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Projections and opinions from 100 experts in long-acting reversible contraception

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Abstract

Objective: This survey of published researchers of long-acting reversible contraceptives (LARCs) examines their opinions about important barriers to LARC use in the United States (US), projections for LARC use in the absence of barriers and attitudes toward incentives for clinicians to provide and women to use LARC methods.

Study design: We identified 182 authors of 59 peer-reviewed papers on LARC use published since 2013. A total of 104 completed an internet survey. We used descriptive and multivariate analyses to assess LARC use barriers and respondent characteristics associated with LARC projections and opinions.

Results: The most commonly identified barrier was the cost of the device (63%), followed by women's knowledge of safety, method acceptability and expectations about use. A shortage of trained providers was a commonly cited barrier, primarily of primary care providers (49%). Median and modal projections of LARC use in the absence of these barriers were 25–29% of contracepting women. There was limited support for provider incentives and almost no support for incentives for women to use LARC methods, primarily out of concern about coercion.

Conclusions: Clinical and social science LARC experts project at least a doubling of the current US rate of LARC use if barriers to method provision and adoption are removed. While LARC experts recognize the promise of LARC methods to better meet women's contraceptive needs, they anticipate that the majority of US women will not choose LARC methods. Reducing unintended pregnancy rates will depend on knowledge, availability and use of a wider range of methods of contraception to meet women's individual needs.

Implications: Efforts to increase LARC use need to meet the dual goals of increasing access to LARC methods and protecting women's reproductive autonomy. To accomplish this, we need reasonable expectations for use, provider training, low-cost devices and noncoercive counseling, rather than incentives for provision or use.

Keywords: Intrauterine contraceptives; Contraceptive implant; Projection; Barrier to use; Policy recommendations

1. Introduction

Intrauterine contraceptives (IUDs) and contraceptive implants, also known as long-acting reversible contraception [long-acting reversible contraceptive (LARC)], are the most effective reversible forms of contraception [1]. In 2002, 15% of women worldwide who were married or in a union used a LARC method, primarily IUDs, second only in popularity to sterilization [2]. In that same year, only 2% of contracepting women in the United States (US) were using a LARC method [3]. Since then, there has been a large push in the medical and public health communities in the US to increase the availability and adoption of IUDs and implants [4,5] to reduce the persistently high unintended pregnancy rate, as well as the costs associated with these pregnancies [6–9]. In 2007, the American College of Obstetricians and Gynecologists published Committee Opinions highlighting IUDs and implants for their potential to reduce unintended pregnancy and recommending them as a first-line option for adolescents and later, in 2009, as a first-line option for nearly all women [10–13]. In 2010, the Centers for Disease Control and Prevention released the US Medical Eligibility Criteria for

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contraception, expanding the groups of women for whom use of these methods is considered safe [14]. Most recently, the American Academy of Pediatrics joined other organizations in recommending LARC as a first-line contraceptive option [15]. During this time, the scientific literature has seen a tremendous growth in scholarship related to LARC access and clinical care, as well as provider and patient knowledge, acceptability and use.

Several national and local initiatives and training programs were launched in the mid to late 2000s with the specific aim of promoting LARC use. Initiatives in Colorado and Iowa made a concerted effort to reduce unintended pregnancy through increased investments in IUD and implant provision that included training providers, funding marketing and media campaigns and reducing the cost of devices [16–18]. In the Contraceptive Choice Project in St. Louis, provision of free IUDs and implants combined with counseling designed to promote their use resulted in large-scale adoption of LARC methods [19]. In California, an IUD provider training program for providers enrolled in the state's Medicaid family planning program resulted in increased provision of IUDs at sites that participated in the training [20]. A national cluster randomized trial recently had success in training providers on IUD and implant provision at 40 reproductive health clinics across the US [21]. These programs have demonstrated a reduction in unintended pregnancies, abortions and teen births due to increased use of LARC methods [16,18,19,21].

Due in part to these policy recommendations and LARC promotion programs, there has been a steady growth in women's use of IUDs and implants across a range of demographic groups, including adolescents and nulliparous women across the US [22,23]. By 2011–2013, 7% of reproductive-age women in the US were using an IUD or implant, representing a nearly 5-fold increase since 2002 [23].

The data also suggest that LARC use varies substantially by population subgroups. In the US, the greatest proportion of users is ages 25–35 years and parous [23]. A survey of female family planning providers in the US demonstrated that 42% used a LARC method and as many as 75% of women enrolled in the St. Louis program chose an IUD or implant [19,24]. Moreover, while there have been substantial increases in LARC use nationally, some other countries and regions have much higher rates of LARC use than we have currently in the US — 43% in Central Asia, 41% in China, 27% in Norway and 19% in France [25].

While there is widespread consensus that access to LARC methods is an important public health goal, the intense focus of some policies and programs on LARC methods over other methods has led some medical and public health experts to voice concern about potential coercion if women are forced to adopt a method that does not match their own preferences or that they do not want and cannot discontinue without clinical intervention [26–29].

The current study surveys LARC experts about their views about the future of LARC use and promotion in the US. We present their assessment of the barriers to greater LARC use, projections of LARC use in the absence of these barriers and opinions of current and proposed LARC promotion policies.

2. Methods

In March 2015, we conducted an electronic PubMed search of all peer-reviewed research articles that contained any of four search terms (Long Acting Reversible Contraception, High Efficacy Reversible Contraception, Intrauterine Device and Implant) published since 2013 in three journals that have strong coverage of contraceptive research (Obstetrics and Gynecology, Perspectives on Sexual and Reproductive Health and Contraception). We excluded editorials, conference abstracts, case reviews, articles unrelated to IUDs and implants, and research articles whose focus was solely on physiology or women outside the US. After retrieving our final set of articles, we searched for all authors' email addresses, first looking for contact information within the article, then using directory searches within each author's institution, searching for contact information in other articles written by this author and finally, for email addresses we still had not found, doing a Google search for the author.

On July 9, 2015, an email inviting these authors to complete a 5-minute online survey in Qualtrics about projections for LARC use and opinions about LARC promotion was sent and signed by the study authors Diana Greene Foster and Antonia Biggs. We asked respondents to complete the survey within 2 weeks. We sent one reminder at 1 week following the survey launch and a final reminder at 2 weeks. Each email had a unique link so that respondents could complete the survey only once. Respondents received no compensation for participating.

The survey asked respondents to identify the top five factors that prevent women from using LARC methods in the US. The list of possible barriers was identified through a review of the literature [30–35]. An open text box was provided for comments or additional barriers.

The second question asked participants to estimate the percentage of contracepting women in the US that would be LARC users if all the barriers listed in the first question were removed. A range was given in 5% increments from 0% to 100%. Labels were added at 10–14% "similar to current," 25–29% "similar to France and Norway," 40–44% "similar to female family planning providers in the US" and 75–79% "similar to women presenting for a new contraceptive method at the Choice Project of Saint Louis". Research supporting each labeled data point was cited below the list. Again, an open text box allowed respondents to provide comments.

The third set of questions solicited respondents' opinions about specific incentives for LARC placement. We describe goals and financial incentives as follows: "some health plans,