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Naima: Hello, everyone. And welcome to the Reproductive Life Planning: Setting Goals for a Healthy Family, Ask the Expert Webinar. I am Naima Cozier with the training team for the Healthy Start EPIC Center and will serve as today's moderator.

We have approximately 60 minutes set aside for this webinar, 30 of which will be a presentation, and the remaining 30 minutes will be for questions and answers. Questions are only submitted via chat which is located on the bottom left corner of your screen. If we do not get to your question by the end of the webinar, we will include all questions in a frequently asked document. As a reminder, this webinar is being recorded. The recording transcript, FAQ document, and slide will all be posted on the EPIC Center website following the webinar.

Before I introduce today's speaker, I'd like to invite everyone's participation during the webinar. So at any point, feel free to chat questions or comments in the bottom left corner of your screen. So now I'd like to introduce our speaker for today. Dr. Jan Shepherd received her MD from Northwestern University, completed a residency in obstetrics and gynecology at he University of Cincinnati, then went on to fellowship in reproductive endocrinology and infertility at the University of South Alabama. She currently serves as a clinical associate professor in obstetrics and gynecology at the University of Colorado School of Medicine, as the medical advisor for the Women's Wellness Connection at the Colorado Department of Public Health and Environment, as an associate medical director of Boulder Valley Women's Health Center in Boulder, Colorado, and finally, as a medical advisor for the Women's Health and Menopause Center in Denver, Colorado.

Dr. Shepherd also has a continuing appointment as an adjunct professor at Florida State University College of Medicine where she was the founding education director for obstetrics and gynecology. She's a nationally recognized speaker on women's health issues and has been invited to give hundreds of talks locally, nationally and internationally. Dr. Shepherd has published numerous papers in peer-reviewed journals, and also taught contraception internationally for USAID.

Before we turn it over to Dr. Shepherd, we'd like to begin with a quick poll. We'd like you to respond to which of the following best represents your role on your Healthy Start program. The options are clinician, case manager, administrator, or

program support. You can take a moment to respond. Give folks another second or so to select your role in terms of the Healthy Start program.

Great. So it's looking like the majority of folks are case managers that are on today's webinar, followed up by administrators. So with that, I'd love to turn it over to Dr. Jan Shepherd.

Dr. Shepherd: Good afternoon. Welcome and thanks for taking time out of your busy day. I know it's a busy day to join us. As you know, we're going to talk today about reproductive life planning. And what I want to focus on is looking at this as a tool that can help us help our clients set goals that will lead to healthy families. So these are my objectives. I'm going to spend about ten minutes talking about the basics of reproductive life planning. And then we'll get to the fun part because I think what we all care about is our clients and the women, men, babies even, that we deal with every day. So we'll move on after ten minutes of basically didactic presentation, so looking at maybe some typical clients and how reproductive life planning might fit in their lives.

But for this part I want to talk, first of all, about what we mean by reproductive life planning and how contraception, preconception care, and interconception care fit into the reproductive life plan. We'll also summarize with the benefits of reproductive life planning. So we'll start out with our basic definition. And notice that this definition comes from the CDC who is really promoting the concept of reproductive life plan. And so they define it as a set of personal goals, about having or not having children, basically pointing out that we can all choose.

But once we make that choice, the second part of the plan is how are we going to achieve those goals. And the CDC says that everyone should make a reproductive life plan. And your plan should be based on, makes perfect sense, your personal values and resources. So I imagine that most people on this call have heard of the one key question initiative.

Dr. Brian Jack in his wonderful webinar a couple of months ago about preconception care talked about this. One key question is an evidence-based practice so it's also in the evidence-based database at the Healthy Start website. But basically, this is something that has been researched and it's been discovered that if we ask women, every woman every year, "Do you plan to get pregnant this year?",

we can get more successful contraception and more successful preconception care depending on what her answer is. So basically we can anticipate what her needs are and help her over the coming year. Again, evidence-based, this works. And this is basically a shortcut, a very simple way of doing reproductive life planning.

The difference between this one key question and the CDC initiative is that the CDC initiative focuses on a woman's whole reproductive life, know women are fertile for like 40 years of their life. And the CDC plan is: Do you want to have children? When do you want to have them? How many do you want to have over your whole life span? And of course both of these initiatives, at the bottom, are basically about being intentional, about preparing for and starting pregnancies.

Now, I'm sure many of you see what I see every day in the clinics where I work, and that is there are so many women who really think pregnancy is just something that happens. And they really feel very little control over it, very little choice. The idea of both of these initiatives - and today we're talking about the reproductive life plan - the idea is when we ask women these questions, when we have women think about it, they begin to understand that they do have a choice and that they can prepare for any pregnancies that they desire. And we know, of course, again from Dr. Jack's wonderful webinar, that planned pregnancies are the healthiest pregnancies, and that's of course what we want for our clients.

So this lovely quote comes from the CDC as well. And, basically, the point of this quote is that reproductive life plan is only part of a woman's life plan. Of course children are just one part of a woman's life. And this quote reads "Women's lives are rich and complex. And the possibility of pregnancy is only one factor affecting women's health choices." So when we start talking reproductive life planning, we're really looking at the total life plan and empowering women, helping them understand that they do have choices and they can control their lives.

So when we counsel women on this subject, we want to emphasize that you can set your goals and can figure out how you would like to reach them. We want to talk about dreams and what would you like your life to be like in five years, ten years. They're few of us ever quite achieve what those dreams were. But we can have them and we can come as close as we want, as close as we're able to anyway - how much education do we want, what kind of work do we want to do.

So the reproductive life plan sits in the middle of the basic life plan of our patients. We said the one key question, we talked about what that question was: Do you want to get pregnant this year? For the reproductive life plan, the CDC recommends we ask three questions. But it's still really only three questions. And those questions are: Do you want to have children or more children if you're interconception? How many and when? Three simple questions - but by asking a woman these questions, we get her thinking. And we get her understanding that she can make some choices here and she can figure out how this fits in with her basic life plan.

The CDC recommends that we ask these three questions to every woman of reproductive age every year. And that's partly so that she keeps thinking and keeps moving towards her goals. But the other reason is, of course, you know the old saying, "A woman's privilege is to change her mind", and we want to be sure that when we ask these questions, people don't feel they're committed to whatever they say. Sure, she can change her mind, but we just want her thinking about it, so every woman every year.

One of the things I like about the reproductive life plan, I've worked in family planning a lot in my life if you heard, as you heard Naima describe, but when we talked about family planning, basically we're talking about contraception or how not to get pregnant. It's kind of a euphemism. I like the reproductive life plan because it turns that on its head. And it's about planning for having children. It's looking at it that way. You want children? When would you like to have them and how can we get you to that time most successfully? How can we protect you from an unplanned pregnancy before you're ready? And how can we help you stay healthy so that when you are ready you will have a healthy pregnancy?

I think when we talk about the reproductive life plan, it becomes pretty obvious that there are two components: one for when somebody is not wanting to get pregnant right now and one for when she is. When somebody says, "Well, I don't want to get pregnant for several more years or at least not this year or maybe never", of course the first component's gonna be helping her with contraception so that she can reach that goal she gave us. And the second component is going to be helping her stay healthy and preserve her fertility so she can have children when she's ready.

So let's look at both of those components just a little bit. One of the nice things about the reproductive life plan concept, and it's shown up in the evidence now, is that when we talk to women about this and we encourage them to make a plan, and they say, "I don't want to get pregnant this year or for a few years", they're more likely to use whatever contraceptive they choose successfully because they feel a little more committed to it. They thought it through.

When we start talking about contraception, of course, we're gonna bring up the various methods. Whatever method a woman chooses is what's going to work best for her. But we want to help her understand if she's had problems in the past with the method, it might not be the best choice this time. And of course we have lots of choices. One of the choices that people are talking a lot about these days, big trend in contraception right now, the biggest one I guess would be long acting reversible contraception. We call it LARC. And it's any method that lasts three years or longer. The advantage of these methods is, number one, you don't have to remember something or do something all the time to reach your goal of not getting pregnant if your goal is a fairly long time.

The second thing is that all of these methods are reversible immediately. So you can always change your mind with these methods. For example, you have somebody that was thinking maybe she was done, maybe she would get her tubes tied but she's not sure. Well, these are perfect because they're as effective as that, but if she changes her mind, then she can get pregnant again immediately.

The biggest advantage of the LARC methods, though, is that they are the most successful thing that we have. So if somebody really is serious about not getting pregnant, they can be a very good choice. Speaking of choice it's a big study called the Choice Project that taught us that these are our most effective methods. This is a study of like 9000 women. And they were each given a choice of what contraceptive they wanted to use, followed for three years to see how successful the various methods were. And you see that pills failed over 4% of the time. But the LARC method, 22 times more effective. So we have to pay attention to that for women who really don't want to get pregnant at the current time, remembering they can always change their minds. All of these methods are immediately reversible. And we are talking about what you see here, the IUDs and the implants that goes in the arm, also known as Implanon or Nexplanon.

So part of the person who doesn't want to get pregnant right now, part of our counseling for them of course is contraception and giving her a choice of what contraception would work for her. But the second part is she may want to get pregnant in the future. She may have even told us she wants to. So the second part will be counseling her about safer sex. And again, if she's now told us that she wants children in the future, we want to help her be sure that she can have babies in the future. And that would be avoiding some of our STIs, particularly chlamydia, gonorrhea, that can scar the reproductive system and make it impossible for a woman to have the babies that she'd want. So part of our counseling in the reproductive life plan is safer sex. And the other part, of course, is staying healthy, getting checkups, because even if you don't think you may want children, you may change your mind about this. And we want you to be as healthy as possible should you choose to have children or more children.

Obviously, the second half of reproductive life plan is preconception care. This is for the woman that says, "I would like to get pregnant this year or soon - maybe this month." Then it's time to talk about preconception care or interconception care if she's just had a baby. Preconception care, as you heard from Dr. Jack, focuses on taking steps now to protect the health of a baby that you will conceive in the future. And I'm not going to say a whole lot about this because Dr. Jack covered it so well, but just to summarize, when someone tells us they want to get pregnant soon, then we have the opportunity to talk to them about all these things, to help them avoid toxic substances. And I'm talking about things like smoking and drinking and recreational drugs.

To be sure, they're taking prenatal vitamins, especially folic acid to be sure they've been tested for anything they're at risk for, to look at their medical conditions, and particularly if they're diabetic or hypertensive to get those conditions under control before pregnancy and get rid of any medications they may be on that could be harmful to a pregnancy. We know that with good preconception care and taking care and covering all these bases, women have a lower chance of miscarriage, a lower chance of pre-term delivery, a lower chance of fetal and infant death and morbidity, and a higher chance of being a healthy mom.

So that's what I wanted to say about the basics of reproductive life planning. But let's get to the fun part. Let's look at some cases that we might see. And I see that

not many of you are clinicians, but if you're a case manager I know you've talked to clients. And I believe that you can bring up these subjects, too, with clients that you talk to.

So let's take a look at some clients. And here's a very cute young 16 year old who comes in and you find out that she's newly sexually active and wisely thinking about contraception. So you ask her the questions. And she may not expect to hear these questions from you, because after all she's asking about contraception. But every woman every year, you're going to ask her the three easy questions. Do you plan to have children? And she kind of looks at you funny, like, "Yeah. Of course I do, but not now." But pursue it a little. How many do you think? "Well, two or three, but not now." Well, when? "Not until I finish school." Or at least that's what we hope she would say. So then she's given us some basic information and she's thought about it. Previously she thought, "I want contraception for this partner that I have or I want contraception for this month." But now she's thinking maybe more long term. I really don't want to get pregnant for several years, but I sure do want children someday. And she's verbalized both of those things.

So how can we help her? Well, first of all, hopefully because she has talked about the fact that she doesn't want to get pregnant now, really at all for a while, she'll use whatever contraception she chooses successfully.

And then we will want to bring up LARC with this young woman. And that's taking some getting used to, talking about things like IUDs and the implant which is especially good I think for teens, talking about those with our teens. Because, of course, for a long time we didn't. We weren't sure they were safe for teens, especially IUDs. But now we carried our modern IUD for 25 years, actually 27. And we know they're safe. We know they're immediately reversible should she change her mind and we know, particularly in a teen's sometimes chaotic life, that she's likely to maybe forget some other method, but with this she doesn't have to think about it and she can be protected until the time that she wants a baby. When she wants a baby again, immediately reversible.

Now I say this and why I chose to emphasize this is because the American Academy of Pediatrics has made a major statement back in September encouraging the use of LARC in teens. But I think we need to pay attention to that. And I would

definitely bring it up to this young woman, but, again, whatever works for her. Hopefully she'll be motivated because she understands what her long term goal is. But she also told us she wants babies in the future and I want her to be able to have them. And so we're going to talk to her about STIs, about using condoms with any new partners. She may not stay with this current partner for a long time, and we just want to be sure she stays safe and healthy so she can have those babies she wants in the future.

Okay, here we have another case. And whatever your capacity, you happen to be talking to this young woman who reveals that she's madly in love. She's in a new relationship. And she's on birth control pills, she has been for several years. But you're going to ask her the reproductive life plan questions. And so you do. You say, "Do you plan to have children?" And she says, "Yes." And if so, how many? "Two." When? "Well, very soon, sometime this year." You might not have expected that if you hadn't asked the questions. You might have thought she's in a new relationship and you might have thought she's on birth control pills. She's protected. But she tells you, "Oh no, I was planning to stop them very soon and get pregnant." So it's a good thing you asked the question.

How might we help this young woman out? Well, I think most of us probably on this call are a little older and probably a little wiser than her. And one thing I think that most of us would want to do is explore this idea a little bit for this new relationship. Is it really what you want? Or is it your partner or somebody pushing you? Do you really think your relationship's ready for a baby? Can you afford a baby? Questions like that. But she may say, "Yes, it's our plan. I want to do it." And of course this is her life plan. So fine, we'll support her. And in supporting her, preconception care. Because we asked, we found out she plans to get pregnant soon, and it's time to begin looking into all these things and getting her ready for that pregnancy.

So we want to get her medical history, be sure there's no condition we need to be concerned about, be sure she's not on any medications to be concerned about. We want to be sure her vaccinations are up to date and her checkups are up to date and she's been screened for the important things. We want to be sure both she and her partner are not smoking, drinking or using recreational drugs. And we have a chance to begin those prenatal vitamins and that all important folic acid.

We can talk to her about diet and exercise and then we also want to talk to her about prenatal care. Where's she gonna get it? Does she have a plan? Does she know where to go? Does she know what her insurance situation is? Because we want her to be ready as soon as she's pregnant to get in for early prenatal care. So we can really make the difference and it's because we asked the questions.

Here we have another kind of unique client. She's 22 years old and she comes to us and she's newly married. But we don't even really get a chance to start asking the questions because she reveals to us that her religion prohibits contraception, and she just believes in letting pregnancy happen when it happens and letting God decide. So you might say, "Okay, that's the end of reproductive life plan talk with her." But really it's not. It's really not at all. And, number one, I'm glad she told me that because I know that there are many cultures, many religions, and just many personal attitudes that don't believe in contraception and don't want to use contraception and maybe don't even believe in planning the family ahead like we're talking about - reproductive life planning.

But I'm really glad I found this out, because I basically learned what her reproductive life plan is. And that is that she will have as many babies as God sends her whenever God sends them. And therefore I can help her, too, because what I want to be sure of with her is that she's all the time basically doing preconception care. I need to be sure that she is healthy all the time, not using any medications that could harm her pregnancy, always taking prenatal vitamins and folic acid. She doesn't look like somebody that probably smokes or drinks or does recreational drugs, but who knows. And I want to be sure she's not doing those so I can help her. And I respect her reproductive life plan and I'm glad I found out about it.

Another case, here we have an interconception case. This young woman had a baby six weeks ago, see that cute little baby there. By the way, none of these are real people. I hope you know that. These are file pictures I got from photographers. She's not real, but I'm pretending she's real. She is 22 years old, this little baby that she is breastfeeding we're happy to find out. But we're gonna ask her about her reproductive life plan. "Do you plan to have more children?" And she says, "Yes." And we ask, "When?" And she says, "In a year or two." And then we're really glad

we asked that question because it's very important for her to understand the benefits of spacing pregnancies.

This is one of the big studies that has shown us how important it is to try to space pregnancies at least 18 months apart. That's 18 months from delivery of one baby until the next baby is conceived. And I want to show you the statistics here on that. If you look at that first column where it's circled, babies that are born closer than 18 months apart almost double the risk of pre-term birth, three and a quarter times the risk of low birth rate, and one and a half times the risk of small for gestational age. So we are really encouraging women to wait 18 months between pregnancies. And when we tell a young woman like this - she's got two little babies that she loves and she wants them safe and healthy - she is liable to listen to us and wait the 18 months. And we can help her use any form of contraception that works for her that will help her get to the 18 month mark.

In fact, it turns out that one-third of pregnancies in our country now are closer than 18 months apart. And a big public health initiative is to decrease this to 25% by 2020, it's part of Healthy People 2020. And asking this woman a question, bringing up the 18 months, perfect opportunity to make a difference there.

Okay, we've got another hypothetical patient here. This is another one that you might think, oh, I don't think I need to talk about reproductive life plan to her. But every woman every year, she's 25 years old and you know that she's in a committed relationship to another woman. And in fact, in some states maybe they're even married. So you're gonna ask her the questions, "Do you plan to have children?" And she may be very glad you asked, because people don't think about that for her. But her and her partner, they're thinking about it. They're undecided. So you find that out and you can help her. You can give her resources for adoption. You can give her resources for maybe artificial insemination. Just help her think about it.

And then, of course, if they do decide to have a pregnancy or adopt a baby, one way or the other, healthy lifestyle is going to be real important for being a mom. And if either one of them decides to carry a pregnancy or both of them, they're going to want to do all the measures of preconception care.

I got just a couple more of these. Here we have a little bit of an older patient. She's 35 years old. And she's a career woman, successful career. Maybe she works in one of the Healthy Start sites. She's doing very, very well. And she's married but they've never had children because they have been kind of into their career. But this year she was away at a national meeting and she forgot her pills and she got pregnant. But they talked about it, her and her partner, and boy it just wasn't the time in their careers and so she had an abortion. And you find all this about her and you want to ask her about her reproductive life plan, very important. And so do you plan to have children? And she says "I think so." How many? When? She hasn't really thought it through. And, of course, really good chance to make a difference in her life to help her make a plan.

Number one, maybe she wants a different method of contraception right now if she still isn't ready. Because, of course, birth control pills didn't work out so well for her this year and we sure don't want to have her go through that again. But more importantly, she's 35, and we know that fertility begins to decline at 35, pregnancies are less safe at 35, and she needs to know that. We want to encourage her to really make these decisions about pregnancy in the future and understanding that she cannot wait much longer.

These are just some statistics about that. And that arrow should say greater than or equal to 35. So she's already at some risk for future pregnancies. Fertility decreases every year after 35. Obviously she was still fertile this year, but she doesn't know if that'll continue. There's more complicated pregnancies in older women as well as risk of things like Trisomy 21 which we know is Down's syndrome. So we're glad we asked the questions and hopefully we help this woman out.

Finally, we have to discuss one more. Moving up in the age group, this woman is 45 and she's divorced. She's had three children. And she thinks she might be nearing menopause. Her periods are changing, they're getting a little heavier. So we though know as long as she's got periods, she's still of reproductive age, and we better ask the questions. First of all, maybe find out if she is in a heterosexual relationship, but she says, "Yes." And then, "Do you plan to have any more children?" And she's like, "No way. I had three children a long time ago. But I'm at menopause. I don't have to worry." And of course we're glad we asked the

question, because we have the perfect chance to point out that she is likely still fertile.

I bet you there are many people on this call right now who have known somebody in their 40s who totally were surprised to find out they were pregnant. They thought it was menopause and they got a pregnancy test. So we don't want this to happen to this woman since she's so adamant about not getting pregnant. And she might be a good case, again, for Mark at the other end of the spectrum, because if she got one of those long acting methods, it might take her to menopause. And she'd never had to think about contraception again.

Okay, so that's the women. But I do just have to point out that men are of course also involved in planning families and planning pregnancies. Almost always you have a man involved. And so we need to think about the reproductive life plans of the male partners as well. When the male partner's available, does he want to be a father? How many children does he want? And when would he like to have them? And this quote came from the CDC. Just a lovely website - and I did leave those materials and the links to them available for you - but on the CDC website they talk about making a reproductive life plan with a young man. And his conclusion ends up being, "I'd like to be a father after I finished school and have a job to support a family. And while I work towards those goals, I'll talk to my partner about her goals for a family, and I'll make sure we use an effective method of contraception until we're ready to have a baby." So that's where, of course, we want to go with males as well.

And the preconception care has a role for males as well. And that also is available on the CDC website. But when a couple is planning a pregnancy, the man should stay as healthy as possible, too. The man should be checked. The man needs to avoid tobacco, alcohol, recreational drugs. And we need to look at many of the same things that we looked at with the woman. So we still don't want to forget the guy.

Put those on my list, cases to discuss. And I hope this is kind of showing you the benefits of reproductive life planning. I think the biggest thing is helping women understand that they have choices as far as whether they have children, when to have them, how many to have. Every time we ask those questions, we remind

women of those things. And when we use the reproductive life plan and she says I don't want to get pregnant, hopefully she uses contraception more effectively. She avoids an unplanned pregnancy, and she maintains control over her life. Not only that, we know that unplanned pregnancies are not as healthy as planned pregnancies.

We know that if we ask them their reproductive life plans and they understand they can choose a time and they do choose that time and get preconception care, they will be healthier moms and they will have healthier babies. And, of course, healthier moms and healthier babies lead to healthy family. So thank you very much. We'll be interested to hear some questions.

Naima: Thank you, Dr. Shepherd - great presentation. So we'd like to open it up for questions that can be submitted via chat which is in the bottom left corner of your screen. And so far it looks like we've received one question and it's asking, "Do you have any recommendations for how we can encourage a female participant to schedule this discussion with her partner?"

Dr. Shepherd: Now, that's a good question because it's so often becomes that the reproductive life plan is all about the woman. She's the one that comes in, she's the one that gets asked the questions and answers the questions. But I think what we need to be doing is encouraging male partners to come in with the women. And these days, when women come in for a contraception check or even preconception care, it often does not involve a pelvic exam or even getting undressed. It involved conversation and vital signs and maybe blood work and tests. But it's not at all embarrassing to bring the partner and it's certainly a much better conversation if the partner's there and they can work on this plan together. And, of course, they don't have to answer those questions right now, but they can go home and talk about them. And if they've both been there, they both understand maybe the importance of thinking about these things. So I think the biggest thing is encouraging men to come in with the women.

Now, having said that, I know it's a challenge - certainly a challenge where I work. But I think that it needs to be our challenge. And we need to encourage women to bring their partners with them.

Naima: Thank you, Dr. Shepherd. Our next question, what age does it become an increased risk factor for a man to become a father?

Dr. Shepherd: It's never fair as we know. Life is never fair because men remain fertile and their risks remain low much longer than women's risks. Now, we used to think that men remained fertile and pretty safe all the way through their lifetime. Now we are learning that as men age there's a gradual falloff in fertility, but it's gradual, and it really, for most men, doesn't get to zero. And we are learning that as men get older, little higher risk of birth defects for them, too.

And I don't believe we have a cutoff age. With women, it's easy to look at age 35 and then menopause and we've pretty much got milestones on that. On men we don't. But you need to think that you've got a gradually sloping down line, and so gradually a man is losing some of his fertility and having a somewhat increased risk of having a child with problems. Now, it never approaches what it is with women because men make new sperm all the time. Women have the eggs they're born with. So as women get older, those eggs are getting older, but men are making new sperm all the time. Although as they get older, some of the sperm aren't as healthy.

Naima: Dr. Shepherd, along those lines, we have another question that came in, particularly around males. "Do you have any links for information where we can go and get materials on male reproductive health?" This person also says, "We have the Show Your Love for women, but I haven't had any luck finding things targeted towards males. Looking for resources for male reproductive health."

Dr. Shepherd: I agree with you that we are sorely lacking in that way, that sometimes as women we feel like we don't get paid attention to enough, but I think when it comes to reproductive health, the men are the ones on the short end of the stick here. We haven't paid enough attention to the men. And we're just beginning to do so. So I agree that it's difficult to find resources. The best ones that I know are on the CDC website. And there is excellent information for men as far as preconception care on there and as far as contraception and reproductive life plan, at least the things we've been talking about. But even there it's not as extensive as what they have for women.

Naima: Okay, thank you. Two other questions that are related to LARCs. The first is when did it become safe for young women who have not had a baby to use an IUD?

Dr. Shepherd: That's a good question. And I have to tell you that I get asked that every day in the clinic because the clinic where I work we are using a lot of LARCs, we're using a lot of LARCs out here in Colorado. But a lot of moms and grandmothers are worried about infection with IUDs and that maybe we shouldn't be using them in teens. In our country, we had a real bad IUD back in the 1970s. And that was called a Dalkon Shield and it did cause infection and it did leave infertility in women. And so it made women rightfully afraid and angry, too, I think. And there were a lot of lawsuits about that. The company went under, those kind of things.

And then IUDs made a comeback in the '80s, particularly the late '80s. And there were different designs in many ways. One of the main ways was that the thread is different, but many ways, they're a different design. And they've been studied now all around the world. And these IUDs do not cause infection. Like I said, we have had these IUDs around for 27 years so we would know. They knew about the Dalkon Shield within a couple of years. We now know that our modern IUDs are safe.

Now, the reason why we were afraid to put IUDs in teens before is because we thought, well, if they got an infection and they haven't even had their babies yet, that'd be terrible. And it would be terrible. But now we know that these are safe and they are safe in anybody. And of course with teens we're worried about pregnancies in our very young women, too. So certainly the risk of pregnancy is much greater than the risk of infections, and so IUDs don't even increase that risk. And the risk of pregnancy is big. And, like I said, teens tend to have chaotic lifestyles, miss pills, and have unplanned pregnancies. So that's something that's totally turned around in the last several years. Like it's taking a lot of getting used to. And a lot of people approach this with trepidation. And I understand anybody who does because we used to be so afraid to do that.

And the only thing I can say is the evidence is good. And when the American Academy of Pediatrics came out and made their statement. I thought that was a

pretty strong vote in favor also. So I'm perfectly safe and put a lot of IUDs in teens. There are some now. There's one that's particularly designed for teens in fact. So there's that. But if somebody remains concerned about it, remember we have a third LARC method, the implant. And of course the implant never did have any kind of risk like that. So that's another choice for people whose mom or grandmother says no way. And, like I said, I do understand that, where they're coming from. So if that comes up and they can't see past it, I'm like get the implant done. It's perfect. It lasts three years, the most effective thing we got, and you can get it renewed any time and get pregnant immediately should that be your choice.

Naima: Dr. Shepherd, along those lines, once a LARC is inserted, how long before it becomes effective?

Dr. Shepherd: The LARCs are all immediately effective basically. As long as you time it right in the menstrual cycle, we try to time it right around the woman's period. And then they are immediately effective. And the other flipside of that is when we remove them, person is immediately fertile again, too. And that's very showing that they're just as fertile as if they never had anything with IUDs and the implant both.

Naima: Okay. Our next question asks, "How do you encourage birth spacing with a woman who does not use contraception for religious reasons?"

Dr. Shepherd: Yeah, that's a good one because I'm certainly not going to try to interfere with her beliefs, but remember that breastfeeding can provide really pretty good contraception. So I would encourage a woman like that to breastfeed. And of course you have to breastfeed exclusively which is difficult. But some of my patients who are of that persuasion and don't believe in artificial birth control, some of the very same people that really do feel strongly that breastfeeding is right also. So if you breastfeed on demand, it's really a fairly good method of contraception. And I would say that would be the very best thing to do.

When we say Mother Nature or if we say God, God kind of planned out the spacing of pregnancies with breastfeeding. And breastfeeding is natural and so is that form of contraception. It's called lactational amenorrhea method. I've taught that for USAID in places where they don't have contraception available. It really can work, but you have to breastfeed on demand and regularly.

Naima: And, Dr. Shepherd, along those lines, just a follow-up, how long does breastfeeding act as a contraceptive if you're using that method?

Dr. Shepherd: It's real good for six months. It's real good for the first six months. And then it kind of falls off because you end up supplementing. But as long as you continue breastfeeding, it can help some.

Naima: Great. Our next question, Dr. Shepherd, is around spacing. So the question asks, "How would you approach a young woman who wants to start a family and not space so that they may start careers and go back to school?" So I guess these are young women who are interested in starting a family, but they would like to space so they can start careers or go back to school.

Dr. Shepherd: Yeah, that's difficult. I would still say 18 months. I mean, that's still pretty close. That wouldn't involve too much time away from career. But the other time we see that is, for example, that hypothetical case we talked about, the 35 year old. And she goes home and talks to her husband and they decide they do want a couple of children, and then can she wait 18 months in between? And I have seen some cases like that where they elected to take the risk because they really just want to be sure that they're fertile and can have a couple of kids. So I think we compromise on that. But I think 18 months is reasonable.

And as you saw, the risks are substantial really because those closer spaced pregnancies. So we need to weigh the benefits to the lifestyle which is of course important with the risk to the pregnancy.

Naima: Dr. Shepherd, since you just brought that up, the harm and the risk, could you just review again what are the adverse effects? What harm comes to a woman if she decides not to at least wait the 18 months between pregnancies?

Dr. Shepherd: Can you help me get back to that slide? I think I see it. How do I do it? Trying to pull up that slide again that I showed before. It's working. So this is one of many studies basically that has shown similar data. And here you're looking at pregnancies that were not spaced 18 months apart and pre-term birth, which we know is a significant risk, is almost twice the risk when pregnancies are close. And we know how difficult that can be for that developing infant.

Low birth rate, look at that, three and a quarter times as big. And it makes sense because a woman's body has only a given amount of resources. And if she doesn't replenish them, then what does she have to offer to that next pregnancy? What does she have left? It basically makes sense, and it looks like it's 18 months that it takes the female body to replenish what it needs to build another baby. And you see over here, the babies will be small, too. The risk is one and a half times that the baby will be small - small for gestation weight, low birth weight, and pre-term both being the most significant risk. And I know that all of you who work for Healthy Start know what a significant risk pre-term birth is and how we're trying to avoid it.

Naima: Thank you, Dr. Shepherd. There is another question here that is about men. And the question is, "Would you consider recommending vasectomy as a LARC method for men?

Dr. Shepherd: No, I would not, because the LARC methods of course are reversible. That's the R in LARC. And vasectomy, well, they can be reversed, but you sure can't rely on them being reversed. So no I wouldn't. I think that's for when the man knows he's done having children. And, of course, maybe he can change his mind, but maybe not. And tubal ligations of course are like that for women, too. Basically, yeah, they can be reversed, but maybe not. And of course reversing either one is expensive and difficult. So those are permanent. And the difference from LARC is that it's reversible. And anytime you get any of those methods discontinued, you can get pregnant again. And you can change your mind, which like I say is a woman's privilege, and a man's too.

Naima: And, Dr. Shepherd, someone asks, "Have you in your experience found any differences in trends in terms of what's going on with reproductive planning in terms of rural and urban communities?"

Dr. Shepherd: That's interesting. I am not sure that I have. LARC is basically the big trend everywhere, but I think it's taking longer to catch on some places, just because there's not the resources that there is in other places. But I don't think so. And, of course, contraception, too, has always been fairly expensive. And so that may limit a woman's choices. Fortunately now, in a lot of places, if you have insurance, it's covered, if you have Medicaid it's covered. All the Obamacare issues

as far as the states that expanded Medicaid, it's actually fairly easy for a woman to get any form of contraception that she wants for free. But not every state has that situation.

So I think a lot of it is cost, a lot of it is knowledge that gets in places, but maybe cost more than anything.

Naima: And our final question, Dr. Shepherd, is, "What are your recommendations, in terms of strategies, for helping adolescents to be receptive to conversations around LARC without making them feel like you're leading them in that direction?"

Dr. Shepherd: I think that's really, really important. But I also think that's where the reproductive life plan questions come in, because if I'm talking to an adolescent and she tells me, yeah, she wants children, who doesn't, but then I say, "When?", and she says, "Well, you know, not for several years.", then it leads into I have something here that would last you until you're ready to have children. Would you be interested in that? Because the other choices, for example, with birth control pills, you would end up taking a pill every day for what? Three years? How do you feel about that? How is that gonna fit into your life? Do you think you can remember a pill every day for three years? Or even a shot every month, every three months for three years, or a one-time thing that would protect you for three years? But certainly it's up to you, and really, really important, too. Yeah, that's supposed to be first line. Pediatricians are telling us that's what to bring up. But we bring up everything.

But those are the advantages. And, again, because she told me that she's looking at several years until she wants a baby, it makes it easy to bring up LARC anyway. You said several years and there's these methods that last just that long. And they're the most effective things we've got. But if you're not comfortable, one would be in your arm, one would be in your uterus. If that doesn't sound good to you, then we can talk about other things, because certainly we have them and I'm sure most places where you talk about contraception, you've got the chart with all the things on there. And it's all there for the person to decide. But of course whenever you look at one of those charts, on the very top level, high effectiveness, are the LARC methods.

So the person also sees that from the World Health Organization and other organizations make that chart, that shows you that LARC are the most effective, and that often will if she's really motivated. And, again, talking about it, really saying I really would like to wait some years, can motivate her and then she may be interested in the most effective things that she doesn't have to think about, but certainly not pushing anything on anybody. And if it's anything we know about contraception, it's that what a woman wants is what's gonna work for her. So we never want to twist anybody at any age's arm to anything. But we can make some good suggestions I think based on the plan that they've given us.

Naima: And Dr. Shepherd, finally, along those lines, if you did have a client, a younger client that came in, do you have any recommendations for what age should you begin the conversation of reproductive life planning and contraception when we may have young women as our clients?

Dr. Shepherd: I think we should start asking those questions when she starts having periods and stop asking them when she stops having periods. And that I believe is the recommendation from the CDC as well. So as soon as somebody's fertile, she had a period, she's fertile, until she's not fertile anymore, we ask the questions.

I'm not encouraging 12 years olds to become sexually active, but I am encouraging her to start thinking now. What do you want your life to look like? Do you want to have children? Do you want to also have a job? How much education do you want to get? How is that all gonna fit together? I think it's never too early to ask those questions. And then that's all we do if she's 12 and not sexually active yet. But we got her thinking. And the more we get her thinking, the more we let her know she has a choice, the more we let her know she can set goals for herself, and have children, when, how many, all of that, when she wants to. As soon as you've got periods, it's not too early, and until those periods go away.

Naima: Thank you, Dr. Shepherd. This has been a phenomenal webinar. And so before we end, we'd like to just have you mark your calendars for some upcoming webinars this month. We are gonna close out April with Centering Pregnancy and Centering Parenting. And for the month of May we have a quite busy schedule for webinars. We have our three Ask the Experts, so the quality family planning recommendations as well as part one of the series of How to Talk to Moms about

Breast Feeding. And then we will also have another Ask the Expert around domestic violence screening and follow-up.

Our Hear From Your Peer this month is going to be around male inclusion in fatherhood. And the focus of that webinar is going to be, of course, why is it important for male involvement, and also what does it take in terms of readiness? What strategies does your staff and your organization need to prepare to implement fatherhood programs and initiatives? And then we will also have this month a webinar that's gonna highlight some peer learning opportunities around collective impact. So that is going to be a joint effort with the division and some of your peers, other Healthy Start grantees, they're leading and co-facilitating these peer learning meetings that will happen for collective impact.

So I invite you all to please visit the EPIC Center website. All of the information will be there as well as the recording for today's webinars, transcripts and slides. So again, I'd like to thank everyone for attending. This concludes our webinar. Thank you so much for your participation and we look forward to having you in future webinars. Talk to you all soon.