Nelison, et al. London: Oxford University Press.2000. [13]Institute of Medicine. *Nutrition During Pregnancy and Lactation.*1992. [14]Institute of Medicine. *Nutrition Services in Perinatal Care: Second Edition.* 1992. [15]Reece EA, et al. *Medicine of the Mother and Fetus.* 1999. [16]Institute of Medicine. *Nutrition During Lactation*. 1991. [17]American Academy of Pediatrics. *Pediatrics* 2001. [18]Larson-Meyer DE. *Obes Res* 2002. [19]Larson-Meyer DE. *Obes Res* 2002. [20]Wright KS, et al. *Pediatrics 2002.* [21]Meyer S, et al. *Obstet Gynecol* 2001. [22]ACOG Committee on Obstetric Practice. ACOG Committee opinion. 2002.

Mood Disorders

Postpartum mood disorders pose health risks for mother and infant and impair family relationships. Screening and counseling for these disorders is essential to preventing the serious consequences of postpartum depression, but are not routinely incorporated into postpartum care. Because delay in receiving adequate treatment is considered the most significant factor in the duration (and perhaps severity) of postpartum depression (PPD),[1] providers must be proactive in identifying the woman at risk, and provide appropriate counseling and/or referral.

POSTPARTUM COUNSELING CHECKLIST
MOOD DISORDERS

- ❑ Common to experience "baby blues" in first week postpartum
- ❑ Postpartum mood changes not the fault of the mother
- ❑ Role of good diet, sleep, and exercise in managing mood swings
- ❑ Importance of being aware of predisposing risk factors
- ❑ Time frame in which serious postpartum depression can develop
- ❑ Strategies for preventing depression
- ❑ Importance of seeking help if depression develops
- ❑ For the woman who appears at risk
  - ❑ Reassurance that she is not alone; help is available
  - ❑ Appropriate referral

Feel free to copy visit www.arhp.org/guide/ for a printable version.

Postpartum mood disorders are usually grouped into the following categories:

- Baby blues
- Postpartum depression (PPD)
- Postpartum psychosis (PPP)[2]

Anxiety disorders, such as panic disorder, social phobia, generalized anxiety, and obsessive-compulsive disorder are also considered part of this cluster.[3]

"Baby blues" refers to commonly occurring mood swings or mild feelings of sadness following childbirth. Also called "*postpartum reactivity*," these feelings usually peak approximately 3-5 days postpartum and disappear within a couple of weeks after the baby is born.[4] *Postpartum depression (PPD)*, a far more serious disorder, usually develops within the first three months postpartum but may develop any time up until a year after childbirth. It is estimated to affect up to 18 percent of postpartum women.[5] Potential for the development of *postpartum psychosis* is highest within the few weeks after childbirth. Onset is sudden, characterized by hallucinations, delusions, agitation and other psychotic symptoms. Incidence is estimated at one to three in 1,000 postpartum women.[6]

Risk factors. Hormonal changes are theorized to be a causative factor in postpartum mood disorders,[7] although such changes may tend to affect those women already predisposed to the development of mood disorders.[8,9] Other factors are also known to put women at risk for the development of serious postpartum depressive problems, and these factors should be assessed by the clinician

POSTPARTUM DEPRESSION PREDICTORS INVENTORY (PDPI)

- Marital status
- Socioeconomic status
- Self-esteem
- Prenatal depression
- Prenatal anxiety
- Social support
- Unplanned/unwanted pregnancy
- Life stress
- History of previous depression
- Child care stress
- Marital satisfaction
- Infant temperament
- Maternity "blues"

Source: see reference 10

periodically during a woman's pregnancy, in the hospital or maternity care center following delivery, as well as at the time of the postpartum follow-up visit.[10] A personal or family history of depression, anxiety, bipolar disorder or other mental illness is key among these risk factors for PPD. Stress, marital conflict, lack of social support, low self-esteem, infant temperament, and fatigue are among other risk factors that may signal vulnerability to PPD.[11,12]

Screening. A combination of provider-administered and patient self-report assessment tools is recommended to identify women at risk for PPD. The Postpartum Depression Predictors Inventory (PDPI-Revised) is a guide for the provider interviewing a patient at any point between the preconception and postpartum periods.[13] It includes questions related to each of 13 predictors of PPD and assists the clinician in identifying issues for follow-up discussion and possible intervention.

Two well-tested, non-threatening self-report screening tools are also available to gather information directly from the patient. The Edinburgh Postnatal Depression Scale (EPDS) assesses depressive mood in the past seven days based on patient responses to 10 questions related to mood, anxiety, guilt and suicidal ideation.[14] The Postpartum Depression Screening Scale (PDSS) comprises 35 items that cover seven dimensions of self-assessment: sleeping/eating disturbances, anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame, and suicidal thoughts.[15] While the EPDS is somewhat briefer than the PDSS, either one can be completed by the patient within 5-10 minutes.

Caring for the patient at risk. How a provider manages the patient at risk of PPD will depend on that provider's level of comfort in dealing with mental and emotional problems, prior experience with PPD, and perception of the seriousness of the presenting patient's problem.

If a patient appears at risk of serious depression or postpartum-related anxiety, the primary care provider should:

- Acknowledge to the patient that you are concerned
- Reassure her that this is a treatable problem, that it is NOT her fault, and that you—her health care provider—are there for her
- Encourage her to discuss how she is feeling
- Help her identify support systems and, if she consents, enlist their support for the patient
- Make referrals only to providers who will offer continuous care for as long as necessary

POSTPARTUM DEPRESSION

What to Say to Your Patient Who May Be at Risk

"Many women experience some degree of sadness or mood change after the birth of a baby. There are a number of things that may contribute to these feelings, and they are understandable. However, I am concerned about the level of sadness and depression that you expressed in your answers to some of the questions on the assessment form you completed (or: that I have asked). This sometimes happens, but not as a result of anything you have done. I think it is important to talk about exactly how you are feeling, and what to do about it. You do not have to deal with this problem alone."

Even women who exhibit no signs of depression, anxiety, or maladjustment at the time of the postpartum follow-up visit need to be educated about the ongoing risk of PPD *beyond* the initial month or two following childbirth. Hormonal shifts that can possibly trigger mood swings or depression may occur at several points in the postpartum period: weaning, resumption of menstruation or use of oral contraceptives.[16]

Review some of the steps that the woman can take to help ward off serious depression or anxiety, as well as promote general good health.

- Get enough rest
- Call on family and friends for help when needed to reduce stress
- Eat a well-balanced diet that provides adequate nutrition
- Get regular exercise
- Consider joining a mothers or postpartum support group

References

[1]Beck CT. *Am J Matern Child Nurs* 2002. [2]ACOG. News Release: Answers to common questions about postpartum depression. 2002. [3]Rapkin AJ, et al. *Curr Psychiatry Rep* 2002. [4]Kennedy HP, et al. *J Midwifery & Women's Health* 2002. [5]Flores DL, et al. *Curr Psychiatry Rep* 2002. [6]Indiana Perinatal Network. Postpartum depression consensus statement. October 2002. [7]Parry BL, et al. *Neuropsychopharmacology* 2001. [8]Parry BL, et al. *Neuropsychopharmacology* 2001. [9]Bloch M, et al. *Am J Psychiatry* 2000. [10]Beck CT. *J Obstet Gynecol Neonatal Nurs* 2002. [11]Cutrona C, et al. *Child Dev* 1986. [12]Bozoky I, et al. *J Obstet, Gynecol Neonatal Nurs* 2002. [13]Beck CT. *J Obstet Gynecol Neonatal Nurs* 2002. [14]Col JL, et al. *Br J Psychiatry.* 1987. [15]Beck CT, et al. *Nurs Res* 2000. [16]Parry BL, et al. *Neuropsychopharmacology* 2001.

Sexuality and Contraception

Sexuality in the postpartum period is subject to a number of physiological, psychological, and cultural influences. As at other times, it is a sensitive subject that can be difficult for both provider and patient to discuss. Yet sexual concerns are common and the majority of patients will welcome help from their primary care provider, who should therefore be prepared both to elicit patient concerns and respond to them.[1,2]

POSTPARTUM COUNSELING CHECKLIST
SEXUALITY AND CONTRACEPTION

- ❑ Status of perineal healing
- ❑ Resuming sexual intercourse
- ❑ Alternatives to intercourse
- ❑ Reassurance that lack of sexual desire is common/normal among women in postpartum period
- ❑ How to minimize discomfort during sexual relations
- ❑ Incontinence
- ❑ Importance of pelvic floor muscle exercises and how to perform them
- ❑ For the woman who is lactating
  - ❑ Effect of sexual activity on letdown reflex
  - ❑ Hormonal effects on sexual desire
  - ❑ Efficacy of lactational amenorrhea method (LAM) for contraception
  - ❑ Effect of estrogen-containing contraceptives
  - ❑ Alternative contraceptive choices
- ❑ Contraceptive options

Feel free to copy or visit www.arhp.org/guide/ for a printable version.

Patient attitudes about sexuality in the postpartum period. Perineal healing is normally sufficient to allow resumption of sexual intercourse somewhere between 4 and 6 weeks postpartum, perhaps even earlier.[3] Women who have not undergone episiotomy or laceration and repair may be comfortable resuming intercourse

earlier than those who have had episiotomy or sustained a laceration. Pain resulting from internal vaginal tears trauma to the perineum or other tissue may also serve to delay return to sexual relations.

Factors other than physical recovery from labor and delivery affect women's decisions about resuming sexual relations. Providers should be sensitive to the possibility of religious or cultural beliefs, fatigue, or other influences on a woman's attitude toward sexual intercourse in the early postpartum period. In some instances, the provider may want to suggest that other forms of sexual expression, such as touching and kissing, can help to re-establish physical closeness with a partner.

Diminished sexual desire. A lack of sexual desire is a very common experience in the postpartum period; studies indicate that a reduction in sexual interest and activity, compared to pre-pregnancy levels, is the norm during the first few months postpartum.[4,5] One study found that only 19 percent of couples studied had engaged in sexual intercourse at one month postpartum but that number increased to approximately 90 percent by the third

COMMON FACTORS IN POSTPARTUM SEXUAL ADJUSTMENT

- Episiotomy discomfort
- Fatigue
- Lack of sexual desire
- Vaginal bleeding or discharge
- Dyspareunia
- Insufficient lubrication
- Fears of awakening or failing to hear the infant
- Fear of injury
- Decreased sense of attractiveness

Source: see reference 7

month postpartum.[6] Most researchers report gradual return to pre-pregnancy levels of sexual desire, enjoyment and coital frequency within a year.[7]

Effects of breastfeeding. Breastfeeding may negatively affect sexual desire.[8] The effect of lactation on hormone levels offers one explanation. A 1986 study found that androgen levels were significantly lower in breastfeeding women who reported greater reduction in sexual interest; however, changes in sexuality and mood did not appear to be related to prolactin or estrogen levels.[9] The decline in estrogen levels during breastfeeding may indirectly affect sexual interest by producing a lack of vaginal lubrication that renders coital experience unpleasant.[10] The use of water-based vaginal lubricants can reduce discomfort during intercourse. (Petroleum-based products may cause irritation.) Vaginal moisturizers can also relieve vaginal dryness and pain.

Incontinence. Women may hesitate to raise the subject of incontinence, which can lead to sexual inhibition. Childbirth-related incontinence is usually temporary and nearly always diminishes over time. Kegel exercises strengthen the muscles of the pelvic floor, and have been shown to improve urine control, especially in women with mild (rather than severe) stress incontinence.[11] While some information resources for pregnant and postpartum women suggest that Kegel exercises also improve sexual response, most research refutes this.[12]

Choosing a contraceptive. Return to fertility is unpredictable and may return before the onset of regular menstrual cycles, even in breastfeeding women. Consequently, use of birth control should begin prior to resuming sexual activity. All women not undergoing sterilization or placement of an IUD/IUS should be offered emergency contraception as well, especially as back-up methods for other contraceptive options.

LAM. The Lactational Amenorrhea Method (LAM) may have a reliable contraceptive effect in the first six months postpartum if the woman is fully breastfeeding, i.e., the woman is amenorrhic, is breastfeeding every three to four hours, and is not supplementing infant suckling with bottle feedings or expressed breast milk.[13] Separation from the infant for many hours may also increase the risk of pregnancy in lactating women.[14] The need for skilled counseling and support, the lack of STI protection, and the intensive demands on a woman's time associated with LAM limit its suitability as a contraceptive choice, but for some women it can be an attractive, cost-effective—albeit temporary—form of birth control.[15]

Hormonal contraception and breastfeeding. Although some health care providers are using low dose estrogen-containing oral contraceptives with little effect on milk production, the standard of care for lactating women has been to avoid contraceptives containing estrogen, including oral and injectable contraceptives, the combination patch and the combination vaginal ring. Recommended options for the woman who is breastfeeding include the progesterone-only pill and injectable (Depo-provera®), diaphragm, cervical cap, IUD, levonorgestrel IUS (Mirena®), and—if she has completed childbearing—sterilization (male or female). Women who are breastfeeding should delay initiating use of progestin-containing contraceptives for 6 weeks after delivery to avoid exposing the newborn to exogenous steroids during the time of greatest neuroendocrine development. For these women, the risk of ovulating in the first 6 weeks postpartum is very low.[16]

Diaphragm/cervical cap. Because pregnancy and childbirth influence vaginal tone and may alter the size of the cervix and vagina, women choosing the diaphragm or cervical cap will need to be refitted for their contraceptive. Fitting should occur no earlier than 6 weeks postpartum to ensure that the cervix is no longer dilated and maximum healing has occurred.

IUD/IUS. The intrauterine device (IUD) and the levonorgestrel intrauterine system (LNG IUS) are long-acting, highly effective contraceptive options for both lactating and non-lactating women. The Copper-T IUD is effective for 10 years. Expulsion rates are slightly higher when the IUD is inserted immediate postpartum,[17] and many clinicians recommend delaying insertion for 4-6 weeks following delivery. The LNG IUS (Mirena®) is effective for a period of five years; the mechanism of action is similar to that of LNG implants or LNG containing mini-pills. Menstrual bleeding is substantially reduced, and women need to be counseled about the possibility of oligomenorrhea or amenorrhea.[18]

Sterilization. The vast majority of women who undergo sterilization (or whose husbands obtain a vasectomy) express no regret about their decision five years later.[19] An exception to this finding is women who had marital conflicts about the sterilization decision. Other studies have found increased incidence of regret following sterilization around the time of pregnancy.[20] Risk factors such as an unstable marriage, recent divorce, or other life changes should be taken into account when counseling women on this contraceptive option. Immediately postpartum is the ideal time to perform surgical sterilization, both from the standpoint of convenience and because the procedure may be covered by the patient's medical insurance. If surgical sterilization is requested later, the most common method is laparoscopy performed as ambulatory surgery.[21] A transcervical sterilization method (Essure™) has recently been approved for use in the US and provides a new option for delayed postpartum sterilization. Microinserts, placed into the fallopian tubes via the uterus, promote formation of scar tissue that blocks the tubes. By three months, both tubes are closed in 96 percent of women and, by six months, 100 percent of women experience tubal occlusion. Reliable contraception is required until an hysterosalpingogram (HSG) demonstrates that the inserts have been correctly placed and tubes are occluded.[22]

Click here or go to www.arhp.org/files/options.pdf
for a chart on contraceptive options in the postpartum period.

References

[1]Nusbaum MR, et al. *J Fam Pract* 2000. [2]Basson R. ww.medicalsexuality.org. November 2000. [3]Richardson AC, et al. *Am J Obstet Gynecol* 1976. [4]Von Sydow K, et al. *J Psychosom Obstet Gynaecol* 2001. [5]Von Sydow K. *J Psychosom Res* 1999. [6]Byrd JE, et al. *J Fam Pract* 1998. [7]Reamy KJ, et al. *Arch Sex Behav* 1987. [8]Kayner CE, et al. *J Fam Pract* 1983. [9]Alder EM, et al. *Br J Psychiatry* 1986. [10]Kayner CE, et al. *J Fam Pract* 1983. [11]Elia G, et al. *Obstet Gynecol* 1993. [12]Hoon, PW. *Clin Obstet Gynecol* 1984. [13]Kennedy, KI. *Adv Exp Med Biol* 2002. [14]Valdes V, et al.Co*ntraception* 2000. [15]Kennedy KI, et al. *J Hum Lact* 1998. [16]Population Information Program. Johns Hopkins School of Public Health. *Population Reports* 1996. [17]Grimes D, et al. *Cochrane Database Syst Rev* 2003. [18]Cos M, et al. *J Fam Plann Reprod Health Care* 2002. [19]Jamieson DJ, et al. *Obstet Gynecol* 2002. [20]Hatcher RA, et al. *Contraceptive Technology: Seventeenth Revised Edition.* 1998. [21]Westhoff C, et al. *Fertil Steril* 2000. [22]Association of Reproductive Health Professionals. *Clinical Proceedings*. May 2002.

Association of Reproductive Health Professionals (ARHP)

2401 Pennslyvania Avenue, NW, Suite 350
Washington, DC 20037
Telephone: (202) 466-3825
Fax: (202) 466-3826
E-Mail: arhp@arhp.org
Web: www.arhp.org

ARHP is non-profit 501(c)(3) educational organization that has been educating front-line health care providers and their patients since 1963. The organization fosters research and advocacy to improve reproductive health.

Additional copies of this guide may be ordered by calling (202) 466-3825 or visiting www.arhp.org. The guide may also be downloaded in PDF format at www.arhp.org/guide/.