

POSTPARTUM COUNSELING

A Quick Reference Guide for Clinicians®



Association of
Reproductive
Health
Professionals

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POSTPARTUM COUNSELING

A Quick Reference Guide for Clinicians

USING THIS GUIDE

This *Quick Reference Guide for Clinicians* is designed to assist health care providers in counseling women in the postpartum period. It addresses three important areas of concern to these patients:

- Diet, nutrition, and exercise
- Postpartum mental health
- Sexuality and contraception

Each section includes a list of counseling points that providers can use as a guide when talking with patients, as well as a review of related health issues.

Comprehensive screening and assessment should be performed first. This evaluation identifies individual patients' needs and concerns and informs appropriate counseling. Key elements in postpartum screening and assessment appear in the box on page 2.

This guide focuses on the postpartum follow-up visit—typically scheduled four to six weeks after delivery—for women who have had an uncomplicated pregnancy and a vaginal delivery. Much of this information is relevant to other women in the postpartum period as well, including those who have had cesarean deliveries. Women who experienced obstetrical complications or other health problems will need counseling on topics that are not covered here.

Health care providers have an important role in counseling their postpartum patients on the issues presented in this guide, but time and opportunity are often limited. The Association of Reproductive Health Professionals (ARHP) hopes this guide provides a brief, easy-to-use resource to facilitate addressing these issues during an important period of change and adjustment.

POSTPARTUM COUNSELING CHECKLIST ASSESSMENT AND SCREENING

Physical exam

- Weight
- Height
- Body mass index (BMI; compare with pre-pregnancy)
- Lab work
- Pelvic exam (perineal healing/vaginal discharge/ pelvic support)
- Breast exam
- Abdominal exam (diastasis recti)

Diet, nutrition, and exercise

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

Postpartum Mental Health

- Postpartum Depression Screening Scale (PDSS)
- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Predictors Inventory (PDPI)
- Sleeping pattern; level of fatigue
- Resources and support
- Relationship with spouse/partner
- Sibling adjustment

Sexuality and contraception

- Sexual relations
- Incontinence
- Contraceptive options

**You may photocopy this checklist or visit
www.arhp.org/PostpartumQRG for a printable version.**

DIET, NUTRITION, AND EXERCISE

The Dietary Guidelines published by the US Department of Agriculture and endorsed by the American Dietetic Association form the basis for nutrition counseling for postpartum women.¹

Counseling can be tailored to the individual woman based on risk factors for poor nutrition such as extremes of maternal age, restrictive dietary practices (e.g., vegan), excessive weight gain during pregnancy, deviations from ideal body weight, multiple gestation, history of eating disorders, and a close interconceptional period. An additional 500 Kcal/day is recommended for women who breastfeed (e.g., 2,300–2,500 Kcal/day versus 1,800–2,000 for a moderately active non-pregnant, non-lactating women).¹ Even higher intake may be recommended for lactating women who are underweight, women who exercise vigorously, or women who are breastfeeding more than one infant.²

Many women consume less than the recommended amounts of calcium, magnesium, zinc, vitamin B6, and folate.² New mothers are likely to have stopped taking a prenatal vitamin. If a nutritional deficit is suspected, reinstatement of prenatal nutritional supplementation may be appropriate. Prenatal supplements generally do not include a significant amount of calcium; in addition, during lactation, 250–350 mg of calcium is transferred daily from the mother to the neonate through breast milk.³ Patients should be apprised of the need for additional supplementation to meet the requirement for this key mineral.

Calcium. The recommended daily allowance of calcium for lactating women ages 19 to 50, as for pregnant and non-pregnant women, is 1,000 mg/day.¹ Adolescents may require 1,300 mg/day.¹ Some postpartum women restrict caloric intake for weight loss, and there is some evidence that diet-induced weight loss results in generalized bone loss in all women.⁴ Calcium has many functions in the body—aiding in muscle relaxation, blood coagulation, transmission of nerve impulses, and enzyme reactions, as well as promoting tooth and bone health and preventing osteoporosis. The postpartum period is a

POSTPARTUM COUNSELING CHECKLIST DIET, NUTRITION, AND EXERCISE

- Nutrition, caloric requirements
- Weight loss
- Supplements
 - Calcium
 - Iron
 - Prenatal vitamins
 - DHA, omega-3 fatty acids
- If patient is anemic
 - Iron
 - Food sources
 - Supplements
- Constipation
- Fluid consumption
- For breastfeeding mothers
 - Support and encouragement
 - Refer to local breastfeeding support groups, such as *La Leche League*, as needed
 - Additional caloric requirements
 - Alcohol and caffeine consumption
- Exercise
 - Pelvic and abdominal muscle conditioning

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time when women tend to be receptive to health counseling, and this provides an excellent opportunity to promote lifelong habits to ensure adequate calcium intake.

Numerous studies reveal transient bone loss during lactation, which is rapidly regained after weaning.³ The rate and extent of recovery are influenced by the duration of lactation and postpartum amenorrhea and differ by skeletal site. However, studies have not revealed that pregnancy and lactation are associated with an increased risk of osteoporotic fracture.³

There is controversial and conflicting evidence that, in comparison with a low-calcium diet, a high-calcium diet may increase weight loss slightly.⁵⁻⁷ This statement 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 Calcium Soft Chews, Caltrate®, Os-Cal®, Tums®, Viactiv®, and other supplements) is readily absorbed by most people and is the least costly form of calcium supplement.^{8,9} Calcium citrate products (such as Citracal®) may also be recommended but may be more expensive and require patients to take more tablets to achieve the optimal dosage. To improve absorption, calcium supplements can be divided into two or three doses and taken with meals. Vitamin D facilitates absorption of calcium, so whenever possible, recommend a calcium supplement that contains 400 to 800 IU of this vitamin.

FOODS HIGH IN CALCIUM

DAIRY PRODUCTS

- Plain, low-fat yogurt, 1 cup – 415 mg
- Skim milk, 1 cup – 306 mg
- Buttermilk, 1 cup – 284 mg
- Part-skim mozzarella cheese, 1½ oz – 311 mg
- Cheddar cheese, 1½ oz – 307 mg

FISH

- Sardines, 3 oz – 325 mg
- Salmon in can, 3 oz – 181 mg
- Ocean perch, Atlantic, cooked, 3 oz – 116 mg
- Clams, canned, 3 oz – 78 mg

GREENS

- Collard greens, ½ cup – 178 mg
- Spinach, ½ cup – 146 mg
- Turnip greens, ½ cup – 124 mg
- Kale, ½ cup – 90 mg
- Beets, ½ cup – 82 mg

OTHER

- Tofu, firm, prepared with nigan, ½ cup – 253 mg
- Waffle/pancake with milk and egg – 179 mg
- Molasses, blackstrap, 1 tbsp – 172 mg
- English muffin – 96 mg

Iron. Dietary requirements for iron return to pre-pregnancy levels in the postpartum period—15mg/day.¹⁰ Postpartum iron supplementation may be indicated when blood loss is higher than usual during vaginal delivery or the interval between pregnancies is less than two years. In the presence of a low hemoglobin or hematocrit, and if other causes of anemia such as thalassemia are ruled out, oral supplementation of 60 to 120 mg of iron can be recommended. Many fortified cereals provide 100 percent (18 mg) of a woman's daily requirement for 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, potatoes 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.¹⁰

Fluid intake. Adequate fluid intake is an important element of good nutrition. Women, especially those who are lactating, should be encouraged to drink enough to satisfy thirst and prevent constipation.¹¹ However, controlled studies provide no evidence that increased fluid intake will result in weight loss, improved lactation, or diuresis.¹²

Weight loss. Returning to their pre-pregnancy weight is a common interest among postpartum women. Many women feel societal pressure—enforced by images of postpartum celebrities who appear to return to their former figures effortlessly—to lose weight and get back into shape quickly after giving birth. With a healthy diet and exercise, much of the weight that women gain during pregnancy will be shed naturally during the first year postpartum. The goal should be gradual weight loss. For all but those women with high or very high pre-pregnancy 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/day, and this figure may need to be revised upward on the basis of such considerations as breastfeeding, nutritional status, and level of activity.^{1,4} Inadequate caloric intake may increase postpartum fatigue and have a negative impact on mood, especially if the mother is breastfeeding. Post-pregnancy dieting may be accompanied by a significant decrease in bone mineral density.³

Weight loss should not be promoted as a benefit of breastfeeding, because some studies suggest that lactation may actually impede weight loss.¹⁴ Often, instructing lactating women to focus on nutritional foods and exercise, and to eat to satisfy their hunger, will result in the desired slow pattern of weight loss.

Women who are overweight or obese before, during, or after pregnancy should be counseled and, if appropriate, referred to weight-loss programs led by specialists. Recent research suggests that excess weight gain that persists after pregnancy is an indicator of obesity in midlife.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 of caffeine may adversely affect the infant who is breastfeeding, also considers moderate consumption of caffeine (e.g., a morning cup of coffee) to be acceptable during breastfeeding.¹⁷ AAP advises women who choose to drink alcohol to do so after nursing, rather than before. Women also can be advised to delay breastfeeding until alcohol is cleared from their milk—e.g., to express milk and store it before they drink alcohol. Some experts note that although an occasional alcoholic drink causes no problem, alcohol can interfere with the letdown reflex and reduce milk production by 23 percent for a few hours after consumption.¹⁸

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 (e.g., impaired motor development, altered sleep patterns, decreased milk intake).¹⁹ Alcohol consumption may also impair a mother's ability to nurture and care for her infant.

Fish consumption. The health benefits of fish and seafood have been well documented and widely promoted in recent years. Fish is low in saturated fat and is a healthy alternative to red meat. It provides the body with essential vitamins and minerals, including iron; zinc (from shellfish); vitamins A, B, and D; and, of course, protein. Omega-3 fatty acids found in fish are also beneficial, particularly for cardiovascular health.

At the same time, women of reproductive age are particularly vulnerable to the industrial pollutants—mercury and polychlorinated biphenyls (PCBs)—that accumulate in fish flesh. Multiple studies have documented prenatal exposure to mercury and its effects on fetal development, and breastfeeding mothers are

WOMEN OF REPRODUCTIVE AGE: RECOMMENDATIONS FOR CONSUMPTION OF FISH

Low levels of mercury and low in fat

- 12 oz per week (two servings)—e.g., cod, haddock, pollock, shrimp, tilapia, and chunk light tuna

Moderate levels of mercury

- No more than 6 oz of fish per week (one serving)—e.g., bluefish, grouper, orange roughy, marlin, and fresh tuna

High levels of mercury

- Do not consume—e.g., swordfish, shark, king mackerel, and tilefish

High levels of PCBs, high in fat and low levels of mercury

- No more than one to two times per month—e.g., farm-raised salmon, herring, and sardines

advised to minimize fish consumption because mercury passes through breast milk.²⁰⁻²³ Early life exposure to PCBs can cause harmful neurological effects, leading to learning deficits, poor memory, and behavioral problems. PCBs are highly toxic, and infants may be particularly vulnerable to the adverse effects of these chemicals.²⁴ Women of child-bearing age can minimize their blood mercury levels by eating fish with care, but PCBs accumulate over time, and lifelong vigilance is required to minimize maternal body burden of these chemicals.

Constipation. Constipation is common during pregnancy and the postpartum period. Contributing factors include relaxed muscle tone following delivery, inadequate fluid intake, a diet low in fiber, iron or calcium supplementation, painful hemorrhoids, or fear of damaging perineal repair during a bowel movement. Suggestions for preventing constipation include eating foods high in fiber, drinking eight to 10 large glasses of liquid daily (water, juice—including prune juice—or milk), and getting regular exercise. The use of ice packs or sitz baths can be encouraged to alleviate persistent hemorrhoidal or perineal pain that interferes 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.²⁵ Women can be reassured that exercise will promote healing, support emotional well-being, and not adversely affect their ability to breastfeed successfully. Even strenuous exercise minimally increases lactic acid levels in breast milk and has no effect on an infant's acceptance of breast milk one hour after exercise.^{26,27} One study found that women who consume adequate amounts of long-chain polyunsaturated fatty acids (LC-PUFA), which are essential for infants' growth and development, can exercise moderately without decreasing the LC-PUFA in their breast milk.²⁷ Breastfeeding before exercise may reduce the discomfort of engorged breasts.

Evaluating the integrity and function of the pelvic floor and assessing the diastasis recti are integral components of the postpartum visit. Kegel exercises have been shown to be effective in reducing the incidence of stress incontinence.²⁸ Proper technique is important. Patients should be instructed to contract the pelvic muscles for 10 seconds and then relax them for 10 seconds for 15 minutes four times per day. Women may need help from a qualified provider in locating the right muscles antepartum.

Providers can offer information on postpartum exercise programs available at the YMCA, fitness centers, or hospitals in the community to all new mothers in the birth center, hospital, or at the four- to six-week visit. Postpartum exercise programs are good resources that offer opportunities for physical activity, mutual support, short-term daycare, and a way to meet other women with infants. New mothers also may find it convenient to use postpartum DVDs or videos to supplement their exercise regimen. Fast walking with a baby jogger-type stroller, either outdoors or in a local indoor mall, also can be recommended. Many pregnancy magazines are an excellent resource for women of all fitness levels, both during pregnancy and postpartum. They offer step-by-step exercise programs, which are particularly useful for women who were not very physically fit before they became pregnant.

The appropriate exercise level will depend on each woman's medical history, obstetrical course, level of fitness, and postpartum recovery. Some women may be able to engage in an exercise routine within days of delivery; others may need to wait four to six weeks.²⁹ Gradual resumption of exercise is recommended to gauge effect and identify appropriate level of intensity.

As with vaginal birth, recommendations for exercise after cesarean birth depend upon obstetric and medical history and rate of physical recovery. In most cases, exercises to restore abdominal muscle tone in the cesarean mother can begin as soon as abdominal soreness

diminishes.³⁰ According to some experts, women can safely start doing straight and diagonal curl-ups within the first few days after a cesarean birth. These exercises can help in bringing the rectus muscles back together.³¹

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POSTPARTUM MENTAL HEALTH

Postpartum mood disorders pose health risks for mother and infant and impair family relationships,¹ yet mental health assessments often are not incorporated into postpartum care. Screening and counseling for disorders such as postpartum depression (PPD), anxiety, and obsessive-compulsive disorder (OCD) can prevent potentially serious consequences. Delay in receiving adequate treatment is associated with an increased duration (and perhaps severity) of PPD.² Clinicians must be proactive in identifying women at risk and providing appropriate counseling, referral, or both.

POSTPARTUM COUNSELING CHECKLIST MESSAGES FOR NEW MOTHERS ABOUT EMOTIONAL HEALTH

- “Baby blues” and anxiety are common in the first week postpartum
- Postpartum mood changes are not the fault of the mother
- Nutritional adjustment, sleep, and exercise may help in managing mood swings
- Awareness of predisposing risk factors may help mothers identify symptoms earlier
- Timeframe for postpartum mood disorders
 - “Blues” peak approximately three to five days postpartum and disappear within a couple of weeks after the baby is born
 - Postpartum depression usually develops within the first three months postpartum but may occur later (up to one year after childbirth)
 - Incidence of psychosis peaks within the first few weeks after childbirth
- Effective strategies exist for preventing and managing postpartum mood disorders
- Early identification of postpartum mood disorders is important
- Reassurance of support and adequate resources and appropriate referral will mitigate risk

**You may photocopy this checklist or visit
www.arhp.org/PostpartumQRG for a printable version.**

Postpartum mood disorders are usually grouped into the following categories:

- Baby blues
- Postpartum depression (PPD)
- Postpartum psychosis (PPP)³
- Postpartum anxiety (panic disorder, social phobia, generalized anxiety)⁴
- Postpartum obsessive-compulsive disorder (OCD)⁴

Baby blues refers to commonly occurring mood swings or mild feelings of sadness after childbirth. Also called *postpartum reactivity*, these feelings usually peak approximately three to five days postpartum and disappear within a couple of weeks after the baby is born.⁵ *Postpartum depression*, a far more serious disorder, usually develops within the first three months postpartum but may develop any time during the first year and includes symptoms such as low mood, sleep disturbance, and poor functioning.⁶ PPD affects up to 20 percent of postpartum women.^{7,8} Potential for the development of *postpartum psychosis* is highest within the first few weeks after childbirth. Onset is sudden and characterized by hallucinations, delusions, agitation, and other psychotic symptoms. Incidence is estimated at one to three per 1,000 postpartum women.⁹

Postpartum anxiety and OCD are less well-recognized disorders and may occur on their own or in conjunction with depression. Anxiety affects 5 to 20 percent of new mothers; onset can be sudden or gradual.¹⁰ The woman may worry excessively or feel anxious, have a short temper, feel irritable and sad, or experience unusual symptoms of anxiety. Roughly 3 to 5 percent of postpartum women experience obsessive symptoms—intrusive, repetitive, and persistent thoughts or mental pictures (often about harming their baby), as well as behaviors targeted to reducing anxiety.

Clinicians should maintain a heightened alertness for the range of possible symptoms that may indicate a mental health problem in a postpartum woman so that early treatment can be initiated.¹¹

Risk factors. Hormonal changes are theorized to be a causative factor in postpartum mood disorders, and such changes may affect women predisposed to the development of mood disorders most.^{12,13} The stress of dealing with a newborn, lack of sleep, and nutritional deficiencies may exacerbate the problem.¹⁴ Other factors known to put women at risk for the development of serious postpartum mood changes should be assessed by the clinician periodically during pregnancy, after delivery, and at the time of the postpartum follow-up visit.¹⁵ These risk factors include a personal or family history of depression, anxiety, bipolar disorder, or other mental illness. Stress, marital conflict, single status, young age, lack of social support, low self-esteem, infant temperament, unplanned pregnancy, unplanned cesarean birth, pre-term labor and delivery, perinatal complications, and fatigue also may signal vulnerability.¹⁶⁻¹⁹

Some women may experience depressive or anxiety-related symptoms when they breastfeed or encounter difficulties with the breastfeeding experience. Similarly, when a woman stops breastfeeding, she may experience these symptoms, likely because of significant hormonal shifts. Many women also may feel sadness and a sense of loss after they stop nursing.

POSTPARTUM COUNSELING CHECKLIST MESSAGES FOR NEW MOTHERS ABOUT EMOTIONAL HEALTH

REVISED POSTPARTUM DEPRESSION PREDICTORS INVENTORY (PDPI)¹⁵

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

Screening. Both provider-administered and patient self-report assessment tools have been recommended to identify women at risk for PPD. The Postpartum Depression Predictors Inventory (PDPI-Revised) provides a guide for interviewing a patient at any point between the preconception and postpartum periods.¹⁵ It includes questions related to 13 predictors of PPD and assists the clinician in identifying issues for discussion and possible intervention.

Two well-tested, self-administered screening tools are available. 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.¹⁵ The Postpartum Depression Screening Scale (PDSS) comprises 35 items that cover seven dimensions: sleeping/eating disturbances, anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame, and suicidal thoughts.²⁰ Although the EPDS has fewer items than the PDSS, either can be completed by the patient within five to 10 minutes. The short-form Depression Anxiety Stress Scales (DASS-21) also can be used to diagnose depression or anxiety in postpartum women.²¹

Caring for the patient at risk. The way a health care provider manages postpartum mood disorders will depend on that practitioner's level of comfort and expertise in dealing with mental and emotional problems, as well as the perception of the seriousness of the woman's problem.

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

- Acknowledge concern to the patient
- Reassure her that treatment is available, 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

- Offer breastfeeding education and support, behavioral counseling, and ongoing reinforcement

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 mood disorders *beyond* the initial month or two following childbirth. Hormonal shifts that can trigger mood swings or depression may occur at any time during the first year postpartum.¹²

POSTPARTUM MOOD CHANGES

What to Say to Your Patient Who May Be at Risk

“Many women experience some degree of sadness, anxiety, or other mood changes after the birth of a baby. Many things 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 that I have asked. This sometimes happens, but not as a result of anything you have done. 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. Help is available.”

Review some of the steps that the woman can take to help ward off depression or anxiety and promote general health:

- Get enough rest
- Call on family and friends for help
- Eat a well-balanced diet
- Get regular exercise
- Consider joining a mothers’ or postpartum support group
- Delay going back to work for at least six weeks postpartum²³

Treatment options. Treatments for postpartum mood disorders include psychological and pharmacological therapy. Research demonstrates that both individual and group counseling as well as

cognitive-behavioral therapy can be effective.^{8,23} Selective serotonin reuptake inhibitors and tricyclic antidepressants are effective in treating postpartum depression and anxiety, and current research suggests little if any adverse effect on the infants of nursing mothers who take these drugs.²⁴⁻²⁶ Carbamazepine, sodium valproate, and short-acting benzodiazepines also appear to be relatively safe during breastfeeding.²⁴ Further research is needed to clarify the risks of these drugs for newborns.

Close follow-up and an interdisciplinary approach are keys in the care of the woman experiencing mood disorders during the postpartum period.

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SEXUALITY AND CONTRACEPTION

Sexuality in the postpartum period is strongly influenced by a woman's culture, her experience before pregnancy, her physiology, and her emotional and psychological make-up. Postpartum sexual changes and adjustment may not be easy to discuss, for the patient or the provider. Yet sexual concerns are common, and the majority of patients will welcome help from their primary care provider, especially one who is prepared to elicit patient concerns and respond to them.^{1,2}

Patient attitudes about sexuality in the postpartum period. Perineal healing is normally sufficient to allow resumption of sexual

POSTPARTUM COUNSELING CHECKLIST SEXUALITY AND CONTRACEPTION

- Status of perineal healing
- Resumption of intimacy and sexual intercourse
- Alternatives to intercourse
- Reassurance that lack of sexual desire is common and normal among women in the postpartum period
- Comfort during sexual relations (e.g., healing and vaginal dryness)
- Incontinence
- Importance of pelvic floor muscle exercises (e.g., Kegels) and how to perform them
- Contraceptive options
- For the woman who is breastfeeding
 - Effect of lactation on vagina and lubrication
 - Effect of sexual activity on letdown reflex
 - Hormonal effects on sexual desire
 - Efficacy of Lactational Amenorrhea Method for contraception
 - Effect of estrogen-containing contraceptives
 - Alternative contraceptive choices

**You may photocopy this checklist or visit
www.arhp.org/PostpartumQRG for a printable version.**

intercourse somewhere between four and six weeks postpartum, and sometimes earlier.³ Women who undergo episiotomy or laceration and repair may be less comfortable resuming intercourse earlier than those who have not.

Short-term changes in sexual functioning have been noted among 22 to 86 percent of postpartum women, particularly those who have had assisted vaginal deliveries as opposed to spontaneous vaginal deliveries or cesarean birth.⁴ Several studies link episiotomy or perineal laceration and operative vaginal delivery to dyspareunia, which can persist for more than six months in a minority of women.⁵⁻⁷ Women who have experienced cesarean birth also may encounter discomfort with intercourse, and cesarean birth does not appear to have protective effects on women's sexual functioning.^{4,8}

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 women's attitudes toward sexual intercourse in the early postpartum period. In some instances, providers may want to suggest that other forms of sexual expression, such as touching, kissing, and mutual pleasuring techniques, can help to re-establish physical closeness with a partner.

Diminished sexual desire.

Low or absent sexual desire is a very common experience in the postpartum period; a reduction in sexual interest and activity, compared with

COMMON FACTORS IN POSTPARTUM SEXUAL ADJUSTMENT¹¹

- 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, poor body image

pre-pregnancy levels, is the norm during the first few months after childbirth.^{9,10} One study found that 57 percent of women had resumed intercourse at six weeks after delivery; 82 and 90 percent reported sexual relations by 12 and 24 weeks postpartum, respectively.⁷ The majority of the women reported experiencing orgasm by 12 weeks postpartum. Most researchers report gradual return to pre-pregnancy levels of sexual desire, enjoyment, and coital frequency within a year.¹¹

Effects of breastfeeding. Breastfeeding may negatively affect sexual desire.¹² The effect of lactation on hormone levels offers one explanation, because estrogen levels decline during breastfeeding.¹³ Decreased estrogen may indirectly affect sexual interest by decreasing vaginal lubrication, which can lead to pain with intercourse.¹² The use of water-based vaginal lubricants can reduce discomfort during intercourse. (Petroleum-based products may cause irritation and can cause condom breakage.) Vaginal moisturizers also can 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.¹⁴

Choosing a contraceptive. Return to fertility is unpredictable and may occur before the onset of regular menstrual cycles, even in breastfeeding women. The first ovulation in non-lactating women typically occurs 45 days postpartum but may occur earlier.¹⁵

Use of birth control should begin before sexual activity is resumed. Ideally, choice of postpartum contraception should take place in the prenatal period. In general, most women should start contraception at the six-week visit or earlier, depending on when they resume intercourse. All women should be offered emergency contraception.

LAM. The Lactational Amenorrhea Method (LAM) has a contraceptive effect in the first six months postpartum if the woman is fully breastfeeding (i.e., the woman is amenorrheic, is breastfeeding every three to four hours, and is not supplementing infant suckling with bottle feedings or expressed breast milk).¹⁶ Separation from the infant for many hours may increase the risk of pregnancy in lactating women.¹⁷ The need for skilled counseling and support, the lack of protection from sexually transmitted infections, and the intensive demands on a woman's time associated with LAM limit its suitability as a contraceptive choice. For some women, it can be an attractive, cost-effective, and temporary form of birth control.¹⁸

Hormonal contraception and breastfeeding. Estrogen may decrease the quantity and quality of breast milk.¹⁹ The standard of care for lactating women has been to avoid contraceptives containing estrogen, including oral contraceptives (OCs), the combination patch, and the combination vaginal ring. Estrogen-containing contraceptives should not be used until three to four weeks postpartum in non-breastfeeding women, to reduce the risk of venous thromboembolism.¹⁹ At that time, women can be offered the option of hormonal regimens that allow them to suppress menstruation if they desire to do so.

Recommended methods for women who are breastfeeding include the progesterone-only pill, copper-T intrauterine device (IUD; ParaGard[®]), levonorgestrel intrauterine system (IUS; Mirena[®]), depot medroxyprogesterone acetate injectable (DMPA; Depo-Provera[®] and Depo-subQ provera 104[®]) and the single-rod implant (Implanon[®]). DMPA has a black box on its labeling that warns it may be appropriate to restrict use to 21 months; a woman should use DMPA as long-term method of birth control (e.g., for longer than two years) only if other birth control methods are inadequate for her.²⁰ At issue is concern that prolonged use may result in significant loss of bone density. The loss is greater the longer the

drug is administered. However, recent research shows complete recovery of bone mineral density after DMPA use, and the World Health Organization does not recommend changes in prescribing practices because of concerns about bone loss in adult users. For adolescents, an increased risk of fracture with long-term use remains theoretical. Until more data are available, providers should reconsider the overall risks and benefits of long-term DMPA use in adolescents over time.

Diaphragm, cervical cap, sponge, spermicides, and condoms.

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 six weeks postpartum to ensure that the cervix is no longer dilated and that maximum healing has occurred.¹⁵ Use of the contraceptive sponge (Today[®]) should also be delayed until six weeks postpartum because of the risk of toxic shock syndrome.¹⁵ Spermicides and condoms may be initiated in the immediate postpartum period.

IUD and IUS. The copper-T IUD and the levonorgestrel (LNG) IUS are long-acting, highly effective contraceptive options for both lactating and non-lactating women. The copper-T IUD (ParaGard[®]) is effective for 10 years. Expulsion rates are slightly higher when the IUD is inserted immediately postpartum,²¹ and many clinicians recommend delaying insertion for four to six weeks following delivery after complete uterine involution. The LNG IUS (Mirena[®]) is effective for five years; the mechanism of action is similar to that of LNG implants or LNG-containing mini-pills. Menstrual bleeding may be substantially reduced, and women need to be counseled about the possibility of oligomenorrhea or amenorrhea with the LNG IUS.²²

Sterilization. The vast majority of women who undergo sterilization (or whose partners have a vasectomy) are satisfied with this

method.²³ An exception to this finding is young age, which is the strongest predictor of regret.²⁴ Risk factors such as an unstable marriage, recent divorce, or other life changes should be taken into account when counseling women on this permanent contraceptive option. Immediately postpartum is the ideal time to perform surgical sterilization. This represents a convenient time if the woman delivers in a hospital setting, and the procedure may be covered by the patient's medical insurance. Postpartum sterilization is also associated with a lower failure rate than procedures performed later. If surgical sterilization is requested later, the most common method is laparoscopy performed as ambulatory surgery with rings, clips, or cautery to the fallopian tubes.²⁵

A transcervical sterilization method (Essure™) provides another option for delayed postpartum sterilization. With this method, 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 a hysterosalpingogram demonstrates that the inserts have been correctly placed and the tubes are occluded.²⁶

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Contraceptive Options for U.S. Women in the Postpartum Period

METHOD	ADVANTAGES	CONSIDER
Most effective (99% or more effective)		
Transcervical sterilization (Essure™)	Permanent. May be placed in an office setting.	Delayed efficacy. Follow-up procedure (hysterosalpingogram) required to confirm efficacy. Non-reversible.
Tubal ligation	Permanently eliminates concerns about birth control. Surgical procedure.	Non-reversible in most cases. Can be done laparoscopically.
Intrauterine contraception (Copper T IUD [ParaGard®] or LNG IUS [Mirena®])	Copper T IUD lasts 10 -12 years; LNG IUS lasts up to 5 years. Can be used by nursing women.	Lower risk of expulsion if insertion delayed until 6 weeks postpartum. Not recommended for women currently at risk of STIs or pelvic inflammatory disease.
Very effective (91% - 99% effective)		
Oral contraceptives (OCs): combination	Does not interfere with sexual activity. Helps ease menstrual cramps and regulate menstrual periods; may be used continuously to suppress periods. Reduces risk of ovarian and endometrial cancer.	Estrogen-containing OCs are not generally recommended for women who are breastfeeding. If not nursing, women can begin using 3-4 weeks postpartum.
Oral contraceptives: progestin-only	Suitable for breastfeeding women. Does not interfere with sexual activity. May cause irregular menstrual bleeding.	Breastfeeding women can initiate 6 weeks postpartum.
Injection (DMPA)	Contains synthetic progesterone. Suitable for nursing mothers.	Injections 4 times/year. Irregular menstrual cycles and weight gain possible. Fertility may take up to 1 year to return.
Patch	Provides 1 week of protection. Easy to apply.	Contains estrogen and therefore not recommended for breastfeeding women.

Vaginal ring	Once-a-month vaginal insertion. Can be used continuously to suppress menstruation.	Small percentage of users report discomfort; some women are uncomfortable with vaginal method.
Effective (81% - 90% effective)		
Condom	Lubricated condoms can ease pain with sex if vaginal dryness is a problem. Provide STI protection. Female condom allows woman to control use of barrier method.	Condoms may tear during intercourse. Some people are allergic to latex, in which case polyurethane condoms are recommended.
Diaphragm (with spermicide)	Good option for women who prefer a barrier method to hormones.	Refitting after childbirth required but should be delayed for 6 weeks postpartum. Not suitable for women allergic to latex. May increase risk of bladder infection. Should be refitted/replaced at least every 2 years.
Moderately effective (80% effective)		
Cervical cap (with spermicide)	An option for women who prefer a barrier method to hormones.	Refitting after childbirth required but should be delayed for 6 weeks postpartum. Not suitable for women who are allergic to latex. Should be refitted/replaced every 2 years.
Spermicides	Non-hormonal contraception that is highly portable and discreet. Protection against some STIs.	Includes foam, creams, gels, vaginal suppositories, and film. Use with a condom boosts effectiveness. Spermicides do not protect against HIV.
Sponge	Non- hormonal contraception that provides a barrier to sperm and contains spermicide.	Delay use until 6 weeks postpartum to reduce risk of toxic shock syndrome. Does not protect against HIV.

Many couples rely on vasectomy, an option for men, as a method of permanently eliminating concerns about birth control. Vasectomy is an office procedure that is non-reversible in most cases. Vasectomy is 99% or more effective.

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