Contraception Update – Adolescents, LARCs and clinical practice

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Disclosure slide

• Dr Quint or her spouse have no significant financial interests or other relationships with industry relative to topics that will be discussed.
Objectives

• At the end of this presentation the participant will be able to:
  – Discuss specific adolescent issues with use of contraception methods, including barriers to contraception and strategies to improve adherence
  – Describe long acting reversible contraception (LARC) as the preferred choice for adolescents
  – Review indications, contraindications and complication management of LARC
Teen pregnancies

- 625,00 teen pregnancies/ year
  - 82% unplanned
    - 50% due to un-use of contraception
    - 50% due to mis-use of contraception
  - 31% end in abortion
Teen birth rates declining in US

• GOOD news:
  – Lowest pregnancy rate in years (13% decrease since 2013)
  – Mostly due to increased use of effective contraceptives

• Not so good news:
  – U.S. teen pregnancy rate is substantially higher than in other western industrialized nations, and racial/ethnic and geographic disparities in teen birth rates persist

• CDC 2016; Laura Lindberg et al, M.P.H. 2016 sept. J adolesc Health
Percentage of High School Students Who Ever Had Sexual Intercourse, by Sex,* Grade,* and Race/Ethnicity,*

2015

*M > F; 10th > 9th, 11th > 9th, 12th > 9th, 12th > 10th, 12th > 11th; B > W (Based on t-test analysis, p < 0.05.)
All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.
Note: This graph contains weighted results.

National Youth Risk Behavior Survey, 2015
Teenagers at last sex...

- **43%** NO condom
- **75%** NO birth control pills, patch, shot, ring, implant or IUD
- **20%** used drugs or alcohol before last sex

CDC. Youth Risk Behavior Surveillance Survey, — United States, 2015
Food for thought

• Improvements in contraceptive use appear to be the primary proximal determinants of declines in adolescent pregnancy and birth rates in the United States from 2007 to 2012.

• Efforts to further improve access to and use of contraception among adolescents are necessary to ensure they have the means to prevent pregnancy.
LARC in adolescents

WHY?

• Combined oral contraceptives and/or condoms are most commonly used contraceptives.
  – Pills have higher failure rates (6-9/100)
  – Pills have higher 1 year discontinuation rates (39.6%)
    • vaginal ring (48.9%)
    • transdermal patch (39.8%)
    • Depo-Provera hormonal injection (39.8%)

• LARC- Long Acting Reversible Contraception
  – Low pregnancy failure rates: less than 1:100
  – No need for patient action
  – Good for 3-10 years, likely longer
  – High continuation rates (85.3%)
  – Cost effective
    • Within 3 years of use

Use of contraceptives by teenagers

Percentage of female teens aged 15–19 years using LARC, among those seeking contraceptive services at Title X service sites — United States, 2005–2013 - CDC
LARC Access and Utilization

Increased Popularity

LARC use more than tripled between 2007-2012
• Female contraceptive users aged 15-44 – 11.6% in 2012

Title X Family Planning Annual Report (FPAR) – 2014
• Nationally, 12% females aged 15-44 used LARC
  – Adolescents : 7%
• Michigan, 8% females aged 15-44 used LARC
  – Adolescents : 4-5%
Percentage of female teens aged 15–19 years using LARC’s among those seeking contraceptive services at Title X service sites, by state — 2013
Contraceptive decision making and barriers

• Factors that influence decision making and provision are organized into four categories:
  1) awareness and attitudes
  2) confidentiality, consent, and parental attitudes
  3) healthcare provider knowledge, attitudes, and counseling
  4) cost and clinical operations
    • training

Adolescent and young women awareness and attitudes
LARC
Barriers to use by teens

• Barriers:
  – lack of familiarity
    • Only 40% of teens have heard of IUD
  – misperceptions about the methods
    • Causes infertility
    • Will get stuck in my uterus
    • Information comes from friends, social media, family
LARC

Barriers to use by teens

• high cost
  – Improved with ACA
  – Cost effective within 3 years

• lack of access
  – Not driving/ bus route
  – Appointment times
  – Same day insertion not always available
College women
“I do not know enough to feel comfortable using LARC”

• 1942 college women
• Only 5% had used and 22% had heard of (22%) LARC
• Most self-reported "little" or "no" knowledge of IUDs (79%) and implants (88%)
• Barriers
  – not knowing enough about the method (42%)
  – not wanting a foreign object in body (44%)
  – preferring a "controllable" method (42%)

IUD
Removing barriers

- Study on females age 14-20
  - Removed cost and other common barriers to LARC methods
  - Included counseling on the full range of birth control options
  - More than two thirds of females aged 14–20 years chose LARC methods

Confidentiality, consent and parental attitudes
Counseling

• Talk with teen in private
  – Confidential
  – Know state laws
  – Remember the teen’s developmental stage
Adolescent Confidentiality

- Less than 20% of adolescents are screened for or receive counseling on high risk behaviors from their health care providers.

- Physicians talk about high risk behaviors 65% of the time, but only spend an average of 36 seconds on these issues.

- Adolescents are unlikely to bring up sensitive issues on their own, though they desire confidential services.

Adolescent Confidentiality

- Adolescents are more likely to seek confidential services only after they are assured confidentiality

- Most primary providers support offering confidential care, but find it to be a challenge

- Difficulty reported due to:
  - Lack of expertise
  - Low patient demand
  - Inadequate staffing
  - Time constraints
  - Insurance billing
  - Electronic records

Michigan State Law

• Patients ages 12 and up have a right to the following WITHOUT parental/guardian consent or knowledge:
  - Birth control information and contraceptives

• A. True
• B. False
Michigan State Law

• Patients ages 12 and up have a right to Birth control information and contraceptives WITHOUT parental/guardian consent or knowledge:

• A. True

• B. False
The Law: Parent/Guardian Consent Exceptions

A parent or legal guardian must provide consent on behalf of a minor (under age 18) before health care services are provided, with several important exceptions.

- **Emergency care**

- **Care for emancipated minors**
  Minors can be emancipated by: court order, marriage, military active duty

- **Specific healthcare services related to:**
  - Sexual health
  - Mental health
  - Substance abuse treatment
Michigan Law

Patients ages 12 and up have a right to the following WITHOUT parental/guardian consent or knowledge:
- Pregnancy testing and prenatal care
- Birth control information and contraceptives
- Testing and treatment for sexually transmitted infections (STI's)
- Substance abuse treatment

Patients ages 14 and up can access mental health counseling without parental/guardian consent/knowledge
- Up to 12 visits, or 4 months
Michigan Law

Healthcare providers must breach the minor’s confidentiality and tell the parent if:
- There is suspicion of abuse by an adult
- The minor is a risk to themselves or someone else
- The minor is under age 12 and has been sexually active
- The provider may choose to tell the parents about any care provided to the minor patient they believe it is in the minor’s best interest

Minors need a parent/guardian’s permission for:
- Vaccines (including HPV)
- Mental health medications and Inpatient mental health treatment
- An abortion (unless a court-approved waiver is obtained)
Counseling

- Adolescents
- Developmental levels
  - Determine how to counsel
Early Adolescence

11-14 years

- **Autonomy**
  - Mood swings, loneliness, argumentative, anti-parent

- **Body Image**
  - Critical of appearance, anxious about menses, breast size

- **Peer Group**
  - Same sex friendships, co-ed groups

- **Identity development**
  - Concrete thinkers, need privacy, “am I normal”, dramatic

Girls who initiate sex at this time often do not connect it to pregnancy. Naturally poor compliance with birth control.
Middle Adolescence (15-17)

- Essence of adolescence
- Autonomy
  - Family conflict, independence
  - More consequences to actions
- Body Image
  - Interest in attracting opposite gender
- Peer Group
  - Strong peer allegiances
  - Sexual drive increasing, dating
- Identity development
  - Abstract thinking
  - Experimentation: sex, drugs, friends, jobs

Limited ability to negotiate with a partner about sex and birth control
Counseling components

• **Counselors**
  – Expertise
  – Trustworthiness
  – Confidential
  – Engage patient in learning
    • Use of models

  – Patient feels empowered to make the choice that she perceives is best for her

Counseling components

- Make choice manageable
- Give priority to more effective methods
- Four facets of contraception counseling:
  - Method choice
  - Correct use
  - Consistent use
  - Method switching

Parental attitudes

• Parents can be very influential
  – Myths around hormones and infertility
  – Not contraceptive educated

• One study showed OCP as the most accepted and LARC as the least accepted by parents

• Parental experiences color their concerns
Health care provider knowledge, attitude and counseling
Health care provider attitudes

• Large study in 2014 showed that only 43% of OB/GYN recommended IUD to teens

• Large randomized trial of provider training
  – 71% of young adult women (aged 18-25 years) received LARC counseling at intervention clinics compared to 39% of women who received counseling at the control sites.

Provider behavior

- 162 staff at school based clinic in NY (69 clinicians)
- Half (55%) would recommend an IUD to a patient under age 20 years.
- 38% would recommend an IUD in patients not in a monogamous relationship
- 77% of respondents indicated that IUDs are safe for adolescents, 18% of those respondents would be unlikely to recommend an IUD to a patient under age 20 years
- 86% of respondents knew that IUDs can be used in nulliparous women, 25% of those respondents would be unlikely to recommend an IUD to a patient who has never been pregnant.

Provider barriers

- Knowledge
  - Comfort with the methods
- Time
  - Same day insertions
- Training
  - IUD
  - LARC
Almost 62% of respondents stated that providers were trained to insert LARCs
- Top: Paragard, Mirena, Nexplanon
- 60% mentoring available with training
- 45% interested in additional training

Barriers to Training
- Time
- Medical Director support
- Responsiveness of Pharm Companies
- Infrequency of request to maintain proficiency
Cost and Clinical operations
LARC Access and Utilization: Title

X Survey

52.4% currently provide LARCs onsite
- Top: Paraguard, Mirena, Nexplanon
- 47.6% protocols allow for same day LARC insertion

Many agencies provide LARCs by paid referral
- On average, clients travel between 10-20 miles to the provider and wait 2-4 weeks for the insertion visit

Challenges Ordering or Purchasing LARC
Funding, Cost, Expensive!!!!!!!
Almost 72% reported that Medicaid Health Plans cover your actual cost of providing LARC

Almost 67% reported that private insurances cover your actual cost of providing LARC

May only cover certain LARC
97% report that clients are made aware of LARC availability

71% provide contraceptive education to new or undecided clients starting with the most effective method

• Other most common response: start with client’s indicated method of choice, then either stop or go on to describe other methods starting with most effective

61% indicated an increased awareness or interest in LARCs among clients in the past year.
Clinical Implications
Case presentation

- 14 year old comes with a request for an IUD for birth control
- Regular cycles but has been having some BTB in last 3 weeks
- O/W no issues

Would you give her a mirena IUD:
A. Yes
B. No
C. Not sure
Case presentation

• 14 year old comes with a request for an IUD for birth control
• Regular cycles but has been having some BTB in last 3 weeks
• O/W no issues

Would you give her a mirena IUD:
A. Yes- 50%
B. No-50%
C. Not sure
Intra uterine device

- Currently four on the market
  - 3 hormonal, Mirena, Skyla, Liletta
  - 1 non-hormonal Paraguard
- Now considered in first line for teenagers
  - ACOG, AAP, CDC
- The primary mechanism of action of both types of IUD is preventing fertilization by inhibiting sperm motility. The levonorgestrel IUDs also thicken cervical mucus.
## LNG- IUD comparison

<table>
<thead>
<tr>
<th></th>
<th>Skyla</th>
<th>Mirena</th>
<th>Liletta</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNG</td>
<td>14 mcg/day</td>
<td>20 mcg/day</td>
<td>19 mcg/day</td>
</tr>
<tr>
<td></td>
<td>5 mcg/day</td>
<td>10 mcg/day</td>
<td>13 mcg/day</td>
</tr>
<tr>
<td>Duration</td>
<td>3 years</td>
<td>5 years</td>
<td>3 years</td>
</tr>
<tr>
<td>size</td>
<td>28 x 30 mm</td>
<td>32x32 mm</td>
<td>32x32</td>
</tr>
<tr>
<td>Inserter diameter</td>
<td>3.8 mm*</td>
<td>4.4 mm</td>
<td>4.75 mm</td>
</tr>
<tr>
<td>Amenorrhea (1 year)</td>
<td>6%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>expulsion</td>
<td>3.2%</td>
<td>5% (range)</td>
<td>4%</td>
</tr>
<tr>
<td>Depth (cm)</td>
<td>Large enough</td>
<td>6-10</td>
<td>&gt; 5.5</td>
</tr>
</tbody>
</table>
## IUD comparison

### Bleeding

<table>
<thead>
<tr>
<th></th>
<th>Skyla</th>
<th>Mirena</th>
<th>Liletta</th>
<th>Paraguard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bleeding</strong></td>
<td>Spotting and irregular or heavy bleeding during the first 3-6 months. Cycles may remain irregular, become infrequent, or cease</td>
<td>Unpredictable with frequent light bleeding for the first three months. By 3-6 months usually reduced bleeding.</td>
<td>During first 3 to 6 months, bleeding and spotting may increase and bleeding may be irregular. After, the amount of bleeding and spotting decreases, but bleeding may remain irregular.</td>
<td>Often increased amount and duration of bleeding; approximately 50% increase in blood loss</td>
</tr>
</tbody>
</table>
Levonorgestrel IUD

• Indications in healthy teenagers
  – Normal uterus, no current or recent (past 3 months) PID or current gonorrhea, Chlamydia, or purulent cervicitis. No pregnancy
  – If medical problems, consult CDC guidelines

• Testing prior to insertion:
  – Pelvic examination
  – Preg test
  – Always have recent GC/CT
IUD no longer contraindicated in nulliparous women

- IUD insertion, not IUD use is associated with PID
  - Risk of PID with placement
    - 0-2% if no infection
    - 0-5% if infection present
  - Cochrane Database, Systematic Review (Grimes et al)

- IUDs do not cause future infertility

ACOG Committee opinion 539 -October 2012
Hubacher et al (N Engl J Med 2001;345:561–7,
Hov et al, Contraception 2007;75:88–92
### Chlamydia—Rates by Age and Sex, United States, 2014

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>55–64</td>
<td>12.8</td>
</tr>
<tr>
<td>65+</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>627.2</td>
</tr>
<tr>
<td>40–44</td>
<td>130.3</td>
</tr>
<tr>
<td>35–39</td>
<td>1523.4</td>
</tr>
<tr>
<td>30–34</td>
<td>633.7</td>
</tr>
<tr>
<td>25–29</td>
<td>1523.4</td>
</tr>
<tr>
<td>20–24</td>
<td>2941.0</td>
</tr>
<tr>
<td>15–19</td>
<td>2941.0</td>
</tr>
<tr>
<td>10–14</td>
<td>99.4</td>
</tr>
<tr>
<td>Total</td>
<td>2.4</td>
</tr>
<tr>
<td>278.4</td>
<td></td>
</tr>
<tr>
<td>234.0</td>
<td></td>
</tr>
<tr>
<td>1368.3</td>
<td></td>
</tr>
<tr>
<td>837.0</td>
<td></td>
</tr>
<tr>
<td>718.3</td>
<td></td>
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<tr>
<td>12.7</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Men**

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+</td>
<td>4.4</td>
</tr>
<tr>
<td>60–64</td>
<td>20.6</td>
</tr>
<tr>
<td>55–64</td>
<td>12.8</td>
</tr>
<tr>
<td>50–54</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>306.4</td>
</tr>
<tr>
<td>278.4</td>
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<tr>
<td>0</td>
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</tbody>
</table>

**Women**

**Graphical Representation:**

- **Men:**
  - Ages: 10–64 years
  - Rates per 100,000 population

- **Women:**
  - Ages: 10–64 years
  - Rates per 100,000 population

**Comparison:**

- Rates are higher for women compared to men across all age groups.

**Analysis:**

- The highest rates for both men and women occur in the 15–19 age group.

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**Note:** The rates are indicative of the prevalence of Chlamydia and may require further investigation for public health strategies.
Chlamydia Symptoms

- Heavy or prolonged menses
- Spotting
- Dysmenhorrhea
- Dyspareunia
- Vaginal discharge

Females:
- Up to 75% asymptomatic

Screen annually if less than 25 years old, incubation 7-21 days
Chlamydia cervicitis

Normal cervix
Does not preclude chlamydia
LNG- IUD
when to place

- Ideally within 7 days of a period, but any time of cycle
- Same day placement
- If unprotected intercourse in last 120 hours, offer EC

- Postpartum/immediately after first trimester abortion
  - in the delivery room, increases expulsion rate (10–27%); Only c.i. sepsis
  - Breastfeeding no data to indicate concern

Immediate Postpartum Long-Acting Reversible Contraception
ACOG: CO 668. August 2016
IUD in nulliparous women

• Expulsion
  – is uncommon, but maybe increased compared to multiparous women (3-5% vs 3-22%)

• No technical issues with insertion in teens

• More than 50% report pain
  – higher than in multiparous women

• Pain maybe higher in anxious patients
IUD insertion and pain

• Intracervical lidocaine gel or misoprostil made no difference in pain or ease of insertion

• Placebo controlled trial of 1% lidocaine paracervical block prior to insertion
  – No stat significant difference, but study may not have been large enough (n=50)

• Placebo controlled trial with naproxen, tramadol and placebo one hour before insertion
  – Tramadol > naproxen > placebo

IUD and adolescents
Title X clinic in Colorado

• n=1147, ages 13 -24 (med 20)
  – 95.5 % initially successful in 694 nulliparous girls (mostly NP/PA)
    • 78% successful at second attempt
  – 3.0% expulsion
  – 4.3% removal at 6 months (bleeding, cramping)

IUD complications: perforation

- Rate: 1/1000
- 10% recognized at time of insertion
- During procedure:
  - Sudden onset of intense pelvic pain
  - Cramping
  - Dizziness

What to do: Attempt to gently retract,
- if difficult stop and refer to MD/ED
- If able to remove, no stool or hemorrhage
  - watch patient closely any concern about bleeding, to ED
- Provide alternative method of birth control.
- Advise strict pelvic rest for 48 hours.
- Have patient RTC in 1-2 weeks. May consider another IUD placement attempt at that time. Consider reason why perforation/ usn guidance?

IUD complications

• **Post procedure:**
  - Missing IUD strings
    • Get usn
    • KUB if neg USN
  - Pregnancy symptoms
    • Get preg test
    • Check strings
    • Get usn and hcg levels for ectopic
IUD side effects

• AUB:
  - Always make sure IUD is in place, pregnancy test
    • Assess stability
  - If continued aub/heavy bleeding:
    • NSAIDs Naprosyn 500 mg for 5 days- monthly
    • Tranexamic acid 500 mg 3 times daily
    • Low dose mefipristone
  - 1-2 months of COCP- no data
    • 1 mg estradiol orally for 30 days- data suggests increase in bleeding

Friedlander E, Kaneshiro B. Obstet Gynecol Clin North Am. 2015 Dec;42(4):593-603
LNG-IUD side effects

- Headache
- Acne
- Breast tenderness
- Mood changes
- Weight gain
- Ovarian cysts
- Cramping or pelvic pain
IMPLANT
Etonogestrel Implant

- Progestin-only method
- 4 x 0.2cm
- Prevents ovulation
- Long-acting (3 years)
- Fertility returns within a few days of removal
- Highly effective
Implant

- Placement in arm in clinic with local anesthetic
- Within 7 days of last menses
  - Anytime
  - Same day insertion
- Pregnancy test
- Does not appear to affect bone density
- None to minimal weight gain

Implant Bleeding

- Bleeding pattern in 942 etonogestrel implant users of all ages,
  - Infrequent bleeding in 33.3% of 90-day cycles,
  - Amenorrhea in 21.4% of cycles.
  - Prolonged bleeding occurred in 16.9% of cycles
  - Frequent bleeding occurred in 6.1% of cycles

- Irregular bleeding: Primary reason for early discontinuation
  - Of 750 adolescent patients, 10.3% discontinued within one year.

- The bleeding pattern women experience in the first 3 months is broadly predictive of future bleeding patterns
Implants
Treat AUB

• Hormones
  – One months of OCP (but similar to placebo)
  – One study used tamoxifen for 7 days, with decrease of AUB from 23-6 days in next 30 days (placebo: 20 to 12 days)

• NSAIDs
  – Mefenamic acid 500 mg 3 times daily for 5 days

• Matrix metalloproteinase inhibitors (MMI)
  – Doxycycline 100 mg twice daily for 5 days, starting on day 2: decrease in bleeding, not sustained

Implant side effects

- headache (24.9%)
- vaginitis (14.5%)
- weight increase (13.7%)
- acne (13.5%)
- breast pain (12.8%)
Implant contra indications

- One MEC 4 contraindications, several MEC 3:
  - Breastcancer (current= MEC4)
  - Liverdisease-severe
  - SLE with pos antiphospholipid antibodies
  - Stroke
Condom use

• A few studies suggest that using LARCs may decrease use of condoms

• Make sure that remains a part of our practice

# When to start a contraceptive method

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>When to start, if provider is reasonably certain woman is not pregnant</th>
<th>Back-up needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNG IUD</td>
<td>Any time</td>
<td>If &gt; 7 days of cycle, use back-up method or abstain for 7 days</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>Any time</td>
<td>Not needed</td>
</tr>
<tr>
<td>Implant (etongestrel)</td>
<td>Any time</td>
<td>If &gt; 5 days of cycle, use back-up method or abstain for 7 days</td>
</tr>
</tbody>
</table>

CDC.gov, MMWR Recomm Rep 2013;62:1–60
Contraceptive efficacy chart

HOW WELL DOES BIRTH CONTROL WORK?

Really, really well
- The Implant (Nexplanon)
- IUD (Skyla)
- IUD (Mirena)
- IUD (ParaGard)
- Sterilization, for men and women

Works, hassle-free, for up to...
- 3 years
- 3 years
- 5 years
- 12 years
- Forever

Less than 1 in 100 women

Okay
- The Pill
- The Patch
- The Ring (Depo-Provera)

For it to work best, use it...
- Every week
- Every month
- Every 3 months

6-9 in 100 women, depending on method

Not so well
- Withdrawal
- Diaphragm
- Fertility Awareness
- Condoms, for men and women

For each of these methods to work, you or your partner must use it every single time you have sex.

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.
Overall Recommendations
Teenagers

- Counseling
  - Start with most effective

- Patient autonomy
  - Starting a methods
  - Switching methods

- Acknowledge side effects
Overall Recommendations
Teenagers

- LARCS should be considered as a first line option
  - Superior pregnancy protection
  - IUD possibly higher expulsion rate
  - Cost effective if kept at least 3 years

- DMPA- good option if patient desires and is not obese

- COC/ patch/ring-good option, if patient desires
Questions?
Reasonably certain someone is not pregnant

• If she has no symptoms or signs of pregnancy and meets any one of the following criteria:
  – is ≤7 days after the start of normal menses
  – has not had sexual intercourse since the start of last normal menses
  – has been correctly and consistently using a reliable method of contraception
  – is ≤7 days after spontaneous or induced abortion
  – is within 4 weeks postpartum
  – is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds),* amenorrheic, and <6 months postpartum

CDC.gov, MMWR Recomm Rep 2013;62:1–60