Introduction

OVERVIEW

The purpose of this toolkit is to guide providers in Los Angeles County in their efforts to offer long-acting reversible contraceptives (LARC) to their postpartum patients immediately after birth, and to help hospitals overcome administrative and logistical barriers to immediate postpartum LARC provision.

Long Acting Reversible Contraception (LARC)

LARC methods are highly effective forms of birth control. LARC methods, which include intrauterine devices or systems (IUD/IUS) and contraceptive implants, are 10-20 times more effective than birth control pills, the patch or vaginal ring.[1]

- IUDs and implants yield less than 1 pregnancy per 100 women in a year.
- Oral contraceptive pills typically result in 9 pregnancies per 100 women each year.
- External condoms, conversely, yield 18 or more pregnancies per 100 women each year.[2]

Effective forms of contraception can promote women's long-term physical and emotional well-being.[3] Due to their high efficacy rates and low day-to-day maintenance, LARC methods are a highly desirable form of contraception for many women.

Immediate Postpartum (IPP) LARC

Though LARC can benefit women at any time, the prenatal and postpartum periods are ideal opportunities to provide contraceptive counseling and care including LARC. During these months, women have increased contact with health care providers and may be more motivated to take charge of their reproductive health to prevent or plan the timing of a subsequent pregnancy.

Why Immediate Postpartum (Post-Placental) LARC?

- Women at highest risk of short-interval pregnancies have the lowest rates of postpartum follow-up visits, further benefiting from immediate placement.
- 40-75% of women who plan to use an IUD postpartum do not obtain it.[4]
- Access to a clinician is one of the many barriers to LARC, but immediately after having a baby, the clinician and patient are physically in the same place at the same time.
- Nationally, 40-57% of women have unprotected sex before the six-week postpartum visit after a delivery,[5] and 10-40% of women do not attend their postpartum visit.[6,7]
- In the first year postpartum, 70% of pregnancies are unintended.[8]
- Women with immediate inpatient postpartum implant insertion are less likely to seek removal. One study found that at 12 months post-insertion, inpatient insertions were removed in 7% of patients, as opposed to 14% of patients requesting removals from outpatient insertions.[9]

The Los Angeles County Department of Public Health, with support from the Centers for Disease Control and Prevention 6|18 Initiative and the Association of State and Territorial Health Organizations Improving Access to Contraception Learning Community, has joined states around the nation to advance postpartum women's access to these highly effective, convenient forms of contraception.

Despite new evidence, physicians, nurses, and other health professionals commonly hold misunderstandings about LARC.

The fact sheet on the following pages, courtesy of ACOG District II, which serves New York and Bermuda, clarifies important clinical issues.

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS
District II

Dispelling Long-Acting Reversible Contraception (LARC) Myths & Misconceptions Fact Sheet

MYTH: Adolescents and nulliparous women are not appropriate candidates for IUDs.	FACT: Adolescents and nulliparous women can be offered LARC methods, including IUDs.[1] The *U.S. Medical Eligibility Criteria for Contraceptive Use*, classifies both women who haven't had children and adolescents as Category 2, finding the advantages generally outweigh the risks. IUDs and implants have the highest effectiveness, continuation rates, and user satisfaction of all reversible methods.[2]
MYTH: IUDs cause infertility.	FACT: IUDs do NOT cause infertility or make it harder to conceive in the future. Infertility is no more likely after discontinuation of IUD use than after discontinuation of other reversible methods of contraception.[3] In the past, there was concern that IUD use could lead to infertility due to increased chance of sexually transmitted infections (STIs). While untreated STIs can lead to pelvic infection, preventing some women from getting pregnant, ample research shows that today's IUDs do not increase STI infection rates or lead to infertility. STI testing should be performed at the time of IUD insertion, if indicated. However, all women, including those using IUDs, should see a health care provider if they have new or unusual vaginal discharge or pelvic pain.
MYTH: IUDs cause ectopic pregnancy.	FACT: The IUD does not cause ectopic pregnancy. An ectopic pregnancy happens when a fertilized egg implants somewhere outside the uterus, like in the fallopian tubes. There is a chance any pregnancy could be ectopic, and in the very unlikely event a woman becomes pregnant while using an IUD, her chances of having an ectopic pregnancy may be increased. However, since the chance of becoming pregnant while using an IUD is so low, the overall risk of having an ectopic pregnancy is greatly reduced while using an IUD as compared to not using any contraceptive method.
MYTH: A woman who has had an ectopic pregnancy should not use an IUD.	FACT: Women who have had an ectopic pregnancy can use IUDs.[4] IUDs decrease the absolute risk of ectopic pregnancy, whether a woman has had an ectopic pregnancy before or not. Since the chance of becoming pregnant with an IUD is so low, the overall risk of having an ectopic pregnancy is greatly reduced while using an IUD as compared to not using any contraceptive method.
MYTH: If a woman using an IUD develops an STI or pelvic inflammatory disease (PID), the IUD should be removed immediately.	FACT: If a woman using an IUD develops an STI or PID she should be treated with antibiotics right away and can keep the device in place if her symptoms improve within 72 hours (3 days). If the symptoms do not improve within that time, the device should be removed.

[1] American College of Obstetricians and Gynecologists. ACOG Practice Bulletin: *Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, Number 121, July 2011; reaffirmed 2015.
[2] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy, Number 642, October 2015.
[3] Ibid.
[4] Ibid.

MYTH: Results of STI screening must be confirmed before IUD insertion.	**FACT: Studies show that IUD insertion in patients without clinical signs of an STI is safe. Requiring testing and then a return visit for IUD insertion decreases the chance that a patient gets her IUD, leaving her at risk for an unintended pregnancy.** For this reason, same-day insertion of an IUD is a recommended best practice, with routine treatment of any subsequent positive STI screening results undertaken following insertion. Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before IUD insertion.[5]
MYTH: Patients should be menstruating for IUD insertion *(i.e., return to the office/ clinic when menses starts).*	**FACT: Studies show that there is no clinical advantage to IUD insertion during menses[6]** and that it decreases the chance that a patient will actually return to the office to get an IUD, potentially leaving her at risk for an unintended pregnancy. For this reason, same-day insertion of an IUD is a recommended best practice as long as pregnancy may be reasonably excluded. Refer to the CDC US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016.
MYTH: Immediate Postpartum (IPP) IUD insertion is associated with high expulsion rates.	**FACT: IUD expulsion rates are slightly higher with immediate postpartum placement (10-27% versus 2-10% for interval insertion).[8,9]** The vast majority of women who receive an IUD immediately postpartum will not experience an expulsion and the advantages of IPP placement outweigh the risks.[7,8] Many women do not return for postpartum follow-up appointments when contraception is often discussed. Therefore, immediate postpartum LARC insertion presents an opportunity to provide a woman with a contraceptive method of her choice while in the hospital for delivery and should not be dismissed.
MYTH: Breastfeeding mothers are not appropriate candidates for immediate postpartum LARC.	**FACT: Most women can successfully breastfeed after immediate postpartum initiation of any LARC method.** Women considering immediate postpartum hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that the preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.[9] The *U.S. Medical Eligibility Criteria for Contraceptive Use* rates the copper IUD a category 1 (no restriction) for breastfeeding women due to its lack of hormones and the hormonal IUD and implant a category 2 less than 4 weeks postpartum (otherwise a category 1), making LARC an option for immediate postpartum use.

[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: *Clinical Challenges of Long-Acting Reversible Contraceptive Methods*, Number 672, September 2016.
[9] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: *Immediate Postpartum Long-Acting Reversible Contraception*, Number 670, August 2016.

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WHY IMMEDIATE POSTPARTUM LARC?

Reproductive health inequities: Unintended and short interval pregnancy, and infant mortality in LA County

LARC holds great potential to decrease unintended and short-interval pregnancies, which are both associated with adverse maternal and child health outcomes, such as delayed prenatal care, premature birth, low birth weight, and negative physical and mental health effects for children.[10] (Short interval pregnancies are defined as those that occur within one year of a delivery). In 2010, they resulted in $21 billion in direct medical costs in the U.S.[11]

The Los Angeles Mommy Baby (LAMB) Survey, a population-based survey of new mothers, found that 43% of all births in the County in 2016 were unintended-- that is, the mother reported that her baby resulted from a pregnancy that was unwanted or mistimed. This figure does not include unwanted or mistimed pregnancies that resulted in miscarriage or abortion, so the actual proportion of pregnancies that are unintended in LA County is substantially higher than 43%.

Table 1: Percent of Los Angeles County Live Births Described as Unintended by Mother, 2016

LA County	**42.7**							
By Mother's Race/Ethnicity	**Asian**		**Black**		**Latina**		**White**	
	23.8		52.0		55.9		30.0	
By Service Planning Area (SPA)	**SPA 1 (Antelope Valley)**	**SPA 2 (San Fernando)**	**SPA 3 (San Gabriel)**	**SPA 4 (Metro)**	**SPA 5 (West)**	**SPA 6 (South)**	**SPA 7 (East)**	**SPA 8 (South Bay)**
	50.1	38.5	40.0	42.3	22.2	57.1	45.7	41.7

Rates of unintended births in LA County in 2016 varied starkly by race/ethnicity. Table 1 demonstrates that black and Latina women in LA County reported much higher rates of unwanted or mistimed births than did white and Asian women. Troubling geographic disparities also exist, with LAMB data showing that women who live in the Antelope Valley and South Service Planning Areas (SPAs) had much higher rates of unintended births than women in the West, San Fernando, and San Gabriel SPAs.[12]

Effective contraception that meets women's needs is also a key factor in protecting maternal health and preventing infant mortality, which is most commonly a consequence of preterm birth and low birth weight.[13] While infant mortality overall in LA County is 4.2 deaths per 1,000 infants, better than the overall U.S. rate of 5.8 deaths per 1,000,[14] African American infant mortality in LA County remains 10.4 deaths per 1,000, compared to 2.0 babies per 1,000 born to Asian mothers (see Table 2).[15,18] This inequity generally reflects not racial/ethnic variation in personal behaviors, but rather differential exposures to chronic, intergenerational stress and developmental trajectories during pregnancy and across the life span.[16,17] Nonetheless, improving women's knowledge of and access to all contraceptive methods, including LARC, is key to enabling them to prepare for, plan, and space their pregnancies. Provision of immediate postpartum LARC allows expectant mothers to consider their family planning desires while they are pregnant, and leave the hospital knowing that their contraceptive needs have been addressed.

Table 2: Infant Death Rates in Los Angeles County per 1,000 live birth by Race/Ethnicity, 2016[18]

LA County	**4.2**							
By Mother's Self-Reported Race/Ethnicity	**Asian**		**Black**		**Hispanic**		**White**	
	2.0		10.4		3.9		3.2	
By Service Planning Area (SPA)	**SPA 1 (Antelope Valley)**	**SPA 2 (San Fernando)**	**SPA 3 (San Gabriel)**	**SPA 4 (Metro)**	**SPA 5 (West)**	**SPA 6 (South)**	**SPA 7 (East)**	**SPA 8 (South Bay)**
	6.5	3.1	4.0	3.6	2.4	7.1	3.3	3.3

A LARC Success Story: Colorado

Between 2009 and 2014, Colorado made more progress than any other state in reducing unplanned pregnancies. A key factor to this success was improving access to effective contraception. In 2008, the Colorado Department of Public Health and Environment (CDPHE) launched the Colorado Family Planning Initiative (CFPI), which provides LARC to low-income women throughout the state. As a part of this initiative, local Title X health centers* across Colorado received private funding to augment their long-standing publicly-funded family planning programs. CFPI provided funding for the acquisition of LARC devices, trained physicians, and provided outreach and operational support. Through this process, clinics were able to hire new medical and operational staff members, upgrade medical equipment, and change billing procedures. Women faced fewer barriers to choosing and using the birth control method that works best for them, and more women were able to access contraceptive services.[1] By 2015, more than 36,000 women had received LARC, with excellent outcomes. Between 2009 and 2014,

- Abortion and birth rates both declined by 48% among 15-19 year-old women
- The number of repeat teen births dropped 58%
- Abortion and birth rates declined by nearly 20% for women ages 20-24.
- An estimated $54.6 and $60.6 million in entitlement programs were averted.

[1]Colorado is Reducing Unplanned Pregnancy. Available at: www.LARC4CO.com.

*Title X clinics are funded by a federal grant program that provides low income individuals with comprehensive family planning and related preventive health services.

A LARC Success Story: The St. Louis Contraceptive CHOICE Project [a]

The Contraceptive CHOICE Project, conducted through Washington University in St. Louis, Missouri studied 10,000 women between the ages of 14 and 45 who wanted to avoid pregnancy for at least one year. Currently, in the United States, less than 3% of women use LARC, but through CHOICE, which eliminated many common barriers to LARC, 67% of patients selected LARC (with 56% opting for an IUD, and 11% selecting an implant). This discrepancy indicates the high levels of interest of LARC, given its high efficacy rates, and lack of dependence on patient adherence. The CHOICE project attributes high LARC rates to three factors: 1) offering a standardized description of LARC to all women; 2) eliminating financial barriers; and 3) offering all women LARC, regardless of their age, previous births, and STI history. In sum, by removing these barriers and addressing common misconceptions, CHOICE was able to provide 1,700 of its initial 2,500 participants with LARC. After three years, CHOICE followed up with these participants, and found that continuation of LARC was 70% higher than non-LARC methods, indicating further success of the study.[b]

More information about the Contraception CHOICE Project can be accessed here.

THE CONTRACEPTIVE CHOICE PROJECT

a Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The contraceptive CHOICE project: reducing barriers to long-acting reversible contraception. Am J Obstet Gynecol. 2010;203(2):115.e1-115.e7. doi:10.1016/j.ajog.2010.04.017.

b Diedrich JT, Zhao Q, Madden T, Secura GM, Peipert JF. Three-year continuation of reversible contraception. Am J Obstet Gynecol. 2015;213(5):662.e1-662.e8. doi:10.1016/j.ajog.2015.08.001.