

Immediate Postpartum Contraception & Breastfeeding



ACOG

The American College of
Obstetricians and Gynecologists

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

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Speaker disclosures

- Institution has received research funds from NIH, Arnold Ventures, Merck and WHO for projects on which I am the primary investigator.
- I have served as a consultant for ACOG, Bayer, Merck and WHO.

Topics covered in presentation

- Section 1: Unmet patient need for postpartum contraception**
- Section 2: Postpartum contraception overview**
- Section 3: Evidence and key considerations for breastfeeding**
- Section 4: Contraceptive counseling through shared decision-making**

* 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 need for contraception postpartum
2. Describe postpartum contraceptive methods currently available
3. Discuss current evidence available on immediate postpartum LARC & breastfeeding
4. Understand the importance of shared decision-making for 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

OVERVIEW

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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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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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

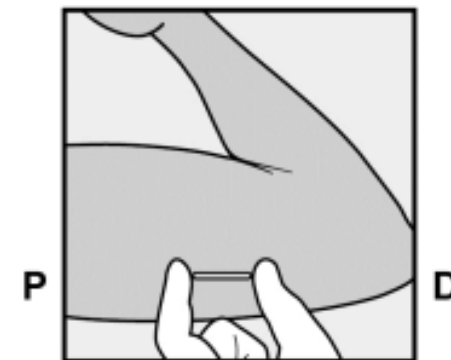
- Mechanism of action:
 - Inhibition of sperm migration and viability
- Contains no hormones
- Does not disrupt pregnancy and is not an abortifacient
- The most common adverse effects reported are abnormal bleeding and pain
- 99.2% effective; the one-year typical use failure rate is 0.8 per 100 women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

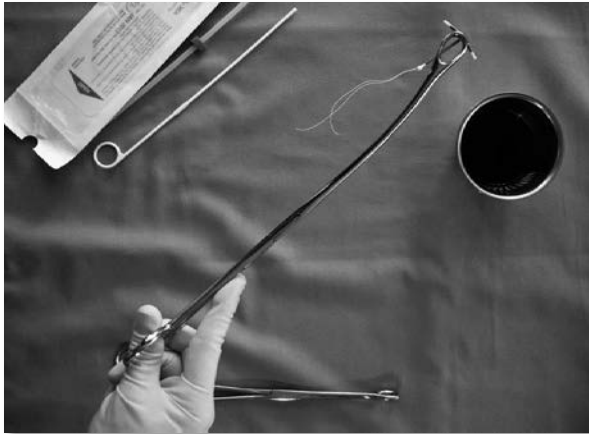


Troubleshooting Side Effects

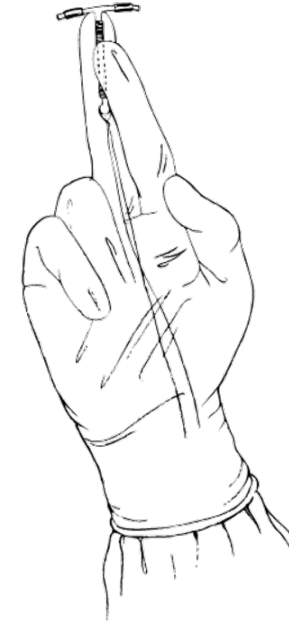
- **Consider including these tips during counseling so patients can try them before an in-person appointment:**
 - **Copper IUD**
 - **To prevent heavy and painful menses: Take ibuprofen 400mg every 4 hours for 7 days starting Day 1 of menses for the first 3-6 cycles**
 - **LNG-IUD and ENG Implant**
 - **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](#)

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)

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 creatinocrit values (estimated fat & energy content)

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

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

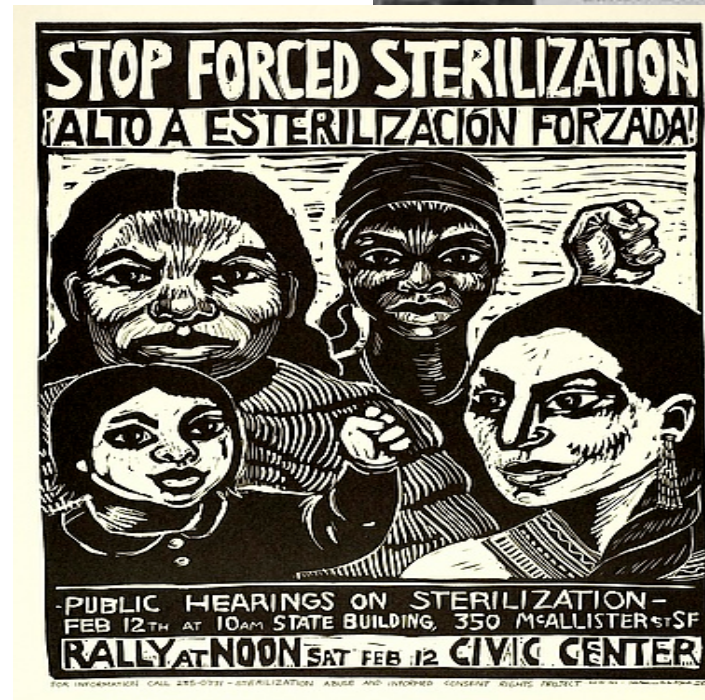
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Reproductive injustices

- 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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Effective patient-physician communication. Committee Opinion No. 587. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:389-93. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24451677>.

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.

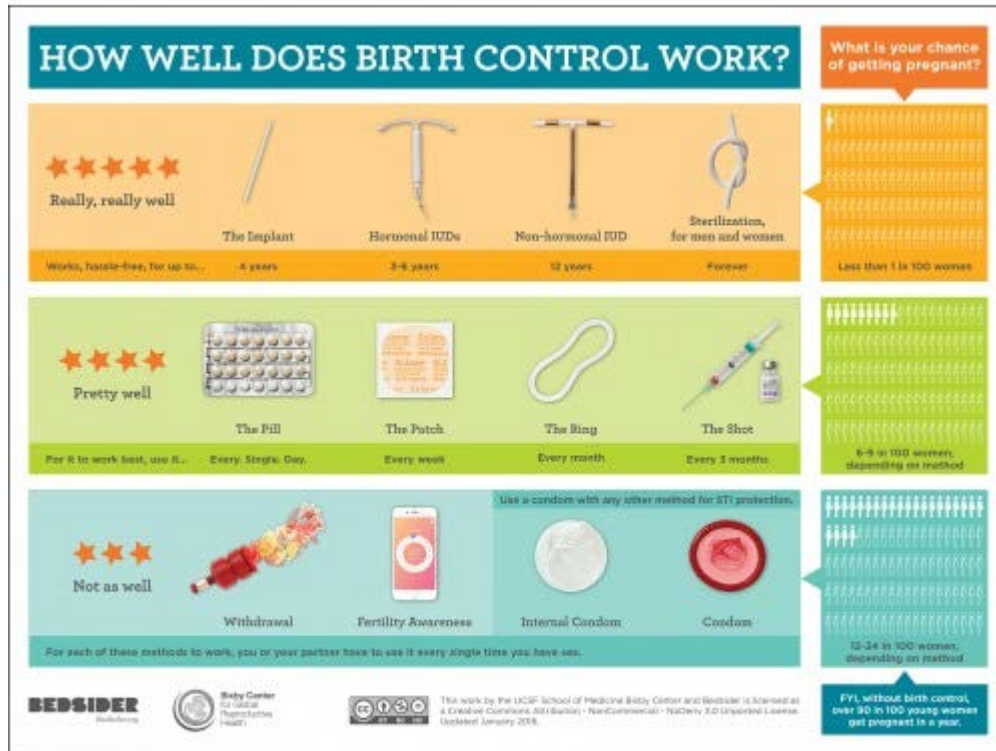
Talking with patients about LARC

- Highlight the reliance on a provider for insertion/removal
- Be mindful that LARC can cause a decreased sense of control or the feeling of being pressured into a contraceptive method
- Discuss options for low or no-cost removal services, including Title X or other clinics

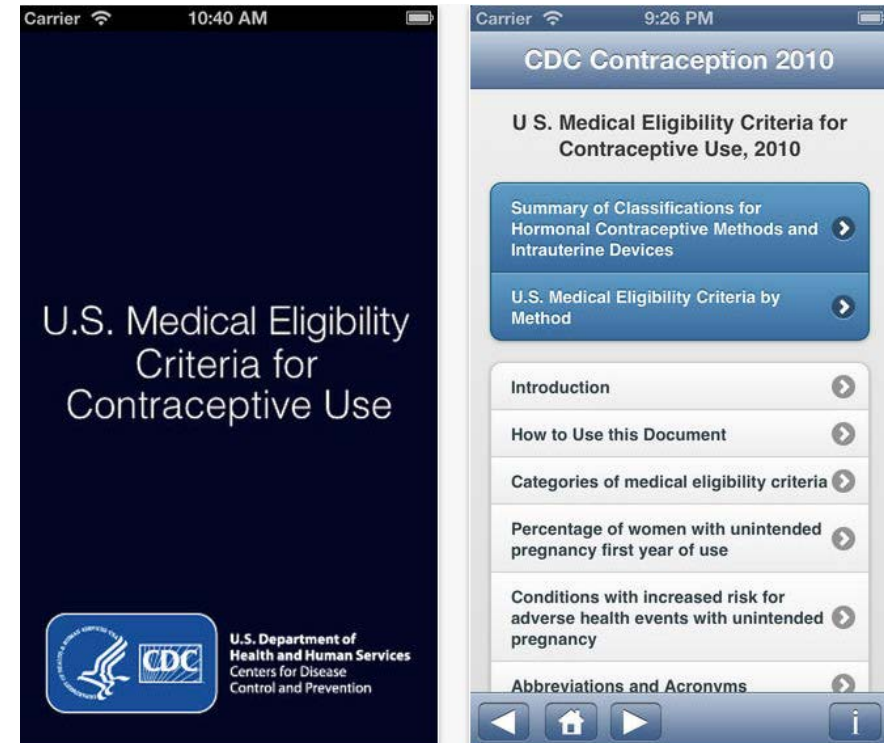
Immediate postpartum LARC counseling

- 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

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](#)

KEY TAKEAWAYS

Things to Keep in Mind

Summary of ACOG recommendations

1. Contraceptive counseling should use shared medical decision-making and include all contraceptive options
2. Contraceptive counseling should include benefits and limitations of all methods
3. LARC methods have few contraindications and almost all women are eligible for implants and IUDs
4. The immediate postpartum period can be particularly favorable time for IUD or implant insertion
5. Immediate postpartum IUD placement is cost-effective despite higher expulsion rates and concerns related to expulsion and breastfeeding should be discussed
5. Providers should be aware of changes to insurance coverage in the postpartum period and how that may affect coverage of device removal for patients
6. Discuss options for low or no-cost removal services for LARC

The ACOG LARC Program 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.

References

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