



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 642 • October 2015

(Replaces Committee Opinion Number 450, December 2009)

Committee on Gynecologic Practice Long-Acting Reversible Contraception Working Group

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Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy

ABSTRACT: Unintended pregnancy persists as a major public health problem in the United States. Although lowering unintended pregnancy rates requires multiple approaches, individual obstetrician–gynecologists may contribute by increasing access to contraceptive implants and intrauterine devices. Obstetrician–gynecologists should encourage consideration of implants and intrauterine devices for all appropriate candidates, including nulliparous women and adolescents. Obstetrician–gynecologists should adopt best practices for long-acting reversible contraception insertion. Obstetrician–gynecologists are encouraged to advocate for coverage and appropriate payment and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances.

Unintended pregnancy persists as a major public health problem in the United States. Although lowering unintended pregnancy rates requires multiple approaches, individual obstetrician–gynecologists may contribute by increasing access to contraceptive implants and intrauterine devices (IUDs) for their patients.

Recommendations

The American College of Obstetricians and Gynecologists recommends the following strategies to reduce barriers and increase access to implants and IUDs (ie, long-acting reversible contraception [LARC] methods):

- For all women at risk of unintended pregnancy, obstetrician–gynecologists should provide counseling on all contraceptive options, including implants and IUDs.
- Encourage consideration of implants and IUDs for all appropriate candidates, including nulliparous women and adolescents.
- Adopt best practices for LARC insertion.
- Advocate for coverage and appropriate payment and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances.

- Become familiar with and support local, state (including Medicaid), federal, and private programs that improve affordability of all contraceptive methods.

Background

Over the past 20 years, overall rates of unintended pregnancy (pregnancies not desired now or in the next 2 years) in the United States have remained unacceptably high at approximately 50% of all pregnancies (1). Combined oral contraceptives and condoms, the predominant reversible contraceptive methods used in the United States, are user dependent and have relatively low continuation rates and high failure rates with typical use (2). For all women at risk of unintended pregnancy, obstetrician–gynecologists should provide counseling on all contraceptive options, including implants and IUDs. Long-acting reversible contraception methods require a single act of motivation for long-term use, eliminating adherence and user dependence from the effectiveness equation (see Fig. 1 and Box 1). These top-tier methods share the highest continuation rates of all contraceptives, which is one of the most important factors in contraceptive success (2).

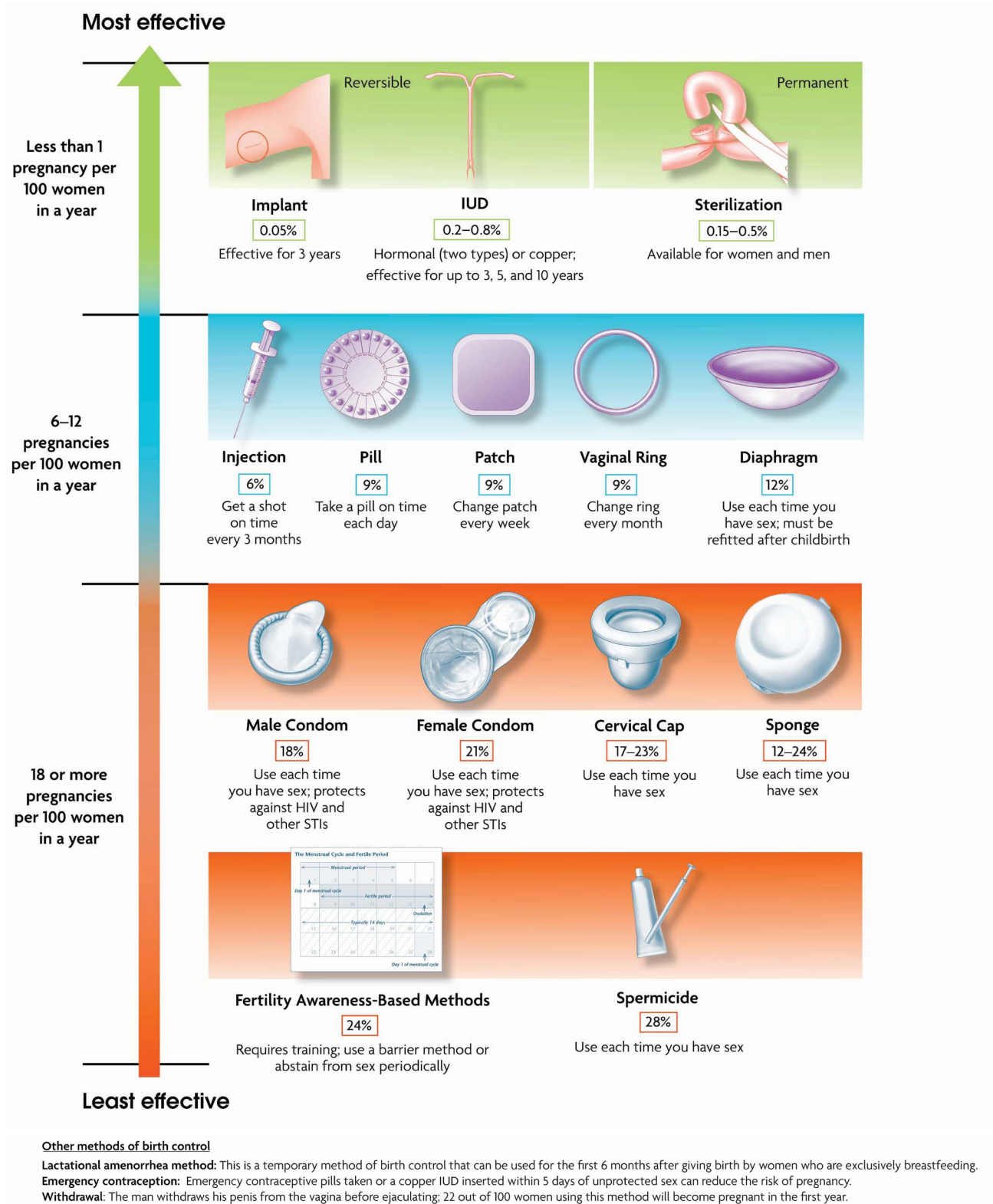


Fig. 1. Effectiveness of birth control methods.* Abbreviations: HIV, human immunodeficiency virus; IUD, intrauterine device; STIs, sexually transmitted infections. ←

*Percentage of women who will become pregnant within the first year of typical use of the method.

Box 1. Advantages of Long-Acting Reversible Contraception Methods ↩

- Effectiveness independent from coitus, user motivation, and adherence
- Highest effectiveness, continuation rates, and user satisfaction of all reversible methods
- No requirement for frequent visits for resupply
- No requirement for additional funding for consistent use once placed
- Highly cost-effective
- Reversible, with a rapid return to fertility after removal
- Few contraindications

Long-Acting Reversible Contraceptive Methods

Currently, five LARC devices are available in the United States: one single-rod etonogestrel implant approved for use up to 3 years and four IUDs. The copper T380A IUD is approved for use up to 10 years. Additionally, three levonorgestrel-releasing intrauterine systems are available: two approved for use up to 3 years and one approved for use up to 5 years. Long-acting reversible contraception methods have few contraindications (see the *United States Medical Eligibility Criteria for Contraceptive Use, 2010*, available at <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm> for detailed information on contraindications), and almost all women are appropriate candidates for the etonogestrel implant and the IUDs (3, 4). Despite potentially high up-front costs and the need for office visits and trained obstetrician–gynecologists and other gynecologic and obstetric care providers for insertion and removal, LARC methods have advantages over other methods (see Box 1).

Long-Acting Reversible Contraception and Unintended Pregnancy

In the Contraceptive CHOICE Project, an observational clinical trial, participants received a contraceptive method of their choice at no cost after standardized counseling that emphasized method effectiveness. Several reports from this project have shown that improving access to and knowledge of LARC methods increases method uptake and may decrease unintended pregnancy, abortion, repeat abortion, and adolescent birth rates (5). Additionally, studies from the CHOICE Project confirm the superiority of LARC methods over short-acting methods; implants and IUDs were 20 times more effective than oral contraceptive pills, patches, or rings (6). Evidence from several other studies indicates that increasing use of LARC methods can reduce rapid repeat pregnancy among adolescents and repeat abortion among women who have had an induced abortion (7, 8).

Barriers to Increasing the Adoption of Long-Acting Reversible Contraception

Approximately one half of obstetrician–gynecologists offer the implant in their practice, with lack of patient interest and lack of training cited as the most frequent reasons for not offering this method (9). Increasing familiarity with changes in practice guidelines and improvements associated with the newer LARC devices may address some obstetrician–gynecologists' reluctance to encourage LARC use. Although obstetrician–gynecologists generally have favorable attitudes about IUDs, they may use overly restrictive criteria to identify IUD candidates (10). Obstetrician–gynecologists should encourage consideration of implants and IUDs for all appropriate candidates, including nulliparous women and adolescents (3, 4, 11, 12). Educating obstetrician–gynecologists about LARC and encouraging them to offer these methods to their patients may increase uptake because data show that women who have heard of the IUD from their obstetrician–gynecologists are more likely to be interested in it than women who have not (13).

Obstetrician–gynecologists should adopt best practices for LARC insertion (see Box 2). The convenience and subsequent high continuation rates of LARC placement immediately postpartum or after second-trimester abortion may outweigh the disadvantage of higher IUD expulsion rates (14). There is no increased risk of IUD expulsion with insertion immediately after a first-trimester abortion (15).

Obstetrician–gynecologists are encouraged to advocate for coverage and appropriate payment and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances. Obstetrician–gynecologists should become familiar with and support

Box 2. Best Practices for Long-Acting Reversible Contraception Insertion* ↩

- Provide long-acting reversible contraception (LARC) methods the same day as requested, whenever possible, if pregnancy can reasonably be excluded.
- Offer LARC methods at the time of delivery, abortion, or dilation and curettage for miscarriage.
- Screen for sexually transmitted infections at the time of intrauterine device (IUD) insertion; if the screening test result is positive, treat the infection without removal of the IUD.
- Offer the copper IUD as the most effective method of emergency contraception.

*For more information, see U.S. selected practice recommendations for contraceptive use, 2013: adapted from the World Health Organization selected practice recommendations for contraceptive use, 2nd edition. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. *MMWR Recomm Rep* 2013;62:1–60.

local, state (including Medicaid), federal, and private programs that improve affordability of all contraceptive methods so that they can offer LARC in all clinically appropriate circumstances. Since implementation of the Affordable Care Act, most insurance plans cover all contraceptives, including LARC methods, with no patient cost sharing. Many obstetrician–gynecologists and other gynecologic and obstetric care providers who receive federal Title X family planning funding, Planned Parenthood clinics, and Federally Qualified Health Centers offer LARC methods at low or no cost. However, some women do not have coverage under the Affordable Care Act or do not have access to low-cost clinics and may encounter high up-front costs for an IUD or implant. Despite such costs, the implant and the IUDs are highly cost-effective, even with relatively short-term (12–24 months) use (16).

The high cost of LARC devices also presents a barrier when obstetrician–gynecologists experience difficulty in receiving appropriate reimbursement and payment for the device and insertion services from payers. The uptake of immediate postpartum LARC has been slowed by the difficulties hospitals and obstetrician–gynecologists encounter in receiving reimbursement and payment for devices and services separate from the global fee for delivery. Additionally, Medicare does not provide coverage for contraception. Payment and reimbursement policies that restrict abortion coverage can complicate billing procedures for covered contraceptive services and serve as a barrier to postabortion contraceptive access (17).

For More Information

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's web site, or the content of the resource. The resources may change without notice.

ACOG has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/IncreasingLARC.

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ISSN 1074-861X

Increasing access to contraceptive implants and intrauterine devices to reduce unintended pregnancy. Committee Opinion No. 642. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e44–8.