The Role of Nurses in Immediate Postpartum LARC Implementation
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Disclosures

- All health care providers who perform implant insertions and removals must receive training from the manufacturer. Therefore, the insertion process is deferred to the manufacturer and not covered in this presentation.
Topics covered in presentation

Section 1: Unmet need for postpartum contraception
Section 2: Clinical considerations of immediate postpartum (IPP) contraception
Section 3: Breastfeeding: clinical considerations
Section 4: IPP IUD: insertion techniques
Section 5: Assessing candidacy for IPP long-acting reversible contraception (LARC)
Section 6: Follow up instructions for postpartum LARC
Section 7: Contraceptive counseling: shared decision-making & reproductive justice framework
Section 8: Special considerations for nurses
Learning objectives

1. Describe the importance of offering the full range of contraceptive methods postpartum, including long-acting reversible contraception (LARC)
2. Describe the efficacy, safety, and advantages of immediate postpartum (IPP) LARC
3. Review immediate post-placental IUD insertion techniques
4. Describe the importance of and identify resources for patient-centered contraceptive counseling
5. Explain operational barriers to IPP LARC provision
6. Explain the role of nurses in IPP LARC provision and identify resources for support
UNMET NEED

for Postpartum Contraception
Nearly half of U.S. pregnancies were unintended in 2011.
Pregnancy spacing is important for healthy families

• ACOG Committee Opinion #544, Over-the-Counter to Oral Contraceptives, states that short interpregnancy intervals have been associated with adverse neonatal outcomes, including low birth weight and prematurity.

• ACOG Committee Opinion #736, Optimizing Postpartum Care, states that:
  o Women should be advised to avoid interpregnancy intervals shorter than 6 months.
  o Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months.
The challenge with postpartum visits

• ACOG Committee Opinion #736, Optimizing Postpartum Care, states that:
  o As many as 40% of women do not return for the 6 week postpartum visit
  o Attendance rates are even lower in limited resource areas, further contributing to health disparities

• Women have difficulty returning for a postpartum visit because of:
  o Childcare obligations
  o Unable to get off work
  o Unstable housing
  o No transportation
  o Communication or language barrier
  o Lack of insurance coverage or potential expiration of Medicaid eligibility

• Non-breastfeeding women can ovulate as early as 25 days postpartum
  o 40% will ovulate by 6 weeks postpartum

• 57% women are sexually active by 6 weeks postpartum
Unfilled immediate postpartum sterilization requests

• At least 1/3 of women who want a postpartum sterilization will not have it done
  o Insurmountable systems barriers like lack of OR room, physician availability or uncompleted consent forms

• 47% of women who leave without having a desired postpartum sterilization done will be pregnant within 1 year

• Insurance Issues
  o Medicaid coverage may end postpartum
  o Uninsured – cost of sterilization can be prohibitive
What is LARC? ACOG Practice Bulletin #121 says:

- LARC stands for **long-acting reversible contraception**
- The **intrauterine device** and the **contraceptive implant**, also called LARC, are the most effective reversible forms of contraception.
- 2 major advantages of LARC include:
  1. Compared with other methods, LARC does not require ongoing effort for long-term and effective use.
  2. Rapid return to fertility after removal of the device.

Contraceptive implant ➔
(about the size of a match stick)
What is immediate postpartum LARC?

When LARC methods are available to women in the hospital after a delivery before discharge

- ACOG, CDC, WHO, and Cochrane reviews all agree that immediate postpartum (IPP) LARC is safe and effective
- Can be an ideal time to provide LARC methods for many women
Definitions: timing of LARC placement

1. **Immediate postplacental** – placement within 10 minutes of delivery of placenta

2. **Immediate postpartum** – placement during hospital admission for delivery

3. **Postpartum** – placement within 6 weeks of delivery

4. **Interval placement** – placement 6 weeks or later following delivery
ACOG Committee Opinion #670, IPP LARC

- Immediate postpartum LARC can reduce unintended pregnancy & lengthen interpregnancy intervals

- Women’s health care providers should support IPP LARC placement after vaginal and cesarean births and at the postpartum visit

- Women should be counseled prenatally about the option of IPP LARC, including its convenience, effectiveness, and increased IUD expulsion rates
What are the benefits of IPP LARC?

1. Unintended pregnancy remains a significant issue in the U.S. and LARC methods can decrease unintended pregnancy and lengthen interpregnancy intervals
2. Patient is still in the midst of care and can be convenient for both woman and clinician
3. Time limit on postpartum insurance coverage for some women
4. Reasonable certainty that the patient is not pregnant
What are the benefits of IPP LARC? (continued)

5. Providing IUDs immediately postpartum is cost-effective despite higher expulsion rates

6. Provision of immediate postpartum contraception can extend interpregnancy intervals
   ○ 70% of pregnancies are unintended in the first year postpartum

7. Women using LARC methods have high satisfaction and continuation rates as compared to oral contraceptive pill users
IPP LARC Satisfaction & Continuation Rates

- Many women like and continue their LARC method received postpartum
  - 74% of women who had an IUD placed immediately postpartum did not experience an expulsion and still had their IUD in place at one year
  - 84% of women who had an implant placed immediately postpartum still had the implant at one year

- Elective discontinuation for IUDs and implants on par with interval placement

Cohen; Contraception; 2016  Goldthwaite; Curr Opin Obstet Gynecol; 2015
Woo; Contraception; 2015  Crockett; Contraception; 2017
IPP LARC can help meet women’s needs

- Safe
- Convenient
- Highly effective
- Reversible
- Forgettable
- High patient satisfaction
- High continuation rates
CLINICAL CONSIDERATIONS
of Immediate Postpartum Contraception
# Method Efficacy & Considerations: Postpartum Contraception

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etonogestrel (ENG) Implant</td>
<td>99%+</td>
<td>- Must be placed and removed by trained clinician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clinicians must attend manufacture training prior to placement</td>
</tr>
<tr>
<td>IUD: Copper</td>
<td>99%+</td>
<td>- Must be placed and removed by trained clinician</td>
</tr>
<tr>
<td>IUD: Levonorgestrel (LNG)</td>
<td>99%+</td>
<td>- Must be placed and removed by trained clinician</td>
</tr>
<tr>
<td>Injectable (Medroxy-progesterone acetate)</td>
<td>94%</td>
<td>- Must obtain injection every 3 months</td>
</tr>
<tr>
<td>Lactational amenorrhea method (LAM)</td>
<td>92-98%</td>
<td>May not be practical for many women because this level of effectiveness is reached when:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Infant frequently &amp; exclusively breastfed (no pumping or bottles)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Less than 6 months postpartum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Amenorrheic</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>91%</td>
<td>- Must take pill at same time every day with 3 hour late window</td>
</tr>
<tr>
<td>Estrogen/progestin combined pill, patch, ring</td>
<td>91%</td>
<td>- Cannot be used within 3 weeks of delivery due to increased risk of blood clots</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Women with risk factors must wait until 6 weeks after delivery to use these methods safely</td>
</tr>
</tbody>
</table>
## Current LARC methods on the market

<table>
<thead>
<tr>
<th>Brand Name of Method</th>
<th>Type of Method</th>
<th>FDA-Approved Duration of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirena®</td>
<td>52 mg LNG IUD</td>
<td>5 years</td>
</tr>
<tr>
<td>Skyla®</td>
<td>13.5 mg LNG IUD</td>
<td>3 years</td>
</tr>
<tr>
<td>Kyleena®</td>
<td>19.5 mg LNG IUD</td>
<td>5 years</td>
</tr>
<tr>
<td>Liletta®</td>
<td>52 mg LNG IUD</td>
<td>4 years</td>
</tr>
<tr>
<td>Paragard®</td>
<td>Copper IUD</td>
<td>10 years</td>
</tr>
<tr>
<td>Nexplanon®</td>
<td>68 mg ENG implant</td>
<td>3 years</td>
</tr>
</tbody>
</table>
# CDC Recommendations for IPP LARC

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>CHC</th>
<th>POP</th>
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<tbody>
<tr>
<td>Breastfeeding (see also Postpartum)</td>
<td>a) &lt;1 month postpartum</td>
<td>3*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>b) 1 month or more postpartum</td>
<td>2*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Postpartum (see also Breastfeeding)</td>
<td>a) &lt;21 days</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>i) with other risk factors for venous thromboembolism (VTE)</td>
<td>3*</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) without other risk factors for VTE</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>c) &gt;42 days</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section)</td>
<td>a) &lt;10 minutes after delivery of the placenta</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>b) 10 minutes after delivery of the placenta to &lt;4 weeks</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>c) ≥4 weeks</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>C</td>
</tr>
<tr>
<td></td>
<td>d) Puerperal sepsis</td>
<td>4</td>
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**Legend:**

1. No restriction (method can be used)
2. Advantages generally outweigh theoretical or proven risks
3. Theoretical or proven risks usually outweigh the advantages
4. Unacceptable health risk (method not to be used)

*Please see the complete guidance for clarification to this classification*
Levonorgestrel IUDs

ACOG Committee Practice Bulletin #121, LARC: Implants and IUDs, provides information on clinical issues and candidate selection, including the following:

• Mechanism of Action:
  o Inhibiting sperm survival
  o Suppression of the endometrium

• Most women ovulate normally but experience diminished menstrual bleeding because of the local effect of levonorgestrel on the endometrium

• 99.8% effective; the one-year typical use failure rate is 0.2 per 100 women
ACOG Committee Practice Bulletin #121, LARC: Implants and IUDs, provides information on clinical issues and candidate selection, including the following:

• Mechanism of Action:
  o Inhibition of sperm migration
  o Change in transport speed of ovum
  o Damage to or destruction of the ovum

• Evidence suggests mechanism of action for pregnancy prevention occurs before implantation

• The most common adverse effects reported are abnormal bleeding and pain

• 99.2% effective; the one-year typical use failure rate is 0.8 per 100 women
Radiopaque 68 mg Etonogestrel implant

ACOG Committee Practice Bulletin #121, LARC: Implants and IUDs, provides information on clinical issues and candidate selection, including the following:

• Mechanism of Action:
  o Primary: ovulation suppression
  o Additional: thickening of cervical mucus and alteration of the endometrial lining

• After implant insertion, changes in bleeding patterns are common and include amenorrhea or infrequent, frequent, or prolonged bleeding

• Placed in upper arm; comparable in size to a match stick

• 99.9% effective; the one-year typical use failure rate is 0.05 per 100 women
Key ACOG Recommendations for IPP LARC:
Committee Opinion #670, IPP LARC

- IPP LARC should be offered as an effective option for postpartum contraception
- Women should be counseled prenatally about the option of IPP LARC, including advantages, risks of expulsion, contraindications, and alternatives to allow for informed decision making
- Providers should counsel women about the convenience and effectiveness of IPP LARC, including the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals
BREASTFEEDING

Clinical Considerations
CDC Recommendations: IPP LARC & Breastfeeding

### Condition Sub-Condition

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<td>a) &lt;21 days</td>
<td>4</td>
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<td></td>
<td>b) 21 days to 42 days</td>
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<td>c) &gt;42 days</td>
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ACOG Recommendations: IPP LARC & Breastfeeding

**ACOG Practice Bulletin #121, LARC: Implants & IUDs**, states that:

- Although data is limited, observational studies of progestin-only contraceptives suggest no effect either on the ability to successfully initiate & continue breastfeeding or on an infant's growth and development

**ACOG Committee Opinion #670, IPP LARC**, states that:

- IPP placement of the levonorgestrel IUD and implant are rated as MEC Category 2 for women who are breastfeeding
- There are **theoretical** concerns that exogenous progesterone could prevent lactogenesis, but observational studies of progestin-only contraceptives suggest no effect on successful initiation and continuation of breastfeeding or on infant growth and development
ACOG Practice Bulletin #121, LARC: Implants & IUDs, states that:

- A randomized trial compared postpartum insertion of the etonogestrel contraceptive implant at 1–3 days with standard insertion at 4–8 weeks postpartum
  - The study reported no differences in breastfeeding outcomes between groups, including lactogenesis and the risk of lactation failure

- A prospective nonrandomized comparative study examined breast milk composition using the contraceptive implant versus a nonhormonal IUD, initiated at least 28–56 days after childbirth.
  - Neither breast milk quantity nor composition differed between the groups
  - At 3-year follow-up, there was no difference in neonatal body length, biparietal head circumference, or body weight between the groups
IPPP LARC & Breastfeeding: Key Takeaway

- The Copper IUD lacks hormones, which avoids any theoretical effect on breastfeeding, and is classified as MEC Category 1 (no restriction on use) for women who are breastfeeding.

ACOG Committee Opinion #670, IPP LARC, states that:

“Given available evidence, women considering immediate postpartum hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.”
What should you tell patients?

• When discussing IPP LARC & breastfeeding with patients:
  o Review future child-bearing intentions
  o Review safety and high user satisfaction with IPP LARC
  o Discuss the theoretical risk of LARC methods, but that this has not been observed in clinical practice
  o Review potential rapid return to fertility after delivery

• If patients desire IPP LARC, its provision should be supported in the hospital setting
IPP IUD

Insertion Techniques
Post-Placental IUD Insertion Equipment

• Two Forceps
  o One for cervical traction and another for device placement
    • Kelly Placental forceps
    • Ring/Ovum forceps
• Method of vaginal retraction
• Betadine, radiopaque surgical sponge
• Scissors
• Light source
• Ultrasound recommended, not required
• IUD and its inserter
Importance of Fundal Placement

Manual Insertion

Instrument Insertion

• Strongly recommend ultrasound guidance, if available, especially for training but absence of ultrasound should never prevent insertion

Images courtesy of the ACQUIRE Project and JHPIEGO
IUD Forceps Method

1. Identify cervix, place atraumatic (ring) forceps on anterior lip of cervix
2. Grasp the IUD with the forceps but do NOT close the ratchets
3. Insert the forceps through the cervix
4. Place non-forceps hand on the abdomen, palpating the fundus
5. Move the IUD-holding forceps up to the fundus
6. Open the forceps and release the IUD
7. Slowly remove the forceps, keeping them slightly open
8. Cut the strings flush with the external os
   • Strings will lengthen with uterine involution, and may require trimming

IUD Manual Insertion Method

1. Grasp the IUD between your 2nd and 3rd fingers
2. Insert your hand to the fundus
3. Use your other hand to palpate the fundus abdominally to confirm
4. Slowly open your fingers and remove them from the uterus
5. Cut the strings flush with the external os
   • Strings will lengthen with uterine involution, and may require trimming

IUD Inserter Method

1. Follow manufacture instructions for loading the IUD
2. Move the flange all the way back to the handle
3. Move inserter to appropriate place in uterus
   • Note angle of uterus can change postpartum, especially the lower uterine segment
4. Ensure fundal placement
   • If available, use ultrasound to confirm location
5. Deploy IUD per standard instructions
6. Cut the strings flush with the external os
   • Strings will lengthen with uterine involution, and may require trimming
Post placental IUD placement at time of cesarean delivery

1. Perform routine external massage and internal sweep to ensure all placental tissue is removed
2. Grasp the body of the IUD with forceps, hand or inserter
3. Strings of an LNG IUD should be trimmed to about 10 cm. Strings of the Paragard cooper IUD do not need to be trimmed.
4. Place the IUD at the fundus
5. Carefully point strings to cervix/vagina
6. Close the hysterotomy – take care to not incorporate the strings into the closure
IPP IUD Simulation Video: Mama-U Model

Laerdal Global Health. Mama U. https://www.youtube.com/watch?v=xNIKUI5v_0
ASSESSING CANDIDACY
for Immediate Postpartum LARC
Routine Contraindications

- Uterine anomaly or fibroids
  - Dependent on severity of anomaly and/or fibroids
- Active gynecologic malignancy
- Allergy to any component of the IUD
- Severe anemia or Wilson’s disease (for copper IUD)
- Breast cancer (for LNG IUS)
- Pelvic tuberculosis

IPP Contraindications

- Peripartum chorioamnionitis, endometritis, or puerperal sepsis
- Prolonged rupture of membranes (>18 hours)
- **Unresolved** post-partum hemorrhage

ACOG Practice Bulletin #121: LARC, Implants and IUDs, states that “LARC methods have few contraindications, and almost all women are eligible for implants and IUDs.”
EXPULSION

Clinical Considerations
ACOG Recommendations for IPP LARC & Expulsion Rates: Committee Opinion #670, IPP LARC

• Expulsion rates for immediate postpartum IUD insertions are higher than for interval or postabortion insertions, vary by study, and may be as high as 10–27% (73-90% of women retain the device)

• Women should be counseled about the increased expulsion risk, as well as signs and symptoms of expulsion

• A woman who experiences or suspects expulsion should contact her health care provider and use a back-up contraceptive method

• Many women experience barriers to interval LARC placement, such that the advantages of immediate placement outweigh the disadvantages
ACOG Committee Opinion #670, IPP LARC, states that:

“Despite the higher expulsion rate of immediate postpartum IUD placement over interval placement, evidence from clinical trials and from cost-benefit analyses strongly suggest the superiority of immediate placement in reduction of unintended pregnancy, especially for those at greatest risk of not having recommended postpartum follow-up.”
IMPLANT

Insertion
Contraceptive Implant Insertion

• All health care providers who perform implant insertions and removals must receive training from the manufacturer. Therefore, the insertion process is deferred to the manufacturer and not covered in this presentation.

• IPP insertion identical to interval insertion and can be inserted any time post-delivery

• Request a training:
  2. Phone number to request Nexplanon® training: 1-877-467-5266
FOLLOW UP INSTRUCTIONS

For Postpartum LARC
IPP IUD follow-up instructions

• Many will need a follow-up appointment to have strings trimmed
  o Offering, but not mandating, a string check is important
  o Instruct patient not to mess with strings if bothersome

• If patient experiences usual bleeding accompanied by cramping different from lochia or postpartum cramps, she should be seen by a provider for possible partial expulsion
  o Instruct patient to inspect pads for evidence of expelled IUD

• Instruct patient to remind her provider that an IUD was placed postpartum and to notify a provider if she has:
  o Fevers, chills, severe abdominal pain or temperature > 100.4°F
  o Heavy bleeding
  o Expulsion of the device
IPP Implant follow-up instructions

• Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks after placement

• A patient should see a provider if they:
  o Have redness, swelling or drainage near the implant
  o Cannot feel the implant under their skin

• A patient should always remind their provider that they had an implant placed postpartum
CONTRACEPTIVE COUNSELING

Shared Decision-Making & Reproductive Justice Framework
Reproductive Coercion

- Reproductive coercion is the act of forcing a woman to use a method of birth control that she did not choose
- The U.S. has history of reproductive coercion and forced sterilization
- Minority and socioeconomically disadvantaged women may have mistrust of health care system because of this history

Reproductive Coercion

• Any counseling for postpartum contraception, especially sterilization or IPP LARC, must be sensitive to this history
  o Highlight the reliance provider for removal
  o LARC devices can give women a decreased sense of control or the feeling of being forced into a contraceptive method

Contraceptive Counseling for IPP LARC

• ACOG Committee Opinion #490, Partnering With Patients to Improve Safety, states:

  **Shared medical decision making**
  
  A process in which the physicians shares with the patient all relevant risk and benefit information on all treatment alternatives and the patient shares with the physician all relevant personal information that might make one treatment or side effect more or less tolerable than others

• Shared medical decision making can increase patient engagement and reduce risk resulting in improved outcomes, satisfaction, and treatment adherence

• Although medical knowledge is tipped towards the provider, in shared medical decision making, a middle ground is sought that incorporates sound medical care and a patient’s person preferences

• Patient-centered goals may also have a part in the decision-making process
A Reproductive Justice Framework for Contraceptive Counseling

ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity, states:

“The framework of reproductive justice connects family planning and other aspects of sexual and reproductive health with the disparities and complexities that affect patients’ lives. Furthermore, it encourages gynecologic health care providers to examine issues of bias and coercion and advocate for equitable access and change.”
A Reproductive Justice Framework for Contraceptive Counseling

ACOG Committee Onion #699, Adolescent Pregnancy, Contraception, and Sexual Activity, states:

• “A reproductive justice framework for contraceptive counseling and access is essential to providing equitable health care, accessing and having coverage for contraceptive methods, and resisting potential coercion by health care providers.”

• “When engaging in shared decision making regarding contraceptive use, obstetrician–gynecologists should be aware of and address their own biases, work to empower patients, and strive for equitable outcomes for all patients regardless of age, race or ethnicity, class, or socioeconomic status.”
ACOG Guidance on IPP LARC Counseling

ACOG Committee Opinion #670, IPP LARC, states:

• “Women should be counseled about all forms of postpartum contraception in a context that allows informed decision making.”

• “Optimally, women should be counseled prenatally about IPP LARC. Counseling should include advantages, risk of IUD expulsion, contraindications, and alternatives to allow for informed decision making.”

• “Counsel women about the convenience and effectiveness of IPP LARC, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals.”
ACOG Guidance on IPP LARC Counseling (cont.)

ACOG Committee Opinion #670, IPP LARC, states that:

- Counseling should include “the increased risk of expulsion, including unrecognized expulsion, with IPP IUD insertion compared with interval IUD insertion.”

- “Given available evidence, women considering IPP hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that the preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.”

- See the ACOG LARC Program’s Contraceptive Counseling Resource Digest for more information and additional resources.
Tools for contraceptive counseling

**HOW WELL DOES BIRTH CONTROL WORK?**

<table>
<thead>
<tr>
<th>Level</th>
<th>Method</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Really, really well</td>
<td>The Implant ( Nexplanon)</td>
<td>3 years</td>
</tr>
<tr>
<td></td>
<td>IUD (Skyla)</td>
<td>3 years</td>
</tr>
<tr>
<td></td>
<td>IUD (Mirena)</td>
<td>5 years</td>
</tr>
<tr>
<td></td>
<td>IUD (ParaGard)</td>
<td>12 years</td>
</tr>
<tr>
<td></td>
<td>Sterilization, for men and women</td>
<td>Forever</td>
</tr>
<tr>
<td>Okay</td>
<td>The Pill</td>
<td>Every Single Day</td>
</tr>
<tr>
<td></td>
<td>The Patch</td>
<td>Every week</td>
</tr>
<tr>
<td></td>
<td>The Ring</td>
<td>Every month</td>
</tr>
<tr>
<td></td>
<td>The Shot (Depo-Provera)</td>
<td>Every 3 months</td>
</tr>
<tr>
<td>Not so well</td>
<td>Withdrawal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diaphragm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fertility Awareness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condoms, for men and women</td>
<td></td>
</tr>
</tbody>
</table>

**What is your chance of getting pregnant?**

- Less than 1 in 100 women
- 6-8 in 100 women, depending on method
- 12/24 in 100 women, depending on method
- LV: without birth control, over 10 in 100 young women get pregnant in a year.

**U.S. Medical Eligibility Criteria Wheel For Contraceptive Use**

June 2012

[Image of the U.S. Medical Eligibility Criteria Wheel For Contraceptive Use]
More ACOG Guidance on Contraceptive Counseling

ACOG has many contraceptive counseling resources, including, but not limited to:

1. ACOG Practice Bulletin #121, LARC: Implants and Intrauterine Devices
2. ACOG Committee Opinion #672, Clinical Challenges of LARC Methods
3. ACOG Committee Opinion #670, IPP LARC
4. ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity
5. ACOG Committee Opinion #490, Partnering With Patients to Improve Safety
6. ACOG Committee Opinion #587, Effective Patient-Physician Communication
7. ACOG Committee Opinion #736, Optimizing Postpartum Care
8. ACOG LARC Program Contraceptive Counseling Resource Digest
SPECIAL CONSIDERATIONS

For Nurses
How can nurses support IPP LARC?

• Patient Education
  o Provide contraceptive counseling to patients
    • Discussion of LARC and non-LARC methods
  o Confirm proper consent forms are completed
  o Provide patient education materials like follow up instructions

• Procedure
  o Assist with setting up the needed instruments, supplies, and device
  o Provide assistance during the insertion
  o Assist with device tracking, per unit protocol

• Support the provision of IPP LARC in L&D
Procedure/instrument checklist

**Implant and IUD procedure checklist:**

- Device available
- Consent signed and witnessed
- Instruments available

**IUD instruments/supplies:**

- Ultrasound
- Ring forceps and/or Kelly clamp
- Scissors
- +/- speculum
- Confirm no contraindication to placement

**Implant instruments/supplies:**

- 1% lidocaine, 3-5 mL
- Betadine
- Band-aid or steri-strips
- Kerlex
Important things to keep in mind

- Consent
  - Consent form must be signed by patient, physician, and witness before device is placed
  - There is no mandatory waiting period for IPP LARC

- Devices
  - Where will they be stored?
    - PIXIS? A cabinet?
  - Who will be responsible for getting them? (Hint, probably you!)
    - Treated like a medication
Important things to keep in mind

• Billing
  o Physicians will likely be billing – make sure the responsible person is doing this!

• Stocking
  o Who will be responsible for stocking the devices?
  o Do you know who to go to if you see that the supply is running low?

• Documentation
  o Both physicians and nurses will need to document placement
  o Lot number, expiration date
  o Right or left arm, if applicable
Potential challenges you may face

• Patient
  o Doesn’t want a LARC or isn’t sure – don’t pressure, just give information
  o Wants more information – where will you get it from?

• Provider
  o Doesn’t want to place the device – advocate for your patient if she does want it!
    • Is someone else available who has the necessary training?
  o Doesn’t have the device or supplies that are needed – help us get what we need!

• Pharmacy
  o Do they need to stock the devices?
  o Is there a contact person you can call?
We need you!

• We cannot be successful without your help! Offering IPP LARC requires a team approach

• You are crucial in helping your patients understand benefits and risk of postpartum contraception

• You are at their bedside hourly – patients trust you and listen to what you say

• It’s been proven that women want their choices and options to be presented to them, not to be told what birth control to choose
  o We will have information sheets to share with our patients about their options for postpartum birth control

• Even though LARC works really well, it is no one’s job to push it on a woman who may not want one
KEY TAKEAWAYS

Things to Keep in Mind
ACOG Clinical Guidance: Summary & Key Takeaways

1. Women should be counseled prenatally about all postpartum contraceptive options, including IPP LARC
2. IPP LARC should be offered as a safe and effective option for postpartum contraception
3. LARC methods have few contraindications, and almost all women are eligible for implants and IUDs
4. Counseling should include benefits and limitations of IPP LARC
ACOG Clinical Guidance: Summary & Key Takeaways (cont.)

5. Despite higher expulsion rates, evidence from clinical trials and from cost-benefit analyses strongly suggest the superiority of immediate placement in reduction of unintended pregnancy.

6. Women considering IPP LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on breastfeeding outcomes.

7. The immediate postpartum period can be particularly favorable time for IUD or implant insertion.
Who can you contact for assistance?

- LARC champion at your institution
- Nursing manager or administrator
- Pharmacy
- The LARC Program at the American College of Obstetricians and Gynecologists
  - www.acog.org/larc
  - www.pcainitiative.org