Please Complete Training Pre-Test Now

(Training To Start Shortly)

1. Open the Camera App on your smartphone.
2. Hold your device so that the QR code appears in the Camera App's viewfinder.
3. A notification should pop up. Tap the notification to open the link.

bit.ly/4fgbfPW

ACOG

PCAI
Postpartum Contraceptive Access Initiative

ACOG
The American College of Obstetricians and Gynecologists

Immediate Postpartum LARC

For Clinicians Doing Deliveries

ACOG Disclaimer

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center.

While ACOG makes every effort to present accurate and reliable information, this publication is provided "as is" without any warranty of accuracy, reliability, or otherwise, either express or implied. ACOG does not guarantee, warrant, or endorse the products or services of any firm, organization, or person. Neither ACOG nor its officers, directors, members, employees, or agents will be liable for any loss, damage, or claim with respect to any liabilities, including direct, special, indirect, or consequential damages, incurred in connection with this publication or reliance on the information presented.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Speaker Disclosures

- Dr. Ivana Thompson is a Nexplanon trainer for Organon
- Megan Young previously did data analysis for Organon
- Dr. Jona Bandyopadhyay has no financial disclosures

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Learning Objectives

1. Understand the unmet contraceptive needs postpartum
2. Explain the efficacy and safety of LARC in the immediate postpartum period
3. Understand the importance of shared decision-making for contraceptive counseling
4. Understand immediate postpartum IUD insertion techniques

ACOG

PCAI
Postpartum Contraceptive Access Initiative

IPP LARC in context

ACOG

PCAI
Postpartum Contraceptive Access Initiative

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
- Contraceptive coercion may be intentional or unintentional, and subject to influences such as a clinician's personal biases
- The U.S. has a long history of contraceptive coercion and forced sterilization perpetrated against economically marginalized individuals and persons of color

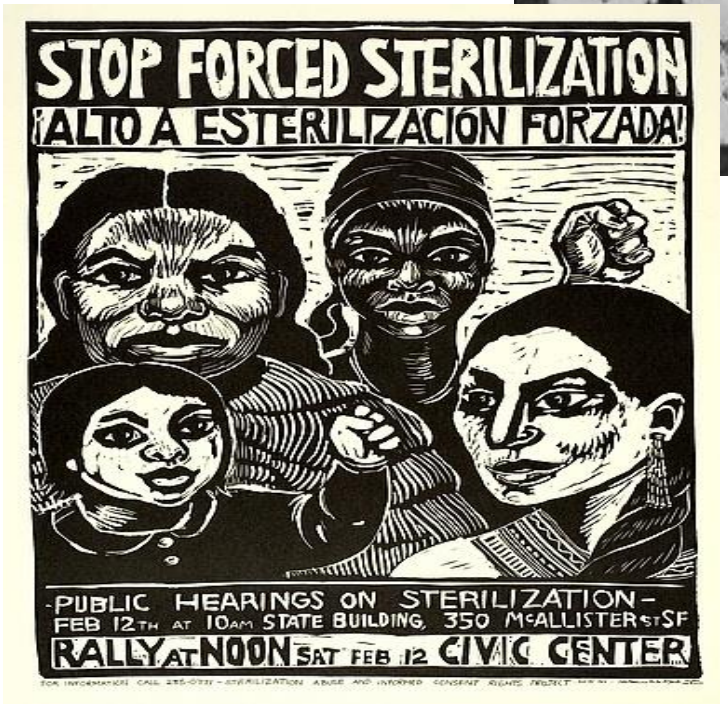
ACOG

Slide adapted from Dr. Serina Floyd

PCAI
Postpartum Contraceptive Access Initiative

Coercion Examples

- Forced Sterilization
- "Mississippi Appendectomy"
- Indian Health Services
- La Operación
- Oral contraception clinical trials
- Norplant and Depo Provera
- California Prisons



ACOG

Slide content courtesy of Dr. Serina Floyd

PCAI
Postpartum Contraceptive Access Initiative

UNMET PATIENT NEED

for Postpartum Contraception

ACOG

PCAI
Postpartum Contraceptive Access Initiative

The Role of Postpartum Contraception

- Patient-centered postpartum contraception counseling enables:
  - Prevention or delay of subsequent pregnancy
  - Improvement in maternal, perinatal, and infant outcomes
  - Shared decision-making and patient preference

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Interpregnancy Interval and Contraception Access

- About 40% of women will ovulate by 6 weeks postpartum
- Conception intervals of <6 months may be associated with low birth weight and preterm birth
- Data suggests a modest increase in risk of adverse outcomes associated with intervals of <18 months
- The clinically recommended interval between delivery and subsequent pregnancy is 18 months to 5 years

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Barriers to Accessing Postpartum Follow-Up

- As many as 40% of women do not return for the 6-week postpartum visit
- Patients may have difficulty returning for a postpartum visit due to:
  - Childcare obligations
  - Unable to get off work
  - Unstable housing
  - No transportation
  - Communication or language barrier
  - Lack of insurance coverage or expiration of Medicaid eligibility

ACOG

PCAI
Postpartum Contraceptive Access Initiative

What Is LARC?

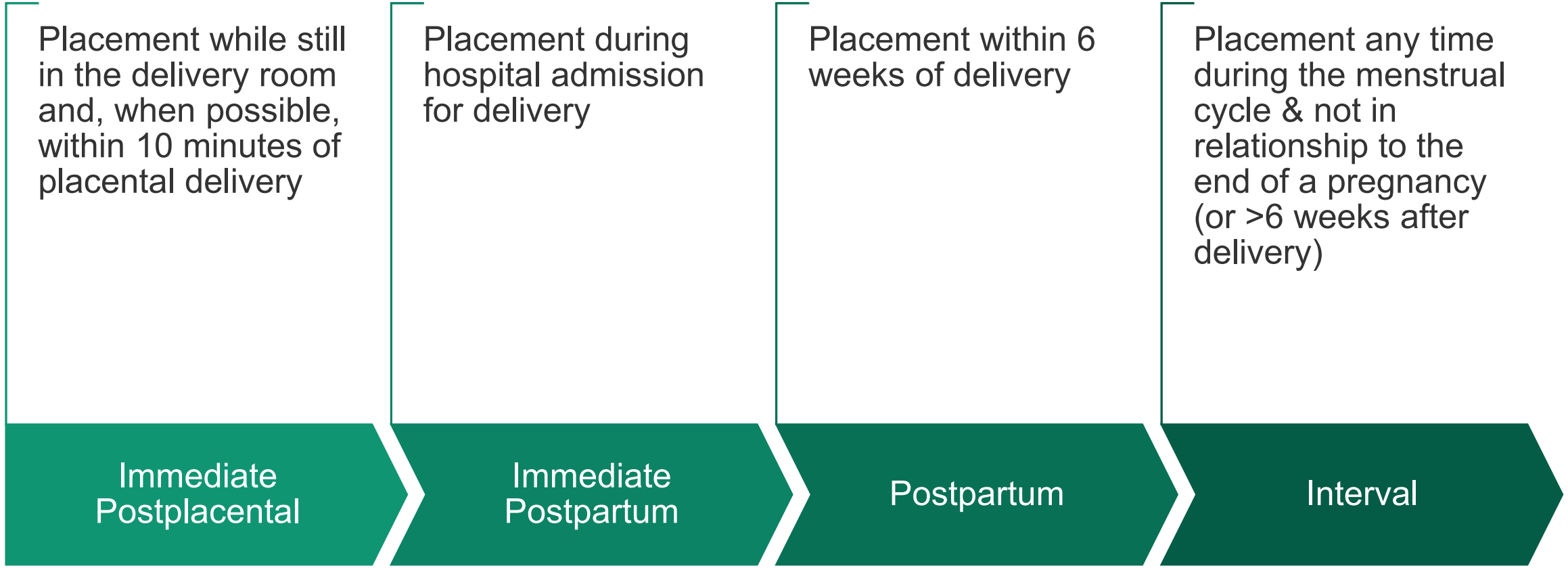
- LARC stands for long-acting reversible contraception

- Two types of LARC:
  - IUD
    - Hormonal
    - Non-hormonal
  - Contraceptive implant

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Definitions: Timing of LARC Placement



ACOG

PCAI
Postpartum Contraceptive Access Initiative

ACOG Guidance for Postpartum LARC

"Immediate postpartum [LARC] should be offered routinely as a safe and effective option for postpartum contraception"

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

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Advantages and Disadvantages

Advantages of IPP 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
3. Can be used as a bridge method to tubal ligation
4. The hospital stay can be an ideal time for many patients who want them
5. High satisfaction and continuation rates

Disadvantage:

1. Must be placed and removed by a trained clinician, which impacts patient autonomy

ACOG

PCAI
Postpartum Contraceptive Access Initiative

CLINICAL CONSIDERATIONS

of Immediate Postpartum Contraception

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Key Considerations

- All methods except combined hormonal contraception can be an option in the immediate postpartum period
- Combined hormonal contraception contraindicated if:
  - Less than 21 days postpartum (US MEC 4)
  - Other risk factors for VTE and 21-42 days postpartum (US MEC 3-4)
  - Breastfeeding, no other risks for VTE, and 21-30 days postpartum (US MEC 3)

Key Considerations

- Consider waiting 6 weeks for:
  - Diaphragm
  - Cervical cap
  - Vaginal sponge

- Fertility-awareness based methods should be used with caution as postpartum cycles may be too irregular to predict fertility

Postpartum Contraception Options

Can be provided prior to discharge	Need prescription to start	Can be started on own
• Permanent contraception • Implant • IUDs • Injection	• Progestin-only pill (norethindrone, drospirenone) • Vaginal pH modulator gel	• Progestin-only pill (norgestrel) • Lactational amenorrhea • Barrier methods • Spermicide • Withdrawal method

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Levonorgestrel (LNG) IUD

- Mechanism of action:
  - Prevents fertilization by changing amount and viscosity of cervical mucus
- Does not disrupt pregnancy and therefore does not cause an abortion
- Most women ovulate normally, but experience diminished menstrual bleeding because of the local effect of levonorgestrel on the endometrium

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Copper IUD

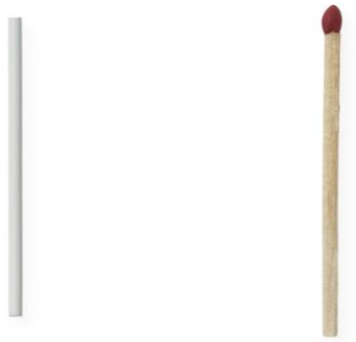
- Mechanism of action:
  - Inhibition of sperm migration and viability
- Contains no hormones
- Does not disrupt pregnancy and therefore does not cause an abortion
- Most common adverse effects: abnormal bleeding and pain

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Etonogestrel (ENG) Implant

- Mechanism of action:
  - Primary: ovulation suppression
  - Additional: thickening of cervical mucus and alteration of the endometrial lining
- Changes in bleeding patterns are common and include amenorrhea or infrequent, frequent, or prolonged bleeding
- Placed subdermally in upper arm
  - Size: 4cm x 2mm



ACOG

PCAI
Postpartum Contraceptive Access Initiative

Comparing LARC Methods

	ParaGard® CopperT 380A	Liletta®	Mirena®	Kyleena®	Skyla®	Nexplanon®
Hormone and Dose	Non-hormonal	52mg LNG	52mg LNG	19.5mg LNG	13.5mg LNG	68mg ENG
Efficacy	> 99%					
FDA-Approved Duration of Use	10-12 years*	8 years		5 years	3 years	3-5 years*
Expected Bleeding Patterns	Typically heavier	Typically lighter – rates of amenorrhea associated with hormone dose				Typically lighter, often unpredictable

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

ACOG

PCAI
Postpartum Contraceptive Access Initiative

IPP IUD Contraindications
Category 4 – ACOG & U.S. MEC

Routine Contraindications

- Active gynecologic malignancy
- Current breast cancer
- Current active purulent cervicitis, chlamydial/gonococcal infection, or PID*
- Gestational trophoblastic disease with persistent intrauterine disease or malignancy
- Pelvic tuberculosis
- Post-abortion or postpartum sepsis
- Uterine anomaly
- Unexplained vaginal bleeding

IPP Contraindications

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

***STI testing should be done as indicated, but IUD insertion does not require testing & should not be delayed while awaiting test results.**

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Immediate Postpartum IUD Expulsion

- Expulsion rates vary by:
  - Study
  - Device type
  - Route of delivery
  - Provider experience
- Expulsion rates:
  - Immediate postplacental: ~8-10%
  - 10 minutes to 4 weeks: may be as high as 10-27%
- Continuation rates for IUDs and implants at 1 year are similar to interval placement

ACOG

PCAI Postpartum Contraceptive Access Initiative

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

ACOG

PCAI
Postpartum Contraceptive Access Initiative

IUD Expulsion

Key Takeaway:

"The benefits of immediate insertion may outweigh the increased risk of expulsion. Disadvantages of waiting 4-6 weeks postpartum for interval insertion include failure to return for follow up and not obtaining an IUD at the follow-up visit."

- ACOG Committee Opinion #186, LARC: Implants & IUDs

ACOG

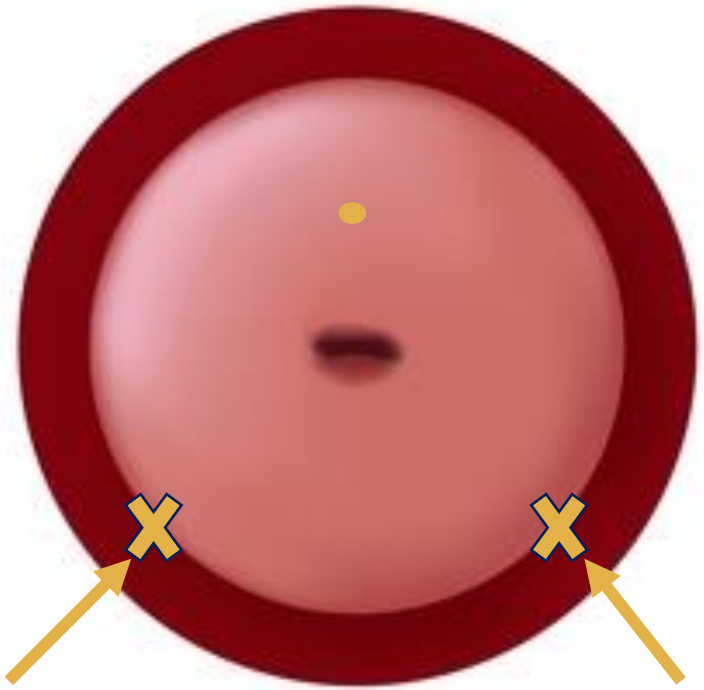
PCAI
Postpartum Contraceptive Access Initiative

Postplacental IUD Pain Management

- For many patients, the immediate postpartum period can be an ideal time for IUD placement due to pain control from an epidural
  - One study found that 80% of patients reported no or mild pain with postplacental IUD insertion
- Minimal evidence on pain management for patients without an epidural; ACOG's guidance on pain management for IUD insertion does not specifically address the IPP period
  - Counsel patients on pain management options used in the interval period like paracervical block and lidocaine spray/cream
  - Consider forcep placement in patients without epidural

Paracervical Block

- 20 ml 1% Lidocaine
- 2 ml intracervical at 12 o'clock
  - Prior to ring forcep placement
- 10 ml at cervicovaginal junction at 4 & 8 o'clock
  - Avoid the uterine arteries at 3 & 9 o'clock
  - Aspirate to confirm the needle is NOT in a vessel prior to injection



ACOG

PCAI Postpartum Contraceptive Access Initiative

BREASTFEEDING

Clinical Considerations

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Breastfeeding – IUD

- The copper IUD lacks hormones and avoids any theoretical effect on breastfeeding
- The LNG IUD is 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

Condition	Sub-Condition	Cu-IUD		LNG-IUD	
		I	C	I	C
Postpartum *(including cesarean delivery, breastfeeding, or nonbreastfeeding)*	a. <10 minutes after delivery of the placenta	2*		2*	
	b. 10 minutes after delivery of the placenta to <4 weeks	2*		2*	
	c. ≥4 weeks	1*		1*	
	d. Postpartum sepsis	4		4	

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*)

ACOG

PCAI Postpartum Contraceptive Access Initiative

Breastfeeding – Implant

- The US MEC classifies initiating the implant less than 30 days postpartum as Category 2
  - Due to theoretical concerns regarding milk production and infant growth and development
- Systematic review findings show that the implant does not appear to adversely affect successfully initiating and continuing breastfeeding or an infant's growth and development

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP	
		I	C	I	C	I	C	I	C	I	C
Breastfeeding	a. <21 days postpartum					**2***		**2***		**2***	
	b. 21 to <30 days postpartum										
	i. With other risk factors for VTE					**2***		**2***		**2***	
	ii. Without other risk factors for VTE					**2***		**2***		**2***	
	c. 30-42 days postpartum										
	i. With other risk factors for VTE					**1***		**2***		**1***	
	ii. Without other risk factors for VTE					**1***		**1***		**1***	
	d. >42 days postpartum					**1***		**1***		**1***	

ACOG

PCAI Postpartum Contraceptive Access Initiative

CONTRACEPTIVE COUNSELING

Shared Decision-Making

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Contraceptive counseling, especially on permanent contraception or LARC methods, must be sensitive to the previously discussed history of coercion

ACOG

Slide content courtesy of Dr. Serina Floyd

PCAI
Postpartum Contraceptive Access Initiative

What is Shared Decision-Making?

- Shared decision-making seeks a middle ground where both patients and clinicians share information, express treatment preferences, and agree on a patient-centered treatment plan

- Can increase patient engagement and reduce risk, resulting in improved outcomes, satisfaction, and treatment adherence

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Provider Bias

- Contraceptive counseling may be subject to undue influence, such as a providers' personal biases (implicit or explicit) or even the ideology of the institution at which someone is seeking care

- 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

ACOG

Adapted from Dr. Serina Floyd

PCAI
Postpartum Contraceptive Access Initiative

5 Components of Shared 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.

ACOG

Remember the goal: be person-centered!

PCAI
Postpartum Contraceptive Access Initiative

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
- Optimally, patients should be counseled prenatally

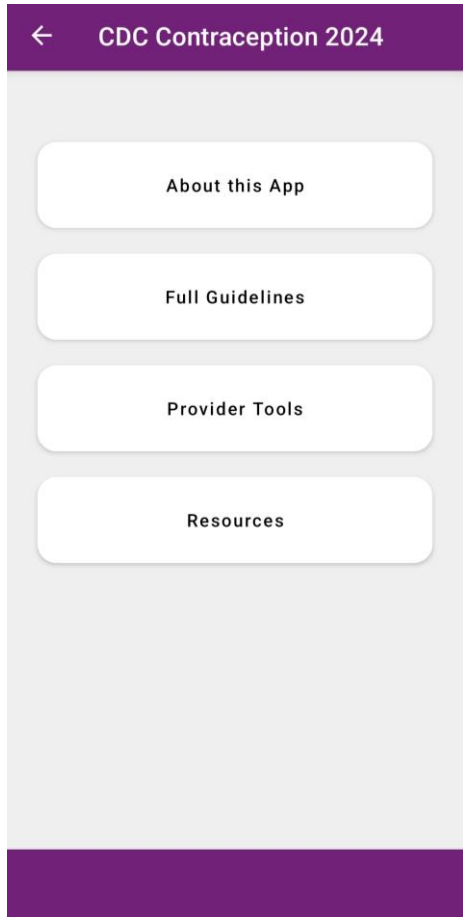
Immediate Postpartum LARC Counseling

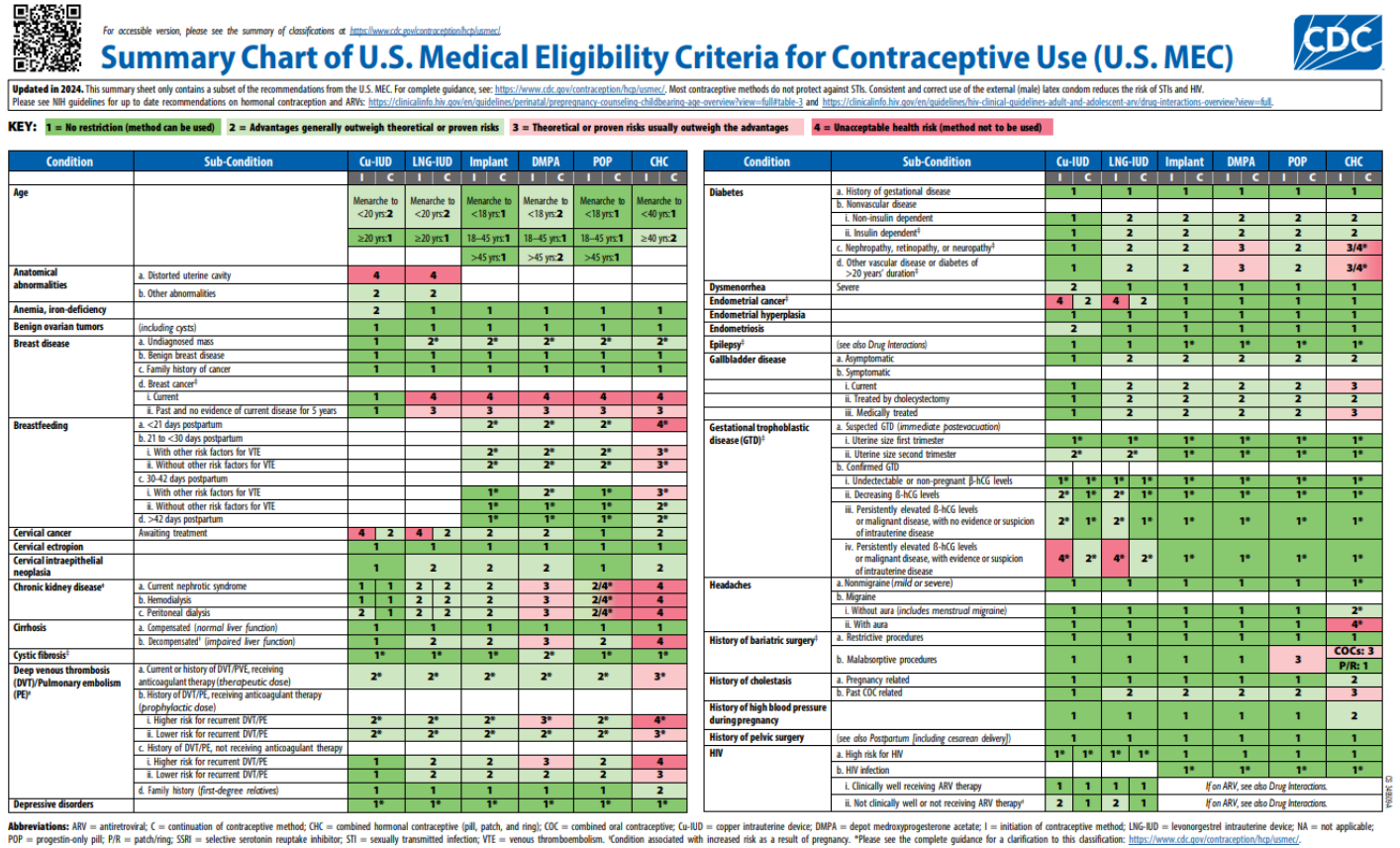
- Counseling on immediate postpartum LARC should include:
  - All indicated forms of contraception
  - Advantages, contraindications, and alternatives
  - Increased risk of expulsion, including unrecognized expulsion of IUD
  - Convenience and effectiveness, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals
  - A discussion on the theoretical risk of reduced duration of breastfeeding
  - Possibility of non-visualized strings and difficult removal

ACOG

PCAI
Postpartum Contraceptive Access Initiative

U.S. Medical Eligibility Criteria (MEC) Phone App





For accessible version, please see the summary of classifications at https://www.cdc.gov/contraception/hcp/usmec/

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

Updated in 2024. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/contraception/hcp/usmec/. Most contraceptive methods do not protect against STIs. Consistent and correct use of the external (male) latex condom reduces the risk of STIs and HIV.
Please see NIH guidelines for up to date recommendations on hormonal contraception and ARVs: https://clinicalinfo.hiv.gov/en/guidelines/perinatal/pregnancy-counseling-childbearing-age-overview?view=full#table-3 and https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview?view=full.

KEY: 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)

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age		Menarche to <20 yrs: 2		Menarche to <20 yrs: 2		Menarche to <18 yrs: 1		Menarche to <18 yrs: 2		Menarche to <18 yrs: 1		Menarche to <40 yrs: 1	
		≥20 yrs: 1		≥20 yrs: 1		18–45 yrs: 1		18–45 yrs: 1		18–45 yrs: 1		≥40 yrs: 2	
						>45 yrs: 1		>45 yrs: 2		>45 yrs: 1			
Anatomical abnormalities	a. Distorted uterine cavity	4		4									
	b. Other abnormalities	2		2									
Anemia, iron-deficiency		2		1		1		1		1		1	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a. Undiagnosed mass	1		2*		2*		2*		2*		2*	
	b. Benign breast disease	1		1		1		1		1		1	
	c. Family history of cancer	1		1		1		1		1		1	
	d. Breast cancer[2]												
	i. Current	1		4		4		4		4		4	
	ii. Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a. <21 days postpartum					2*		2*		2*		4*	
	b. 21 to <30 days postpartum												
	i. With other risk factors for VTE					2*		2*		2*		3*	
	ii. Without other risk factors for VTE					2*		2*		2*		3*	
	c. 30–42 days postpartum												
	i. With other risk factors for VTE					1*		2*		1*		3*	
	ii. Without other risk factors for VTE					1*		1*		1*		2*	
	d. >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Chronic kidney disease[3]	a. Current nephrotic syndrome	1	1	2	2	2		3		2/4*		4	
	b. Hemodialysis	1	1	2	2	2		3		2/4*		4	
	c. Peritoneal dialysis	2	1	2	2	2		3		2/4*		4	
Cirrhosis	a. Compensated (normal liver function)	1		1		1		1		1		1	
	b. Decompensated[1] (impaired liver function)	1		2		2		3		2		4	
Cystic fibrosis[3]		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)[3]	a. Current or history of DVT/PVE, receiving anticoagulant therapy (therapeutic dose)	2*		2*		2*		2*		2*		3*	
	b. History of DVT/PE, receiving anticoagulant therapy (prophylactic dose)												
	i. Higher risk for recurrent DVT/PE	2*		2*		2*		3*		2*		4*	
	ii. Lower risk for recurrent DVT/PE	2*		2*		2*		2*		2*		3*	
	c. History of DVT/PE, not receiving anticoagulant therapy												
	i. Higher risk for recurrent DVT/PE	1		2		2		3		2		4	
	ii. Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	d. Family history (first-degree relatives)	1		1		1		1		1		2	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a. History of gestational disease	1		1		1		1		1		1	
	b. Nonvascular disease												
	i. Non-insulin dependent	1		2		2		2		2		2	
	ii. Insulin dependent[2]	1		2		2		2		2		2	
	c. Nephropathy, retinopathy, or neuropathy[2]	1		2		2		3		2		3/4*	
	d. Other vascular disease or diabetes of >20 years' duration[2]	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer[2]		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy[2]	(see also Drug Interactions)	1		1		1*		1*		1*		1*	
Gallbladder disease	a. Asymptomatic	1		2		2		2		2		2	
	b. Symptomatic												
	i. Current	1		2		2		2		2		3	
	ii. Treated by cholecystectomy	1		2		2		2		2		2	
	iii. Medically treated	1		2		2		2		2		3	
Gestational trophoblastic disease (GTD)[3]	a. Suspected GTD (immediate postevacuation)												
	i. Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii. Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b. Confirmed GTD												
	i. Undetectable or non-pregnant β-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii. Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii. Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv. Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a. Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b. Migraine												
	i. Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii. With aura	1		1		1		1		1		4*	
History of bariatric surgery[3]	a. Restrictive procedures	1		1		1		1		1		1	
	b. Malabsorptive procedures	1		1		1		1		3		COCs: 3	
												P/R: 1	
History of cholestasis	a. Pregnancy related	1		1		1		1		1		2	
	b. Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of pelvic surgery	(see also Postpartum [including cesarean delivery])	1		1		1		1		1		1	
HIV	a. High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b. HIV infection					1*		1*		1*		1*	
	i. Clinically well receiving ARV therapy	1	1	1	1	If on ARV, see also Drug Interactions.							
	ii. Not clinically well or not receiving ARV therapy[4]	2	1	2	1	If on ARV, see also Drug Interactions.							

Abbreviations: ARV = antiretroviral; C = continuation of contraceptive method; CHC = combined hormonal contraceptive (pill, patch, and ring); COC = combined oral contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiation of contraceptive method; LNG-IUD = levonorgestrel intrauterine device; NA = not applicable; POP = progestin-only pill; P/R = patch/ring; SSRI = selective serotonin reuptake inhibitor; STI = sexually transmitted infection; VTE = venous thromboembolism. [1]Condition associated with increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/contraception/hcp/usmec/.

US_MEC_2024_A

LARC INSERTION

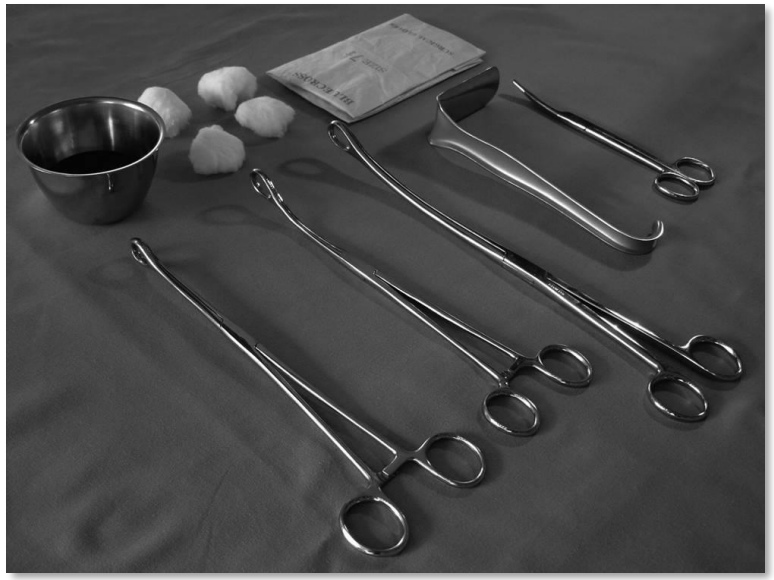
Immediately Postpartum

ACOG

PCAI
Postpartum Contraceptive Access Initiative

IPP IUD Insertion Equipment

- Two forceps
  - One for cervical traction and another for device placement
    - Kelly Placental forceps
    - Ring/Ovum forceps
- Method of vaginal retraction
- Scissors
- Light source
- IUD
- New sterile gloves
- Ultrasound recommended, not required
- +/- antiseptic cleanser and radiopaque surgical sponge

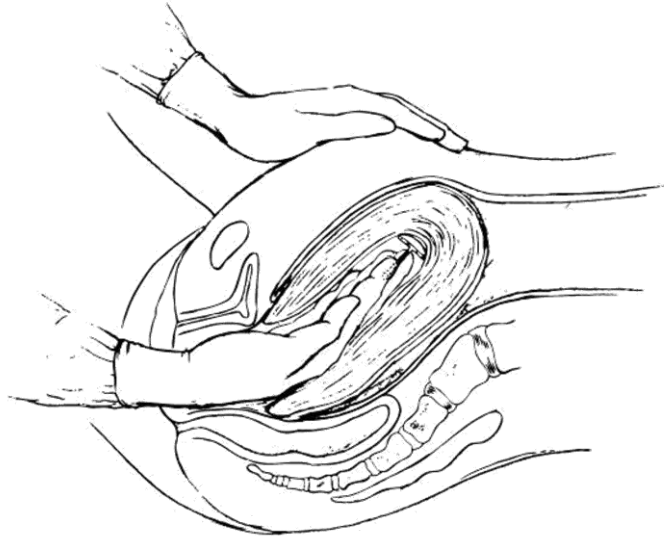


ACOG

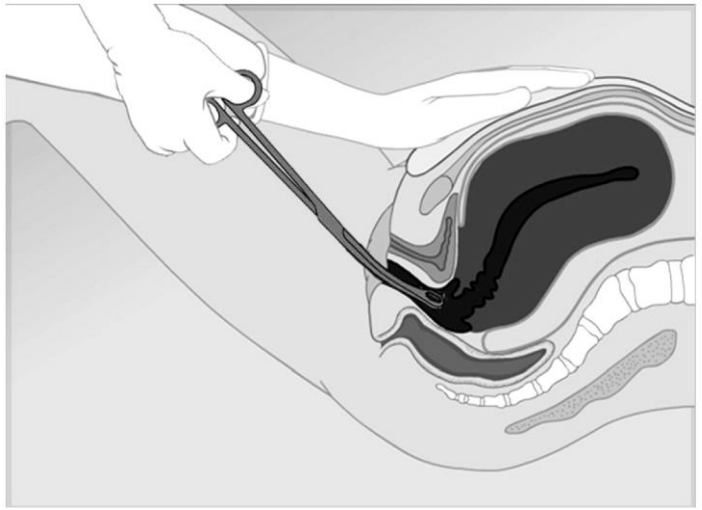
PCAI
Postpartum Contraceptive Access Initiative

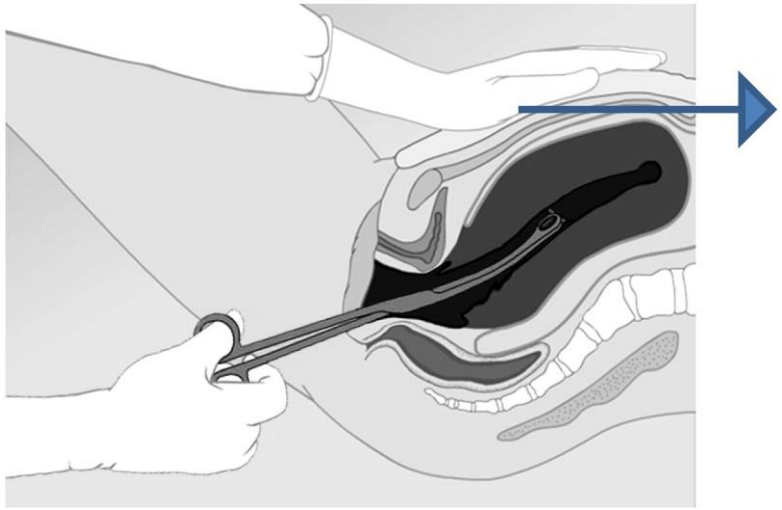
Importance of Fundal Placement

Manual Insertion



Instrument Insertion





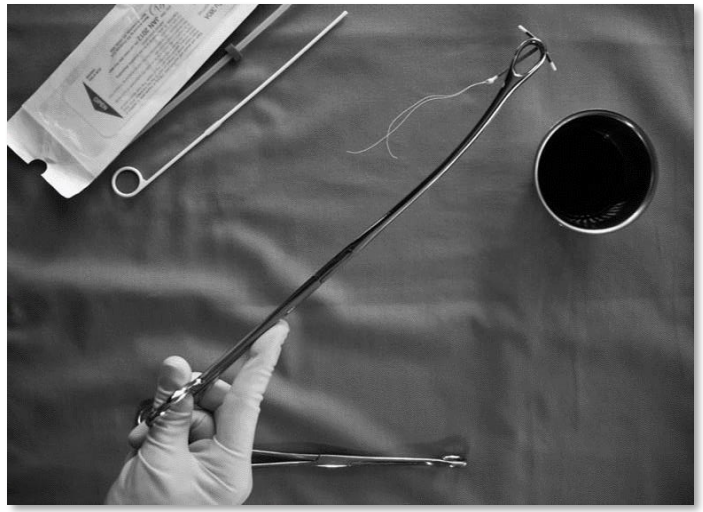
- Fundal placement is key to decreased expulsions rates
- The ACOG Contraceptive Equity Expert Work Group recommends ultrasound guidance for insertion, especially during training, but lack of availability should not preclude insertion

ACOG

PCAI
Postpartum Contraceptive Access Initiative

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 to 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
    - Alternatively, may pre-cut strings to 10 cm from the top of the device

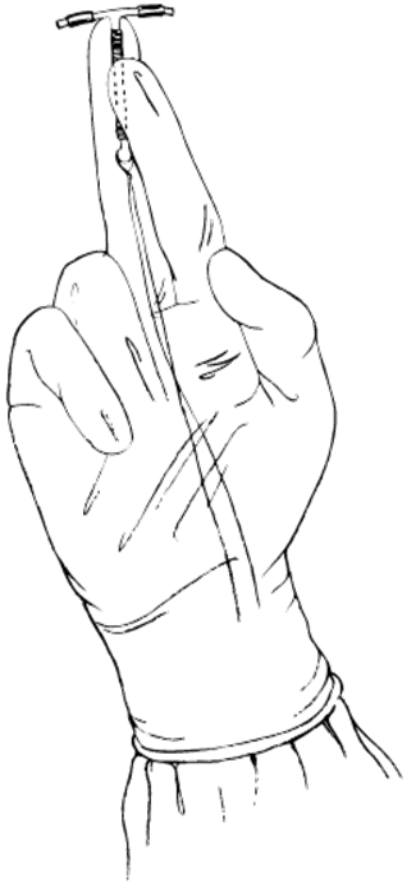


ACOG

PCAI
Postpartum Contraceptive Access Initiative

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
    - Alternatively, may pre-cut strings to 10 cm from the top of the device



ACOG

PCAI
Postpartum Contraceptive Access Initiative

IUD Insertion Tips & Tricks After Vaginal Delivery

- Put on new sterile gloves before beginning
- Retrieve the ultrasound prior to delivery, if possible
- Ensure appropriate bleeding
  - Uterine tone
  - Complete placental removal
- Ring forceps for cervical traction, if needed
- Repair bleeding lacerations first, but repair non-bleeding lacs afterward
- If difficulty reaching fundus, lower your hand and adjust speculum/retractor as needed to change the angle of insertion such that the curve of the lower uterine segment can be navigated

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Cesarean Delivery: IPP IUD Placement

1. Perform routine external massage and internal sweep to ensure all placental tissue is removed.
2. Ensure the uterus is hemostatic and initiate closure of the hysterotomy
3. Grasp the body of the IUD with forceps, hand or inserter
4. LNG IUD strings should be trimmed to about 10 cm from the top of the device
5. Strings of the ParaGard copper IUD do not need to be trimmed
6. Place the IUD at the fundus
7. Carefully point strings to cervix/vagina
8. Complete hysterotomy closure – take care to not incorporate the strings into the closure

Contraceptive Implant Insertion

- The Food and Drug Administration requires that all health care providers who perform implant insertions and removals receive training from Organon, the manufacturer of Nexplanon

- Immediate postpartum insertion of the contraceptive implant is **identical** to interval insertion and **can be inserted any time after delivery**

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Postpartum LARC Follow-up

- After IUD insertion, all patients should be offered a string check (not mandatory)

- Follow-up instructions for immediate postpartum placement is similar to interval placement
  - Counsel postpartum patient to notify provider if they have pain or bleeding different from lochia or postpartum cramps

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Postpartum LARC Removal

- Patients can have device removed at any time upon request
- Providers should be aware of changes to insurance coverage in the postpartum period that may affect coverage of device removal
- Discuss with the patient:
  - When fertility could return
  - Contraceptive options if pregnancy is not desired
  - Options for low or no-cost removal services, including Title X or other clinics

ACOG

PCAI
Postpartum Contraceptive Access Initiative


TN
Division of
TennCare

Recipe for Success

Dr. Nikki Zite
Complex Family Planning

Access to IPP LARC Among Hospitals in TN

2017

Zero

Hospitals regularly providing IPP LARC

2018/2019

Twelve

Hospitals participated in TIPQC's IPP LARC Project

2025

Four

Hospitals actively providing IPP LARC

Future

?

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

Hospital IPP LARC Implementation

Megan Young, MPH

Manager of Quality Improvement and Process Review

University of Tennessee Medical Center

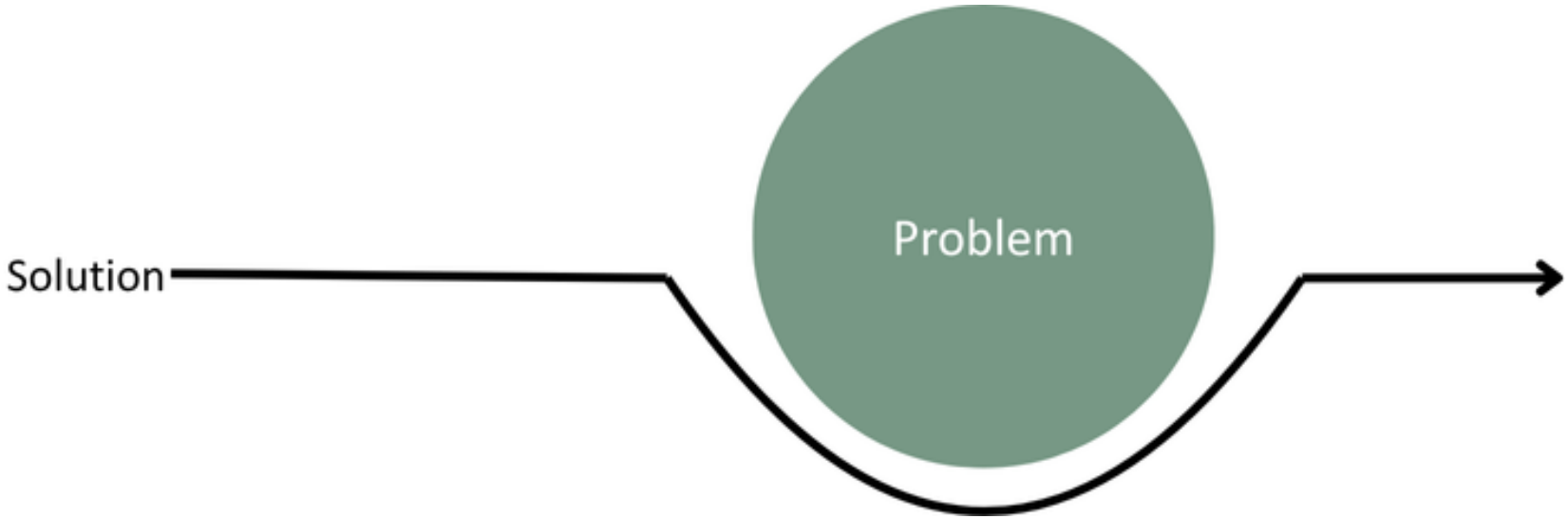
Formerly the Tennessee IPP LARC Champion

MAGNET RECOGNIZED

AMERICAN NURSES CREDENTIALING CENTER

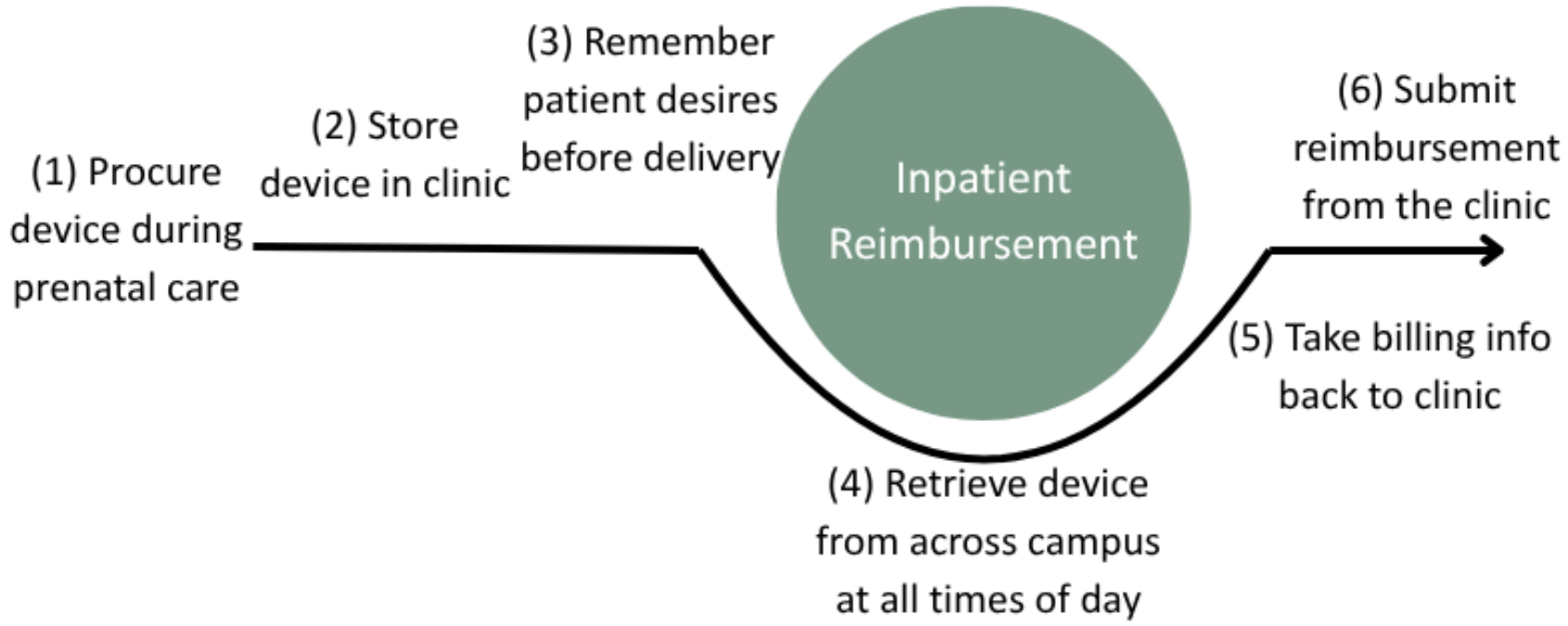
Access to IPP LARC in TN

Before Unbundling
from Global fee of Pregnancy



Access to IPP LARC in TN

Before Unbundling
from Global fee of Pregnancy



Access to IPP LARC in TN

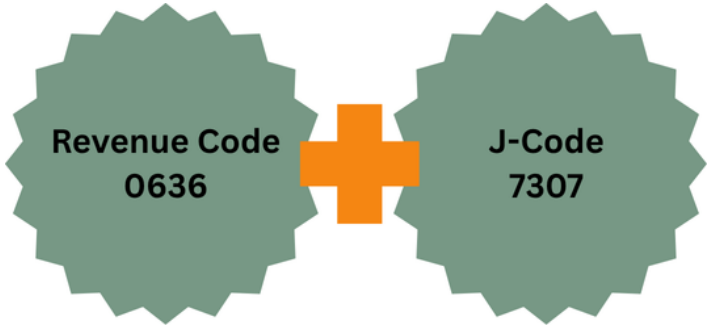
After Unbundling
from Global fee of Pregnancy

Provider – covers risk and benefits, places the device, documents

Nurse – grabs device, documents

Coder – codes based on Provider documentation

Biller – Submit claim



(CPT Z30017 is not enough by itself)

Key Focus for any IPP LARC Program

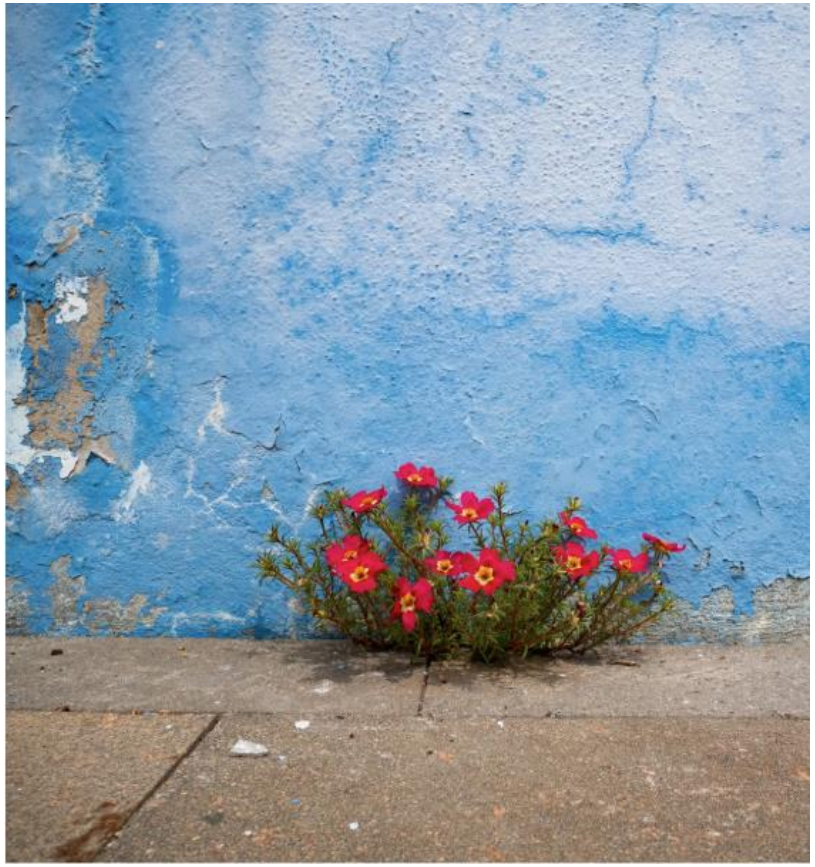
- **MUST BE:** Comprehensive contraceptive counseling and comprehensive access – NEVER on the number of devices placed each month alone
  - We ask every patient
    - "Has your provider discussed contraception with you?"
    - "What kind of contraception would you like before discharge?"
  - At discharge, we document what the patient left with.
  - We use this information to determine – are patients getting the method they want?

Reaching Success

- Champions across specialties are needed:
  - Pharmacy
  - IT
  - Nursing
  - Providers (Physicians/Midwives)
  - Medical Coders
  - Revenue stream teams
  - Executive Leadership

Maintaining Success

- Still tracking each device placed
  - List of those with documented IPP LARC desire is compared to a pharmacy list
  - Once combined and verified, send to coders to verify all accounts coded
  - Send to billers to verify claims all sent
  - Compare to quarterly TennCare report with number of devices placed
- Manual billing requires an enthusiastic billing champion
- Turnover in key personnel can be hard!
  - Perseverance!



Impact of IPP LARC in Tennessee

- Evaluating Institutional data
  - Mothers with Medicaid
  - Delivered January 15, 2018 through August 2018
  - 1,968 maternal patients
    - 47.6% reported contraceptive counseling during prenatal care on delivery admission
- Women who reported prenatal contraceptive counseling were more likely to get their desired contraceptive method, including IPP LARC, (57.1% vs 9.0%)
- Takeaway: **Contraceptive counseling during prenatal care matters!**

Impact of IPP LARC in Tennessee

- Evaluating Institutional data
  - Mothers with Medicaid
  - Delivered March 2018 through June 2023
  - 10,472 maternal patients
    - 24.1% requested and obtained IPP LARC during admission
- Nationally, interval LARC utilization is 11%
- Takeaway: **When patients have access to IPP LARC, they utilize it!**

Impact of IPP LARC in Tennessee

- Evaluating Institutional data
  - Delivery Patients with Medicaid
  - Delivered January 2018 through December 2020
  - Institutional short-interval birth (SIB) rate: 24.9%
    - SIB rate among **all** patients who received IPP LARC: 4.2%
    - SIB rate among **adolescents** who received IPP LARC: 8.2%

  - National SIB rate: 29-35%
  - Tennessee SIB rate: 32.5%

Key Takeaway: **Selecting IPP LARC reduces SIB rate**

Does being a hospital providing IPP LARC impact SIB overall?

Admon et. Al 2025
2022 March of Dimes Prematurity Report

Impact of IPP LARC in Tennessee

- Evaluating Tennessee Birth Certificate data
  - Mothers with Medicaid
  - Delivered January 2015 through December 2021
  - Nulliparas excluded
  - 3 Phases
    - Pre-implementation Jan 2015-Dec 2017
    - Implementation Jan 2018-Dec 2018
    - Post-implementation Jan 2019-Dec 2021

These data were supplied by the State of Tennessee, Department of Finance and Administration, Division of TennCare, Nashville, TN. TennCare specifically disclaims responsibility for any analyses, interpretations or conclusions.

Impact of IPP LARC in Tennessee

- Takeaway: Among 142,192 births: Short-interval birth rates are **significantly lower in hospitals that provide IPP LARC** vs hospitals that do not
  - IPP LARC hospitals: 26.9%
  - Non-IPP LARC hospitals: 28.3%

These data were supplied by the State of Tennessee, Department of Finance and Administration, Division of TennCare, Nashville, TN. TennCare specifically disclaims responsibility for any analyses, interpretations or conclusions.

Next steps in Research

- Evaluating
  - Frequency of IPP IUD expulsion or malpositioning with dissatisfaction
  - Patient Satisfaction long term

Next steps in Advocacy…bigger than this webinar

- Expansion of IPP LARC programs could:
  - Increase access to and uptake of IPP LARC
  - Potentially reduce adverse neonatal and maternal outcomes associated with short-interval birth

- Private MCOs
  - Patients with private insurance request these devices
    - LARC placement under regional anesthesia is a benefit
  - Patients with private insurance also:
    - Need access to discrete contraception
    - Face barriers to postpartum follow-up

QUESTIONS?

pcai@acog.org

ACOG

PCAI
Postpartum Contraceptive Access Initiative

Please Complete Training Post-Test And CME Evaluation

ACOG Post Test

bit.ly/4m9zzps

CME

bit.ly/4mBILTm

ACOG

PCAI
Postpartum Contraceptive Access Initiative

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 #490, Partnering With Patients to Improve Safety
4. ACOG Committee Opinion #587, Effective Patient-Physician Communication
5. ACOG Committee Opinion #736, Optimizing Postpartum Care
6. Obstetric Care Consensus #8: Interpregnancy Care

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

- Lacy MM, McMurtry Baird S, Scott TA, Barker B, Zite NB. Statewide quality improvement initiative to implement immediate postpartum long-acting reversible contraception. Am J Obstet Gynecol. 2020 Apr;222(4S):S910.e1-S910.e8.
- Admon LK, MacCallum-Bridges C, Daw JR. Trends in Short Interpregnancy Interval Births in the United States, 2016-2022. Obstet Gynecol. 2025 Jan 1;145(1):82-90.
- 2022 March of Dimes Prematurity Profile for Tennessee: https://www.marchofdimes.org/peristats/assets/s3/reports/prematurity/PrematurityProfile-Tennessee.pdf
- Lacy, Megan MPH; Monaco, Alexandra MD; Zite, Nikki B. MD, MPH. Initiating and Monitoring a Postpartum Contraceptive Program [8N]. Obstetrics & Gynecology 133():p 152S, May 2019.
- Lacy Young M, Mastronardi A, Shelton Z, Maples JM, Zite NB. Tennessee Medicaid patient immediate postpartum long-acting reversible contraception utilization. Contraception. 2025 Feb;142:110721.
- Mastronardi A, Lacy Young M, Shelton Z, Maples JM, Zite NB. Short-interval births among patients choosing immediate postpartum long-acting reversible contraception (ipp larc) after tennessee medicaid policy change. Contraception. 2022 Dec; 116:89-90
- Kaak, Katherine MD; Zite, Nikki MD; Mastronardi, Alicia MPH; Maples, Jill M. PhD; Young, Megan Lacy MPH. Evaluating Contraception Counseling and Desire for Immediate Postpartum Long-Acting Contraception in Publicly Insured Adolescents. Obstetrics & Gynecology 143(5S):p 10S, May 2024.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

Access to postpartum sterilization. Committee Opinion No. 530. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:212-5. Available at: http://journals.lww.com/greenjournal/Citation/2012/07000/Committee_Opinion_No__530___Access_to_Postpartum.43.aspx. Retrieved September 26, 2017.
DOI: 10.1097/AOG.0b013e318262e354 [doi].
PMID: 22914423.

ACQUIRE Project, EngenderHealth. The postpartum intrauterine device: trainer's manual. New York (NY): EngenderHealth; 2008. Available at: https://www.engenderhealth.org/files/pubs/family-planning/PPIUD_Trainers-Manual.pdf. Retrieved September 21, 2017.

ACQUIRE Project, EngenderHealth. The postpartum intrauterine device: participant handbook. New York (NY): ACQUIRE Project; 2008. Available at: https://www.engenderhealth.org/files/pubs/family-planning/PPIUD_Participant-Handbook.pdf. Retrieved October 3, 2017.

Aiken AR, Aiken CE, Trussell J, Guthrie KA. Immediate postpartum provision of highly effective reversible contraception. BJOG 2015;122:1050-1. Available at: http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.13306/abstract. Retrieved September 13, 2017.
DOI: 10.1111/1471-0528.13306 [doi].
PMID: 25626730.

American College of Obstetricians and Gynecologists. Contraceptive counseling resource digest. Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: https://www.acog.org/-/media/Departments/LARC/ContraceptiveCounselingReplaceable.pdf. Retrieved September 21, 2017.

American Congress of Obstetricians and Gynecologists, District II. Immediate post-placental IUD insertion. ACOG: Albany (NY); 2016. Available at: https://cfweb.acog.org/district_ii/larc/section4.html. Retrieved September 21, 2017.

Bixby Center for Global Reproductive Health, University of California San Francisco. How well does birth control work? San Francisco (CA): UCSF; 2017. Available at: http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/Tiers_Chart_ENGLISH.pdf. Retrieved September 22, 2017.

Bryant AS, Haas JS, McElrath TF, McCormick MC. Predictors of compliance with the postpartum visit among women living in healthy start project areas. Matern Child Health J 2006;10:511-6. Available at: https://link.springer.com/article/10.1007%2Fs10995-006-0128-5. Retrieved September 13, 2017.
DOI: 10.1007/s10995-006-0128-5 [doi].
PMID: 16807794.

Centers for Disease Control and Prevention. Unintended pregnancy prevention. Atlanta (GA): CDC; 2015. Available at: https://www.cdc.gov/reproductivehealth/unintendedpregnancy. Retrieved September 21, 2017.

Clinical challenges of long-acting reversible contraceptive methods. Committee Opinion No. 672. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e69-77. Available at: http://journals.lww.com/greenjournal/fulltext/2016/09000/Committee_Opinion_No_672___Clinical_Challenges_of.54.aspx. Retrieved September 22, 2017.
DOI: 10.1097/AOG.0000000000001644 [doi].
PMID: 27548557.

Cohen R, Sheeder J, Arango N, Teal SB, Tocce K. Twelve-month contraceptive continuation and repeat pregnancy among young mothers choosing postdelivery contraceptive implants or postplacental intrauterine devices. Contraception 2016;93:178-83. Available at: http://www.contraceptionjournal.org/article/S0010-7824(15)30030-5/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2015.10.001 [doi].
PMID: 26475368.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

Connolly A, Thorp J, Pahel L. Effects of pregnancy and childbirth on postpartum sexual function: a longitudinal prospective study. Int Urogynecol J Pelvic Floor Dysfunct 2005;16:263-7. Available at: https://link.springer.com/article/10.1007/s00192-005-1293-6. Retrieved September 13, 2017.
DOI: 10.1007/s00192-005-1293-6 [doi].
PMID: 15838587.

Crockett AH, Pickell LB, Heberlein EC, Billings DL, Mills B. Six- and twelve-month documented removal rates among women electing postpartum inpatient compared to delayed or interval contraceptive implant insertions after Medicaid payment reform. Contraception 2017;95:71-6. Available at: http://www.contraceptionjournal.org/article/S0010-7824(16)30145-7/fulltext. Retrieved September 13, 2017.
DOI: S0010-7824(16)30145-7 [pii].
PMID: 27400823.

Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, et al. U.S. medical eligibility criteria for contraceptive use, 2016. MMWR Recomm Rep 2016;65(RR-3):1-103. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm?s_cid=rr6503a1_w. Retrieved September 13, 2017.
DOI: 10.15585/mmwr.rr6503a1 [doi].
PMID: 27467196.

Dahlke JD, Terpstra ER, Ramseyer AM, Busch JM, Rieg T, Magann EF. Postpartum insertion of levonorgestrel--intrauterine system at three time periods: a prospective randomized pilot study. Contraception 2011;84:244-8. Available at: http://www.contraceptionjournal.org/article/S0010-7824(11)00008-4/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2011.01.007 [doi].
PMID: 21843688.

Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. Contraception 2013;88:250-6. Available at: http://www.contraceptionjournal.org/article/S0010-7824(12)00901-8/fulltext. Retrieved September 21, 2017.
DOI: 10.1016/j.contraception.2012.10.012 [doi].
PMID: 23177265.

Effective patient–physician communication. Committee Opinion No. 587. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:389-93. Available at: http://journals.lww.com/greenjournal/fulltext/2014/02000/Committee_Opinion_No__587___Effective.36.aspx. Retrieved October 3, 2017.
DOI: 10.1097/01.AOG.0000443279.14017.12 [doi].
PMID: 24451677.

Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008-2011. N Engl J Med 2016;374:843-52. Available at: http://www.nejm.org/doi/full/10.1056/NEJMsa1506575. Retrieved September 21, 2017.
DOI: 10.1056/NEJMsa1506575 [doi].
PMID: 26962904.

Gray RH, Campbell OM, Zacur HA, Labbok MH, MacRae SL. Postpartum return of ovarian activity in nonbreastfeeding women monitored by urinary assays. J Clin Endocrinol Metab 1987;64:645-50. Available at: https://academic.oup.com/jcem/article-abstract/64/4/645/2653643/Postpartum-Return-of-Ovarian-Activity-in?redirectedFrom=fulltext. Retrieved September 26, 2017.
DOI: 10.1210/jcem-64-4-645 [doi].
PMID: 3818896.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

Guttmacher Institute. Unintended pregnancy in the United States. New York (NY): Guttmacher Institute; 2016. Available at: https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states. Retrieved September 21, 2017.

Hatcher RA, Trussell J, Nelson AL, Cates WJ, Kowal D, Policar MS. Contraceptive technology. 20th rev. ed. New York (NY): Ardent Media; 2011.

Kapp N, Curtis K, Nanda K. Progestogen-only contraceptive use among breastfeeding women: a systematic review. Contraception 2010;82:17-37. Available at: http://www.contraceptionjournal.org/article/S0010-7824(10)00046-6/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2010.02.002 [doi].
PMID: 20682140.

Kyleena (levonorgestrel-releasing intrauterine system). Highlights of prescribing information. Whippany (NJ): Bayer HealthCare Pharmaceuticals Inc.; 2016. Available at: http://labeling.bayerhealthcare.com/html/products/pi/Kyleena_PI.pdf. Retrieved August 23, 2017.

Laerdal Global Health. Mama-U: postpartum uterus trainer. Available at: https://www.youtube.com/watch?v=-xNlKUl5v_0. Retrieved September 26, 2017.

Levi EE, Stuart GS, Zerden ML, Garrett JM, Bryant AG. Intrauterine device placement during cesarean delivery and continued use 6 months postpartum: a randomized controlled trial. Obstet Gynecol 2015;126:5-11. Available at: http://journals.lww.com/greenjournal/fulltext/2015/07000/Intrauterine_Device_Placement_During_Cesarean.3.aspx. Retrieved September 13, 2017.
DOI: 10.1097/AOG.0000000000000882 [doi].
PMID: 26241250.

Liletta (levonorgestrel-releasing intrauterine system). Highlights of prescribing information. Irvine (CA): Allergan USA, Inc.; 2017. Available at: https://www.allergan.com/assets/pdf/lilettashi_pi. Retrieved August 23, 2017.

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. Retrieved October 25, 2017.
DOI: 10.1097/AOG.0000000000002400 [doi].
PMID: 29064972.

Lopez LM, Bernholc A, Hubacher D, Stuart G, Van Vliet HA. Immediate postpartum insertion of intrauterine device for contraception. Cochrane Database of Systematic Reviews 2015, Issue 6. Art. No.: CD003036. DOI: 10.1002/14651858.CD003036.pub3. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003036.pub3/abstract. Retrieved October 3, 2017.
DOI: 10.1002/14651858.CD003036.pub3.

McNicholas C, Swor E, Wan L, Peipert JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. Am J Obstet Gynecol 2017;216:586.e1-6. Available at: http://www.ajog.org/article/S0002-9378(17)30171-0/fulltext. Retrieved September 21, 2017.
DOI: S0002-9378(17)30171-0 [pii].
PMID: 28147241.

Mirena (levonorgestrel-releasing intrauterine system). Highlights of prescribing information. Whippany (NJ): Bayer HealthCare Pharmaceuticals Inc.; 2017. Available at: https://labeling.bayerhealthcare.com/html/products/pi/Mirena_PI.pdf. Retrieved August 23, 2017.

New York City Department of Health and Mental Hygiene. Breastfeeding and birth control. New York (NY): DOHMH; 2016. Available at: https://www1.nyc.gov/assets/doh/downloads/pdf/ms/breastfeeding-birth-control-postpartum-poster.pdf. Retrieved September 21, 2017.

Nexplanon (etonogestrel implant). Highlights of prescribing information. Whitehouse Station (NJ): Merck & Co., Inc.; 2017. Available at: http://www.merck.com/product/usa/pi_circulars/n/nexplanon/nexplanon_pi.pdf. Retrieved August 23, 2017.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

Organon. Request Clinical Training – Nexplanon Training. Clinical Training Program (CTP) for NEXPLANON (etonogestrel implant) 68 mg Radiopaque. Accessed February 15, 2024. https://nexplanontraining.com/request-clinical-training/

Optimizing postpartum care. Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e949-51. Available at: https://journals.lww.com/greenjournal/Fulltext/2018/05000/ACOG_Committee_Opinion_No__736_Summary__.37.aspx. Retrieved March 13, 2019.
DOI: 10.1097/AOG.0000000000001487 [doi].
PMID: 27214194.

ParaGard T 380A intrauterine copper contraceptive. Prescribing information. North Wales (PA): Teva Women's Health, Inc.; 2014. Available at: http://paragard.com/pdf/PARAGARD-PI.pdf. Retrieved August 23, 2017.

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. Retrieved September 21, 2017.
DOI: 10.1097/AOG.0b013e31821d7d60 [doi].
PMID: 21508784.

Peipert JF, Zhao Q, Allsworth JE, Petrosky E, Madden T, Eisenberg D, et al. Continuation and satisfaction of reversible contraception. Obstet Gynecol 2011;117:1105-13. Available at: http://journals.lww.com/greenjournal/fulltext/2011/05000/Continuation_and_Satisfaction_of_Reversible.12.aspx. Retrieved September 21, 2017.
DOI: 10.1097/AOG.0b013e31821188ad [doi].
PMID: 21508749.

Postpartum Birth Control. FAQ194. American College of Obstetricians and Gynecologists. 2016. Available at: https://www.acog.org/Patients/FAQs/Postpartum-Birth-Control. Retrieved October 25, 2017.

Reilly PR. Eugenics and involuntary sterilization: 1907–2015. Ann Rev Genom Hum Genet 2015;16:351-68. Available at: http://www.annualreviews.org/doi/abs/10.1146/annurev-genom-090314-024930. Retrieved September 21, 2017.
DOI: https://doi.org/10.1146/annurev-genom-090314-024930.

Rivera R, Yacobson I, Grimes D. The mechanism of action of hormonal contraceptives and intrauterine contraceptive devices. Am J Obstet Gynecol 1999;181:1263-9. Available at: http://www.ajog.org/article/S0002-9378(99)70120-1/fulltext. Retrieved September 13, 2017.
DOI: S0002-9378(99)70120-1 [pii].
PMID: 10561657.

Rodriguez MI, Kaunitz AM. An evidence-based approach to postpartum use of depot medroxyprogesterone acetate in breastfeeding women. Contraception 2009;80:4-6. Available at: http://www.contraceptionjournal.org/article/S0010-7824(09)00048-1/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2008.12.014 [doi].
PMID: 19501209.

Shaamash AH, Sayed GH, Hussien MM, Shaaban MM. A comparative study of the levonorgestrel-releasing intrauterine system Mirena versus the Copper T380A intrauterine device during lactation: breast-feeding performance, infant growth and infant development. Contraception 2005;72:346-51. Available at: http://www.contraceptionjournal.org/article/S0010-7824(05)00109-5/fulltext. Retrieved September 13, 2017.
DOI: S0010-7824(05)00109-5 [pii].
PMID: 16246660.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

Skyla (levonorgestrel-releasing intrauterine system). Highlights of Prescribing Information. Whippany (NJ): Bayer HealthCare Pharmaceuticals Inc.; 2017. Available at: http://labeling.bayerhealthcare.com/html/products/pi/Skyla_PI.pdf. Retrieved August 23, 2017.

Sothornwit J, Werawatakul Y, Kaewrudee S, Lumbiganon P, Laopaiboon M. Immediate versus delayed postpartum insertion of contraceptive implant for contraception. Cochrane Database of Systematic Reviews 2017, Issue 4. Art. No.: CD011913. DOI: 10.1002/14651858.CD011913.pub2. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011913.pub2/abstract. Retrieved October 2, 2017.
DOI: 10.1002/14651858.CD011913.pub2.

Sterilization for Women and Men. FAQ011. American College of Obstetricians and Gynecologists. 2015. Available at: https://www.acog.org/Patients/FAQs/Sterilization-for-Women-and-Men. Retrieved December 5, 2017.

Stern AM. Sterilized in the name of public health: race, immigration, and reproductive control in modern California. Am J Public Health 2005;95:1128-38. Available at: http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2004.041608. Retrieved September 21, 2017.
DOI: 95/7/1128 [pii].
PMID: 15983269.

Thiel de Bocanegra H, Chang R, Menz M, Howell M, Darney P. Postpartum contraception in publicly-funded programs and interpregnancy intervals. Obstet Gynecol 2013;122:296-303. Available at: http://journals.lww.com/greenjournal/fulltext/2013/08000/Postpartum_Contraception_in_Publicly_Funded.17.aspx. Retrieved September 13, 2017.
DOI: 10.1097/AOG.0b013e3182991db6 [doi].
PMID: 23969798.

Thurman AR, Janecek T. One-year follow-up of women with unfulfilled postpartum sterilization requests. Obstet Gynecol 2010;116:1071-7. Available at: http://journals.lww.com/greenjournal/fulltext/2010/11000/One_Year_Follow_up_of_Women_With_Unfulfilled.12.aspx. Retrieved September 21, 2017.
DOI: 10.1097/AOG.0b013e3181f73eaa [doi].
PMID: 20966691.

Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397-404. Available at: http://www.contraceptionjournal.org/article/S0010-7824(11)00049-7/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2011.01.021 [doi].
PMID: 21477680.

Voedisch AJ, Blumenthal PD. Postpartum contraception: ways to avoid VTE. Contemp Ob/Gyn 2012;57(1):20-6, 28-9. Available at: http://contemporaryobgyn.modernmedicine.com/contemporary-obgyn/news/modernmedicine/modern-medicine-feature-articles/postpartum-contraception-way?page=full. Retrieved September 21, 2017.

Whitaker AK, Chen BA, Borgatta L. Society of Family Planning guidelines: postplacental insertion of intrauterine devices. Contraception 2017; DOI: 10.1016/j.contraception.2017.09.014. Available at: http://www.contraceptionjournal.org/article/S0010-7824(17)30473-0/fulltext. Retrieved October 16, 2017.
DOI: 10.1016/j.contraception.2017.09.014
PMID: 28987293.

Whitaker AK, Endres LK, Mistretta SQ, Gilliam ML. Postplacental insertion of the levonorgestrel intrauterine device after cesarean delivery vs. delayed insertion: a randomized controlled trial. Contraception 2014;89:534-9. Available at: http://www.contraceptionjournal.org/article/S0010-7824(13)00750-6/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2013.12.007 [doi].
PMID: 24457061.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

References

White K, Teal SB, Potter JE. Contraception after delivery and short interpregnancy intervals among women in the United States. Obstet Gynecol 2015;125:1471-7. Available at: http://journals.lww.com/greenjournal/fulltext/2015/06000/Contraception_After_Delivery_and_Short.28.aspx. Retrieved September 21, 2017.
DOI: 10.1097/AOG.0000000000000841 [doi].
PMID: 26000519.

Woo I, Seifert S, Hendricks D, Jamshidi RM, Burke AE, Fox MC. Six-month and 1-year continuation rates following postpartum insertion of implants and intrauterine devices. Contraception 2015;92:532-5. Available at: http://www.contraceptionjournal.org/article/S0010-7824(15)00582-X/fulltext. Retrieved September 13, 2017.
DOI: 10.1016/j.contraception.2015.09.007 [doi].
PMID: 26408376.

World Health Organization. Medical eligibility criteria for contraceptive use. 5th ed. Geneva: WHO; 2015. Available at: http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/. Retrieved September 27, 2017.

Zapata LB, Murtaza S, Whiteman MK, Jamieson DJ, Robbins CL, Marchbanks PA, et al. Contraceptive counseling and postpartum contraceptive use. Am J Obstet Gynecol 2015;212:171.e1-8. Available at: http://www.ajog.org/article/S0002-9378(14)00808-4/fulltext. Retrieved October 3, 2017.
DOI: 10.1016/j.ajog.2014.07.059 [doi].
PMID: 25093946.

ACOG

PCAI
Postpartum Contraceptive Access Initiative

APPENDIX

ACOG

PCAI
Postpartum Contraceptive Access Initiative

KEY TAKEAWAYS & RESOURCES

Things to Keep in Mind

ACOG

PCAI
Postpartum Contraceptive Access Initiative

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

ACOG

PCAI
Postpartum Contraceptive Access Initiative

THE ACOG PCAI 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.

ACOG

PCAI
Postpartum Contraceptive Access Initiative