FPQC

Florida Perinatal Quality Collaborative

Patient Education and Counseling

Access LARC Healthcare Provider Education

Partnering to Improve Health Care Quality
for Mothers and Babies

Purpose

- To assist providers in educating and counseling pregnant women about long-acting reversible contraception (LARC) as a **contraceptive option** during the immediate postpartum period.

Objectives

- Enhance dialogue and trust between women and providers
- Engage in shared decision-making to appropriately address women' needs and preferences
- Facilitate open communication for future dialogue and care-seeking
- Foster healthy birth spacing

Why Discuss LARC during Prenatal Care Visits?

- Patients may not realize their risk for unintended pregnancy after delivery
- Patients need time to make healthcare decisions
- Up to 40% of patients do not return for 6 week postpartum visit
- Thus, prenatal care visits are opportune time to discuss LARC

ACOG, 2016

Why Immediate Postpartum LARC Might be Good Fit for Your Patient?

- Aligns with patients' experiences, intentions and values
  - Prior experience with contraceptive failure
  - Desire to delay another pregnancy
  - Motivation to obtain contraception
  - Prefer ease of use with LARC
- Utilizes current access to healthcare system
  - Cost and future insurance coverage may make immediate postpartum LARC an accessible and affordable option

Patient Barriers to Postpartum LARC

- Lack of knowledge about postpartum contraception options
- Concerns about side effects
- Restrictions by insurance
- Concerns about impact on milk supply

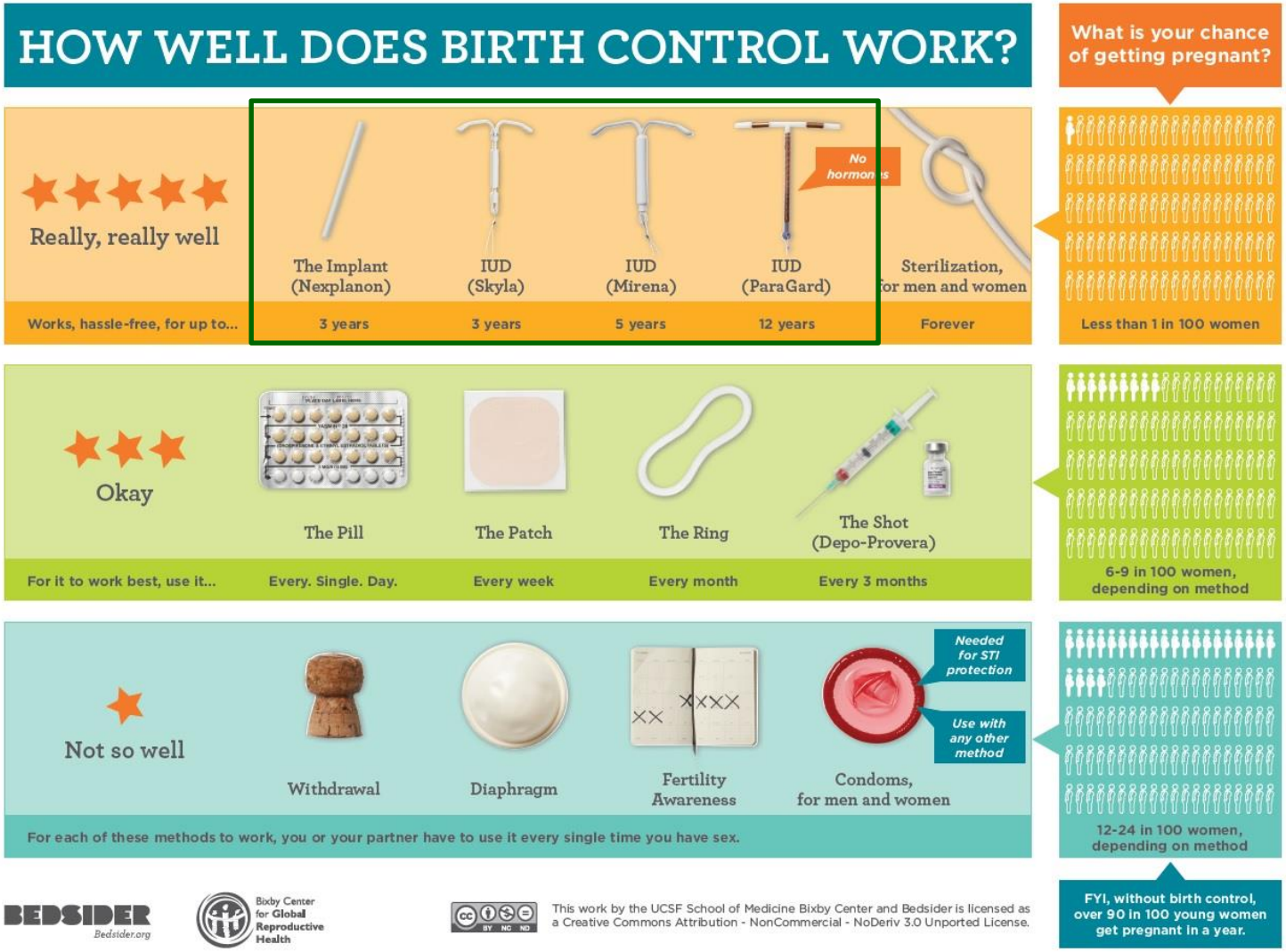
Partnering to Improve Health Care Quality
for Mothers and Babies

CONTRACEPTIVE OPTIONS

Terminology and Definitions

- Immediate postpartum LARC or post-placental LARC
  - Within 10 minutes of placenta delivery
- Post-delivery LARC
  - After delivery but before hospital discharge
- Interval LARC
  - After hospital discharge, often at postpartum visit

Contraceptive Options



Partnering to Improve Health Care Quality
for Mothers and Babies

CONTRACEPTIVE COUNSELING AND DECISION-MAKING

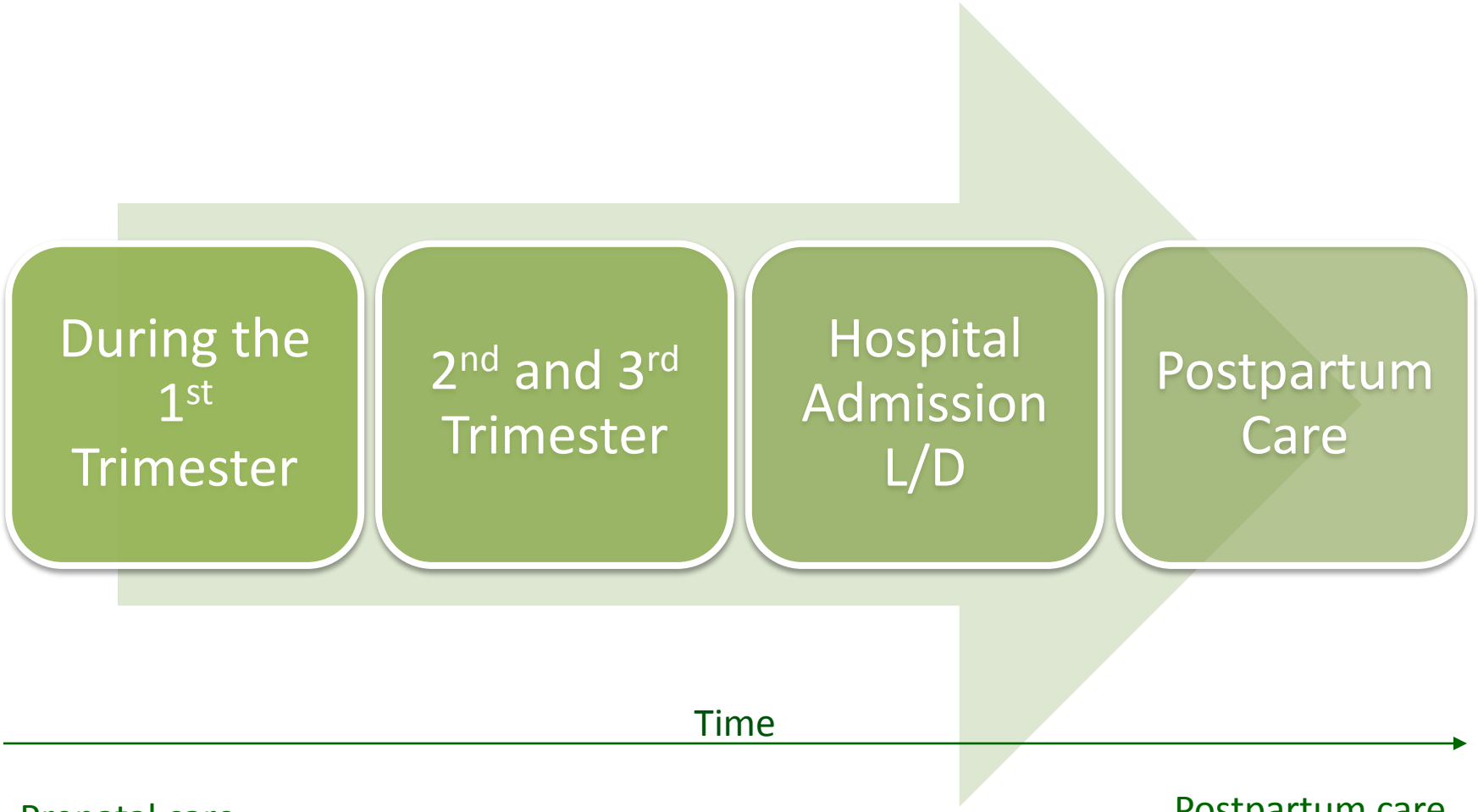
Supporting Patient Health Decision-Making

- American Medical Association (2012), "the patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice."

- Providers can assist in educating and counseling patients, but the final decision is the patients to make

AMA, 2012

Communication Timeline



Communication Timeline

- During 1st Trimester
  - Initiate conversations about contraception
  - Be brief and provide resources
- During 2nd and 3rd Trimester
  - Discuss postpartum contraception in detail
  - Document decisions

Communication Timeline

- During Hospital Admission/Labor and Delivery
  - Initiate or follow-up with postpartum contraception plan discussions
  - Remind women of the ability to get LARC later if they are not ready to decide prior to delivery

- During Postpartum Care
  - Provide women with contacts such as health department or community providers to get contraception or LARC removal
  - Inquire about women's satisfaction with method of choice

Best Practices in Contraceptive Care Encounters

- Developing relationships with patients
  - Friend-like patient-provider relationships
- Building patient trust
  - Patients perceive providers as trustworthy
- Optimizing decision-making (shared)
  - Provider informs and supports patient and patient exercises autonomy

Dehlendorf, Krajewski & Borrero, 2014

Partnering to Improve Health Care Quality
for Mothers and Babies

Educating and Communicating with Patients

PATIENT EDUCATION AND COUNSELING

Steps for Engaging Patients in Contraceptive Decision-making

1. Build rapport with women (and families)

2. Assess and educate women (and families)

3. Document and reinforce education

4. Ensure informed consent and ongoing support

FPQC

Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality
for Mothers and Babies

Creating a Friendly and Open Environment

1. BUILDING RAPPORT

Build rapport → Assess and educate → Document and reinforce education → Ensure inform consent and provide ongoing support

Build Rapport

- Rapport-building is a way to show patients that you respect them and value their opinions.
  - Make small talk
  - Make sure the patient is comfortable (e.g., wearing clothing during discussion, seated upright)
  - Ask patients for **main** and **other** health concerns
  - Encourage questions

Dehlendorf, et al., 2014

Talking Points

- *Hello, I am _____. How's it going?*
- *Before we begin, we tell all our women that whatever is discussed remains between you and me and other members of the care team*
- *Do you have any questions before we get started?*

FPQC

Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality
for Mothers and Babies

Determining Needs and Preferences

2. ASSESS AND EDUCATE WOMEN

Focus on Women's Preferences

- Initiating the contraception discussion:
  - **Say**:"*We recommend that moms wait at least 18 months before getting pregnant again. This is best for healthiest mom and baby.*"
  - **Ask**:"*Have you thought about if and when you would like to have another child?*"

Follow-up Questions

- *"When do you think that might be? How important is it to you to prevent pregnancy until then?"*

Build rapport | Assess and educate | Document and reinforce education | Ensure inform consent and provide ongoing support

Discuss Pros & Cons

- Allow the patient to describe good and bad things related to their response(s):
  - *"What are some of the **good things** about becoming pregnant within a year?"*
  - *"What are some of the **disadvantages** about…?"*

- Summarize patients responses
  - *"So on the one hand _[PROS]_, and on the other hand _[CONS]_."*

Gain Patient Feedback

- Ask permission before sharing information
  - *"I have some information about recommendations for [X]?"*
- Give **specific** and **tailored** information
- Elicit reaction from patient
  - *"What are your thoughts on that?"*

Assess Patient Preferences for Contraception

- Ask about *any* contraceptive use
  - *What forms of birth control have you used before? What about before this pregnancy?*
- Assess likes/dislikes of previous methods or methods of interest
  - *What did you like/dislike about that method?*
  - *What method(s) do you think you would like to use following your pregnancy?*
- Ask patient about knowledge/interest in LARC, if not mentioned

Provide Tailored Information on Methods

- If the patient is interested in a method:
  - Make contraceptive decision-making "easy" not overwhelming
  - Remind patients they can discuss this topic again later
  - Use skill-based strategies (e.g., teach back, show models) to engage patients
  - Discuss method choice, removal and reinsertion, switching methods, and correct/consistent use

Show and Tell

- Show methods, model how they can be used and allow patients to touch and see them

Bedsider.org

Provide Context for Comparing Methods

- Providers can provide context or use scenarios to help patients make an informed decision
  - *"A woman may want to get LARC before leaving the hospital because she might have difficulty coming for a follow-up appointment"*

FPQC

Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality
for Mothers and Babies

Planning or Avoiding Pregnancy

3. DOCUMENT AND REINFORCE EDUCATION

Time to Decide

- In the early part of prenatal care, patients are given information and time to decide their plans for postpartum contraception

- In the 2nd and 3rd trimester, providers can follow-up to see if women have decided on a course of action

Documentation

- Providers should document in the patient chart when additional contraceptive education and counseling takes place

- Once patients reach a decision, providers can limit follow-up to patient-initiated discussions or until the final few visits before delivery to check-in

Factors that May Influence Decision-making

- Pregnancy ambivalence (e.g., methods may seem too permanent)
- Lifestyle (e.g., erratic schedule, transportation issues, cohabitation/married)
- Socio-behavioral factors (e.g., insurance, remembrance, transportation, partner input)
- Medical issues (e.g., pre-term delivery, risk of STIs)

Educating on Side Effects

- Patients complain that they were not adequately informed of the side effects of some methods

- Unanticipated side effects such as irregular or heavy bleeding, headaches, depression, low libido, cause patients to discontinue contraception, particularly LARC

Dickerson et al., 2013

Educating on Other Options

- If patients do not want LARC or do not want LARC immediately postpartum, tell them that there are other options, such as:
  - Hormonal options (e.g., pill, patch, ring, and injectable)
  - Sterilization (e.g., tubal ligation, Essure, vasectomy)
  - Barrier methods (e.g., condoms and diaphragms)
  - Natural methods (e.g., calendar method)

- Remember to discuss advantages, disadvantages, and potential risks for each option

Assess Patient Readiness for Contraceptive Decision-making

- Determine how ready the patient is to address this concern (i.e. postpartum contraceptive use)
  - *"On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to [X]?"*

- Depending on patient response, create an action plan with their preferences in mind

Action Planning

- **Elicit** and **reinforce** self-motivating statements such as "*I am confident that I can take the pill everyday*"

- Help patient think through ways to handle side effects should they occur. Develop at least 2 strategies
  - "*I will carry panty liners or pads with me in case I experience irregular bleeding.*"

Talking Points

- *Will you summarize the steps you will take to [X]?*

- *I've written down a summary of things I will follow-up with you next time.*

FPQC

Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality
for Mothers and Babies

Changing Intention into Action

4. ENSURE INFORMED CONSENT AND PROVIDE ONGOING SUPPORT

A Patient Wants LARC Immediately Postpartum

- Ask patient what questions/concerns they have
- Describe the insertion procedure with images and models
- Discuss how consent will be obtained
- Describe the removal and re-insertion process, how they can schedule an appointment

A Patient Wants a non-LARC Method

- Ask patient what questions/concerns they have
- Describe in detail how the patient will use the method, use models, charts, calendar
- Assess patient's thoughts/attitudes regarding their ability to use method of choice
- Provide patient with comprehensive patient-friendly resources to assist them later:
  - Websites/Apps/Handouts
  - Contact/referral to primary care/free clinic/health department

Patient that Cannot Decide at this Time

- Ask patient what questions/concerns they have
- Tell them that they can have some time to consider their decision
- Provide patient with comprehensive patient-friendly resources to assist them:
  - Websites/Apps
  - Handouts/information
- Inform them that you will follow-up again or schedule a follow-up appointment with them

Patient that Declines Contraception

- Ask patient what questions/concerns they have
- Share/remind patients of the risks associated with short birth spacing
- Assure them that they can make a decision at a later date
- Give them contact information/referral to an agency that can provide contraception after delivery

What is informed consent?

- As an ethical doctrine, informed consent is a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care

ACOG, 2009

Gaining Consent

- ACOG affirms 8 statements, that include:
  - Patient acknowledgement of participation in medical treatment
  - Respect for patient's moral right, bodily integrity and self-determination regarding sexual and reproductive health
  - Active patient involvement
  - Consent as an ongoing process rather than a signed form

ACOG, 2009

Removing LARC

- "Women using LARC methods must always be free to discontinue use, even absent of a medical reason for doing so."

CONSENT FOR THE REMOVAL OF THE IUD

I have asked to have my IUD removed. I am aware that once the IUD is removed, I will need another method of contraception unless I am planning a pregnancy.

I have had an opportunity to discuss my questions and concerns and after doing so give my consent for the IUD removal.

_____	_____	_____
Patient Signature	**Today's Date**	**Professional Obtaining Consent**

UCSF Bixby Center for Global Reproductive Health. n.d.

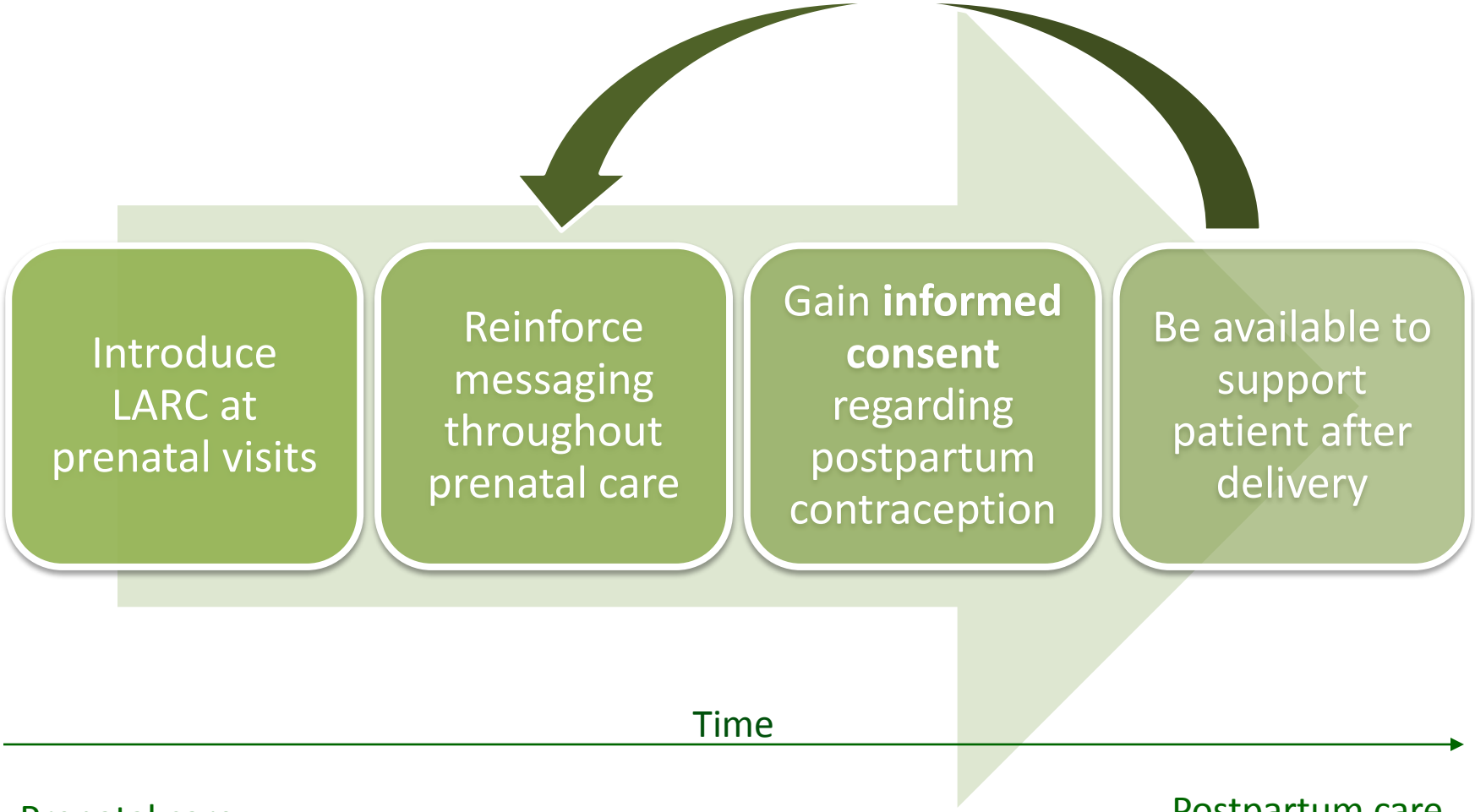
Talking Points

- *I would like to now share information with you about the specific procedure…*
- *What questions do you have?*

Partnering to Improve Health Care Quality
for Mothers and Babies

COMMUNICATION AS A PROCESS

Communication Timeline



Reiterating Health Messages

- Each healthcare team member can play a role in ongoing education about contraception:
  - **In-take**: Ask patient about prior education or post-delivery plans through forms or virtual check-in system (link to electronic health record)
  - **Work-up**: Ask permission to share information about contraception or ask if patients have questions or concerns
  - **Examination**: Follow-up with patient regarding information other staff shared and continue the conversation until a decision is reached*

*Waiting to make a decision is a decision and decisions may be made after several interactions

Ensuring Women's Reproductive Autonomy

- Not all patients will follow provider suggestions and may not choose LARC or any other form of contraception—it is the patient's choice to do so
- Future follow-up/interactions should include tailored information that reflects patient's preferences
- Be sure to document reasons why patients do not wish to use contraception

FPQC

Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality
for Mothers and Babies

FAQs

How do I know who is eligible for ippLARC?

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

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <40=1		Menarche to <18=1		Menarche to <18=2		Menarche to <18=1		Menarche to <20=2		Menarche to <20=2	
		≥40=2		18-45=1		18-45=1		18-45=1		≥20=1		≥20=1	
				>45=1		>45=2		>45=1					
Anatomic abnormalities	a) Distorted uterine cavity									4		4	
	b) Other abnormalities									2		2	
Anemias	a) Thalassemia	1		1		1		1		1		2	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	1		1		1		1		1		2	
Benign ovarian tumors	*(including cysts)*	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	2*		2*		2*		2*		2		1	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer†												
	i) current	4		4		4		4		4		1	
	ii) past and no evidence of current disease for 5 years	3		3		3		3		3		1	
Breastfeeding *(see also Postpartum)*	a) <1 month postpartum	3*		2*		2*		2*					
	b) 1 month or more postpartum	2*		1*		1*		1*					
Cervical cancer	Awaiting treatment	2		1		2		2		4	2	4	2
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		2		1		2		2		2		1	
Cirrhosis	a) Mild *(compensated)*	1		1		1		1		1		1	
	b) Severe‡ *(decompensated)*	4		3		3		3		3		1	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy												
	i) higher risk for recurrent DVT/PE	4		2		2		2		2		1	
	ii) lower risk for recurrent DVT/PE	3		2		2		2		2		1	
	b) Acute DVT/PE	4		2		2		2		2		2	
	c) DVT/PE and established on anticoagulant therapy for at least 3 months												
	i) higher risk for recurrent DVT/PE	4*		2		2		2		2		2	
	ii) lower risk for recurrent DVT/PE	3*		2		2		2		2		2	
	d) Family history *(first-degree relatives)*	2		1		1		1		1		1	
	e) Major surgery												
	i) with prolonged immobilization	4		2		2		2		2		1	
	ii) without prolonged immobilization	2		1		1		1		1		1	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	
Diabetes mellitus (DM)	a) History of gestational DM only	1		1		1		1		1		1	
	b) Non-vascular disease												
	i) non-insulin dependent	2		2		2		2		2		1	
	ii) insulin dependent‡	2		2		2		2		2		1	
	c) Nephropathy/retinopathy/neuropathy‡	3/4*		2		3		2		2		1	
	d) Other vascular disease or diabetes of >20 years' duration‡	3/4*		2		3		2		2		1	

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Endometrial cancer‡		1		1		1		1		4	2	4	2
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		1		1		1		1		1		2	
Epilepsy‡	*(see also Drug Interactions)*	1*		1*		1*		1*		1		1	
Gallbladder disease	a) Symptomatic												
	i) treated by cholecystectomy	2		2		2		2		2		1	
	ii) medically treated	3		2		2		2		2		1	
	iii) current	3		2		2		2		2		1	
	b) Asymptomatic	2		2		2		2		2		1	
Gestational trophoblastic disease	a) Decreasing or undetectable ß-hCG levels	1		1		1		1		3		3	
	b) Persistently elevated ß-hCG levels or malignant disease‡	1		1		1		1		4		4	
Headaches	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	ii) without aura, age ≥35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	iii) with aura, any age	4*	4*	2*	3*	2*	3*	2*	3*	2*	3*	1*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	COCs: 3 P/R: 1		3		1		1		1		1	
History of cholestasis	a) Pregnancy-related	2		1		1		1		1		1	
	b) Past COC-related	3		2		2		2		2		1	
History of high blood pressure during pregnancy		2		1		1		1		1		1	
History of pelvic surgery		1		1		1		1		1		1	
Human immunodeficiency virus (HIV)	High risk	1		1		1*		1		2	2	2	2
	HIV infected *(see also Drug Interactions)*‡	1*		1*		1*		1*		2	2	2	2
	AIDS *(see also Drug Interactions)*‡	1*		1*		1*		1*		3	2*	3	2*
	Clinically well on therapy	*If on treatment, see Drug Interactions*								2	2	2	2
Hyperlipidemias		2/3*		2*		2*		2*		2*		1*	
Hypertension	a) Adequately controlled hypertension	3*		1*		2*		1*		1		1	
	b) Elevated blood pressure levels *(properly taken measurements)*												
	i) systolic 140-159 or diastolic 90-99	3		1		2		1		1		1	
	ii) systolic ≥160 or diastolic ≥100‡	4		2		3		2		2		1	
	c) Vascular disease	4		2		3		2		2		1	
Inflammatory bowel disease	*(Ulcerative colitis, Crohn's disease)*	2/3*		2		2		1		1		1	

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraceptive (pill, patch, and ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring.

Legend:

1	No restriction *(method can be used)*	3	Theoretical or proven risks usually outweigh the advantages
2	Advantages generally outweigh theoretical or proven risks	4	Unacceptable health risk *(method not to be used)*

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

For full access, visit:
https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html

Do all pregnant women have health coverage for LARC?

- Pregnant women who have Medicaid should be able to receive LARC during their hospital stay and after discharge
- Women with private insurance should check with their insurer
- Providers should check women's insurance before offering these methods and communicate that they may gain access to this method after discharge through the health department or Federally Qualified Health Centers (FQHCs) for low or no cost

Do expulsion rates increase with immediate postpartum insertion?

- Expulsion of LARC following immediate postpartum insertion is higher than insertions at other time points, however, the cost-benefit of providing these methods is great since the majority of women fail to return for follow-up appointments

What are the side effects of LARC?

- Most women discontinue LARC because of:
  - Irregular bleeding
  - Nausea
  - Depression or anxiety
  - Headaches

ACOG, 2012

Does LARC Affect Breastfeeding?

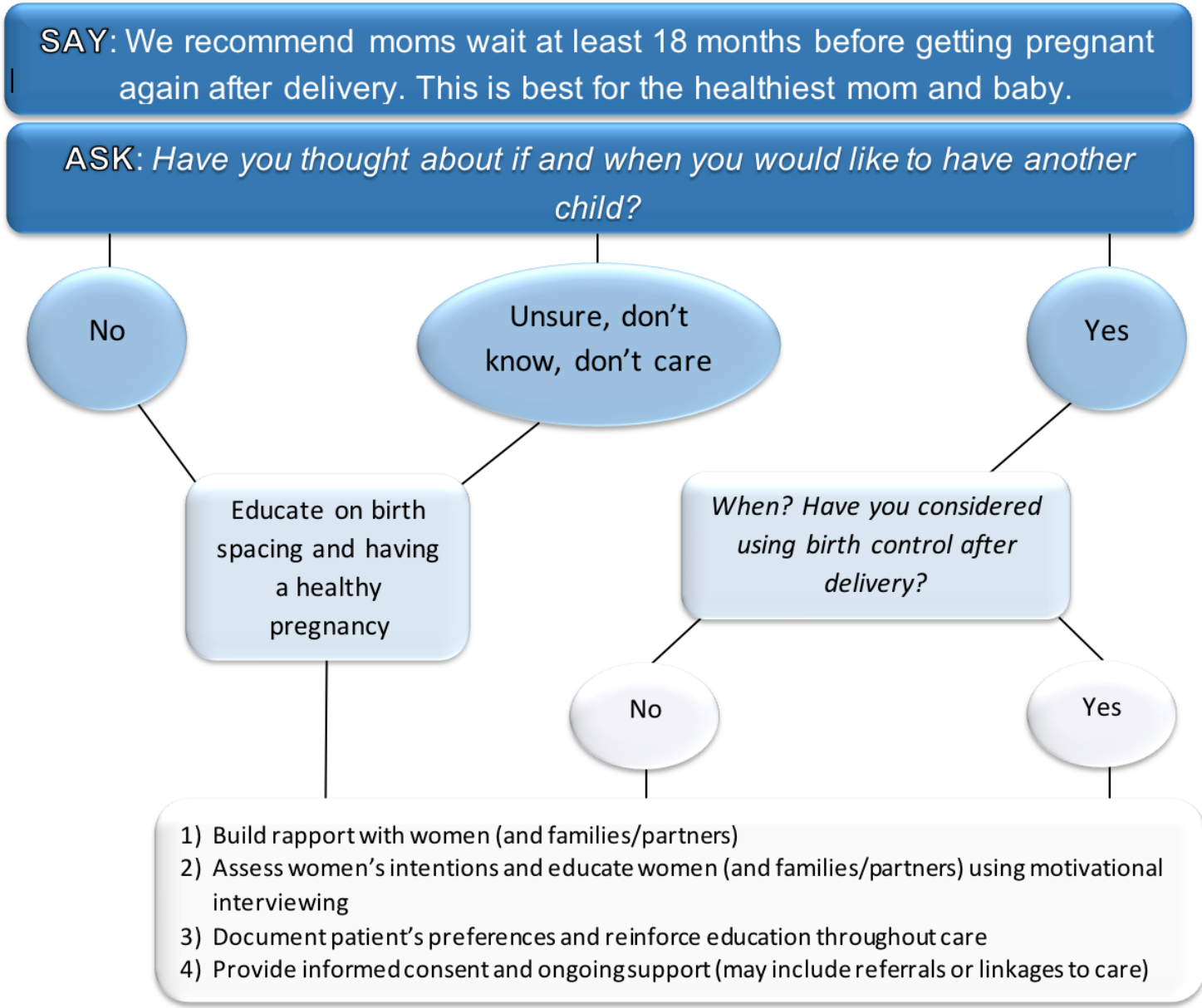
- Progestin-based contraceptives are safe for breastfeeding moms and babies
  - A systematic review of 43 studies showed no evidence of adverse effects (Kapp et al., 2010)

- Immediate postpartum LARC do not increase risk of adverse events

  (i.e. poor infant growth and development) (Shaamash et al., 2005)

Partnering to Improve Health Care Quality
for Mothers and Babies

SAMPLE MATERIALS


SAY: We recommend moms wait at least 18 months before getting pregnant again after delivery. This is best for the healthiest mom and baby.
ASK: Have you thought about if and when you would like to have another child?
No
Unsure, don't know, don't care
Yes
Educate on birth spacing and having a healthy pregnancy
When? Have you considered using birth control after delivery?
No
Yes
1) Build rapport with women (and families/partners)
2) Assess women's intentions and educate women (and families/partners) using motivational interviewing
3) Document patient's preferences and reinforce education throughout care
4) Provide informed consent and ongoing support (may include referrals or linkages to care)

Consent for Immediate Postpartum Intrauterine Contraceptive Insertion

Why is birth control important after having a baby?

The return to fertility after having a baby can be unpredictable. You may be able to get pregnant before your next period even begins. Using birth control to help plan for your future family is important. Waiting at least **a year and a half** (18 months) before you get pregnant improves your health and the health of your next baby. For example, by waiting to get pregnant you can decrease the risk of health problems, such as having a baby too early (preterm birth), or having a baby who has health issues (growth and development; birth defects).

What is an intrauterine device (IUD)?

An intrauterine device (IUD) is a very effective birth control method that is made of a T-shaped plastic rod that stays in your uterus. There are 2 types of IUDs available:

- Copper IUD (**Paragard®**): Contains no hormones, works for up to 10 years
- Hormonal IUD (**Mirena®, Liletta®, Skyla®, Kyleena®**): Provides a low dose of a hormone (progestin), works for up to 3- 7 years, depending on which device you choose.

Once the IUD is placed, it prevents pregnancy in over 99% of women who use it, similar to getting your tubes tied. The IUD can be removed at any time, and you can get pregnant right after it is removed.

Additional Resources

- For more resources, see…

[FPQC Access LARC Toolbox]

References

American College of Obstetricians and Gynecologists. 2016. "Optimizing Postpartum Care." Retrieved (https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care).

American College of Obstetricians and Gynecologists. 2015. "Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy."

American College of Obstetricians and Gynecologists. 2016a. "Collaboration in Practice: Implementing Team-Based Care". Washington, DC. Retrieved (https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care).

American College of Obstetricians and Gynecologists. 2016b. "Contraceptive Counseling." Retrieved (https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements/Contraceptive-Counseling).

American College of Obstetricians and Gynecologists. 2009. "Informed Consent." Retrieved (https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent).

American Medical Association. 2012. "The AMA Code of Medical Ethics' Opinions on Informing Patients". *AMA Journal of Ethics. 14*(7). 555-6. *Retrieved March* 1, 2018. http://virtualmentor.ama-assn.org/2012/07/coet1-1207.html

Dickerson, Lori M. et al. 2013. "Satisfaction, Early Removal, and Side Effects Associated with Long-Acting Reversible Contraception." Family Medicine 45(10):701–7. Retrieved February 6, 2018 (http://www.ncbi.nlm.nih.gov/pubmed/24347187).

Guttmacher Institute. 2015. "Contraceptive Use in the United States." (1–4). Retrieved March 27, 2016 (http://www.guttmacher.org/pubs/fb_contr_use.html).

Institute of Medicine. 2001. No Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC. Retrieved (https://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the).

Kapp, N., Curtis, K., & Nanda, K. 2010. "Progestogen-only Contraceptive Use Among Breastfeeding Women: A Systematic Review". *Contraception*, *82*(1), 17-37.

Maternal and Child Health Bureau. 2013. "Pregnancy Spacing." Child Health USA 2013.

Office of Disease Prevention and Health Promotion. 2016. "Family Planning Healthy People 2020." Retrieved March 24, 2017 (https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives).

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. 2005. Contraception. 72:346–51

Sok, Christina, Jessica N. Sanders, Hanna M. Saltzman, and David K. Turok. 2016. "Sexual Behavior, Satisfaction, and Contraceptive Use Among Postpartum Women." Journal of Midwifery & Women's Health 61(2):158–65. Retrieved February 5, 2018 (http://www.ncbi.nlm.nih.gov/pubmed/26849286).

UCSF Bixby Center for Global Reproductive Health. n.d. "Intrauterine Devices and Implants: A Guide to Reimbursement. Removal". Retrieved from http://larcprogram.ucsf.edu/removal