Pills Are Not Enough:
The Case for Long-Acting Reversible Contraceptives—and How North Carolinians Can Benefit

Amy Bryant, MD; Cheryl L. Kovar, RN, MSN, CNS; Alicia T. Luchowski, MPH

The Problem

Ms. N lost her job and health insurance at the same time and missed a month of birth control pills because she could not afford her prescription. She became pregnant but miscarried after only nine weeks. She was seen in the ER and required a dilation and curettage procedure and a blood transfusion.

Ms. L gave birth to her second child in September and was given a DepoProvera shot that was covered by Medicaid. She wanted to continue using Depo, but her Medicaid coverage expired 60 days after the birth of her child, and she was not able to afford the next shot. Unfortunately, she did not realize that she was eligible for further services. She became pregnant within four months of her last delivery and delivered at term, covered again by Medicaid. She now has three children under the age of five at home, all of whom qualify for Medicaid. She has quit her job because paying for childcare costs more than what she was making as a cashier.

Ms. S is a 17-year-old high school student who was not able to fill her contraceptive patch prescription on time and became pregnant. Though she did not see herself wanting children until after finishing college, her doctor did not offer her an intrauterine device (IUD) because of her age and because she had never before given birth. She decided to have an abortion at 10 weeks so that she could finish high school and start college in the fall.

Ms. F is a 32-year-old who had a gastric bypass procedure two months prior to becoming pregnant. She had irregular periods before her surgery and did not know she could become pregnant so quickly. Her doctor never discussed contraception with her, though the doctor recommended not getting pregnant right away. She elected to have an abortion at 12 weeks because she was worried about the effects her rapid weight loss would have on her pregnancy.

Ms. T is a 40-year-old morbidly obese woman who was taken off her oral contraceptives due to worsening blood pressure. She chose to use condoms as her primary method of birth control but now is nine weeks pregnant and seeking an abortion.

Unfortunately, these scenarios are all too familiar to health care providers across North Carolina. What they all have in common is that each of these cases could have been averted by long-acting, reversible contraception (LARC). Most women spend the majority of their reproductive lives desiring to not get pregnant, so it is important to think of contraceptive methods that address these long-term needs. Long-acting reversible contraception should be considered the first line option for contraception for almost all women.

What Exactly is LARC and Why Aren't More Women Using It?

Long-acting reversible contraception includes two basic contraceptive methods: hormonal implants and intrauterine devices. These methods are safe, long-acting, convenient, and extremely effective. They also have the added benefit of

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Amy Bryant, MD, is the family planning fellow in women's primary healthcare at the University of North Carolina at Chapel Hill. She can be reached at amy_bryant (at) med.unc.edu.

Cheryl L. Kovar, RN, MSN, CNS, is the family planning and reproductive health nurse consultant in the Women's Health Branch of the North Carolina Division of Public Health.

Alicia T. Luchowski, MPH, is the director of the Long-Acting Reversible Contraception (LARC) Program at the American College of Obstetricians and Gynecologists.

requiring only a single act of motivation to provide pregnancy prevention for years at a time. Other contraceptive methods have the disadvantage of requiring long-term daily, monthly, or weekly use, or use with each act of coitus, a burden that often translates into incorrect use or discontinuation, and can result in unintended pregnancies that can be costly to the health system as well as economically and emotionally costly to individuals and families.

There are currently two forms of IUDs on the market—the copper IUD, ParaGard, and the hormonal IUD, Mirena. ParaGard is a nonhormonal method that lasts for 10 years and has a first year failure rate of 0.8%.[1] Mirena contains locally acting levonorgestrel. It lasts for five years and has a failure rate in the first year of 0.2%.[1]

Today's IUDs are extremely safe. Past concerns regarding pelvic inflammatory disease (PID), sexually transmitted infections (STIs), infertility, and difficult insertion have limited the use of IUDs in nulliparous women (women who have never given birth) and adolescents. However, more recent data supports the safety of using both types of IUDs in nulliparous women and adolescents.[2,3] They do not increase the long-term risk of PID, though there is a modest increased risk of PID in the first 20 days after insertion.[4] While condoms protect against STIs, their contraceptive efficacy, with a failure rate of 15% per year with typical use,[1] is much lower than the IUD. Women are encouraged to use condoms in addition to the IUD if they are at risk for STIs.

Implanon is a hormone-releasing single-rod contraceptive implant that is placed subdermally in the upper arm. It contains the progesterone etonogestrel and is effective for three years. Its failure rate is 0.05% in the first year of use.[1]

All three forms of LARC can be used safely by nulliparous women and, unlike combined hormonal methods such as the oral contraceptive pill, the patch, and the ring, LARC methods can be used by women of all ages and with a range of medical problems including hypertension, tobacco use, and obesity.[1,5]

While all of these methods require skilled providers to place them, with adequate training providers can quickly become proficient in their insertion. All three LARC methods are reversible, with a rapid return to fertility after removal.

The US lags behind most developed countries in its use of LARC. In Europe, IUD use is much more common, and is as high as 27% among contraceptive users in Norway, 21% in Sweden, 18% in Denmark, and 17% in France.[6] However, in the US, the use of LARC is less than 2%.[6]

So why aren't more US women using LARC? The challenge of increasing the use of LARC in the US is manifold. First, there is an issue of provider comfort with offering LARC. Since the Dalkon Shield was taken off the market in the 1970s due to several deaths from septic abortion, the IUD fell out of favor among providers in the US until the copper IUD was reintroduced in 1988 and the hormonal IUD was approved in 2001. Despite data from this and other countries attesting to the remarkable safety and efficacy of the current IUDs, many US providers are still wary of these devices and often do not offer them to patients, even if they are aware of their safety.[7]

In addition, many providers who are in a position to offer women contraceptives, such as family practice physicians and pediatricians, may not offer LARC methods because they are not comfortable with inserting them or need to refer to someone who can. It is certainly much easier for a provider to write a prescription for birth control pills than to actually place a device during a busy clinic schedule.

The other challenging area is patient knowledge and attitudes. One study of young women and adolescents found that 60% of the participants had not heard of the IUD. But after a brief, five minute educational intervention, more than half said that they "liked the idea of the IUD" for themselves.[8]

Though there is a lot of room for improvement in the availability and use of LARC, the trend seems to be going in the right direction. Since the advent of Mirena, which included an onslaught of television ads, more women are requesting IUDs from their gynecologists, which can definitely translate to a substantial increase in its use. A Gallup survey in 2003 showed that up to 28% of female obstetrician-gynecologists would choose the IUD for themselves, which can also contribute to a rise in its popularity.[9]

Even though the US lags behind other countries in using LARC, the good news is that LARC use seems to be on the upswing, providing more women with safe, effective, and long-term contraceptive options.

LARC is Now More Available Than Ever

While insurance will cover the cost of LARC in most cases, for women without insurance the upfront cost can be prohibitive, despite its cost-effectiveness over time. Fortunately, in North Carolina the Family Planning Waiver Program, implemented in 2005, provides coverage for LARC for a large number of women of reproductive age.

The Family Planning Waiver Program is a Medicaid demonstration project designed to reduce unintended pregnancies by expanding eligibility for family planning services to men and women at or below 185% of the federal poverty level. Implemented in 2005, this program, known as "Be Smart," gives access to family planning services to men ages 19–60 and women ages 19–55 who otherwise do not qualify for Medicaid services.

Family Planning Waiver services can be provided by ambulatory surgery centers, federally-qualified health centers, nurse practitioners, nurse midwives, physicians, local health departments, rural health clinics, and outpatient hospitals. These services include an annual physical exam, testing and treatment for STIs, elective sterilization, and contraception—including both Mirena and ParaGard. There are no copayments for any of the services, though the services are rigidly limited to family planning, and any medical problems discovered besides STIs are not covered.

The key objectives of the Family Planning Waiver are to reduce the number of unintended and unwanted pregnancies, reduce the demand for abortion, increase the use of more effective methods of contraception, and positively impact the

utilization of and continuation rates for contraceptive use among the target populations.[10] A key strategy for reaching these objectives is to increase the use of LARC. Long-acting reversible contraceptive methods are highly effective and also enjoy higher continuation rates (the number of women still using the method after one year) than all other methods of reversible contraception, at around 80% for both the IUDs and the implant, compared with 42%–68% for other reversible methods.[1]

In North Carolina, 45% of all live births are the result of an unintended pregnancy and 27,000 abortions are performed yearly.[11] The Family Planning Waiver Program has the potential to reduce the number of unintended pregnancies in North Carolina by 8,500. This would avert an estimated 3,400 abortions and 4,100 live births. The estimated cost of providing family planning services is $372 annually per person, compared to $8,753 per pregnancy carried to term for women who are eligible for Medicaid.[12]

The Be Smart Program addresses these concerns and is on target to enroll as many eligible men and women as possible who desire family planning services. Last year in North Carolina, there were an estimated 497,223 potential female enrollees and 415,694 potential male enrollees based on income and other program qualifications.[13] As can be seen by these large numbers, the need for effective contraceptive methods in this population is great.

Demonstration projects supported by the Centers for Medicare and Medicaid Services (CMS) show that the cost effectiveness of this type of family planning program can lead to expansion of coverage in the future. Given the current health care crisis, it is essential to show that government-funded projects can have positive impacts on health outcomes at a reasonable cost. Long-acting reversible contraception provides a textbook example of how a small intervention can be lasting and cost-effective and result in healthier outcomes for women, families, and communities.

ACOG Advocates for LARC

On the national level, the American College of Obstetricians and Gynecologists (ACOG) LARC Program is working with obstetrician-gynecologists and others around the country to increase access to LARC by updating clinical practice recommendations and developing continuing education programs, practice support tools, and patient education materials.[a]

Current clinical recommendations from ACOG support IUD use by nulliparous women, adolescents, and women with a history of ectopic pregnancy.[2,3] In addition, ACOG has found that there is sufficient evidence to support the use of Mirena as a treatment option for idiopathic menorrhagia and to protect against endometrial hyperplasia in women using menopausal hormone therapy.[b,14]

Though most obstetrician–gynecologists have received training in IUD insertion and have positive views regarding their safety and effectiveness, results from a national survey of OB-GYNs published in 2002 found that almost 80% of OB-GYNs reported inserting 10 or fewer devices in the previous year.[15] In addition, patient selection criteria used to identify candidates for IUD use were not consistent with current evidence-based recommendations. No national survey has evaluated current knowledge or practice patterns regarding the single-rod contraceptive implant.

To evaluate the current status of OB-GYNs' knowledge, attitudes, and practice patterns regarding IUDs and the contraceptive implant, ACOG recently fielded a nationally-representative survey of its membership. For those not currently offering LARC to patients, the survey asks why not and also has questions about availability of training, education, or practice support materials or interventions that would change current practice. ACOG's LARC Program will use these survey findings to guide the development of future materials and programs. ACOG will also be surveying residency programs in obstetrics and gynecology to assess the current state of LARC training and education for residents.

The LARC Program is also offering continuing education sessions at ACOG regional and national meetings, including its District IV annual meeting, held this year in Asheville on October 16–18, 2009. These evidence-based presentations address the potential role of LARC in reducing unintended pregnancy rates and provide clinical guidance on LARC provision and management. Presentations will be posted to the LARC Program website for free use by others providing LARC training and education. In addition, the Fellowship in Family Planning offers nationally–renowned family planning experts as Grand Rounds speakers for presentations focused on recent research developments and evidence-based approaches to LARC and other family planning topics. All speaker expenses, including travel costs and honoraria, are covered by the Fellowship in Family Planning.[16]

Patient education also plays an important role in increasing the knowledge and use of LARC, and ACOG currently offers several publications for patients on its Patient Page.[17] In addition, ACOG recently published a flip chart for offices to assist providers during birth control method counseling. The flip chart provides quick reference to each contraceptive method, with an accompanying tear-off pad of information for the patient to keep.[18]

Finally, since systems barriers often present a hurdle for LARC provision even when providers possess the appropriate clinical knowledge and training, ACOG is developing tools to

a These resources are continually posted and updated on the LARC Program website at www.acog.org/goto/larc.

b ACOG's clinical recommendations are available at no cost to members on the ACOG website (http://www.acog.org), and others can request single copies of ACOG documents from the College Resource Center by email at resources (at) acog.org or by calling 202.863.2518. College clinical recommendations are also published and indexed in the journal *Obstetrics & Gynecology*.

assist in coding, reimbursement, and other administrative concerns. For example, the LARC Program is developing a coding guide to help practices seek the appropriate compensation for family planning services.

Recommendations

It is crucial for providers in all specialties that treat women of reproductive age to address the contraceptive needs of patients. Long-acting reversible contraception is the best tool currently available for most women desiring effective, long-term contraception and should routinely be offered as the first option.

Just as the reasons for less than optimal utilization of LARC are complex, the strategies for increasing its use require improved knowledge and awareness on multiple levels:

- Increased enrollment of eligible women and men in the Be Smart Program.
- Increased training of providers—physicians, physician assistants, and nurse practitioners from various disciplines, including pediatricians and family practice physicians—in LARC placement.
- Word of mouth—encouraging patients to tell their friends and family about their satisfaction with LARC.
- Development of an effective referral network to help providers who don't offer LARC refer patients to those who do.
- General provider education on the availability of comprehensive family planning services and LARC through the Be Smart Program.

This multifaceted approach to increasing use and access to LARC can help achieve the potential of LARC to reduce unintended pregnancy and improve health outcomes for women and families. **NCMJ**

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