



Long acting reversible contraception

This statement has been developed and reviewed by

Objectives: To provide advice on long acting reversible contraception.

Options: For the purposes of this statement Long acting reversible contraception (LARC) includes the contraceptive implants, intrauterine contraception including the copper containing devices and the levonorgestrel intrauterine system.

Outcomes: Information about effective, reversible non user dependent contraception.

Target audience: All health practitioners providing gynaecological care and contraceptive advice and device insertion and removal to women.

Evidence: Medline was searched for randomised trials, prospective cohort studies, and selected retrospective cohort studies examining the safety and efficacy, advantages and disadvantages of LARC methods over user dependent methods.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Validation: This statement was compared with guidance published by ACOG,¹ NICE,² WHO,³ and Sexual Health and Family Planning Australia.⁴

Background: This statement was first developed by RANZCOG in July 2017.

Funding: The development and review of this statement was funded by RANZCOG.

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1. Patient summary

Long acting reversible contraception (LARC) includes the contraceptive implants (Implanon NXT in Australia and Jadelle in New Zealand), the copper containing intrauterine devices (Cu-IUDs), and the lev+ -onorgestrel intrauterine system (IUS). While uptake of LARC methods is increasing, rates in Australian and New Zealand still lag behind other similar countries.

LARC methods have the following advantages for women

- Are the most effective reversible methods available; are more effective at reducing unintended pregnancy than shorter acting methods.
- Have high rates of user satisfaction as indicated by high continuation rates
- Are set and forget methods that do not require daily adherence
- Require fewer visits to health services than many other methods
- Compared to using the pill for one year, LARC methods are more cost effective for women and governments because of the reduction in unplanned pregnancy.^{5,6}
- Are easily reversible
- Are suitable for women of all ages including young nulliparous women
- Do not affect fertility after removal

The methods also have some non-contraceptive benefits such as reduction in menstrual bleeding and pain with the IUS and a reduction in dysmenorrhoea and pelvic pain with the implants.

2. Summary of recommendations

Recommendation 1	Grade and reference
LARC methods are the most effective reversible methods of contraception available and have high continuation and satisfaction rates amongst users.	Evidence based recommendation Reference 3
Recommendation 2	Grade and reference
There are very few contraindications to use of LARC methods and according to the World Health Organization, the majority of women are eligible for implants and intrauterine contraception (IUC) including young and nulliparous women.	Consensus-based recommendation
Recommendation 3	Grade and reference

4. Discussion and Recommendations

4.1 What are the advantages of LARC methods?

Women using LARC methods have less chance of unintended pregnancy compared to women using user dependent methods. LARCs do not require daily adherence and are the most effective reversible methods available. They are also equally or more effective than female sterilisation. They have higher continuation rates than the oral contraceptive pill and very high satisfaction rates.⁸ All LARC methods are very cost-effective both in terms of the money spent by the patient (which may be high initially but is low over a one year period) and bring cost savings to governments in terms of the public health impact on reducing unintended pregnancies.⁹ Importantly, LARC methods are suitable for women of all ages and parity. In addition, IUC methods and implants are easily reversible and do not affect fertility after removal.

4.2 How is patient suitability for a LARC method assessed?

There are very few contraindications to use of LARC methods and according to the World Health Organization,³ the majority of women are eligible for implants and intrauterine contraception (IUC) including young, nulliparous women and those immediately postpartum. Guidance on assessment prior to IUC can be found in the RANZCOG statement "Intrauterine Contraception". The only absolute contraindications to IUD use are pregnancy, insertions after puerperal sepsis or septic abortion, unexplained vaginal bleeding, Gestational trophoblastic disease (GTD) with rising hcg, endometrial cancer, distortion of the uterine cavity from fibroids or congenital abnormality, and current Pelvic Inflammatory Disease (PID).

The only absolute contraindication to use of implants is current breast cancer but the risks of use outweigh the benefits with severe cirrhosis, unexplained vaginal bleeding, past history of breast cancer.

4.3 What are the current barriers to LARC provision?

There appears to be a lack of accurate knowledge among providers and women about LARC methods, as well as insufficient training in LARC insertion and removal procedures and management of complications. A lack of appropriate remuneration for these procedures in general practice remains a barrier in Australia. Some women and providers have little awareness of the benefits of LARCs and hold misperceptions about the risks of infection and infertility and concerns about the potential side effects such as irregular bleeding.¹⁰ Modern IUC methods are not

4.4 How can the low uptake of LARC methods be addressed?

Health professionals should update their knowledge of LARC methods and when discussing contraception, should provide information about the benefits of LARCs methods to all women including young women. LARC should be recommended as a first line method. Implant and IUD insertion requires specific skills, training and ongoing practice to maintain competence. These services are likely to be undertaken by obstetricians and gynaecologists, family planning clinics, trained general practitioners (GPs) and selected pregnancy termination clinics.

4. References

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Janet Vaughan	Deputy Chair, Obstetrics
Associate Professor Ian Pettigrew	EAC Representative
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Associate Professor Lisa Hui	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.