Addressing Misinformation about Postpartum LARC through Contraceptive Counseling

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- **None**

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Learning objectives

1. Understand key elements of person-centered postpartum contraceptive counseling
2. Discuss common myths and misinformation related to the IUD and implant
3. Apply person-centered postpartum contraceptive counseling to discussions of misinformation with patients

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CONTRACEPTIVE COUNSELING

Shared Medical Decision Making

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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.**

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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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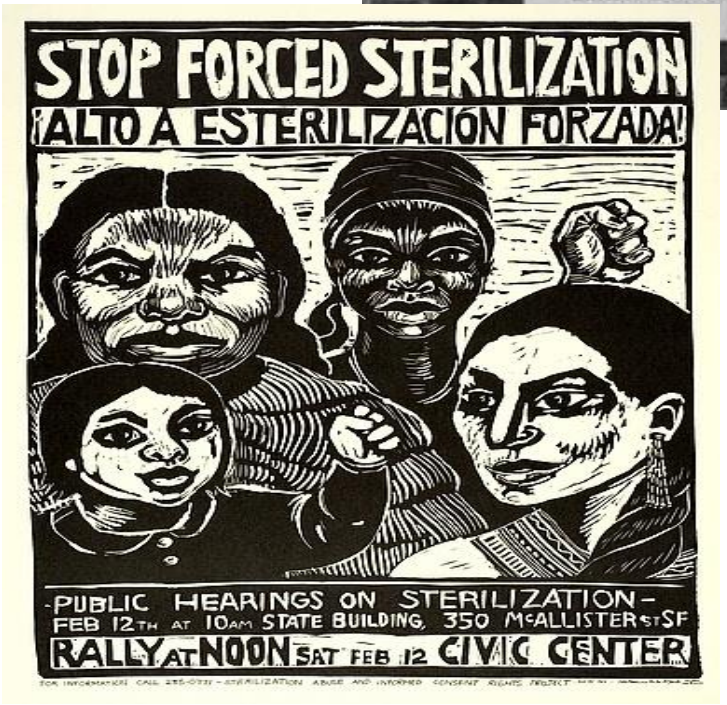
Reproductive Injustices

- 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**

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“Reproductive Justice.” Sister Song, www.sistersong.net/reproductive-justice.

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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

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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**

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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.**

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Adolescent pregnancy, contraception, and sexual activity. Committee Opinion No. 699. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e142-9. Available at: http://journals.lww.com/greenjournal/fulltext/2017/05000/Committee_Opinion_No_699___Adolescent_Pregnancy,.49.aspx.

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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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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.

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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?”**

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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."

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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.

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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

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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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ADDRESSING COMMON MYTHS AND MISINFORMATION

Related to LARC methods

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Validate concerns/experiences

- I’m sorry your aunt had that experience.
- I’m glad you brought that up.
- Great question. That is a really common concern.
- That sounds frustrating.
- We haven’t found that the IUD causes this side effect in studies, but I understand that everyone’s body responds differently to medicines, and I’m sorry you are experiencing this.

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Address misinformation

- **Present accurate information to address myths and misconceptions**

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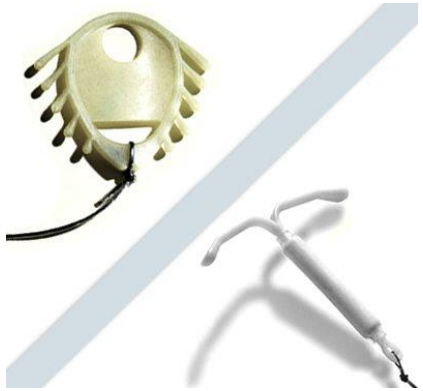
MYTH: The IUD is dangerous – it causes infections and infertility

- People did experience problems with previous IUDs that have been off the market for decades (e.g. Dalkon Shield).
- Many studies show no increased risk of pelvic infection or infertility in people using current IUDs.



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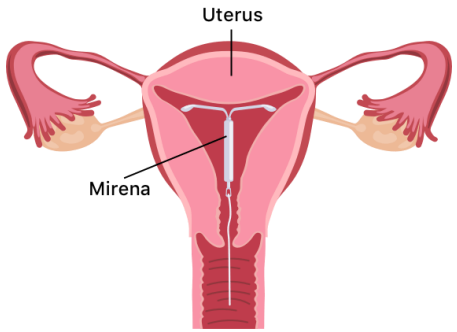
MYTH: My partner will be able to feel the IUD during sex.

- The IUD is placed at the top of the uterus. Plastic strings are attached to the end, and tuck up behind the cervix. They are soft enough that they should not bother your partner.
- If you or your partner are experiencing discomfort during sex, you can go to your healthcare provider to make sure the IUD is in the proper place. The strings can also be adjusted to make you more comfortable if needed.



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MYTH: The implant can move to another part of my body.

- The implant can shift a little, but almost always less than an inch from where it started.
- Rarely, if the implant isn't placed correctly, it can end up in a place it shouldn't be.
- You can feel the implant with your fingers if you have any concerns to make sure it is in the right place.

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MYTH: The IUD and implant will make me gain weight.

- Overall, studies have not shown an association between the implant and weight gain.
- With the hormonal IUD, there are very low levels of hormones that get into the bloodstream.

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MYTH: The IUD and implant are long-term commitments.

- While the IUD and implant prevent pregnancy for many years, you absolutely don't have to keep them in place that whole time.
- You can have either of these methods removed at any time on request.

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MYTH: The IUD and implant will prevent me from being able to breastfeed.

- 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

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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.

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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

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Be up front about 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**

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Video: Responding to patient concerns

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KEY TAKEAWAYS

Things to Keep in Mind

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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

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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

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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.**

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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

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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 #627, Health Care for Unauthorized Immigrants
3. ACOG Committee Opinion #576, Health Care for Homeless Women
4. ACOG Committee Opinion #547, Health Care for Women in the Military and Women Veterans
5. ACOG Committee Opinion #586, Health Disparities in Rural Women
6. ACOG Committee Opinion #515, Health Care for Urban American Indian and Alaska Native Women
7. ACOG Committee Opinion #708, Improving Awareness of and Screening for Health Risks Among Sex Workers
8. ACOG Committee Opinion #518, Intimate Partner Violence
9. ACOG Committee Opinion #554, Reproductive and Sexual Coercion
10. ACOG Committee Opinion #830, Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals
11. ACOG Committee Opinion #820, Breastfeeding Challenges
12. ACOG Committee Opinion #496, At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implication
13. ACOG Committee Opinion #633, Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice

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QUESTIONS?

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