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Access to the copper IUD as post-coital contraception: results from a mystery caller study

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Abstract

Objective: To assess access to the copper IUD as post-coital contraception (PCC) and identify barriers to obtaining this contraceptive method.
Study design: We used a "mystery caller" approach to survey primary care, family planning, and Ob/Gyn clinics in nine U.S. cities, identified via online search. A single researcher called 199 clinics, assuming the role of a patient seeking the copper IUD for PCC. Using a standard script, the researcher collected information regarding access to the copper IUD and respondent's knowledge of the copper IUD's indication for PCC. The primary outcome was availability of the copper IUD as PCC. Secondary outcomes included any provision of the copper IUD, awareness of the copper IUD's indication for use as PCC, and offering accurate information regarding the copper IUD as PCC. Fisher's exact test was used to compare outcomes by clinic type.
Results: Two thirds (68%) of primary care clinics, 87% of family planning clinics, and all Ob/Gyn clinics offered the copper IUD ($p<.001$). Only 11% of primary care clinics, however, were aware of the copper IUD's use as PCC, as compared with 63% of family planning clinics and 24% of Ob/Gyn clinics ($p<.001$). Few primary care or Ob/Gyn clinics offered the copper IUD as PCC, while 49% of family planning clinics did so ($p<.001$).
Conclusion: Access to the copper IUD as PCC is limited and varies by clinic type. Knowledge gaps exist regarding the use of the copper IUD as PCC, as well as regarding the general medical guidelines for copper IUD placement.
Implications: A majority of primary care and Ob/Gyn clinics do not offer the copper IUD as PCC, and only about half of family planning clinics do so. Barriers included lack of knowledge, unavailability of device, unavailability of an appointment with a trained provider, and outdated IUD provision protocols.

Keywords: Emergency contraception; Postcoital contraception; Copper intrauterine device; Health care access

1. Introduction

The copper intrauterine device (IUD)—ParaGard® in the US—is 99.9% effective in preventing pregnancy when inserted up to five days after unprotected sex, making it the most effective method of post-coital ("emergency") contraception (PCC) [1]. There are also two dedicated pill formulations for PCC (ulipristal acetate and levonorgestrel), both of which are less effective than the copper IUD [2–5], especially in women with a body mass index (BMI) greater than 30 [2]. The median BMI among US women is 27.3 [3], so these methods may be less effective or ineffective in many women. The copper IUD is also the only option for PCC that can be continued for ongoing contraception, offering the benefit of highly effective long-term contraception for those who choose to keep it.

Unfortunately, the limited available data on the use of the copper IUD for PCC suggests that it is not widely offered for this indication: a 2012 survey of physicians in a California state family planning program found that 85% of clinicians never recommend the copper IUD for PCC [4], while a newer study of physicians and advanced practice clinicians in a variety of specialties found that only 14.4% of respondents provide or recommend the copper IUD as PCC, and only half of respondents had heard of this method [6]. Other studies found that most patients were not aware of the copper IUD as PCC [5] and that cost was a potential barrier [5,7].

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These barriers to using the copper IUD as PCC may be reflective of barriers to IUD provision more generally in the US. IUDs are less frequently offered than oral contraceptive pills or depot medroxyprogesterone acetate (DMPA) by Title X family planning clinics [8], and only approximately half of federally qualified health centers (FQHCs) provide IUDs on site [9].

Previous research has identified several potential reasons for these low rates of IUD provision, including lack of patient knowledge about the device [10–12], lack of provider knowledge about current medical eligibility guidelines [13–21], lack of provider training in insertion techniques [22], and barriers related to cost [23] and insurance coverage [24].

These barriers to access to the copper IUD have particularly important implications for patients' ability to access the device as a method of PCC. There is little current research that estimates the percentage of providers that currently offer the copper IUD as PCC and that quantifies the common reasons that providers do not offer this service. This study surveys primary care, family planning, and Ob/Gyn clinics in multiple U.S. cities in order to provide initial data regarding the availability of the copper IUD as PCC and the barriers to patient access to this service.

2. Methods

2.1. Inclusion criteria

We used 2010 U.S. Census estimates [25] and the Health Resources and Services Administration (HRSA) 340b database [26] to identify cities with populations between 600,000 and 900,000 that were estimated to have 20–40 primary care, family planning, and Ob/Gyn clinics eligible for inclusion in our study. This approach allowed us to gather data from a geographically varied sample of mid-sized cities. Selecting cities with 20–40 estimated eligible clinics ensured that it would be feasible for us to attempt contact with all eligible clinics in the included cities, thus avoiding bias due to problems sampling within a city. We included all cities that met the above criteria, with the exception of Portland, OR, which was excluded based on its proximity to another included city (Seattle, WA), and its smaller size relative to Seattle.

We identified clinics for inclusion using three methods: the HRSA 340b database [26], the Association of Reproductive Health Professionals (ARHP) Long-Acting Reversible Contraception (LARC) Locator [27], and Google search. Search methods are described in Table 1. We excluded clinics if they offered services to special populations (e.g. homeless shelter, school), or if they offered only non-reproductive health specialty care (e.g. dental, psychiatry). In addition, we contacted clinics that were offered as referrals during calls to eligible clinics.

2.2. Data collection

A single researcher (ESB) called clinics assuming the role of a 22-year-old, single, nulligravid female, on her parent's private insurance, who had recently moved to the study city, did not have a primary care provider, and had had unprotected intercourse the previous night. The researcher used a standardized script to inquire whether she could obtain the copper IUD as emergency contraception from the clinic within five days of unprotected intercourse. The script included follow-up questions to determine whether the respondent was aware that the copper IUD could be used post-coitally for immediate pregnancy prevention, whether the clinic offered other contraceptive services, availability of new patient appointments, and ability to make a referral if the

Table 1
Methods to identify Ob/Gyn, family planning, and primary care clinics for participation.

Source	Search Method
HRSA 340b database	Clinics in the study cities were identified using search inputs "City" and "State", and clinics with the following designations were included: Consolidated Health Center Program (CH), Family Planning (FP), Sexually Transmitted Diseases (STD)* and Federally Qualified Health Center Look-alike (FQHC). Clinics that served only a particular population (e.g. school, homeless shelter) were excluded, as were clinics that specialized in care other than reproductive health (e.g. psychiatry, dental).
Association of Reproductive Health Professionals (ARHP) LARC Provider Locator Tool	Clinics in the study cities were identified using the search input "City" and "State"
Google search	Searches were conducted with the search terms "birth control clinic [city, state]", and clinics identified in the first 30 search results were documented. When a search result identified multiple clinics (e.g. online directory) all clinics were documented. Search results for private physicians' offices and other services were not included in the study.

* Only one STD clinic was found that met inclusion criteria. This was removed from analysis because it was not appropriate to group it with any of the other clinic types.