Preventing Unintended Pregnancy: A Pediatric Opportunity

Prevention is the cornerstone of pediatric practice, with immunization the prototype strategy because of its significant effectiveness in preventing selected infections. Other targets of prevention such as obesity, injuries, birth defects, and drug and alcohol use are important but lack simple, evidence-based, and equally effective strategies. We suggest that in response to the improvement in the effectiveness and safety of long-acting reversible contraceptives (LARCs; eg, intrauterine devices [IUDs], contraceptive implants), pediatricians have a special opportunity to prevent unintended pregnancy, not only in adolescents but in all women of childbearing age who bring their children into our offices for pediatric care. This commentary provides information about unintended pregnancy and the safety and effectiveness of LARC methods. We suggest specific opportunities for pediatricians to engage and motivate women to actively choose their reproductive futures and when to have their children.

One-half of the 6.7 million pregnancies in the United States each year are unintended, 43% of which end in abortion. Although the studies have limitations, the data show that unintended live births suffer a disproportionately high rate of maternal and infant health problems, interfere with young mothers completing their education, and reduce the financial and emotional resources available to support and nurture existing children. The cost for births resulting from unintended pregnancies was estimated to be $11.1 billion in 2006.

LARC methods are the most effective, safest, and most cost-effective reversible options to prevent unintended pregnancy. The 2 US Food and Drug Administration–approved methods (IUDs and the contraceptive implant) have higher efficacy rates compared with other reversible methods. The typical success rates during the first year of use are >99% for the copper IUD, levonorgestrel IUD, and the etonogestrel implant. Birth control pills have to be remembered to be taken daily and are 93% effective with typical use. Although physicians traditionally provide patients and parents with information on treatment options, we would unlikely recommend a vaccine that is 93% effective when another vaccine with a similar safety profile existed that was 99% effective like all LARC methods. These US Food and Drug Administration–approved LARC methods are very safe for most women. The contraceptive implant is one-half the cost of the contraceptive pill to the consumer at 12 months. Cost savings of preventing an unintended pregnancy...
pregnancy is significant because it fully negates the cost of prenatal care, labor, and delivery, as well as newborn and primary care of the child. This is a conservative estimate because it does not include the cost of maternal or infant health problems.

Although contraceptive care is now covered by insurance as part of the Patient Protection and Affordable Care Act, pediatric health care provides an opportunity to increase timely access to information and care at point of service for adolescents and for mothers of child patients. The value of LARCs should be a call to action for pediatricians to: (1) question mothers of all ages regarding plans for timing of the next infant, and (2) expand the number of clinical sites providing tailored site-specific information and/or access to LARC methods to prevent unplanned pregnancy. Pediatricians in primary care should ask mothers their child spacing plans and record this information in the chart. We suggest asking, “When do you plan to have your next baby?” because it represents a child focus, rather than asking about use of birth control. Because reporting in the medical record and communicating to child and parents a child’s BMI is considered a quality practice indicator by some payers, eliciting and recording mothers’ child spacing plans and contraception strategies should be a higher priority as a quality indicator because effective intervention is available for preventing unplanned pregnancy and not for obesity. The pediatricians’ focus and interest for the child can provide a special perspective for parents because an unplanned patient pregnancy may dilute a family’s emotional and financial resources to the present child patient. In addition, pediatricians can communicate to mothers that both short (<18 months) and long (>59 months) intervals between pregnancies are associated with poorer perinatal outcomes. Pediatricians can also provide mothers with handouts or Web sites about the pros and cons of various contraceptive approaches, but they should emphasize that the best evidence of efficacy supports LARC methods. Although LARC methods, especially IUDs, were previously associated with health problems, the newer versions are much improved and are considered safe.

The adolescent medicine clinic is another potential site for expansion. Not all adolescent medicine pediatricians provide LARCs at adolescent clinic visits. Competency in discussing and administering all forms of contraception, regardless of duration, should be a core fellowship training requirement and best practice for adolescent specialists. Similarly, pediatric emergency departments are a potential site for prevention beyond prescriptions for birth control pills or contraceptive injection for high-risk, sexually active adolescents. The present procedure is to address the acute problem and refer the adolescent for follow-up contraceptive care elsewhere, creating a missed opportunity for adolescents to obtain long-acting contraceptive care. Lack of follow-up usually means inadequate protection to prevent pregnancy. One potential solution is counseling and insertion of implantable LARCs in the pediatric emergency department and/or a referral directly to a family planning clinic that same day unless there is a contradiction (eg, for IUDs, when a patient has a sexually transmitted disease). This approach provides adolescents what they want and need, at the point of service: just in time care. This option is being piloted at Boston Medical Center.

In many hospitals globally, LARCs are inserted in the postpartum period before discharge because it is a safe, effective, and efficient time and place to provide IUDs and contraceptive implants. Pediatricians who care for newborns can work collaboratively with their obstetric colleagues to promote this practice. Pediatricians can also support schools to improve education and access to LARCs to prevent unintended pregnancies. Using these and related strategies, New York City public schools have decreased unintended teenage pregnancies by >25% in the past 10 years.

States need to examine their reimbursement policies to remove barriers to LARC methods, especially unintended financial disincentives such as bundling LARCs as part of pregnancy reimbursement or not reimbursing pediatric emergency departments for LARC placement. Incentives such as enhancing reimbursement for LARC placement may increase insertion rates and may even encourage some primary care pediatricians to become trained to provide the implant because of its value to families. Such interventions need careful and continuous measurement. Given the 99% efficacy of LARC methods at preventing pregnancy, the volume of LARCs provided from claims data can be used to model the impact across a large and diverse population on pregnancy rates. Pediatricians can evaluate the effect of LARC coverage on unintended pregnancy rates within their own practices.

Pediatricians take great pride and have a long history in being physician leaders in prevention. The effectiveness and safety of LARCs, coupled with anticipated cost savings to patients, their families, and society, should stimulate pediatricians to take on this challenge to prevent unintended pregnancies. In response to the concern of inadequate time or “another thing to do,” insertion of an implantable LARC takes only minutes and will need to become reimbursable for trained clinicians. Because
it is an ~100% effective prevention health strategy and a safe option that also saves money, it should be among the highest priority during clinical visits. Placement of IUDs takes more time and training and likely will need a referral. Insurers should also see it as among the highest priority and provide incentives for counseling and insertion. Our family-focus mission and tradition of prevention deserve no less.

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REFERENCES
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