Immediate Postpartum Provision of Highly Effective Reversible
Contraception
Abigail R.A. Aiken, MBBChir, MPH, PhD ^{1*} , Catherine E.M. Aiken, MRCOG,
MRCP, PhD ² , James Trussell, PhD ¹ , and Katherine A. Guthrie, FRCOG, FFSRH ³
¹ Office of Population Research, Princeton University; Princeton, NJ, USA
² Department of Obstetrics and Gynaecology and NIHR Cambridge Comprehensive
Biomedical Research Centre, University of Cambridge; Cambridge, UK
³ Sexual and Reproductive Healthcare Partnership, Hull, UK
*Corresponding Author: 228 Wallace Hall, Office of Population Research, Princeton
University; Princeton, NJ, 08544. Tel: 609-258-5514 Email: aaiken@princeton.edu
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36 Unplanned pregnancies are associated with a higher risk of adverse maternal and 37 neonatal outcomes, particularly when they occur within a short time interval from a 38 previous birth.¹ Early access to highly effective reversible contraception (implants and 39 intrauterine contraceptives (IUCs), including both copper intrauterine devices and 40 levonorgestrel-releasing intrauterine systems) in the postpartum period has been demonstrated to help women prevent unplanned and rapid-repeat pregnancies.² We 41 42 discuss several compelling reasons for immediate postpartum provision of such methods 43 to women who desire them.

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IUCs and implants are in the highest tier of contraceptive effectiveness³ because they 45 46 require no active adherence on the part of the user. Provision of these methods in 47 hospital following delivery is particularly attractive because it is convenient for women 48 who may be particularly motivated to prevent another pregnancy and logistically optimal 49 in that health professionals trained in method placement could be readily available. 50 Despite previous concerns, immediate postpartum placement of IUCs and implants is 51 also extremely safe.⁴ There is no increased risk of pain, bleeding, infection or uterine 52 perforation for IUCs placed immediately (within ten minutes of placental delivery) 53 compared to delayed placement (weeks later). Reported expulsion rates vary widely, 54 partly due to differences in follow-up intervals and quality of evidence across studies. For 55 copper-releasing IUCs, immediate postpartum placement is consistently associated with higher expulsion rates than for delayed placement $(1-36.9\% \text{ versus } \sim 3.0\%)^5$ and the 56 57 expulsion rate following immediate placement after Caesarean delivery is consistently 58 lower than that following immediate placement after vaginal delivery (0-13.9% versus 7.5-22.6%).⁵ However, these risks seem tolerable given the alternative of no early 59 60 contraception cover at all. Up to 41% of women will attempt vaginal intercourse within six weeks of delivery,8 and among women who are not exclusively breastfeeding, 61

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ovulation may already have returned by that time or will return soon thereafter.⁹ Offering
IUCs and implants to all women prior to hospital discharge (or at home, in the case of
home births) would circumvent this problem.¹⁰

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66 The safety of post-delivery placement of IUCs and implants is reflected in the most 67 recently updated Medical Eligibility Criteria for Contraceptive Use, which provides evidence-68 based guidance regarding medically eligiblity for specific contraceptive methods. These 69 guidelines are used by specialists in sexual and reproductive health worldwide to balance 70 the risks and benefits of contraceptive methods for individual women. The 2009 World 71 Health Organization Medical Eligibility Criteria (WHO MEC) supports immediate 72 postpartum placement of levonorgestrel-releasing implants and IUCs for non-73 breastfeeding women and copper IUCs for all women. Some country-specific MECs 74 differ regarding the evidence on levonorgestrel and breastfeeding. The 2009 UK MEC 75 and the 2010 US MEC both support immediate postpartum placement of implants for 76 all women and the <u>US MEC also</u> extends this guidance to levonorgestrel-releasing IUCs.

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78 Women who choose immediate postpartum IUCs and implants have a high level of 79 method satisfaction: US studies have shown high levels of continuation at six and 12 80 months postpartum (84.3-87.6% and 76.3% respectively for IUCs, and 96.9% and 86.3% 81 for implants).³ Moreover, for immediate postpartum implant placement, a reduction in 82 the likelihood of repeat pregnancy within 12 months has also been demonstrated (2.6% 83 versus 18.6% among women using other methods).³ For immediate IUC placement, a 84 decision-analysis model based upon data from the US estimated that 88 unintended 85 pregnancies per 1,000 women would be prevented over two years.⁶

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87 In addition to improving women's health by preventing unplanned pregnancies,

immediate postpartum provision of IUCs and implants would also save money. The
decision-analysis model of immediate postpartum IUC placement mentioned above
found cost-savings of US\$282,540 per 1,000 women who desired a postpartum IUC.⁶ A
US cost-effectiveness analysis of implants placed prior to hospital discharge following
delivery found cost-savings of US\$550,000, US\$2.5 million, and US\$4.5 million per 1,000
women at 12, 24 and 36 months postpartum respectively.⁷.

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Implementation of post-delivery IUC and implant services in many countries would not 95 96 be without challenges. An initial monetary out-lay would be needed to train the relevant 97 healthcare professionals in contraceptive counseling and device-fitting. Significant 98 investments would be required in terms of time, equipment and devices. Yet in the 99 longer-term, these costs would likely be more than offset by a drop in the medical and 100 social care cost of unintended pregnancies. In addition, reducing the need for 101 contraceptive provision appointments in the later postpartum period would lead to time 102 and cost savings to both women and healthcare systems.

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In light of the Parliamentary Assembly Council of Europe (PACE) resolution on
reducing unintended pregnancy among EU member states¹¹ and the Millennium
Development goal of reducing the worldwide maternal mortality ratio by three-quarters
by 2015,¹² widespread adoption of postpartum provision of IUCs and implants
represents an important step towards improving global women's reproductive health.

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110 The authors have no acknowledgements to make.

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112 Disclosure of Interests: JT is a consultant to Bayer and a member of Merck and Teva113 advisory boards. KAG, CEMA, and ARAA have no interests to disclose.

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115	Contribution to Authorship: JT, KAG, CEMA, and ARAA all contributed to the
116	conception, writing, and revising of the manuscript, and all approved the final submitted
117	version.
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119	No ethics board approval was required.
120	
121	Funding: JT and ARAA are supported by the Eunice Kennedy Shriver National
122	Institute of Child Health and Human Development grant for Infrastructure for
123	Population Research at Princeton University, Grant R24HD047879.
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