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Access to Contraception

This Committee Statement was developed by the American College of Obstetricians & Gynecologists' Committee on Advancing Equity in Obstetric and Gynecologic Health Care in collaboration with Ann Baylor, MD, and Noah Nattell, MD, MS.

Access to desired contraception is essential to the health and well-being of those who can get pregnant; a reproductive justice framework that acknowledges the interconnectedness of social and structural forces on sexual and reproductive health is key to the equitable provision of contraception to all patients. Obstetrician–gynecologists should be aware of social and structural barriers to care and the potential for bias and be prepared to address the most common misperceptions about contraceptive methods in a way that is age appropriate and compatible with the patient's health literacy. Payers (state, federal, and private insurance), hospitals, and health care systems should include all U.S. Food and Drug Administration–approved methods on formulary and should ensure access to all contraceptive methods without cost sharing or copays.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

Based on the principles outlined in this Committee Statement, the American College of Obstetricians & Gynecologists (ACOG) makes the following recommendations:

- **Physicians and other health care professionals should respect a patient's reproductive autonomy by initiating, continuing, switching, or discontinuing contraceptive methods on request and without barriers**.
- **Payers (state, federal, and private insurance), hospitals, and health care systems should include all U.S. Food and Drug Administration–approved methods on formulary, including long-acting reversible contraceptives, and should ensure access to all contraceptive methods without cost sharing or copays**.
- **Health care professionals and public health officials should work to reduce misinformation and stigmatization related to contraceptive use**.
- **Obstetrician–gynecologists and other health care professionals should use shared decision making in all patient encounters, with special attention to individuals facing unique**

constraints around consent, coercion, and access (eg, adolescents, gender-diverse individuals, those who speak languages other than English, those with disabilities, and others).

- **Religious doctrines of hospital systems or health care professionals should not affect patients' access to the full range of contraceptive methods**.
- **Obstetrician–gynecologists and other health care professionals should provide accurate information and timely access or referrals to the full scope of contraceptive methods, including permanent contraception and vasectomy**.
- **Funding and institutional support should promote development of novel contraceptive methods, including male contraception, and research to reduce inequities in contraceptive access and reproductive health outcomes**.
- **Physician groups and health care institutions should publicly oppose and advocate to overcome regulatory, legislative, and judicial actions that reduce access to contraception. State and federal governments should protect contraceptive access and increase funding to expand access**.
- **To improve access to contraception, access to training for health care professionals other than obstetrician–gynecologists should be increased**.

BACKGROUND

Contraceptive access allows individuals to choose if and when they desire pregnancy. This corresponds to the concept of reproductive justice: the right to have children, not have children, and to parent children in a safe environment (1). There are physical, emotional, and financial costs to restrictions on bodily autonomy. The ability to access desired contraception is paramount for individuals, allowing them to decide when or if to have children and parent. Although more than 99% of sexually active women have used some form of contraception (2), the rate of unintended pregnancy in the United States was 35.7% in 2019 and was highest among adolescents, those with low incomes, and racial or ethnic minoritized individuals (3). Although unintended pregnancy is an imperfect marker of an unmet need for contraception, and there are complex reasons that pregnancy may occur, increased access to contraception may help lower the rate of unintended pregnancy and its associated adverse infant and maternal health outcomes (4).

As with health care generally, access to contraception and unintended pregnancy are intertwined with social determinants of health and the social conditions that not only influence individual health but also work to create cycles that perpetuate intergenerational disadvantage (5). The reproductive rights of minoritized individuals have been adversely affected by biases, discrimination, paternalism, and a history of involuntary sterilization and medical experimentation that has led to mistrust of the medical community (Box 1). Building trust requires evidence-based, patient-centered counseling of options and shared decision making, with an understanding of patient goals and preferences (6). Additionally, people have a variety of reasons for utilizing contraception. Individuals may desire hormonal contraception for its noncontraceptive benefits, such as management of menstrual cycle irregularity, premenstrual syndrome, acne or hirsutism, and pelvic pain, among other conditions.

Clinicians must be knowledgeable about current laws governing contraceptive access where they practice. The U.S. Supreme Court found that the use of contraception was a constitutional right for married individuals in the mid-1960s (7) and for nonmarried individuals in the 1970s (8). Despite this guarantee, federal and state policies can expand or contract contraceptive access through directives and the control of funds for educational initiatives and contraceptive coverage; they can affect discrimination and inequities in the provision of contraception (9). Unfavorable legal rulings and restrictive legislation impede contraceptive access for minors and adults and interfere with the patient–physician relationship by restricting counseling, coverage, and provision. State legislatures, along with court rulings, have limited adolescent access to contraception by requiring parental consent. Since the Supreme Court abolished federal protection of abortion (10), overturning years of precedent, Justice Clarence Thomas has signaled an interest in reviewing the *Griswold v. Connecticut* decision. The *Dobbs v. Jackson Women's Health Organization* decision makes comprehensive and equitable access to contraception of paramount importance; access seems increasingly at risk (11). Over-the-counter (OTC), telehealth, and pharmacist-prescribed hormonal contraception are ways to increase patient access (12–14). Training in the provision of contraceptives, including long-acting reversible contraceptives (LARC), should be available to all clinicians, and every effort should be made to offer same-day access to LARC (15). Clinicians should familiarize themselves with the ACOG-endorsed Centers for Disease Control and Prevention Medical Eligibility Criteria for Contraceptive Use and understand the implications of each category (16). For "category 3" recommendations (risks may outweigh benefits), the

Box 1. Obstetrics and Gynecology: Racism, Coercion, and Eugenics

The history of the obstetrics and gynecology specialty is rooted in racism and oppression. A pioneer of the field, James Marion Sims, experimented on enslaved Black women without anesthesia, including three women—Betsey, Lucy, and Anarcha—who underwent repetitive gynecologic procedures without consent.* The eugenics movement of the early 20th century notoriously forced sterilization as a means of population control on members of society who were deemed "unfit to reproduce," including individuals who were institutionalized, those with disabilities, those with low incomes, women of color, immigrants, and those labeled "mentally incompetent" or "feeble-minded."† Recent examples of coercion in reproductive health include coerced sterilizations in prisons, financial incentives for individuals with substance use disorder to undergo sterilization, and hysterectomies performed on women in the custody of U.S. Immigration and Customs Enforcement.‡ More frequently, coercion may take place by providing differential contraceptive counseling based on race, ethnicity, socioeconomic status, or demographic factors.§

The American College of Obstetricians & Gynecologists notes that the actualization of an equitable health care system that serves all people can occur only through acknowledgement of the historical context from which modern health inequities grew, including reproductive injustices. For more information, see ACOG's Statement of Policy, *Racism in Obstetrics and Gynecology*.‖

* American College of Obstetricians and Gynecologists. Obstetrics and gynecology: collective action addressing racism. Joint Statement. Accessed March 22, 2022. https://www.acog.org/news/news-articles/2020/08/joint-statement-obstetrics-and-gynecology-collective-action-addressing-racism.

† Access to postpartum sterilization. ACOG Committee Opinion No. 827. American College of Obstetricians and Gynecologists. Obstet Gynecol 2021;137:e169–76. doi: 10.1097/AOG.0000000000004381.

‡ Reproductive health care for incarcerated pregnant, postpartum, and nonpregnant individuals. ACOG Committee Opinion No. 830. American College of Obstetricians and Gynecologists. Obstet Gynecol 2021;138:e24–34. doi: 10.1097/AOG.0000000000004429; Abbass N, Malhotra T, Bullington B, Arora KS. Ethical issues in providing and promoting contraception to women with opioid use disorder. J Clin Ethics 2022;33:112–23. doi: 10.1086/JCE2022332112; and Project South. Re: lack of medical care, unsafe work practices, and absence of adequate protection against COVID-19 for detained immigrants and employees alike at the Irwin County Detention Center. Accessed September 8, 2025. https://projectsouth.org/wp-content/uploads/2020/09/OIG-ICDC-Complaint-1.pdf

§ Permanent contraception: ethical issues and considerations. ACOG Committee Statement No. 8. American College of Obstetricians and Gynecologists. Obstet Gynecol 2024;143:e31–9. doi: 10.1097/AOG.0000000000005474.

‖ American College of Obstetricians and Gynecologists. Racism in obstetrics and gynecology. Statement of Policy. Accessed April 26, 2024. https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/racism-in-obstetrics-gynecology.

clinician should have a patient-centered discussion detailing potential risks, using shared decision for a final determination. Health care professionals should not hinder access by imposing obstacles to contraception based on antiquated or inaccurate practice methods or non–evidence-based patient requisites for care. Patient education resources on contraception can be found at https://www.acog.org/womens-health/healthy-living/birth-control.

RECOMMENDATIONS AND CONCLUSIONS

Physicians and other health care professionals should respect a patient's reproductive autonomy by initiating, continuing, switching, or discontinuing contraceptive methods on request and without barriers.

Physicians and other health care professionals often impose obstacles to patients obtaining, continuing, or discontinuing contraceptive methods. This may be due to lack of knowledge, operational barriers, or individual or cultural biases toward parenting and pregnancy prevention. Eligibility for intrauterine device (IUD) insertion is not predicated on age, parity, or confirmed negative sexually transmitted infection test results, and all contraception can be initiated same-day whenever pregnancy is unlikely (17). There is no medical or safety benefit to requiring a routine pelvic examination or cervical cancer screening before initiating hormonal contraception, and the prospect of a pelvic examination may be a deterrent to initiating very highly effective contraceptive methods (18). Blood pressure monitoring is not indicated for normotensive patients using estrogen-containing contraceptives.

Box 2. Sources for Combatting Misinformation

ACOG's Birth Control: Resource Overview

This page lists the key publications and resources for patients from ACOG.

ACOG's Healthy Teens

ACOG's patient education website for adolescents has information on body image, sexuality, birth control, the first gynecologic visit, and other topics.

ACOG's Combating Misinformation

This page includes ACOG resources to help people identify misinformation when they see it, combat myths, provide evidence-based information, and help clinicians talk with their patients about misinformation and communicate the facts.

Bedsider

Bedsider is an online birth control support network for individuals aged 18–29 years, operated by Power to Decide, a private, nonprofit organization.

ACOG, American College of Obstetricians & Gynecologists.

Whereas health professionals may see pregnancy prevention as the most important function of contraception, and therefore provide tiered-effectiveness counseling, effectiveness is not the sole or primary factor in choosing a method for many patients (19). By reframing the discussion to prioritize the needs and desires of the patient, health professionals can ensure access to a preferred method (20). Long-acting reversible contraceptives, though among the most effective methods of pregnancy prevention and therefore desirable for many, require an invasive procedure and a potentially painful pelvic examination for IUD initiation and discontinuation. Not only does this limit a patient's ability to start or stop on demand, but such interactions also can be anxiety provoking or traumatic, especially for those with experiences of personal or historical sexual violence or medical trauma and those who have limited experience with gynecologic examinations (21). The incorporation of pain-modulating interventions (oral or intravenous medications, local or topical anesthesia, anxiolytics, or a combination of approaches) may reduce anxiety and trauma associated with insertion and removal of LARC methods. Both ACOG and the CDC recommend offering pain-management options to patients during IUD insertion and removal (17, 22). To increase patient-centered options, health care professionals should ensure the availability of pain-management options, with counseling about the risks and benefits.

Access to contraception includes access to changing or stopping methods. Patients face barriers when choosing to discontinue a method when this requires interaction with the health care system (eg, the removal of an IUD or implant). This may be due to operational obstacles (ie, obtaining an appointment) or a health care professional's hesitance or refusal to remove a device, an example of reproductive coercion (23). Health care professionals should assist patients to start, stop, or switch methods on demand, ensuring that information on methods is readily available and that operational barriers are minimized.

Extensive knowledge about all contraceptive methods, including accurate information on correct use and contraindications, is essential to the provision of comprehensive contraceptive care. A health professional tasked with counseling on contraception should be aware of all prescribed, OTC, and nonpharmacologic methods of pregnancy prevention. Contraceptive options should be tailored to a patient's goals, which may or may not include efficacy, self-start or discontinuation, ease of use, avoiding pain, minimizing cost, preventing adverse effects, or noncontraceptive benefits (ie, menstrual control or acne treatment). Patient-centered counseling ensures that patients' needs are paramount when choosing a method.

Health care professionals should be prepared to discuss nonpharmacologic methods, including barrier methods, fertility-awareness methods (which may have associated apps), and withdrawal. Though the pregnancy-prevention efficacy of these methods is lower when compared with hormonal and LARC methods, they are inexpensive, accessible, well-tolerated, and well-known and have few, if any, contraindications. Nonpharmacologic methods do not contain hormones and most are patient-initiated at the time of or preceding intercourse, both highly desirable features for many patients. They also may be used in conjunction with hormonal methods to increase efficacy, or, in the case of internal and external condoms, to prevent transmission of

sexually transmitted infections. The efficacy of nonpharmacologic methods may be reduced significantly through user error; therefore, to ensure patients are able to access the most effective form of their chosen method, health care professionals should be able to counsel on efficacy and correct use. Other methods of contraception that are patient-initiated and timed include emergency contraception (available OTC or by prescription for advanced provision) and prescription vaginal gel. Additionally, when discussing smartphone or computer applications (apps) that track information such as menstrual cycles, ovulation, and medical appointments, clinicians should be aware of potential privacy breaches, legal surveillance, and criminalization that could arise from information provided to the apps (24). The data inputted in apps are not protected under the Health Insurance Portability and Accountability Act and could be shared externally.

Payers (state, federal, and private insurance), hospitals, and health care systems should include all U.S. Food and Drug Administration–approved methods on formulary, including long-acting reversible contraceptives, and should ensure access to all contraceptive methods without cost sharing or copays.

Payers should provide appropriate compensation for contraceptive services. Although access to the full range of contraceptive options improves quality of care and optimizes health outcomes, high upfront costs and limited reimbursement discourage some clinicians from stocking LARC methods. Public and private payers can contribute to efforts to improve contraceptive access by working with health care professionals to ensure appropriate payment for clinician services and to provide reimbursement for contraceptive devices at acquisition-cost levels. Access to immediate postpartum and postabortion contraception is important because the patient often is highly motivated to avoid pregnancy, is already in the health care system, and is not pregnant. However, appropriate reimbursement for LARC methods immediately postpartum or postabortion can be difficult to obtain. When there are structural barriers that delay access (eg, institutional policies requiring multiple visits instead of same-day provision of LARC methods), payment models should reflect these additional steps and clinicians still should be appropriately reimbursed. Obstetrician–gynecologists (ob-gyns) should advocate for improved payment structures for LARC methods and for patient-centered systems.

Access to affordable contraception requires eliminating not only expenses related to insurance coverage of contraceptives (ie, cost sharing or copays), but also reducing or eliminating the financial burden of OTC methods such as condoms, the OTC contraceptive pill, and OTC emergency contraception. U.S. Food and Drug Administration–approved OTC methods should be covered without cost sharing under the Affordable Care Act, as with currently covered prescribed contraceptive methods. The American College of Obstetricians & Gynecologists supports OTC access to hormonal contraception without age restrictions. For more information, see ACOG Committee Opinion No. 788, *Over-the-Counter Access to Hormonal Contraception* (12). Additionally, payment and practice policies should support the provision of a 13-month supply of contraceptives to remove barriers related to prescription refill and renewal. Data show that provision of a year's supply of contraceptives is cost effective and improves adherence and continuation rates (25).

To further decrease the financial burden of contraception on individuals and health systems, federal funding of Title X programs should be protected and expanded. Such funding should be available only to providers of scientifically accurate, evidence-based, and comprehensive contraceptive care, excluding deceptive organizations such as Crisis Pregnancy Centers. Federal and state governments should not withhold funding based on ideology. States should expand Medicaid eligibility for individuals and families with lower income and increase reimbursement for contraceptive services (26). Patients eligible for Medicaid insurance while pregnant should have extended coverage after the end of pregnancy to ensure contraceptive access, including initiating, continuing, or switching methods. For more details, see ACOG Committee Opinion No. 826, *Protecting and Expanding Medicaid to Improve Women's Health* (26).

Health care professionals and public health officials should work to reduce misinformation and stigmatization related to contraceptive use.

Comprehensive sexuality education, both in schools and in the community, should be medically accurate, evidence-based, and age-appropriate and should include information about contraception, sexual orientation, and gender identity. Because of their knowledge, experience, and awareness of a community's unique challenges, ob-gyns can be an important resource for sexuality education programs. As subject matter experts, ob-gyns should be involved in advising and supporting sex education programs (27). See ACOG Committee Opinion No. 678, *Comprehensive Sexuality Education*, for additional guidance on comprehensive sexuality education, including characteristics of effective programs (27).

Obstetrician–gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age-appropriate and compatible with the patient's health literacy. Although many patients seek information about contraception from online sources, data show that online

searches can yield great variability in information (28). Through its "Combating Misinformation" resource (29), ACOG is countering misinformation about obstetric and gynecologic health care. Health care professionals also can collaborate with consumers to develop accurate online education (28). Notably, although social media can be a source of misinformation, it also can serve as a source of community where individuals can share personal experiences. Although artificial intelligence may be used for patient education and has potential to provide important information, its accuracy remains concerning. See Box 2 for patient resources on reproductive health that can be useful in combatting misinformation.

Obstetrician–gynecologists and other health care professionals should use shared decision making in all patient encounters, with special attention to individuals facing unique constraints around consent, coercion, and access (eg, adolescents, gender-diverse individuals, those who speak languages other than English, those with disabilities, and others).

Patients are individuals with different needs, preferences, values, spiritual beliefs, and goals; as such, clinicians should tailor their contraceptive counseling to the specific patient. Although all individuals should receive respectful, patient-centered care based on their unique needs, there are some commonalities among groups that should be considered. Some patients may be more likely to experience bias or coercion from clinicians and may be more likely to avoid medical care due to mistrust of the health care system. Health care professionals should be aware of social and structural barriers to care and the potential for bias against patients, including, but not limited to, individuals with temporary or permanent medical disability, those with mental health diagnoses, adolescents, those who speak languages other than English, and gender-diverse individuals.

Obstetrician–gynecologists and other reproductive health care professionals should understand the barriers that prevent people with disabilities from accessing reproductive health care. This is critical in identifying inequities and informing patient-centered approaches to services (30). Patients with medical or mental health diagnoses, or both, and those with disabilities must be given the same access to all forms of contraception that are not specifically contraindicated. Depending on the patient's disability, clinicians should ensure that information is in a format that is accessible to them, that adverse effects are discussed, and that shared decision making or supported decision making is employed (31). Adolescents should undergo patient-centered counseling regarding all forms of contraception, with the knowledge that common barriers include misperceptions, cost, and legal implications. Appropriateness of LARC methods is not based on age or parity, and adolescence is not a contraindication for individuals who desire a LARC method. Confidentiality is key to building trust with adolescent patients (32, 33), and decision aids may be beneficial (34). Patients who speak languages other than English should have a certified medical interpreter rather than relying on a family member or caregiver. Additionally, intimate partner violence disproportionately affects individuals who are young, those who are poor, and those who are minoritized. Screening for intimate partner violence should include potential reproductive coercion, for example, withholding contraception or forcing abortion (35, 36).

Individuals with substance use disorders may have additional barriers and concerns. One program found the following components to be effective in increasing access to desired contraception in individuals with opioid use disorders: 1) reaching women with unmet need; 2) providing free or affordable contraception; 3) maximizing service accessibility; 4) providing patient-centered care; 5) employing willing, qualified providers of contraception; and 6) utilizing peer educators (37). Due to a history of mass incarceration and inherent coercion potential, it is imperative that incarcerated patients receive reproductive health care that is guided by their preferences (38). Finally, gender-diverse individuals with the potential to become pregnant should be asked about their contraceptive needs and counseled on the full range of contraceptive options, free from stigma, discrimination, or coercion (39, 40).

Religious doctrines of hospital systems or health care professionals should not affect patients' access to the full range of contraceptive methods.

Institutional or insurance policies, laws, and clinicians' actions that prohibit or limit essential care based on religious or other nonscientific grounds can jeopardize patients' health and safety. Religiously affiliated hospital systems, including Catholic hospitals, impose barriers and restrictions on evidence-based patient care; these policies can damage the patient–physician relationship (41). As of 2020, 4 of the 10 largest health systems in the United States, with facilities in 41 states, had a Catholic affiliation (42). As hospitals merge or develop affiliations with religious organizations, officials should evaluate and protect community access to contraception. Patients tend to use the hospital closest to where they live, and many patients are not aware that their local hospital is religiously affiliated or that the full spectrum of reproductive health care, including contraceptive services, is not provided (43). To compound matters, some hospitals do not advertise their religious affiliation (42).

Although the Affordable Care Act currently requires that nongrandfathered insurance plans provide contraceptives without cost sharing, religious organizations are exempt from this rule. Additionally, the Supreme Court

ruled in the 2014 *Burwell v. Hobby Lobby* case that a private corporation can exclude contraceptive coverage from workers' insurance benefits based on the company owner's religious beliefs (44). Because hormonal contraceptive methods, including levonorgestrel-releasing IUDs, have medical indications beyond contraception, there exist some "workarounds" that may allow provision of certain contraceptives. However, patients should receive their preferred method of contraception regardless of indication. Patients who do not have coverage due to an employer or plan's religious exemption should have access to alternative coverage for contraception. Conscientious refusal due to a religious or moral belief of a health care professional, facility, or pharmacy should not prevent patient access to any method of contraception. Patients desiring contraception should receive medically accurate information and prompt referral if the health care professional or health care system cannot provide desired care due to personal beliefs or religious affiliation (45, 46).

Obstetrician–gynecologists and other health care professionals should provide accurate information and timely access or referrals to the full scope of contraceptive methods, including permanent contraception and vasectomy.

Tubal sterilization, also called permanent contraception, is the most widely used contraceptive method in the United States, at 18.1% (47). Health care professionals should be aware of the historical and contemporary reality of unjust or coercive practices regarding permanent contraception, particularly for patients with low income, incarcerated patients, and patients whose fertility and parenting historically have been devalued or stereotyped as problematic or in need of control or surveillance (48). Age and parity should not be seen as contraindications to permanent contraception, and counseling should include reversible options, irreversibility, failure rate, ectopic pregnancy, and the potential for regret. A sterilization procedure can be performed safely before or after pregnancy or at the time of abortion. Clinicians must be aware of laws regarding age of consent and timing of the procedure.

Male sterilization, vasectomy, is used by 4.5% of couples and is less invasive, less expensive, and more effective when compared with female permanent contraception (49). It is not immediately effective and requires testing to confirm azoospermia. Counseling regarding vasectomy should be included in discussions of contraceptive options. A barrier to provision of vasectomy is lack of trained clinicians. The inclusion of this training in the Fellowship in Family Planning has the potential to expand access (50).

Funding and institutional support should promote development of novel contraceptive methods, including male contraception, and research to reduce inequities in contraceptive access and reproductive health outcomes.

Many individuals opt not to initiate or continue contraception due to potential adverse effects or risk factors. Novel contraceptives that reduce undesirable effects and outcomes will increase access by broadening the number of eligible patients. Although the burden of pregnancy prevention falls heavily on those who can become pregnant, there is increased interest in development and implementation of male contraceptives (51). Additionally, research demonstrating the safety and acceptability of contraception leads to broader accessibility and use. Research into the expansion of OTC methods (eg, self-administered depot medroxyprogesterone acetate) is another avenue to increase access. Continued institutional and governmental support of contraceptive research should be protected and expanded.

Physician groups and health care institutions should publicly oppose and advocate to overcome regulatory, legislative, and judicial actions that reduce access to contraception. State and federal governments should protect contraceptive access and increase funding to expand access.

The government should not remove or obscure information on contraception, and access to guidance should not be dictated by the ideology of a specific administration. Data, clinical guidance, and education should remain evidence-based and equitable and should remain available to the public and clinicians. Obstetrician–gynecologists are well positioned to speak out against legislation and policies that are based on misinformation rather than science. For example, contrary to legislative efforts in some states, based on the available data, LARC methods do not disrupt pregnancy and are not abortifacients (52). Obstetrician–gynecologists and other health care professionals should unequivocally and publicly oppose actions that decrease access to contraception. Avenues in which to advocate for contraception access include writing or lobbying legislators and government officials, authoring opinion pieces in newspapers, participating in media interviews, testifying in legislative or judicial proceedings, and signing amicus briefs.

To improve access to contraception, access to training for health care professionals other than obstetrician–gynecologists should be increased.

Contraception is not solely the purview of ob-gyns. Access for under-resourced populations and populations with low income can be improved through a broad integration of family planning services within the primary care setting (53). Additionally, known and trusted providers of pediatric health care can improve access for adolescents. All health care professionals should have basic knowledge of contraception and the ability

to prescribe, especially if they care for patients with illnesses that may be exacerbated by pregnancy or that have treatments that would be compromised should a patient become pregnant. Hospital-based clinicians and those caring for incarcerated individuals should evaluate patients for pregnancy risk and ensure continuation of the patient's chosen contraceptive method, because discontinuation can result in unintended pregnancy.

Though operational barriers (ie, short appointment times, untrained support staff, inability to stock contraceptive devices) often limit the availability of LARC methods in many primary care or pediatric settings, physicians from various specialties (family medicine, internal medicine, and pediatrics) are able to insert and remove IUDs and implants with the appropriate training. However, many non–ob-gyn physicians report difficulty obtaining training or preceptorship to feel comfortable initiating LARCs for their patients (54). Expanding training opportunities for physicians increases access to the spectrum of contraceptive options for their patients (55). Advanced practice clinicians are equally well-suited to provide contraception, including LARC methods. Training in contraception and LARC placement should be integrated into the training of physician associates, nurse practitioners, and midwives (56). In many states, registered nurses and pharmacists also can dispense self-administered contraceptives, and such expansion of services, along with training in the provision of contraception, expands patient access.

CONCLUSION

Access to desired contraception is essential to the health and well-being of those who can get pregnant and is even more important in the wake of the *Dobbs* decision. A reproductive justice framework that acknowledges the interconnectedness of social and structural forces on sexual and reproductive health is key to the equitable provision of contraception to all patients. Obstetrician–gynecologists and other health care professionals should tailor contraceptive counseling based on the individual patient's values, preferences, goals, and beliefs and should advocate to overcome barriers to contraceptive access. Programs that increase access to the full spectrum of contraceptive methods, such as Title X and Medicaid, should be protected and expanded.

Use of Language

The American College of Obstetricians & Gynecologists recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

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