

Immediate Postpartum LARC for Clinicians Doing Deliveries



ACOG

The American College of
Obstetricians and Gynecologists

the **LARC**
program
Long-Acting Reversible Contraception

ACOG disclosure

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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: Assessing candidacy for IPP long-acting reversible contraception (LARC)
- Section 4: IPP intrauterine devices (IUD) insertion techniques
- Section 5: Follow up instructions for postpartum LARC
- Section 6: Contraceptive counseling: shared decision-making & reproductive justice framework

Learning objectives

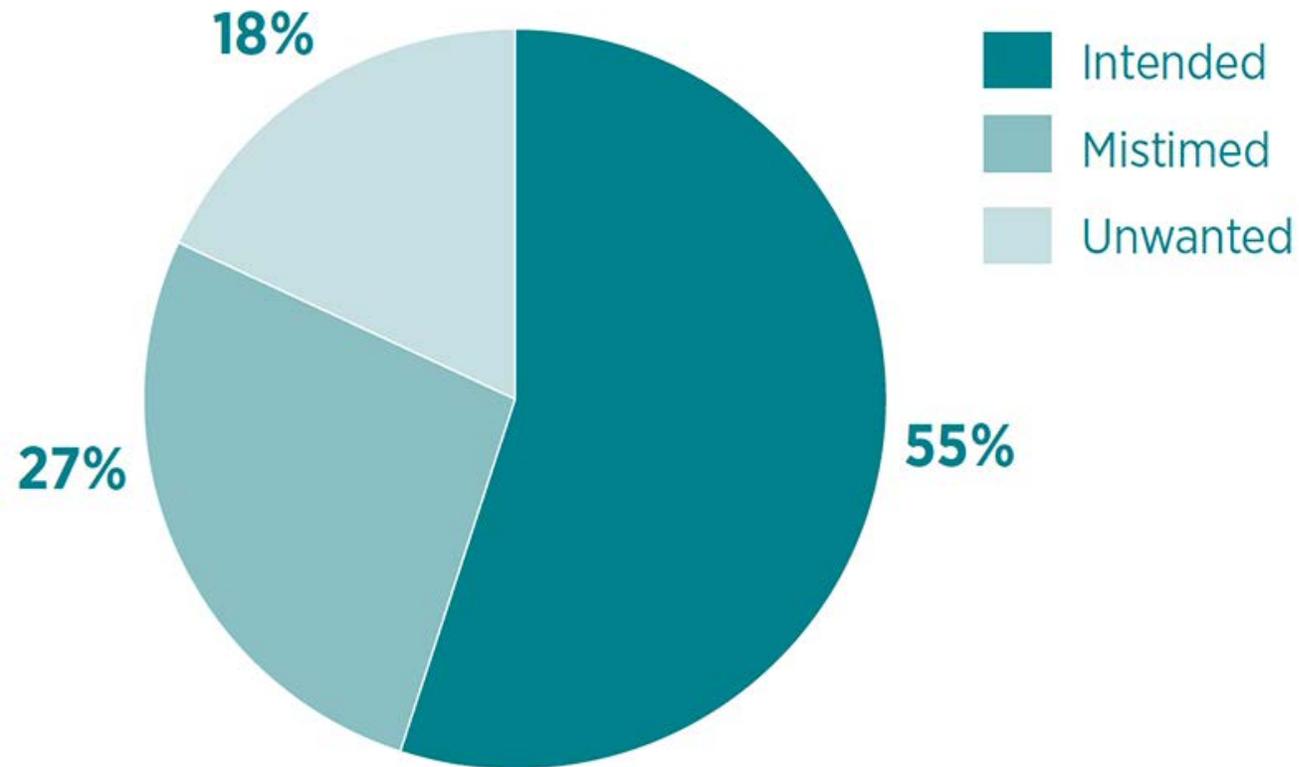
1. Understand the impact of unintended pregnancy in the postpartum period
2. Summarize existing data on the efficacy and safety of long-acting reversible contraception (LARC) in the immediate postpartum period
3. Understand and practice immediate postpartum (IPP) IUD insertion techniques
4. Understand the importance of shared decision-making for contraceptive counseling

UNMET NEED

for Postpartum Contraception

PREGNANCIES BY INTENTION STATUS

Nearly half of U.S. pregnancies were unintended in 2011.



www.guttmacher.org

the **LARC**
program
Long-Acting Reversible Contraception

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 neo natal outcomes, including low birth weight and prematurity
- **ACOG Committee Opinion #736, Optimizing Postpartum Care**, states that:
 - Women should be advised to avoid interpregnancy intervals shorter than 6 months
 - 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:
 - As many as 40% of women do not return for the 6 week postpartum visit
 - Attendance rates are even lower in limited resource areas, further contributing to health disparities
- Women have difficulty returning for a postpartum visit because of:
 - Childcare obligations
 - Unable to get off work
 - Unstable housing
 - No transportation
 - Communication or language barrier
 - Lack of insurance coverage or potential expiration of Medicaid eligibility
- Non-breastfeeding women can ovulate as early as 25 days postpartum
 - 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
 - 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
 - Medicaid coverage may end postpartum
 - Uninsured – cost of sterilization can be prohibitive

What is LARC? ACOG Practice Bulletin #186 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

← Intrauterine device (IUD)

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 while still in the delivery room and, when possible, within 10 minutes of placental delivery
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



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 670 • August 2016

Committee on Obstetric Practice

The American College of Nurse-Midwives and the Society for Maternal-Fetal Medicine endorse this document. The American Academy of Family Physicians and the Association of Women's Health, Obstetric and Neonatal Nurses support this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Ann E. Borders, MD, MSc, MPH and Alison M. Stuebe, MD, MSc, and reviewed by the Long-Acting Reversible Contraception Work Group.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Immediate Postpartum Long-Acting Reversible Contraception

ABSTRACT: Immediate postpartum long-acting reversible contraception (LARC) has the potential to reduce unintended and short-interval pregnancy. Women should be counseled about all forms of postpartum contraception in a context that allows informed decision making. Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum intrauterine devices and implants. Obstetrician-gynecologists and other obstetric care providers should discuss LARC during the antepartum period and counsel all pregnant women about options for immediate postpartum initiation. Education and institutional protocols are needed to raise clinician awareness and to improve access to immediate postpartum LARC insertion. Obstetrician-gynecologists and other obstetric care providers should incorporate immediate postpartum LARC into their practices, counsel women appropriately about advantages and risks, and advocate for institutional and payment policy changes to support provision.

Recommendations

The American College of Obstetricians and Gynecologists (the College) recommends the following strategies for immediate postpartum long-acting reversible contraception (LARC):

- Optimally, women should be counseled prenatally about the option of immediate postpartum LARC. Counseling should include advantages, risks of intrauterine device (IUD) expulsion, contraindications, and alternatives to allow for informed decision making.
- Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum IUDs and implants. Obstetrician-gynecologists and other obstetric care providers should counsel women about the convenience and effectiveness of immediate postpartum LARC, as well as the benefits of

reducing unintended pregnancy and lengthening interpregnancy intervals.

- Obstetrician-gynecologists and other obstetric care providers should include in their contraceptive counseling the increased risk of expulsion, including unrecognized expulsion, with immediate postpartum IUD insertion compared with interval IUD insertion.
- Systems should be in place to ensure that women who desire LARC can receive it during the comprehensive postpartum visit if immediate postpartum placement was not undertaken.
- Obstetrician-gynecologists, other obstetric care providers, and institutions should develop the resources, processes, and infrastructure, including stocking LARC devices in the labor and delivery unit and coding and reimbursement strategies, to support immediate LARC placement after vaginal and cesarean births.

- IPP LARC:
 - Should be offered as an effective option for postpartum contraception
 - Can reduce unintended pregnancy & lengthen interpregnancy intervals
- Women should be counseled prenatally about IPP LARC, including:
 - Advantages
 - Risks of IUD expulsion
 - Contraindications & alternatives to allow for informed decision making

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

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
7. Women using LARC methods have high satisfaction and continuation rates as compared to oral contraceptive pill users

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

Method	Effectiveness	Special Considerations
Sterilization (male & female)	99%+	- Permanent
Etonogestrel (ENG) Implant	99%+	- Must be placed and removed by trained clinician - Clinicians must attend manufacture training prior to placement
IUD: Copper	99%+	- Must be placed and removed by trained clinician
IUD: Levonorgestrel (LNG)	99%+	- Must be placed and removed by trained clinician
Injectable (Medroxyprogesterone acetate)	94%	- Must obtain injection every 3 months
Lactational amenorrhea method (LAM)	92-98%	May be impractical for many women; this effectiveness is reached when: <ul style="list-style-type: none"> - Infant frequently & exclusively breastfed (no pumping or bottles; time between feeding during day <4 hours & <6 hours at night) - <6 months postpartum - Amenorrheic
Progestin-only pill	91%	- Must take pill at same time every day with 3 hour late window
Estrogen/progestin combined pill, patch or ring	91%	- Cannot be used within 3 weeks of delivery due to increased risk of blood clots - Women with risk factors must wait until 6 weeks after delivery to use these methods safely

Current LARC methods on the market

Description	Brand Name of Method	Type of Method	FDA-Approved Duration of Use
Hormonal IUD	Mirena®	52 mg LNG IUD	5 years
	Skyla®	13.5 mg LNG IUD	3 years
	Kyleena®	19.5 mg LNG IUD	5 years
	Liletta®	52 mg LNG IUD	4 years
Non-hormonal IUD	Paragard®	Copper IUD	10 years
Contraceptive Implant	Nexplanon®	68 mg ENG implant	3 years

CDC recommendations for IPP LARC

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Postpartum (see also Breastfeeding)	a) <21 days	4		1		1		1					
	b) 21 days to 42 days												
	i) with other risk factors for venous thromboembolism (VTE)	3*		1		1		1					
	ii) without other risk factors for VTE	2		1		1		1					
	c) >42 days	1		1		1		1					
Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section)	a) <10 minutes after delivery of the placenta									2		1	
	b) 10 minutes after delivery of the placenta to <4 weeks									2		2	
	c) ≥4 weeks									1		1	
	d) Puerperal sepsis									4		4	

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)



Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

*Please see the complete guidance for clarification to this classification

Levonorgestrel IUDs

- **ACOG Committee Practice Bulletin #186, LARC: Implants and IUDs**, provides information on clinical issues and candidate selection, including the following:
 - Mechanism of Action
 - Prevent fertilization by changing amount and viscosity of cervical mucus, making it impenetrable to sperm
 - Evidence supports that LNG IUDs do not disrupt pregnancy and are not abortifacients
 - 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

Copper IUD

- **ACOG Committee Practice Bulletin #186, LARC: Implants and IUDs**, provides information on clinical issues and candidate selection, including the following:
 - Mechanism of Action – Prevents fertilization by:
 - Inhibition of sperm migration
 - Change in transport speed of ovum
 - Damage to or destruction of the ovum
 - Evidence supports that the Copper IUD does not disrupt pregnancy and is not an abortifacient
 - 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 #186, LARC: Implants and IUDs**, provides information on clinical issues and candidate selection, including the following:
 - Mechanism of Action:
 - Primary: ovulation suppression
 - 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 subdermally in upper arm; size: 4cm x 2mm (comparable in size to a match stick)
- 99.9% effective; the one-year typical use failure rate is 0.05 per 100 women

ASSESSING CANDIDACY

for Immediate Postpartum LARC

IPP IUD contraindications – U.S. MEC & ACOG

ACOG Practice Bulletin #186: LARC, Implants and IUDs, states LARC has “few contraindications & should be offered routinely as safe & effective contraceptive options for most women.”

Routine Contraindications

- Uterine anomaly
 - Dependent on severity of anomaly
- Active gynecologic malignancy
- Pelvic tuberculosis
- Rheumatic diseases
- Cervical cancer
- Endometrial cancer
- Breast cancer (LNG IUD only)
- Liver tumors (LNG IUD only)

IPP Contraindications

- Uterine infection:
 - Peripartum chorioamnionitis
 - Endometritis
 - Puerperal sepsis
- **Ongoing** Postpartum hemorrhage

IPP LARC & infection: key takeaways

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

“IPP IUD placement is contraindicated in the setting of intrauterine infection at time of delivery, postpartum hemorrhage, and puerperal sepsis. In the absence of puerperal sepsis, IPP IUD insertion is not associated with increased risks of bleeding or infection.

- **Currently, minimal data exists on IPP IUD and endometritis and ACOG has no official guidance on treating IPP IUD and endometritis**
- Although rare, if endometritis develops after IPP IUD insertion, treat per your usual clinical practice
- If infection occurs after insertion or removal of the implant, treat per your usual clinical practice

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**

IPP LARC & expulsion rates: key takeaway

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 visit.”

BREASTFEEDING

Clinical Considerations

CDC recommendations: IPP LARC & breastfeeding

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Breastfeeding (see also Postpartum)	a) <1 month postpartum	3*		2*		2*		2*					
	b) 1 month or more postpartum	2*		1*		1*		1*					
Postpartum (see also Breastfeeding)	a) <21 days	4		1		1		1					
	b) 21 days to 42 days												
	i) with other risk factors for venous thromboembolism (VTE)	3*		1		1		1					
	ii) without other risk factors for VTE	2		1		1		1					
	c) >42 days	1		1		1		1					
Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section)	a) <10 minutes after delivery of the placenta									2		1	
	b) 10 minutes after delivery of the placenta to <4 weeks									2		2	
	c) ≥4 weeks									1		1	
	d) Puerperal sepsis									4		4	

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)



Centers for Disease Control and Prevention
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*Please see the complete guidance for clarification to this classification

Evidence on IPP hormonal LARC & breastfeeding

Study 1

- **Design:** Single, randomized controlled trial
- **Aim:** Examined effect of IUDs (both Cu & LNG) on breastfeeding women randomized to insertion of LNG IUD or Cu IUD at 6-8 weeks postpartum
- **Result:** No differences in:
 - Breastfeeding duration
 - Infant growth

Study 2

- **Design:** Small, randomized controlled trial
- **Aim:** Compared breastfeeding outcomes of women receiving IPP implant with those using no contraception
- **Result:** No significant differences in:
 - Breast milk volume
 - Newborn weight
 - Exclusive breastfeeding rates

Evidence on IPP hormonal LARC & breastfeeding

Study 3

- **Design:** Prospective nonrandomized cohort study (80 women)
- **Aim:** Examined breast milk composition of women using implant vs. nonhormonal IUD, initiated 28-56 days postpartum
- **Result:** No significant differences in:
 - Breast milk composition (total protein, fat & lactose)
 - Breast milk quantity
 - Infant body length, weight & head circumference at 3-year follow-up

Study 4

- **Design:** Randomized, noninferiority trial
- **Aim:** Compared insertion of implant at 1-3 days postpartum with standard insertion at 4-8 weeks postpartum
- **Result:** No differences in:
 - Time to lactogenesis
 - Lactation failure
 - Mean milk creatocrit values (estimated fat & energy content)

IPP LARC & breastfeeding: key takeaway

- The Copper IUD lacks hormones, which avoids any theoretical effect on breastfeeding, and is classified as CDC MEC Category 1 (no restriction on use) for women who are breastfeeding
- For hormonal IPP LARC use, **ACOG Practice Bulletin #186, LARC: Implants & IUDs**, states that:

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

IPP IUD

Insertion Techniques

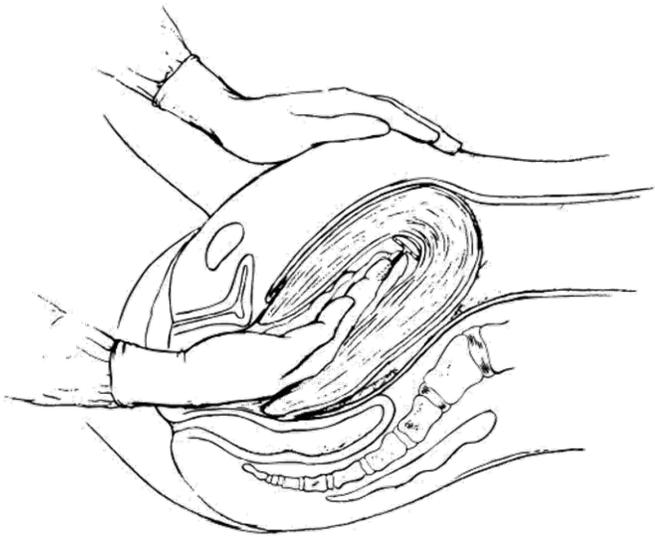
Post-placental IUD insertion equipment

- Two Forceps
 - 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

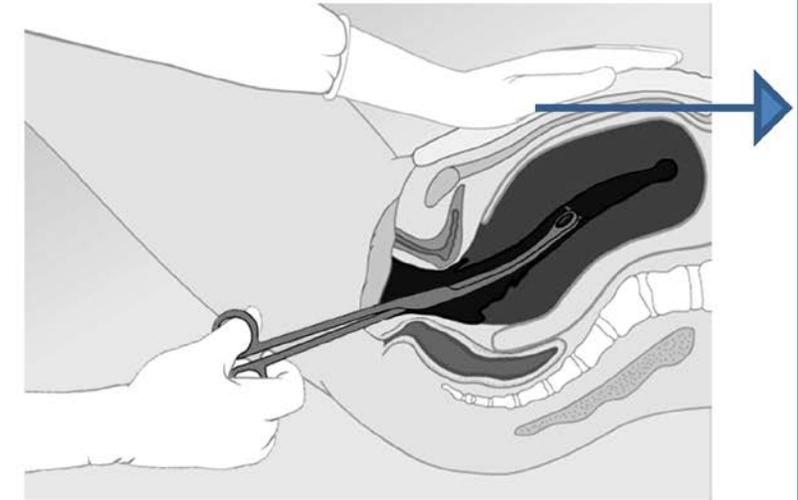
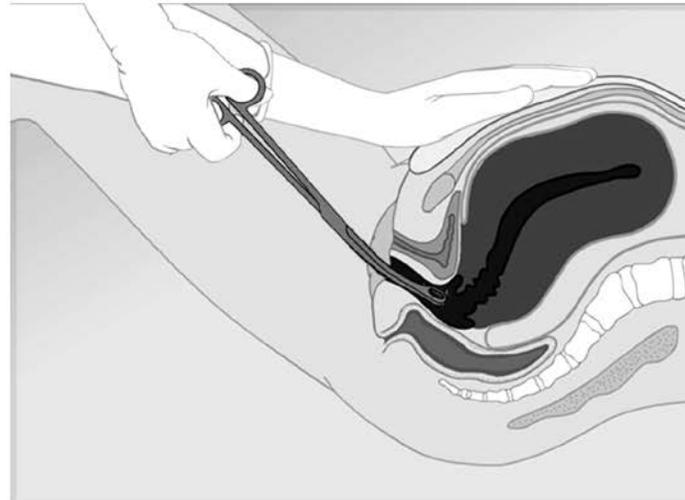


Importance of fundal placement

Manual Insertion



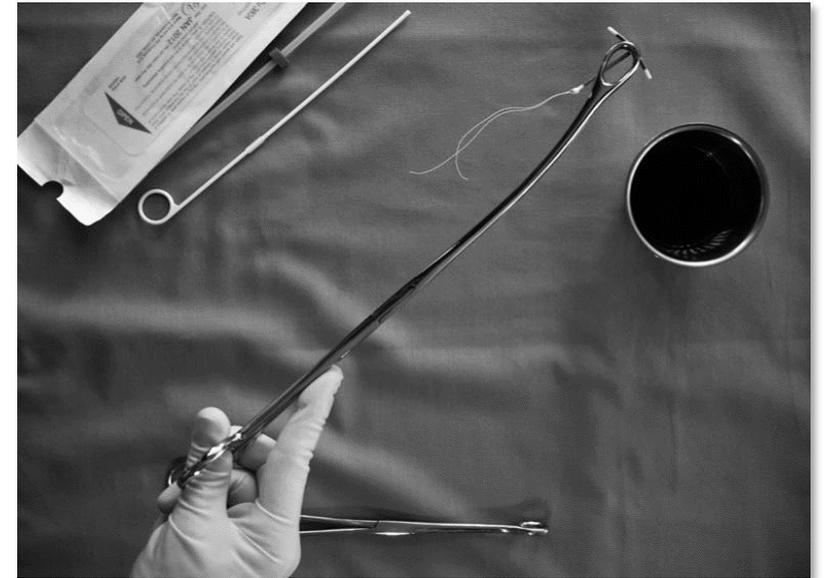
Instrument Insertion



- The ACOG LARC Work Group recommends ultrasound guidance for insertion, especially during training, but unavailability of ultrasound should not preclude insertion

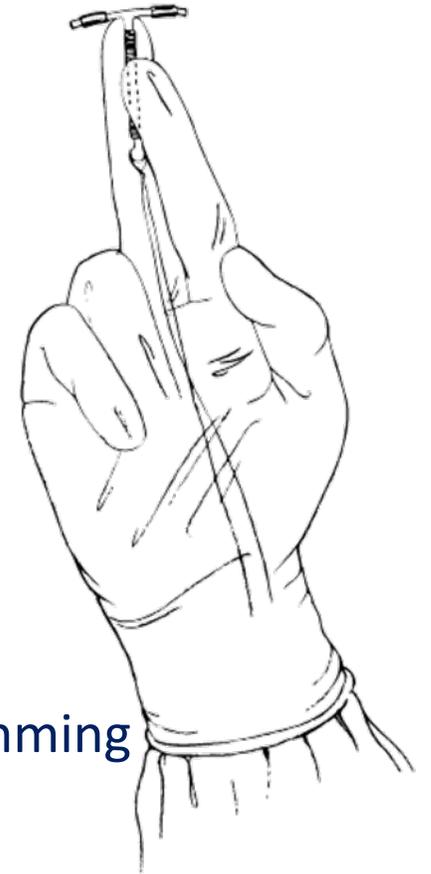
IUD ring forceps method

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



IUD insertion tips & tricks: post vaginal delivery

- Put on new sterile gloves before beginning
- Retrieve the ultrasound prior to delivery, if possible
- Ensure appropriate bleeding, and confirm uterine tone and complete placental removal via placental examination
- Can use ring forceps to apply cervical traction, if needed
- If difficulty reaching fundus, lower your hand and adjust speculum/retractor as needed to change the angle of insertion such that the bend of the lower uterine segment can be navigated
- Repair bleeding lacerations first, but can leave non-bleeding lacs to be repaired after

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: ACOG District II

https://cfweb.acog.org/district_ii/larc/section4.html.

IMPLANT

Insertion

Contraceptive implant insertion

- The Food and Drug Association requires that all health care providers who perform implant insertions and removals receive training from the Merck, the manufacturer of Nexplanon®. Therefore, the insertion process is deferred to the manufacturer and not covered in this presentation.
- **Request a Nexplanon® training:**
 1. Website: <http://www.nexplanon-usa.com/en/hcp/services-and-support/request-training/>
 2. Phone number: 1-877-467-5266

Note: IPP insertion of the contraceptive implant is identical to interval insertion and can be inserted any time post-delivery

FOLLOW UP INSTRUCTIONS

For Postpartum LARC

IPP IUD follow-up instructions

- Many will need a follow-up appointment to have strings trimmed
 - Offering, but not mandating, a string check is important
 - 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
 - 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:
 - Fevers, chills, severe abdominal pain or temperature $> 100.4^{\circ}\text{F}$
 - Heavy bleeding
 - Expulsion of the device

IPP implant follow-up instructions

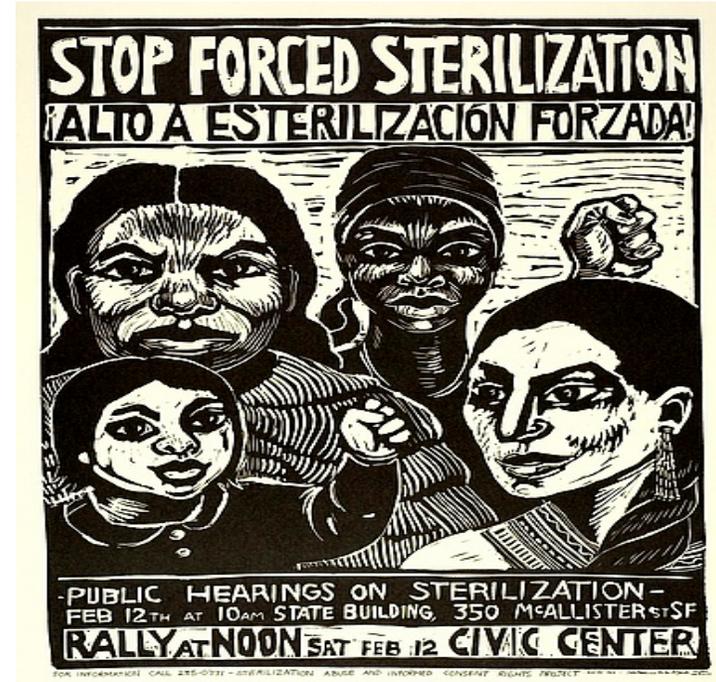
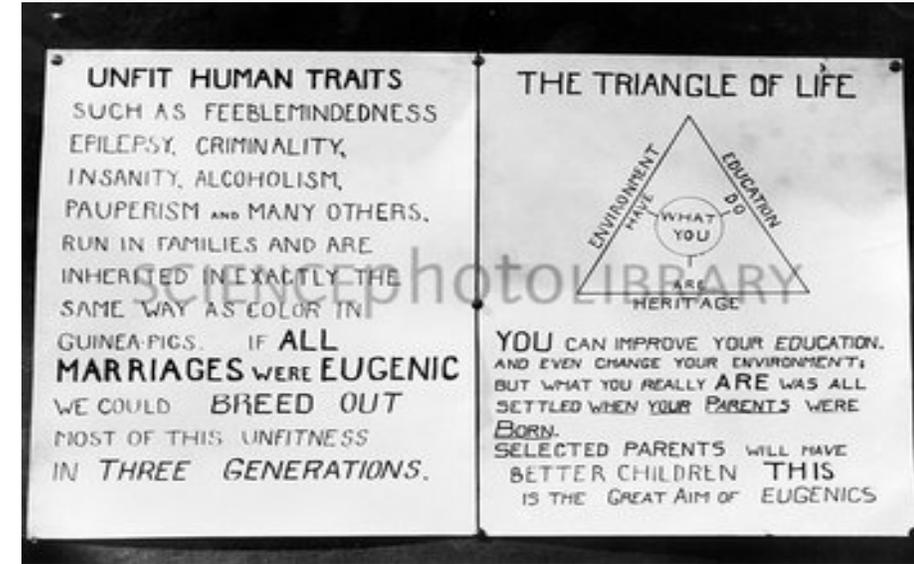
- Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks after placement
- A patient should see a provider if they:
 - Have redness, swelling or drainage near the implant
 - Cannot feel the implant under their skin
- A patient should always remind their provider that they had an implant placed postpartum

CONTRACEPTIVE COUNSELING

Shared Decision-Making & Reproductive
Justice Framework

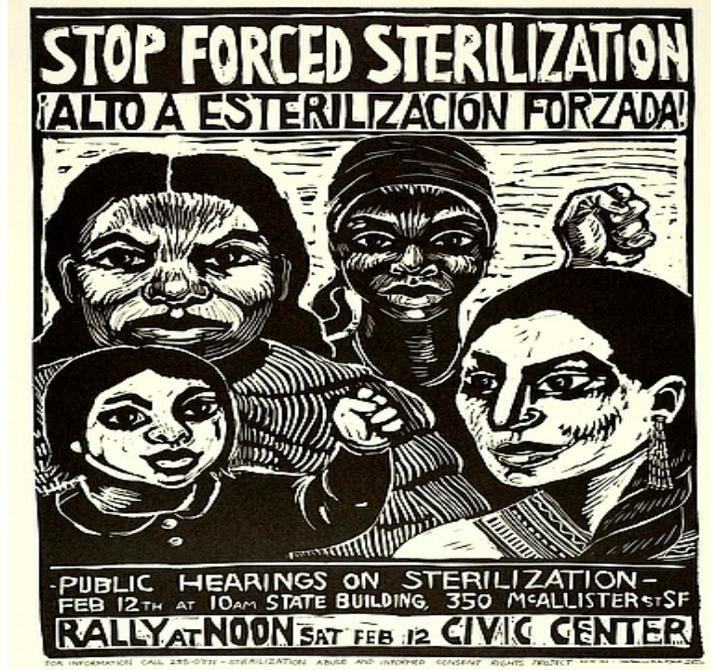
Reproductive coercion

- 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
 - Highlight the reliance provider for removal
 - 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 Opinion #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?

Really, really well

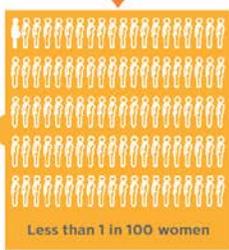


Works, hassle-free, for up to...

				
The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
3 years	3 years	5 years	12 years	Forever

No hormones

What is your chance of getting pregnant?



Okay



For it to work best, use it...

			
The Pill	The Patch	The Ring	The Shot (Depo-Provera)
Every. Single. Day.	Every week	Every month	Every 3 months



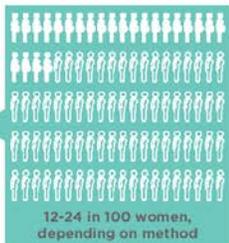
Not so well



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

			
Withdrawal	Diaphragm	Fertility Awareness	Condoms, for men and women

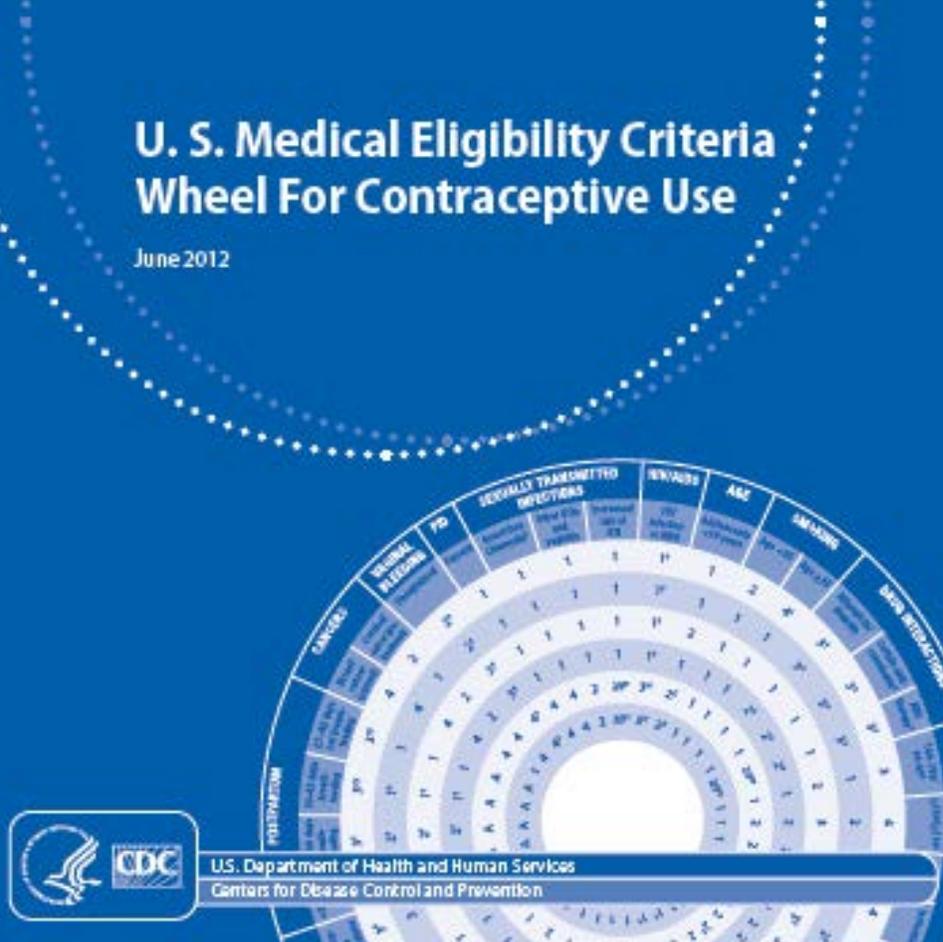
Needed for STI protection
Use with any other method



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

U. S. Medical Eligibility Criteria Wheel For Contraceptive Use

June 2012



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

More ACOG guidance on contraceptive counseling

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

1. [ACOG Practice Bulletin #186, 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](#)

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, research strongly suggests 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

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