

Contraceptive Counseling for the Immediate Postpartum Period



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The American College of
Obstetricians and Gynecologists

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

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Speaker disclosures

- No financial disclosures

Topics covered in presentation

- Section 1: Unmet patient need for postpartum contraception**
- Section 2: Contraceptive counseling with shared medical decision-making framework**
- Section 3: Clinical considerations***
- Section 4: Breastfeeding & IUD expulsion**
- Section 5: Follow up instructions**

* Note: The Food and Drug Administration requires all health care providers who perform implant insertions and removals receive training from the manufacturer. Therefore, the implant insertion process is not covered in this presentation.

Learning objectives

1. Understand the unmet contraceptive needs postpartum
2. Describe postpartum contraceptive methods currently available
3. Understand key elements of person-centered postpartum contraceptive counseling
4. Describe different methods and tools to engage in person-centered contraceptive counseling

UNMET PATIENT NEED

for Postpartum Contraception

The need for postpartum contraception

- The greatest risk of low birth weight and preterm birth occurs when the birth to conception interval is <6 months
- Data suggests a modest increase in risk of adverse outcomes associated with intervals of <18 months
- The optimal interval between delivery and subsequent pregnancy is 18 months to 5 years

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Interpregnancy care. *Obstetric Care Consensus No. 8. American College of Obstetricians and Gynecologists. Obstet Gynecol* 2019;133:e51-72. Available at:

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Challenges with initiating postpartum contraception

Patients may 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**

Challenges with initiating postpartum contraception

- **As many as 40% of women do not return for the 6 week postpartum visit**
 - **Even lower in under-resourced areas, further contributing to health disparities**
- **Non-breastfeeding women can ovulate as early as 25 days postpartum**
 - **40% of women will ovulate by 6 weeks postpartum**
- **57% of women are sexually active by 6 weeks postpartum**

LARC can serve as a bridge method to tubal ligation

- At least 1/3 of women who want a postpartum tubal ligation will **not** have it done
- 47% of women discharged without having a desired postpartum tubal ligation will be pregnant within 1 year
- Issues preventing tubal ligation at the time of delivery:
 - Insurmountable systems barriers like lack of an operating room, physician availability, or incomplete consent forms
 - Insurance Issues
 - Medicaid coverage may end postpartum
 - Uninsured – cost of sterilization can be prohibitive
- Immediate postpartum LARC can serve as a bridge method for those unable to get a desired tubal ligation

What is LARC?

- LARC stands for long-acting reversible contraception
- 2 types of LARC: the intrauterine device and the contraceptive implant, which are the most effective reversible forms of contraception
- Advantages of LARC include:
 1. Methods do not require ongoing effort for long-term and effective use
 2. Rapid return to fertility after removal of the device
- Disadvantage: must be placed and removed by a trained clinician, which impacts patient autonomy

What is immediate postpartum LARC?

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

- **ACOG, CDC, WHO, and Cochrane Reviews all support immediate postpartum LARC as a safe and effective option**
- **Can be an ideal time to provide LARC methods for many women who want them**

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 at any time during the menstrual cycle and not in relationship to the end of a pregnancy (or >6 weeks after delivery)

IPP LARC satisfaction & continuation rates

- Many women like and continue using their immediate postpartum LARC method
 - 74% of women who had an IUD placed immediately postpartum 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 are similar with interval placement

IPP LARC can help meet patients' needs

- Safe
- Convenient
- Highly effective
- Reversible
- Forgettable
- High continuation rates

CONTRACEPTIVE COUNSELING

Shared Medical Decision Making

Contraceptive coercion

- Contraceptive coercion is the act of pressuring or forcing an individual to use a method of birth control that they do not desire
- The U.S. has a long history of contraceptive coercion and forced sterilization perpetrated against economically marginalized individuals and persons of color.

Forced sterilization

- The Eugenics movement of the early 1900s
- Continued forced or coerced sterilization through 1970's of the economically marginalized, those with mental illnesses, persons of color, and immigrant individuals
 - Population control
 - Social control
 - Form of punishment
 - Extortion to ensure receipt of public assistance
 - Trainee education
- Recent cases in the 2000s in California prisons

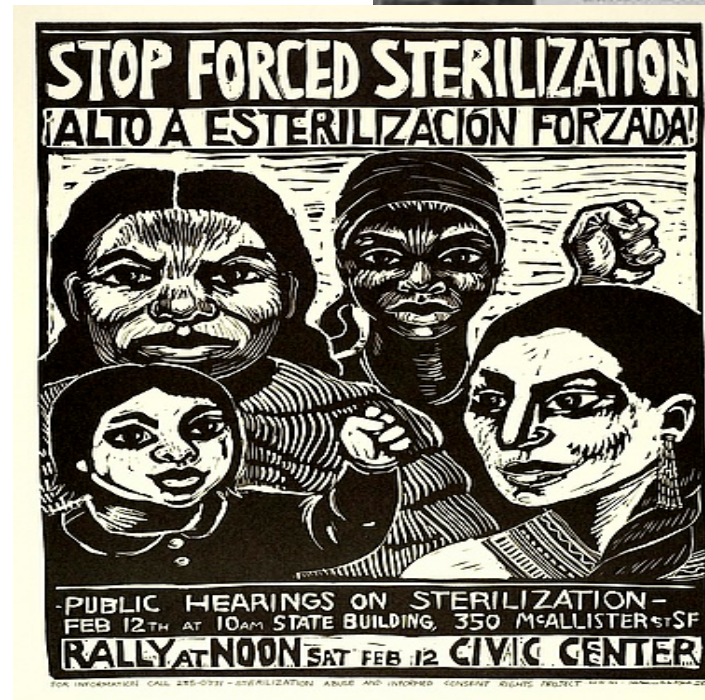
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Reproductive injustices

- Mississippi Appendectomy
- Indian Health Services
- La Operación
- Oral contraception clinical trials
- Norplant and Depo Provera



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Contraceptive counseling, especially on sterilization or LARC methods, must be sensitive to this history

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Reproductive justice

SisterSong defines reproductive justice as:

“The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”

- **SisterSong Women of Color Reproductive Justice Collective**

A reproductive justice framework for contraceptive counseling

Key Takeaway:

“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.”

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

Provider bias

- **Explicit bias**: a bias that a person is aware of and believes is correct in some manner
- **Implicit bias**: a bias that is unintentional and unconscious but is activated quickly and unknowingly by situational factors
- Implicit association tests: <https://implicit.harvard.edu/implicit/>
- Consequences on patient-provider relationship include:
 - Rapid discontinuation of methods that client felt pressured to select
 - Delaying future healthcare access and contraceptive use due to previous negative encounters
 - Undermining trust and decreased receptiveness to contraceptive counseling

Slide courtesy of Dr. Serina Floyd

Shared medical decision making for contraceptive counseling

- When engaging in shared medical decision making:
 - Be aware of and address your own biases
 - Practice perspective-taking and individuation when caring for each person
 - Acknowledge historical racial injustices during counseling sessions
 - Strive for equitable outcomes for all people, especially for disadvantaged or marginalized groups.

Talking with patients about contraception

- Shared medical decision making is a process where both patients and clinicians share information, express treatment preferences, and agree on a treatment plan.
- It 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 accurate medical information and a patient's personal preferences
- Person-centered goals may also have a part in the decision-making process

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Partnering with patients to improve safety. Committee Opinion No. 490. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:1247-9. Available at: http://journals.lww.com/greenjournal/Citation/2011/05000/Committee_Opinion_No_490_Partnering_With.49.aspx.

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5 components of shared medical decision making

1.

Focus on interpersonal relationship.

2.

Elicit patient preferences for methods.

3.

Be attuned to diverse patient preferences.

4.

Provide relevant information in accordance with patient preferences.

5.

Be aware of and responsive to patient preferences during counseling.

5 components of shared medical decision making

1. Focus on interpersonal relationship

Intimate, friend-like interactions establish trust and openness between providers and patients and are consistent with patient preferences for counseling about contraception.

- **Examples:**
 - “Hi ____! It’s nice to see you again. How’s everything been since we saw each other last?”
 - “How are you liking the implant you received last time?”

2. Elicit patient preferences for methods

Open the discussion of contraceptive method options with an open-ended question that provides a clear indication that the patients’ preferences are the focus of the discussion.

- **Examples:**
 - “What brings you to our office today?”
 - “What is important to you about your birth control method?”

5 components of shared medical decision making

3. Be attuned to diverse patient preferences

Patients will have varied preferences around issues including the relative importance of preventing pregnancy and the significance of specific side effects, including menstrual changes.

- Examples:
 - “It’s really important for me to continue having a monthly period, so it’s less obvious I’m using contraception.”
 - “I absolutely cannot gain any weight.”

4. Provide relevant information in accordance with patient preferences

Prioritize sharing information about methods based on what is most important to the patient, whether that is side effects, efficacy, mode of use, or other method characteristics.

- Examples:
 - “Since you said you want regular menses, you might consider oral contraceptive pills.”
 - “I hear you. The injectable contraceptive is the only method proven to cause weight gain, but every body reacts differently so we can work together to see which method works best for you.”

5 components of shared medical decision making

5. Be aware of and responsive to patient preferences during counseling

Either through direct questioning or by assessing her response to a shared decision making approach, understand and adjust counseling, and specifically the extent of provider guidance in the decision-making process according to how the patient would like decisions to be made.

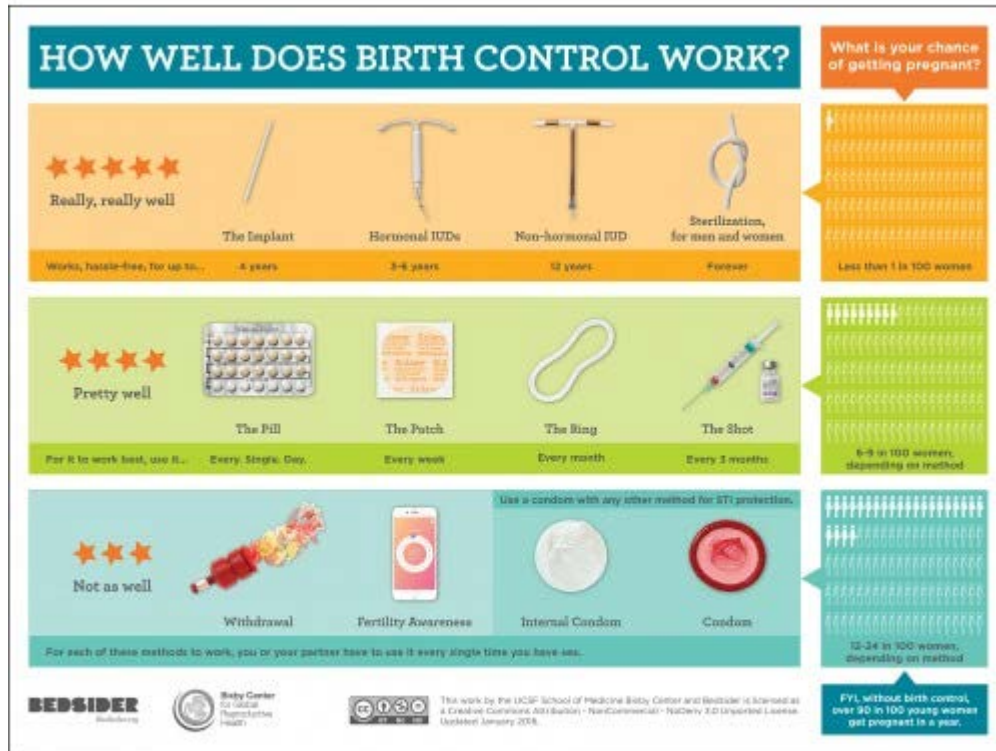
- Examples:
 - “Do you want to use a method that you can easily start and stop on your own?”
 - “How do you feel about having to take a pill at the same time everyday? Does that fit into your daily life?”

Remember the goal! Be person-centered.

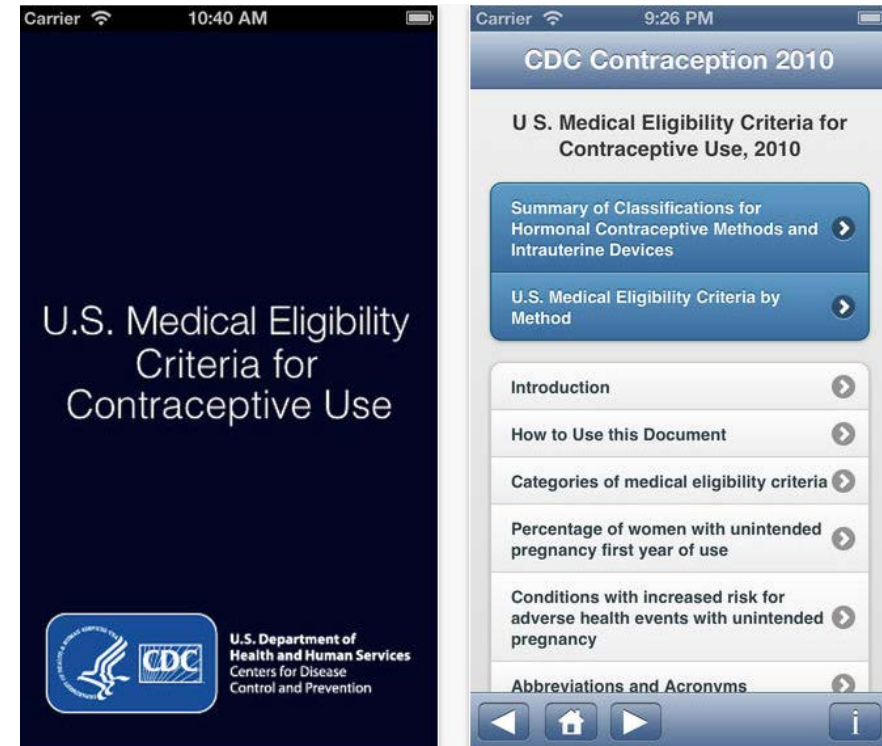
Immediate postpartum LARC counseling

- Optimally, patients should be counseled prenatally
- Counseling on immediate postpartum LARC should include:
 - All indicated forms of contraception
 - Advantages, contraindications, and alternatives
 - Increased risk of expulsion, including unrecognized expulsion of IUD
 - Convenience and effectiveness, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals
 - A discussion on the theoretical risk of reduced duration of breastfeeding
 - Possibility of non-visualized strings and difficult removal
- More info & resources: [ACOG Postpartum Contraceptive Access Initiative Website](#)

Tools for contraceptive counseling



Bedsider.org



U.S. MEC phone app

Trauma-informed care

- Trauma-informed care is an approach that:
 - Uses a framework that acknowledges the effects of trauma
 - Recognizes signs and symptoms of trauma
 - Responds by integrating knowledge about trauma into practices
 - Seeks to resist re-traumatization
- **Acute trauma:** single traumatic event that causes extreme emotional or physical distress
- **Chronic trauma:** ongoing traumatic event, such as abuse or neglect over time, multiple experiences of single events, or chronic traumatic experiences such as mistreatment and discrimination affecting a person's sense of self in the world

Slide courtesy of Dr. Colleen McNicholas

Trauma-informed care

Key Takeaway:


“This [trauma-informed care] framework can help optimize the patient–provider relationship, improve health outcomes, and reduce long lasting burdens of trauma. ”

- ACOG Committee Opinion #777, Sexual Assault


CLINICAL CONSIDERATIONS

of Immediate Postpartum Contraception


Birth control options




The Implant
(Nexplanon)



IUD
(Skyla)




IUD
(Mirena)



IUD
(ParaGard)

No
hormones



Sterilization,
for men and women



The Pill



The Patch



The Ring



The Shot
(Depo-Provera)



Withdrawal



Diaphragm



Fertility
Awareness



Condoms,
for men and women

Needed
for STI
protection

Use with
any other
method

BEDSIDER

We've got you covered

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Method	Pregnancy Rate in 1 Year	Special Considerations
Sterilization (female & male)	0.5%, 0.15%	- Permanent
Etonogestrel (ENG) Implant	0.05%	
IUD: Copper	0.8%	
IUD: Levonorgestrel (LNG)	0.2%	

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Method	Pregnancy Rate in 1 Year	Special Considerations
Injectable (Medroxyprogesterone acetate)	6%	- Must obtain injection every 3 months
Progestin-only pill (norethindrone)	9%	
Estrogen/progestin combined pill, patch or ring	9%	
Barrier Methods (condoms, diaphragm)	12-21%	

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Estrogen/progestin combined pill, patch or ring	9%	<ul style="list-style-type: none"> - Must take pill at the same time every day, change patch every week, or ring every month. - Estrogen containing methods are contraindicated with some medical conditions, including immediately post-partum
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Barrier Methods (condoms, diaphragm)	12-21%	<ul style="list-style-type: none"> - Must use with every act of intercourse - Condoms are only method that prevent STI transmission

Method	Pregnancy Rate in 1 Year	Special Considerations
Lactational amenorrhea method (LAM)	2-8%	<ul style="list-style-type: none">- May be impractical for many women- Must breastfeed infant frequently & exclusively; be amenorrhoeic, and <6 months postpartum
Fertility awareness-based methods	24%	
Withdrawal	22%	

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Withdrawal	22%	<ul style="list-style-type: none"> - Continuation rates are low (46% at 1 year) - Requires active participation by a willing partner - Requires user involvement at each act of intercourse

Comparing LARC Methods

	ParaGard® CopperT 380A	Liletta®	Mirena®	Kyleena®	Skyla®	Nexplanon®
Hormone and Dose	Non-hormonal	52mg LNG (18.6 mcg/day)	52mg LNG (20 mcg/day)	19.5mg LNG (17.5 mcg/day)	13.5mg LNG (14 mcg/day)	68mg ENG (35-45 mcg/day)
Efficacy	> 99%					
FDA- Approved Duration of Use*	10 years	6 years	5 years		3 years	
Expected Bleeding Patterns	Typically heavier	Typically lighter – rates of amenorrhea associated with hormone dose				Typically lighter, often unpredictable

* Ongoing studies suggest high efficacy with extended use beyond FDA-approved durations

Levonorgestrel (LNG) IUD

- Mechanism of action:
 - Prevents fertilization by changing amount and viscosity of cervical mucus, making it impenetrable to sperm
- Does not disrupt pregnancy and is not an abortifacient
- 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

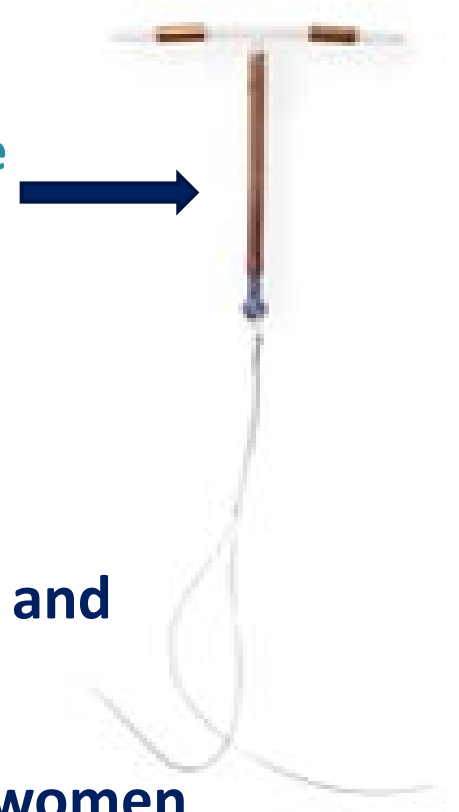


about the size
of a quarter

Copper IUD

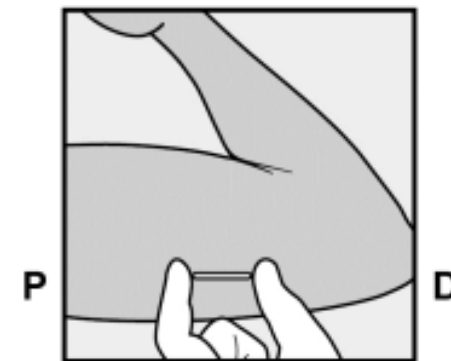
- Mechanism of action:
 - Inhibition of sperm migration and viability
- Contains no hormones
- Does not disrupt pregnancy and is not an abortifacient
- The most common adverse effects reported are abnormal bleeding and pain
- 99.2% effective; the one-year typical use failure rate is 0.8 per 100 women
- Most effective method of emergency contraception when inserted within 5 days of unprotected intercourse

about the size
of a quarter



Etonogestrel (ENG) implant

- 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

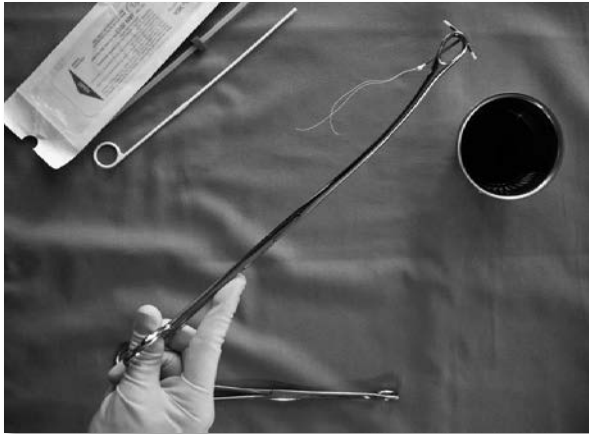


Troubleshooting Side Effects

- **Consider including these tips during counseling so patients can try them before an in-person appointment:**
 - **Copper IUD**
 - **To prevent heavy and painful menses: Take ibuprofen 400mg every 4 hours for 7 days starting Day 1 of menses for the first 3-6 cycles**
 - **LNG-IUD and ENG Implant**
 - **For unscheduled bleeding: Take naproxen 500mg every 12 hours for 5 days OR ibuprofen 800mg every 8 hours for 5 days**

Two postplacental IUD insertion methods

1. Ring forceps



2. Manual/hand



No matter which method, the IUD should always be placed at the fundus of the uterus for both vaginal & cesarean births

IUD removal

- Patients can have an IUD removed at any time upon request
- Prophylactic antibiotics are NOT needed for IUD removal
- Providers should be aware of changes to insurance coverage in the postpartum period that may affect coverage of device removal for patients
- Discuss with the patient:
 - When fertility could return
 - Contraceptive options if pregnancy is not desired
 - Mild uterine cramping and a small amount of bleeding is expected
 - Options for low or no-cost removal services, including Title X or other clinics

Implant follow up

- Immediate postpartum insertion of the contraceptive implant is identical to interval insertion and can be inserted any time after delivery
- Instruct patient to make a follow up appointment if:
 - Experiencing redness, swelling, or drainage near the implant insertion site
 - Unable feel the implant under their skin
- Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks
- Providers should be aware of changes to insurance coverage in the postpartum period that may affect coverage of device removal for patients
 - Discuss options for low or no-cost removal services, including Title X or other clinics

Implant removal

- Patients can have an implant removed at any time upon request
- Discuss with the patient:
 - When fertility could return
 - Contraceptive options if pregnancy is not desired
- If the implant is not palpable, pregnancy should be excluded and patients should be offered a method of backup contraception until the implant is located
- The removal process is included in the training required to be provided by Merck, the manufacturer of Nexplanon®, and is not covered in the presentation
- More info & resources: [ACOG LARC Program's Video Series-Implant Removal](#)

IUD EXPULSION

Clinical Considerations

IUD expulsion

- **Expulsion rates for immediate postpartum IUD insertions vary by:**
 - **Study**
 - **Device type**
 - **Route of delivery**
- **Expulsion rates:**
 - **Immediate postplacental: ~10%**
 - **10 minutes to 4 weeks: may be as high as 10-27%**
- **Continuation rates for IUDs and implants at 1 year are similar with interval placement**

Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;128:e32-7. Available at: <http://journals.lww.com/greenjournal/pages/results.aspx?txtkeywords=10.1097%2fAOG.0000000000001587>.

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IUD expulsion

- Counsel patients about increased risk of expulsion and signs and symptoms of expulsion
- A person who experiences or suspects expulsion should contact their health care provider and use a back-up contraceptive method

Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;128:e32-7. Available at: <http://journals.lww.com/greenjournal/pages/results.aspx?txtkeywords=10.1097%2fAOG.0000000000001587>.

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Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No_186_Long_Acting_Reversible.50.aspx.

IUD expulsion

Key Takeaway:

Many women experience barriers to interval LARC placement, such that the advantages of immediate placement outweigh the disadvantages.

“The immediate postpartum period has several potential benefits for implant insertion or IUD placement because women are known not to be pregnant and many women are motivated to avoid short-interval pregnancy. Additionally, the woman and clinician are in the same place at the same time, which eliminates potential access barriers, including the need for an additional visit and potential loss of insurance coverage postpartum.”

- ACOG Committee Opinion #670, Immediate Postpartum LARC

BREASTFEEDING

Clinical Considerations

Breastfeeding

- The Copper IUD lacks hormones and is classified as CDC MEC Category 1 (no restriction on use) for people who are breastfeeding
- The LNG IUD and implant are category 2 for theoretical impact on lactation
- Several small randomized control trials (RCTs) have shown no significant differences in:
 - Breast milk quality or quantity
 - Infant size

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)

Breastfeeding

Key Takeaway:

“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”

- ACOG Practice Bulletin #186, LARC: IUDs & Implants

FOLLOW UP INSTRUCTIONS

for Immediate Postpartum LARC

Postpartum IUD follow-up instructions

- All patients should be offered a string check (not mandatory)
- Instruct patient to notify a provider if they have:
 - Fevers, chills, severe abdominal pain, or temperature > 100.4°F
 - Heavy bleeding
 - Pain not controlled by over the counter medicine
 - Expulsion of the device
 - Pain or cramping different from lochia or postpartum cramps

Postpartum implant: follow-up instructions

- Immediate postpartum insertion of the contraceptive implant is identical to interval insertion and can be inserted any time after delivery
- Instruct patient to make a follow up appointment if:
 - Experiencing redness, swelling, or drainage near the implant insertion site
 - Unable feel the implant under their skin
- Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks
- Providers should be aware of changes to insurance coverage in the postpartum period and how that may affect coverage of device removal for patients
 - Discuss options for low or no-cost removal services, including Title X or other clinics

KEY TAKEAWAYS

Things to Keep in Mind

Remember the goal! Be person-centered.

- The goal of contraceptive counseling is to:
 - Discuss all contraceptive options with patients
 - Have patients leave with a plan for contraception they are comfortable with
 - Allow patients to make the contraceptive choices that are best for them
 - Remind patients that there is not one perfect method for everyone
- Shared Medical Decision Making:
 - Focuses on the interpersonal relationship
 - Uses open-ended questions
 - Helps your patient choose the best method for them
 - Takes into account social and cultural contexts

Key Takeaways: Important things to keep in mind

Respect

- Cultural differences
- Personal preferences
- Dislike of method or side effects
- Patient's decision whether to use birth control after delivery

Listen

- To your patient's preferences
- To your patient's concerns
- Shared decision-making is best, but can take time – be patient

Engage

- Allow patient time to consider their options
- Provide information to help patient make a decision

ACOG's Postpartum Contraceptive Access Initiative can help!

- Email us: pcai@acog.org
- Find more resources online:
 - <https://pcainitiative.acog.org>
 - <https://www.acog.org/programs/long-acting-reversible-contraception-larc>
- Send us your LARC-related questions:
 - www.acoglarc.freshdesk.com
 - The LARC Program Help Desk is a free service open to all, ACOG members and non-members alike
 - All questions will be responded to within 10 business days.

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, Immediate Postpartum 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. [Obstetric Care Consensus #8: Interpregnancy Care](#)

ACOG guidance on care for underserved communities

1. [ACOG Committee Opinion #729, Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care](#)
2. [ACOG Committee Opinion #649, Racial and Ethnic Disparities in Obstetrics and Gynecology](#)
3. [ACOG Committee Opinion #627, Health Care for Unauthorized Immigrants](#)
4. [ACOG Committee Opinion #576, Health Care for Homeless Women](#)
5. [ACOG Committee Opinion #547, Health Care for Women in the Military and Women Veterans](#)
6. [ACOG Committee Opinion #586, Health Disparities in Rural Women](#)
7. [ACOG Committee Opinion #515, Health Care for Urban American Indian and Alaska Native Women](#)
8. [ACOG Committee Opinion #708, Improving Awareness of and Screening for Health Risks Among Sex Workers](#)
9. [ACOG Committee Opinion #518, Intimate Partner Violence](#)
10. [ACOG Committee Opinion #554, Reproductive and Sexual Coercion](#)
11. [ACOG Committee Opinion #511, Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females](#)
12. [ACOG Committee Opinion #535, Reproductive Health Care for Incarcerated Women and Adolescent Females](#)
13. [ACOG Committee Opinion #570, Breastfeeding in Underserved Women: Increasing Initiation and Continuation of Breastfeeding](#)
14. [ACOG Committee Opinion #496, At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implication](#)
15. [ACOG Committee Opinion #633, Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice](#)
16. [ACOG Committee Opinion #591, Challenges for Overweight and Obese Women](#)

ACOG guidance on contraceptive counseling and care for LGBTQIA+ communities

1. [ACOG Committee Opinion #749, Marriage and Family Building Equality for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and Gender Nonconforming Individuals](#)
2. [ACOG Committee Opinion #512, Healthcare for Transgender Individuals](#)
3. [ACOG Committee Opinion #685, Care for Transgender Adolescents](#)
4. [ACOG Transgender Healthcare Curriculum](#)
5. [ACOG Practice Bulletin #186, LARC: Implants and Intrauterine Devices](#)
6. [ACOG Committee Opinion #490, Partnering With Patients to Improve Safety](#)
7. [ACOG Committee Opinion #587, Effective Patient-Physician Communication](#)
8. [ACOG Committee Opinion #762 Prepregnancy Counseling](#)

Slide courtesy of Dr. Colleen McNicholas

Resources on trauma-informed care

1. [Reproductive Health Access Project: Contraceptive Pearl: Trauma-Informed Pelvic Exams](#)
2. [University of Washington School of Medicine Provider Resource: Trauma-Informed Care for the Obstetrician-Gynecologist](#)
3. [SAMHSA-HRSA Webinar: Improving Health Through Trauma-Informed Care](#)
4. [National Resource Center for Mental Health Promotion and Youth Violence Prevention: Adopting a Trauma-Informed Approach for LGBTQ Youth](#)

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