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REVIEW

Shared Decision-Making: The Way Forward for Postpartum Contraceptive Counseling

Brooke W Bullington[1,2], Asha Sata[3], Kavita Shah Arora[3]

[1]Department of Epidemiology, Gillings School of Global Public Health, University of North Carolina, Chapel Hill, NC, 27516, USA; [2]Carolina Population Center, University of North Carolina, Chapel Hill, NC, 27516, USA; [3]Department of Obstetrics and Gynecology, University of North Carolina, Chapel Hill, NC, 27516, USA

Correspondence: Kavita Shah Arora, Department of Obstetrics and Gynecology, University of North Carolina, 3031 Old Clinic Building, CB 7570, Chapel Hill, NC, 27599-7570, USA, Email kavita_arora@med.unc.edu

Abstract: There are multi-level barriers that impact uptake of postpartum contraception and result in disparities, including clinical barriers such as provider bias. Fortunately, clinicians have direct control over their contraceptive counseling practices, and thus reducing structural barriers is actionable through high quality contraceptive counseling that equips patients with the knowledge and guidance they need to fulfill their reproductive desires. Yet, many commonly employed contraceptive counseling strategies, like One Key Question and WHO tiered contraceptive counseling, are not patient-driven, do not account for the important nuances of contraceptive choices, and are not focused specifically on the postpartum period. Given the history of eugenics and reproductive coercion in the US, supporting patient through their contraceptive decision-making process is especially vital. Additionally, contraceptive preferences vary based on patient-level factors and fluctuate over time and counseling should account for such differences. Shared contraceptive decision-making occurs when patients provide input on their values, desires, and preferences and clinicians share medical knowledge and evidence-based information without judgement. This approach is considered the most ethically sound form of counseling, as it maximizes patient autonomy. Shared decision-making also has clinical benefits, including increased patient satisfaction. In sum, shared contraceptive decision-making should be universally adopted to promote ethical, high-quality care and reproductive autonomy.

Keywords: postpartum contraception, shared decision-making, contraceptive counseling

Introduction

Short interval pregnancies are associated with maternal and neonatal morbidity and mortality.[1] To lengthen interpregnancy intervals and therefore prevent poor pregnancy outcomes, provision of postpartum contraception is essential.[2,3] Medical societies around the world, including the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and World Health Organization (WHO), acknowledge the importance of access to a variety of contraceptive methods during the postpartum period, including long-acting reversible contraceptives (LARCs) and permanent contraception.[4–7]

Yet, there are multi-level factors and barriers that impact uptake of postpartum contraception among those who desire to prevent pregnancy.[8] These include factors at the level of the individual patient such as preferences, partner's views, and familial and cultural context, among others. These also include barriers at all levels of the medical system, such as patient and clinician knowledge, practice-related barriers, and insurance and payment. Further, social and structural determinants of health also impact fulfillment of desired postpartum contraception.[9] These multi-level factors and barriers have contributed to marked racial, ethnic, and socioeconomic disparities in postpartum contraceptive use. Barriers to care both act alone and interact with each other, such that individuals who desire postpartum contraception may be differentially impacted based on their patient-level characteristics. For example, insurance status has frequently been noted as a barrier to contraception, though this has been partially mitigated by recent expansions of Medicaid.[10–13]

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However, racial and ethnic disparities to access to postpartum contraception remain, even among those similarly covered under Medicaid insurance.[14]

A thorough review of the multi-level factors and barriers impacting postpartum contraception is outside the scope of this manuscript. Many of these factors and barriers are outside the purview of the individual clinician caring for the individual patient in the context of a therapeutic relationship. However, high-quality contraceptive counseling and shared decision-making is within the purview and scope of this therapeutic relationship and can reduce barriers for individuals seeking postpartum contraceptive care. Counseling can equip patients with the knowledge and guidance they need to understand their options and choose a method that works best for them.

Commonly Employed Contraceptive Counseling Strategies

In the past few decades, a variety of standardized contraceptive counseling frameworks, including One Key Question (OKQ) and the WHO tiered contraceptive counseling approaches, have been developed and integrated into clinical care. The OKQ contraceptive counseling approach calls for the integration of one question about pregnancy intentions in routine prenatal care: "Would you like to get pregnant in the next year?" This method allows people to respond with a range of options, including "yes", "no", "I'm unsure", and "I'm okay either way" to account for potential pregnancy ambivalence. It is designed to increase access to patient-centered contraceptive counseling by utilizing a variety of follow-up care plans recommended to different women based on their pregnancy intention.[15] Some studies have found that the OKQ approach leads to patient and clinician satisfaction. For example, one study found that in primary care settings, implementation of OKQ increased patient satisfaction.[16] This study also reported that 80% of care clinicians reported feeling that they were able to address a patient's healthcare needs during visits where OKQ was deployed.[17–19]

While the OKQ approach is streamlined and generally met with positive feedback, it also has drawbacks. First, OKQ was not designed for the postpartum period. To our knowledge, there are no studies that focus on OKQ in the postpartum period. Thus, focusing exclusively on pregnancy intentions for that year with OKQ may have limited utility. Additionally, due to increased risk for maternal and neonatal morbidity and mortality, ACOG suggests that women should avoid interpregnancy intervals less than six months and should be counseled on potential risks associated with intervals less than 18 months.[20] OKQ was not designed for postpartum permanent contraception and therefore does not consider the aspects of contraceptive counseling important for postpartum care, such as recommended interpregnancy intervals. Additionally, other limitations of OKQ studied in non-postpartum settings are also relevant for postpartum contraceptive counseling. Clinicians may be reluctant to adopt OKQ because of its potential to influence workflow, by increasing time concerns, slowing room turnover, or increasing visit time.[16,16] OKQ may also be viewed by clinicians as a distraction from the main goal of the appointment. For example, one family medicine physician noted that asking the OKQ, "totally derailed the visit".[16] This may also be true of postpartum care visits.[16] Finally, OKQ is based on the assumption that patients should know and understand their own pregnancy intentions and that all pregnancies should be planned. Yet, a growing body of literature highlights the issues with measuring pregnancy intentions, especially as a binary measure.[21–23]

The other commonly used approach, WHO tiered contraceptive counseling, is centered around prioritizing contraceptive efficacy. Employing this approach, clinicians emphasize the most effective contraceptive methods first, like long-acting and permanent methods, followed by other contraceptive methods in order of their efficacy. Advocates of this approach argue that efficacy is often one of the contraceptive attributes most important to patients, and thus stress the importance of providing information about efficacy first and foremost to promote informed method choice.[24] Additionally, educating and raising awareness about the most effective methods may reduce uptake barriers for people who want to use these methods. This is because accessing LARCs can be limited by structural barriers to care such as access to trained clinicians and finances.[24]

While some view the focus on efficacy of tiered counseling as unambiguously important, others caution against this approach. Some scholars argue that while efficacy is a crucial contraceptive attribute for some, ranking and promoting methods based on efficacy rather than side effects or other contraceptive attributes important to a given individual may inhibit person-centered care.[25] The sole emphasis on efficacy may result in counseling that is too direct and ultimately impedes upon reproductive autonomy. Patients may feel pushed into choosing LARCs, which is especially problematic

given that LARC methods are clinician dependent and thus cannot be discontinued without removal from a trained clinician.[26,27] Additionally, clinician biases may become particularly prominent during tiered counseling, with certain methods more often promoted to specific types of patients based on sociodemographic characteristics, such as race, age, and socioeconomic status.[27] Both advocates and critics of WHO tiered contraceptive counseling have emphasized that tiered counseling should be implemented in conjunction with other counseling approaches.[24,27] This is especially important during postpartum counseling, when other considerations such as breastfeeding, new medical contraindications from pregnancy, fluctuations in contraceptive decision-making, and changing factors that are weighed to arrive at a contraceptive choice need to be included in counseling sessions.[28,29] In practice, however, clinicians often have the WHO tier-based efficacy or similar charts posted, which reinforce this potentially problematic approach.

Both One Key Question and the WHO tiered counseling approaches contain elements that contribute to high-quality contraceptive counseling. OKQ is driven by a patient's reproductive goals, which is vital for person-centered care. WHO tiered counseling informs patients about method efficacy, which many consider a highly important aspect of counseling and decision-making.[30] However, using one of these approaches alone could limit quality of care, especially for postpartum people. To ensure that patients can make holistic, informed decisions about what methods are right for them, clinicians should conduct counseling driven by the patient's desires that also provides information about contraceptive attributes beyond efficacy, including duration, side effects, hormones, and route of administration.

The overarching goal of contraceptive counseling should be to provide patient-centered care that allows an individual to fulfill the choice that best fits their reproductive needs, whatever that choice may be. This is true both inside and outside of the postpartum period. To achieve this, we must understand the factors and processes that influence why a patient chooses a contraceptive method. Leaving room for nuance and individualization in the counseling process is necessary to allow women to make the best decisions for themselves. Gaining a deeper understanding into the decision-making process is vital to promote autonomy, dismantle barriers, and reduce disparities.

Historical Context and Present-Day Biases

When discussing contraceptive counseling practices, it is necessary to acknowledge the history of paternalistic medical practices, eugenics, and contraceptive coercion that targeted low-income women and women of color. This historical context contributes to ongoing disparities in contraceptive access, uptake, and autonomy. Stratified reproduction continues to be highly prominent in the US, with the fertility of women of color systematically devalued. This impacts access and experiences with reproductive health care, including contraceptive counseling.[31]

There are numerous examples of present-day stratified reproduction. For example, one judge in Tennessee offered reduced sentences for people who would adopt birth control methods, thus coercing people who are incarcerated to use contraception regardless of their desires.[32] In many states, patients with Medicaid insurance desiring permanent contraception are required to undergo a complicated consent process, including a 30-day waiting period, whereas women with private insurance are not required to wait prior to receiving their autonomously-desired method of contraception.[33] Also, programs and policies that promote LARCs at all cost, especially for low income women and women of color, inhibit reproductive autonomy and devalue the reproduction of certain types of women.[26,34] Additionally, there is well-documented implicit bias in contraceptive counseling. Clinicians often offer differential contraceptive options on the basis of race, ethnicity, and socioeconomic status.[35,36]

Implicit bias among clinicians also leads to inequities, with women recommended certain types of contraceptive methods based on their sociodemographic characteristics. Black and Latina women, as well as low income women, are more likely to report that they are advised to limit the amount of children they have compared to their white, high-class counterparts.[37,38] Low income Black and Latina women are more likely to be recommended long-acting methods compared to white women with low income status, indicating that racial disparities persist even within socioeconomic categories.[38] When patients are pressured to adopt a contraceptive method that does not align with their goals, their long-term contraceptive needs are often not met. Rather, they use the method they adopted for a short period of time and subsequently discontinue use. This cyclical process leads to further distrust in the health system and may ultimately prevent a patient from fulfilling their reproductive goals.[39,40] Women often disclose that they were not satisfied with their contraceptive counseling experience because they felt that they were unable to talk openly about their concerns and did

not feel comfortable with their clinician.[39,40] Additionally, studies have shown that physicians are most willing to sterilize older, postpartum, Black or poor women.[41–44] Such implicit biases and gendered racism contribute to increased mental and physical stress which results in racial disparities in maternal morbidity and mortality.[45,46]

This history and contemporary experience has resulted in contraceptive disparities. In terms of contraceptive uptake, Black and Hispanic women are less likely to use a contraceptive method compared to white women.[47] Additionally, Black and Hispanic women more commonly use less effective contraceptive methods.[14] Finally, studies have found that Black and Hispanic women are more likely to plan for postpartum contraception, yet have lower rates of adopting their chosen method after birth and have higher rates of contraceptive nonuse, failure, and unplanned pregnancies compared to white women.[48]

Contraceptive Decision-Making

Reproductive choices are often very personal. Therefore, contraceptive decision-making varies substantially by patient-level factors and preferences may change over time.[28,49] Clinicians should acknowledge these nuances and be accepting of their patients as they navigate their contraceptive decision-making, both inside and outside of the postpartum period.

Interpersonal and systemic barriers to care, such as inconvenience, cost, and/or stigma from partner, family, community member, or clinician may prevent an individual from choosing and accessing their preferred contraceptive method. When these barriers are removed, studies show that patients can more freely fulfill their preferences. For example, the contraceptive CHOICE study reported that once barriers such as cost, access, and knowledge were removed, 75% of participants chose long-acting reversible contraception. In the same study, LARC users were more likely to continue their method for both 12 and 24 months compared to users of short-acting methods.[50] When barriers are removed and patients are given a wide variety of choices, they will use a variety of contraceptive methods.[51]

During pregnancy and the immediate postpartum period, some barriers to contraception, such as insurance coverage and access to care, may be mitigated. Medicaid for pregnant people allows coverage to pregnant individuals who otherwise would not have insurance, thus reducing systemic barriers to care. In some states, Medicaid insurance has been extended to 12 months postpartum, as recommended by ACOG, to improve health outcomes for the patient and her neonate. Additionally, a pregnant or postpartum patient will have more interactions with the health system and therefore will have more opportunities to discuss contraception options, potentially with a variety of clinicians. Thus, the postpartum period provides a unique opportunity for people who desire contraception to access counseling and methods they need to prevent future unwanted pregnancies.

Contraceptive choices are not stagnant, as individual desires, preferences, and knowledge will change over time. What information a patient has, where that information came from, and how certain they are about the choice they made may all contribute to fluctuation in contraceptive desires. Beyond fluctuations in knowledge, individual preferences and reproductive goals change over time. For instance, during and after pregnancy, contraceptive preferences and choices often change. Prior work has demonstrated that as few as 12% of patients desire the same category of efficacy method of contraception from prenatal care through the postpartum period.[49] This is because the richness and complexity of factors weighed such as efficacy, hormones, side effects, route of administration, ease, cost, etc. are also not static considerations. Individuals who impact and influence choice also may change during the course of a pregnancy and postpartum period.[29] Additionally, once a person has experienced pregnancy and birth, their desire for children may vary. Also, a contraceptive method that worked well for a person prior to pregnancy may no longer be a feasible option in the postpartum period, especially among people who develop contraindications to estrogen during pregnancy. Thus, longitudinal counseling that acknowledges and accepts changes in preferences and needs and correctly views contraceptive decision-making as a journey rather than a static process is ideal.[52–54] It is critical to begin the shared decision-making conversation in antepartum care, continue to revisit throughout pregnancy, and discuss and implement prior to postpartum discharge from the hospital. This is imperative given the barriers to outpatient postpartum care including social determinants of health compounded by potential expiration of insurance for some patients, policy-level barriers to permanent contraception, structural factors limiting access to LARCs, and misinformation regarding the safety of contraceptive methods postpartum. However, the postpartum contraceptive journey should not end at time of hospital

discharge and the conversation should continue at the outpatient postpartum visit and beyond given this known fluctuation in choice and decision-making.

Shared Decision-Making

Contraceptive counseling impacts decision-making. Thus, clinician-level factors that influence counseling play an important role in contraceptive choice. Fortunately, clinicians have direct control over their contraceptive counseling; therefore, clinician-level barriers to high quality, comprehensive contraceptive counseling are actionable. Under the shared decision-making framework, contraceptive counseling is a collaboration between patient and clinician. This is unlike in more traditional models of paternalistic contraceptive counseling, where power in the therapeutic relationship is only given to the clinician and information flows in only one direction. Shared decision-making acknowledges the patient as the expert in their own life, values, preferences, and reproductive goals – and the clinician as the expert in the medical facts. Thus, during this bidirectional conversation, patients will provide input regarding their personal values and desires, while clinicians will share medical knowledge and evidence-based information, including contraceptive attributes like efficacy and duration of use of various methods, without judgement. In the postpartum setting, the clinician will also share aspects of contraception specific to the postpartum period, including the impacts of breastfeeding on contraceptive choice and contraceptive choice on breastfeeding, any contraindications to estrogen that may have developed during pregnancy, and recommended interpregnancy intervals. The patient and the clinician will therefore work together to discover the option that best fits the reproductive needs of the patient.

Shared decision-making is considered the most ethically sound contraceptive counseling framework and thus should be adopted for postpartum contraceptive counseling. Shared decision-making has been defined as

> an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences[55]

It is the recommended approach from ACOG and AAP.[56,57] This is because it maximizes patient autonomy in their reproductive decision-making while also leaning into a clinician's duty to inform and counsel. It has been described as having three primary components – (1) choice talk, (2) option talk, and (3) decision talk.[58] Choice talk involves informing patients about the various options available for contraception, options talk refers to exploring preferences and providing support, and decision talk continues to focus on preferences to move to a decision.

Developing a close, therapeutic relationship between patient and clinician can allow for comfort, trust, and openness, giving space for the patient to guide the conversation honestly. This may be especially applicable during the postpartum period, as clinicians may have the opportunity to develop relationships with patients through repeated interactions during prenatal care and delivery. Clinicians should also prioritize patient choice, allowing them to decide what option is best for them after gathering the necessary evidence. To achieve this, clinicians should be objective, non-judgmental, and focused on providing accurate, relevant information. Shared decision-making also allows clinicians to build rapport with their patients and share the necessary information on various methods, which has been shown to increase contraceptive uptake. Patients who like and trust their clinicians may have increased satisfaction with their visit. One study found that low income women who were more satisfied with their last gynecologist appointment were more likely to use contraception.[59] Additionally, shared decision-making allows clinicians to share necessary details on potential side effects. Having more information about side effects prior to adoption of a method has been associated with improved outcomes in both high and low- and middle- income countries.[60,61]

Given that shared decision-making is guided by the patient, it is important to note that it's not possible for contraceptive counseling to be fully standardized or scripted and no two shared decision-making conversations will be the same. For example, a postpartum person's experience with pregnancy or delivery may impact their contraceptive desires, and a clinician should tailor counseling to their specific needs (option talk). The goal of counseling is therefore to have an individualized, nuanced conversation. However, given the widespread implicit bias in contraceptive counseling, standardizing some pieces of shared-decision making may be a useful tactic (choice talk). For example, clinicians could elicit patients' values and preferences in a standardized way or share the same medical information on methods and

interpregnancy intervals to all patients. This could potentially help pinpoint patients' individual preferences and ensure that there are no racial or socioeconomic differences in the way counseling is completed.

Further, non-directive and unbiased counseling is especially important for counseling on long-acting and permanent contraceptive methods given the history of eugenics, need for clinician engagement for removal, and/or permanence. This is especially important given the push in recent years for immediate postpartum LARC insertion.[62] While access to desired long-acting contraceptive methods is imperative for people to make autonomous decisions about their reproductive lives, it's also important to acknowledge potential pitfalls of LARC-centered counseling.[26,63] Research indicates that some postpartum people lack autonomy in contraceptive decision-making after receiving counseling on immediate postpartum LARC, either because they lack informed choice or felt pressured by a provider to uptake a long-acting method.[64] Additionally, data collected from postpartum LARC key-informants suggests that while many aspire to administer patient-centered, autonomy-focused contraceptive care, they still often express biases, including focusing on the healthcare system needs above the individual patient.[65] Clinicians should therefore center conversations around postpartum LARC or permanent contraception on equity and autonomy, ensuring that their patients have informed, full, and free choices when deciding if they want to use contraception and, if so, what method they ultimately adopt.[66,67]

Patient and clinician-level factors, like individual preferences or clinician implicit bias, should be carefully considered in the implementation of shared decision-making. Prior to contraceptive counseling, clinicians should attempt to understand and acknowledge the ways in which their biases could impact their counseling. This would help ensure that differences in uptake between patients would be due to individual desires, rather than subtle coercive behaviors from the clinician. Additionally, the larger healthcare system and the barriers it may pose that impact contraceptive decision-making are important context in the operationalization of patient-centered counseling, as clinicians can help their patients navigate a complicated healthcare system and discuss the need for follow-up, cost, and other relevant issues regarding access to a desired method.

Beyond being the most ethical approach to contraceptive counseling, shared decision-making also has clinical benefits, including patient satisfaction and improved use of contraception. Though, to our knowledge, there is limited research specifically into shared decision-making during the postpartum period, many of these benefits are likely applicable. One study reported that patients who engaged with shared decision-making were more satisfied with their decision-making process than patients who decided about their methods for themselves or patients for whom the clinician decided their method for them. In this study, shared decision-making also led to higher satisfaction with the method itself.[68] Another study reported that patients who said that a clinician shared a preference for which method they should adopt had no difference in satisfaction with their contraceptive decision-making compared to patients who underwent shared decision-making. However, these patients had lower satisfaction with the method they ultimately chose compared to those who decided through a shared decision-making process.[68] Yet, despite this potential to improve quality of care, shared decision-making is not the most commonly used contraceptive counseling approach. One study in the US reported that less than 25% of contraceptive counseling appointments use the shared decision-making technique.[68] According to this study, the foreclosed approach, in which the clinician discusses a few methods and allows the patient to freely decide without further clinician input, is most common.[68] While this approach is patient-guided, there is no shared ownership of the process. Thus, patients are presented a cafeteria-style menu of options without individualized context. The clinician is not an active member of the decision-making process. This method likely differentially impacts those with less health literacy or agency.

Because shared-decision making is a back-and-forth process between patient and clinician, clinicians should be thoughtful on their relationship with the patient and what they share. Interestingly, a growing body of literature highlights that patients appreciate having their clinician's input during contraceptive counseling. One study found that women are interested in their clinician's input, as long as the input respects their own values and preferences.[69]

Finally, due to the back-and-forth nature of shared decision-making, the approach gives clinicians an opportunity to account and plan for systemic barriers to contraceptive care that may prevent a patient from fulfilling their contraceptive desire. For example, a clinician can gain a deeper understanding of the financial or insurance barriers a patient might face when adopting their method. They could then assist the patient in navigating such barriers or educate on their contraceptive options that may be easier to fulfill.

Conclusion

To promote ethical, high quality, patient-centered care, shared decision-making should be universally employed for contraceptive counseling, including during the postpartum period. This approach combines the benefits of other commonly used counseling approaches like One Key Question and WHO tiered counseling, while also ensuring patient autonomy. Most importantly, shared decision-making is guided by the patient, yet it also allows the clinician to input their expertise and help the patient make the decision that's right for them. Not only is this approach the most ethically sound, but it also leads to high patient satisfaction and improved clinical outcomes.

High quality of care and ethically-grounded contraceptive counseling are both imperative to promote reproductive autonomy. The goal of clinicians should be to enable and empower patients to do what is best for them. This is especially important given structural inequities driven by racism and sexism that prevent people from achieving their reproductive and contraceptive desires. Patients should be able to fulfill their own decisions about contraception, regardless of what those decisions are.

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