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Same-day LARC insertion attitudes and practices☆

M. Antonia Biggs[a,*], Abigail Arons[a], Rita Turner[b], Claire D. Brindis[a]

[a]Bixby Center for Global Reproductive Health, University of California, San Francisco, San Francisco, CA 94118, USA

[b]Philliber Research Associates, Accord, NY, 12404, USA

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Abstract

Background: Little is known regarding clinicians' attitudes about or the extent to which the recommendation to offer same-day insertions for long-acting reversible contraception (LARC) is applied in practice.

Study Design: Since 2006, 47 family planning agencies in Colorado and Iowa participated in two initiatives to reduce unintended pregnancy by increasing LARC provision. Clinic directors (n=45) and clinicians (n=114) participating in these initiatives were interviewed and surveyed regarding their LARC provision practices and attitudes.

Results: Agencies required fewer visits for the contraceptive implant than for the intrauterine device (IUD). Only 18% of agencies typically offered an IUD, and 36% typically offered an implant in one visit. Years of experience and professional title significantly predicted attitudes about the number of visits required to get LARC.

Discussion: Barriers must be overcome for full implementation of professional LARC guidelines and for more women to receive chosen methods without the extra burden of multiple visits.

Keywords: Women; Low income; Long-acting reversible contraception; Iowa; Colorado; Family planning; Professional guidelines; Barriers to care

1. Introduction

Long-acting reversible contraception (LARC), which includes the intrauterine contraception device (IUD), specifically, hormonal (Mirena®) and copper T (ParaGard®) IUDs, and single rod, contraceptive implants (Implanon® and Nexplanon®), are highly effective because they do not require periodic user initiative, they provide continuous, long-term protection ranging from 3 to 10 years and are coitus independent [1]. Increasingly, LARC methods are being recommended as a first-line contraceptive option for the majority of women [1–4]. The American College of Obstetricians and Gynecologists (ACOG) has noted the few contraindications, many benefits and suitability of these methods for nearly all women [5–7]. In 2009, ACOG issued a recommendation to adopt same-day LARC insertion protocols, with the aim of reducing barriers and increasing LARC use [6]. The clinical recommendations specifically state that LARC can be inserted at any time during the menstrual cycle as long as pregnancy is reasonably excluded and that routine sexually transmitted infection (STI) screening is not required unless the client is at high risk of STIs, in which case screening and insertion can occur on the same day or when the test results are available. In addition, ACOG recommends LARC insertion immediately following miscarriage, abortion and vaginal or cesarean delivery [5,6,8].

The proportion of reproductive-aged (ages 15–44) women using LARC methods in the US has increased in recent years from 2.4% in 2002 to 8.5% in 2009 [9]. This increase can partly be attributed to the expansion of women deemed suitable for LARC, changing demographics, direct to consumer marketing and increases in the number of providers trained in insertion and removal [10,11]. The Centers for Disease Control and Prevention Medical Eligibility Criteria gives IUDs and implants a classification[1] of 1 or 2 for women with a history of pelvic inflammatory disease, ectopic pregnancy, teenagers, nulliparous women, smokers,

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* Corresponding author.

E-mail addresses: antonia.biggs@ucsf.edu, m.antonia.biggs@gmail.com (M.A. Biggs).

[1] Categories: 1 = a condition for which there is no restriction for the use of the contraceptive method, 2 = a condition for which the advantages of using the method generally outweigh the theoretical or proven risks.

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women with a history of hypertension, HIV-positive women and diabetic and obese women [12]. While implant use in the US is higher than in other countries, IUD use continues to be substantially lower [13].

An important barrier to LARC provision may exist when clinic protocols do not allow women to receive a LARC method the same day she requests it, resulting in many women being lost to follow-up and placed at risk of an unintended pregnancy [14,15]. A recent (2012) study of postpartum adolescents in Colorado found that delaying the insertion procedure by just a few weeks resulted in a decreased likelihood of women receiving the LARC method that they intended to use [16]. Similarly, protocols that place IUDs immediately following an abortion have been shown to increase the rate of IUD use and to reduce repeat unintended pregnancies; failure to return for the visit was the most common reason for not getting a postabortion IUD [17,18]. Recent reports from family planning directors and staff have described the challenges that clients face due to outdated facility policies requiring multiple appointments to obtain LARC and to complete requisite consultations and screening tests before LARC insertions [19]. Additional barriers to LARC provision and use include cost barriers, negative attitudes and misconceptions about their safety and clinicians' lack of experience or comfort with insertion and removal [8,20–25].

While the copper T IUD is considered the most effective form of emergency contraception [26], it is not widely used for this purpose [27,28]. The inability of agencies to offer same-day insertions may prevent providers from offering this IUD as emergency contraception [29]. Other barriers to offering the IUD as emergency contraception include providers' concern that the IUD is appropriate for a limited range of clients, limited funds to purchase devices and lack of provider training [27,28].

Few studies have documented how often providers are able to insert LARC in one visit and the barriers leading to delay. A 2006 survey of over 1000 family planning providers in California found that only 7% offered an IUD in one visit [29]. A national study of US abortion providers in 2009 found that a small proportion offered immediate postabortion IUD (36%) and contraceptive implant (17%) placement [25]. Some of the barriers to immediate same-day postabortion LARC insertion included lack of same-day insertion protocols, lack of on-site Chlamydia testing and lack of time. Research on clinicians' attitudes about reducing the number of visits for LARC provision has been limited.

2. Materials and methods

2.1. The Colorado and Iowa initiatives

From 2006 to 2012, two statewide initiatives in Iowa and Colorado granted funding to all Title X providers in each state as well as other non-Title X family planning providers. The non-Title X family planning providers were selected because they were key leaders in family planning provision in the state. A total of 47 family planning service agencies (15 in Iowa[2] and 32 in Colorado) were funded to expand their scope of services, improve their infrastructure and market their services — all with the aim of reducing unintended pregnancies in each state by increasing use of LARC. Forty-two of these agencies are Title X agencies, and 5 are non-Title X agencies. As part of a mixed-methods evaluation of these initiatives, data were collected from clinicians and clinic directors at initiative-funded agencies to assess their experiences providing LARC services. The purpose of this study is to assess clinical protocols and clinician attitudes regarding same-day LARC insertions and to identify the barriers to immediate LARC provision. This study is timed only a few years after ACOG's recommendation to providers to adopt same-day LARC insertion protocols, giving us the unique opportunity to assess whether and how these recommendations have begun to affect clinic protocols and clinician attitudes.

2.2. Study design and data collection

In the summer of 2012, clinicians and clinic directors from the 47 initiative-funded agencies were surveyed regarding clinic protocols and practices, including same-day insertion practices. The clinic directors from these agencies completed a short, online 30-item survey and participated in in-depth telephone interviews regarding their clinic protocols and practices. The clinic director survey included mostly close-ended questions regarding the demographic characteristics of the clinic director, agency characteristics, contraceptive offerings within their agency and LARC delivery strategies and practices being implemented at the agency level. Upon completion of the online survey, clinic directors were asked to participate in a telephone interview that included 18 questions, many of which were open-ended. The interviews lasted approximately 1 hour and captured views about the family planning climate in their communities, collaboration efforts and the reasons behind their LARC delivery protocols and practices. Clinic directors were asked to deliver a separate anonymous online survey link to up to five clinicians in their agency or the maximum number of clinicians available for sites with fewer than five clinicians. The clinician survey included 16 questions about clinician characteristics, experience delivering LARC methods and LARC attitudes. All research protocols and instruments were approved by the University of California, Committee on Human Research.

2.3. Measures

The following domains were included as part of the survey tools completed by clinic directors and clinicians participating in the initiative:

[2] There were originally 17 funded family planning agencies in Iowa; since the Planned Parenthood of the Heartland merger with 2 former Planned Parenthood affiliates, there are 15.