Contraceptive Counseling

When providing contraceptive options, the goal is to ensure that each patient can access a method that will best serve her needs and preferences. Compassionate and culturally sensitive counseling ensures that patients are fully informed and completely comfortable with their decision (*see Section 3 on Reproductive Justice*). When patients are active participants in decision making surrounding their contraceptive use, they are more likely to be satisfied with their choice.[38] Method satisfaction is associated with continued use, which reduces vulnerability to unintended pregnancy.[39,40]

Ideally, contraceptive counseling should begin at the first prenatal visit. When discussions about contraception begin early in a woman's pregnancy, she is given more time to consider her options and ask any pertinent questions. Prenatal counseling combined with postpartum counseling has been shown to greatly increase effective use of contraception for postpartum women, with even greater effects for women with Medicaid or no insurance.[41] Proactive conversations about family planning emphasize the woman's desires for future fertility, rather than framing the conversation around her current partner or current pattern of sexual activity.[42] At a minimum, providers should review and discuss the pros and cons of various contraception methods several weeks before birth. Ideally, lactation consultations are also included in these conversations, ensuring that everything is done to help patients make well-informed decisions based on their needs.[43]

Motivational interviewing techniques can be useful for influencing patient behavior around contraceptive use.[44] Motivational interviewing is defined as a "directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence."[45] This technique is most effective when the provider has already established trust with the patient.

Recommendations on Shared Decision-Making from the Association of State and Territorial Health Organizations[43]

In a shared decision-making model, healthcare providers and patients engage in a dialogue to determine the best treatment for a patient. The model acknowledges that both parties are experts essential to the decision-making process: the healthcare provider regarding the science, the patient regarding their own best interests. If a woman is concerned about using LARC, the provider should provide information and guidance on other contraceptive methods.

Such patient-centered discussions are particularly important for women of color and other populations who have been selectively counseled toward LARC or permanent sterilization in the past.

The American College of Obstetrics and Gynecologists notes that certain general conversational techniques are effective during patient/provider interactions:

- Express empathy and avoid arguments
- Assist patient in understanding the existing gap between a patient's goals and current behavior
- Prepare for resistance, and respond with personalized feedback, which indicates active listening
- Support self-efficacy and internal motivation[44]

It is important to remember that each patient is the expert on her own life, symptoms, and strengths. While the physician or advanced practice clinician holds a specialized body of knowledge, the patient has knowledge outside the scope of the practitioner.[46] Factors the patient may consider in her decisions about contraception include a need for discrete methods of contraception that are not detectable to a partner, a desire for protection against sexually transmitted infections, and her comfort with her own body.

BEST PRACTICES FOR SHARED DECISION MAKING

Dr. Christine Dehlendorf and colleagues have developed best practice guidelines for shared decision making around family planning.[47]

Establish rapport with patient. Make sure patient feels comfortable speaking about her contraceptive options. Demonstrate interest in each patient's care.

Focus on each woman's contraceptive preferences. Determine patient's contraceptive priorities, and how each method may follow or contradict these priorities. It is particularly vital to touch upon the following topics:

Effectiveness	• There are common misconceptions surrounding contraceptive efficacy. Validate any preconceived notions but give patient the facts. • Use visual aids (See Appendix A and B). • Explain statistics using palatable terms (i.e.: less than 1 in 100 women get pregnant while using an IUD, and 9 in 100 women get pregnant on the patch/pill/ring).
Ability to Return to Fertility	• Explain the differences with each method.
Everyday Expectations Requirements, Logistics	• Describe the process of obtaining each method. • Explain the possibility of pain associated with insertion of LARC. • Discuss costs, insurance coverage, and hospital procedures associated with each method. • Describe the process of obtaining each method; many patients do not understand that LARC can be removed earlier than the time period for which it is approved.
Specific Side Effects	• Inform each patient of the side effects and benefits of each method. For example, hormonal IUDs can lead to abnormal bleeding and amenorrhea, but can also lead to decreased cramping. • Answer all questions, and validate patient's concerns, fears, and confusions.

Provide scaffolding for decision making. As patients are given more information, check in with them to see if there is anything that they have questions about, or ask if a particular method seems more interesting to them. **Facilitate the discussion, without stating opinions that are based on anything other than the patient's preferences.**

Once the decision is made:

- Provide patient with an opportunity to ask any remaining questions.
- Work with each patient to determine a proactive plan for obtaining/inserting the method.
- Discuss the process of removal, and what the patient needs to do, both in case of desiring early removal, or removal after the device is no longer effective. Establish a plan for the patient if they decide later they do not like the chosen option.
- Direct patients to online resources, so that patients can access answers when they are not able to contact their provider.

BREASTFEEDING AND IMMEDIATE POSTPARTUM LARC

- **There are common theoretical concerns and misconceptions regarding postpartum LARC and breastfeeding, including:**
    - Hormonal LARC can hinder lactation because of higher levels of progestins, which could reduce milk production.[48]
    - Progestins in LARC can transfer to breast milk and negatively affect infants' reproductive, neuroendocrine, and cognitive development.
- One study of 96 women found a difference in duration of breastfeeding among women who received immediate postpartum LARC compared to those who received LNG-IUD at their 6-week postpartum visit. Only 6% of women whose LARCs were placed immediately postpartum were still breastfeeding at 6 months compared to 24% of women who delayed LNG-IUD placement. In addition, only 2% of women in the immediate postpartum group were exclusively breastfeeding vs. 13% percent of women in the delayed group.[49,50]
- **<u>However, other available evidence does not support either of the above claims.</u>**
    - Most studies show no effect of immediate postpartum hormonal LARC on women's ability to initiate and maintain breastfeeding, or on infant growth and development.
        - A published review found no adverse effects of various progestogen-only contraceptive methods on multiple measures of breastfeeding performance through 12 months postpartum. This review also demonstrated no adverse effects of progestogen-only contraceptive methods on infant growth, health, or development from 6 months to 6 years of age.[51]
        - A non-inferiority randomized control trial inclusive of 259 women found no differences in time to lactogenesis, breastfeeding at 8 weeks, or exclusive breastfeeding at 6 months between the group receiving the LNG-IUD immediately after delivery or delayed to the postpartum visit.[52]

- A randomized trial of 183 women who received a two rod progestin implant either within 3-5 days of delivery vs. 6-8 weeks post delivery found no differences in lactogenesis, infant growth, or breastfeeding continuation at 3 or 6 months postpartum.[53]

Tip for Successful Contraceptive Counseling for Prenatal and Postpartum Patients

It is important to ensure that patient education offered by nurses and lactation consultants is consistent with physician counseling.

(See Section 2 on Planning for Implementation)

RESOURCES FOR EFFECTIVE CONTRACEPTIVE COUNSELING:

Bedsider
https://www.bedsider.org/
https://providers.bedsider.org/

Beyond the Pill
http://beyondthepill.ucsf.edu/educational-materials

Cardea
http://www.cardeaservices.org/resourcecenter/providing-quality-contraceptive-counseling-education-a-toolkit-for-training-staff

Reproductive Health Access Project
https://www.reproductiveaccess.org/contraception/

The American College of Obstetricians and Gynecologists (ACOG):
LARC Practice Resources:
https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Practice-Resources

University of California, San Francisco (UCSF) Bixby Center for Global Reproductive:
Contraceptive Counseling and LARC Uptake (Visual Aids p. 42-44)
https://client.blueskybroadcast.com/ACOG/downloads/Final--Contraceptive%20Counseling.pdf