Universal Access to Effective Pain Management for IUD Insertions

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Executive Summary

Intrauterine devices (IUDs) represent one of the most effective long-acting reversible contraceptive methods available. However, pain and inadequate pain management during insertion present significant barriers to access for many potential users.[2] Clinical evidence demonstrates a clear disparity in pain experiences: while multiparous individuals (those who have given birth) may tolerate IUD insertion with minimal anesthesia or standard Nonsteroidal Anti-inflammatory Drugs (NSAIDs) (such as Advil or Naproxen),[3] nulliparous individuals (those who have never given birth) frequently report moderate to severe pain that often goes inadequately addressed.[4]

Current clinical practice frequently defaults to a one-size-fits-all approach, typically limited to pre-procedural NSAIDs, without discussing comprehensive pain management options.[5] This standardized approach disregards both evidence and patient autonomy. Individuals with previous traumatic experiences or procedural anxiety particularly benefit from enhanced pain management protocols, yet these options are rarely presented systematically.

Research demonstrates that healthcare providers consistently underestimate insertion-related pain and cannot reliably predict which patients will experience significant discomfort.[6] A patient-centered approach offering a "menu of choices" for pain management options empowers individuals to make informed decisions aligned with their personal preferences, medical history, and comfort requirements.[7] This approach respects patient autonomy while potentially increasing IUD uptake rates.[8]

Recent studies confirm that enhanced pain management protocols significantly reduce procedure-related anxiety and may increase adoption rates among eligible candidates.[9] This briefing paper synthesizes current evidence regarding IUD insertion pain management approaches and outlines AccessBC's campaign to improve both quality of care and contraceptive accessibility across the province.

What is an IUD and How Does it Work?

Intrauterine devices (IUDs) are small, typically T-shaped contraceptive devices inserted into the uterus to prevent pregnancy. They are among the most effective forms of reversible contraception with a failure rate of less than 1%.[10] They are significantly more reliable than methods such as condoms (13% typical use failure rate) or oral contraceptive pills (7% typical use failure rate).[11]

There are two primary types of IUDs:

- Hormonal IUDs (such as Mirena, Kyleena, and Liletta) work by slowly releasing small amounts of progestin. This thickens cervical mucus to prevent sperm from reaching an egg, thins the uterine lining to prevent implantation, and may suppress ovulation. These devices are effective for 3-8 years, depending on the specific product.[12]
- Non-hormonal IUDs (such as Copper IUDs/Paragard) work by releasing copper ions that are toxic to sperm and inhibit their movement, preventing fertilization and implantation. These devices can remain effective for up to 10–12 years.[13]

The insertion process involves a healthcare provider using several specialized instruments. First, a speculum is placed to visualize the cervix. The provider then uses a tenaculum (a forceps-like instrument) to grasp and stabilize the cervix. The uterus is measured with a thin rod called a sound, after which the IUD is loaded into an insertion tube and placed through the cervical opening into the uterine cavity. Once properly positioned, the IUD arms are deployed, and the insertion device is removed, leaving the IUD in place with its retrieval strings extending into the vagina.[14]

Since British Columbia implemented universal contraception coverage in 2023, LARC (including IUD) dispensations have increased by approximately 49%, according to research recently published in the BMJ.[15] Ministry of Health data further support this shift: between April 2023 and December 2024, more than 75,000 patients received IUDs (65,000 hormonal IUDs and 10,000 copper IUDs).[16] However, in British Columbia, IUDs still represent a minority (24.5%) of contraceptive users under the free prescription program, compared to oral contraceptives (58.8%) and other methods, despite their superior effectiveness and convenience.[17]

Physiological Mechanisms of Pain During IUD Insertion

Many healthcare providers are still accustomed to patients receiving IUDs being familiar with vaginal exams, which is not always the case. In addition to anxiety around potential pain associated with IUD insertion, many patients may also experience significant anxiety around the pelvic/vaginal exam itself. This is particularly true for younger individuals, those who have never given birth, or those with prior traumatic experiences. The anxiety associated with speculum insertion and cervical manipulation can heighten pain perception and contribute to overall discomfort during the procedure.

There are three main sources of pain during IUD insertion:

- **Tenaculum Placement and Cervical Manipulation (Primary Pain Source)**: The tenaculum is a clamp-like instrument used to hold the cervix in place during insertion. When it pinches the cervix, it causes sharp pain because this area has many nerve endings.[18]

- **Cervical Manipulation and Dilation (Secondary Pain Source)**: The cervical opening must be stretched to allow the IUD to pass through. This stretching activates pain receptors, creating a deep cramping sensation that many patients describe as similar to intense menstrual pain.[19]

- **Prostaglandin-Mediated Uterine Contractions (Prolonged Pain Source)**: The insertion process triggers the release of chemicals called prostaglandins that cause the uterus to contract. These contractions can begin during the procedure and continue for 1-2 days afterward as the uterus adjusts to the IUD. People who have never given birth (nulliparous) often experience stronger contractions.[20]

Additional factors that contribute to discomfort include speculum insertion, individual characteristics (like never having given birth or having painful periods), and psychological state. Research shows that anxiety and fear can significantly increase pain perception, creating a cycle where pain causes more anxiety, which then intensifies the pain experience.[21]

Pain may also be experienced following insertion and during the days after the procedure. This commonly includes cramping and discomfort as the uterus adjusts to the IUD, which can continue for 1-2 days afterward. Some patients experience more prolonged cramping that may last several weeks. Prostaglandin-mediated uterine contractions are typically most intense during the first 24 hours and generally decrease in intensity over time. Many patients find that over-the-counter pain medications like naproxen can effectively manage this post-insertion discomfort.

Pain Management Solutions

Most IUD insertions are performed in outpatient settings with various pain management strategies available:

- **Non-Medicinal Approaches:** Open discussion about pain concerns, informed consent, "verbi-caine" (talking through the procedure), distraction techniques, music, comfort items (like stuffed animals), and presence of a support person can reduce anxiety and pain perception. The provider's skill level and a comfortable environment also make a substantial difference. These non-medicinal options remain essential even when good medicinal pain management is available, as they address the psychological aspects of the procedure and build trust between provider and patient.

- **Cervical Anesthesia:** Several methods can be used to numb the cervix during IUD insertion:

    - Paracervical Block: Injected lidocaine around the cervix effectively manages pain during cervical dilation and uterine manipulation.[22] This technique is available at some specialized facilities across BC, including the Vancouver Island Women's Clinic.[23] This provides deeper and more effective anesthesia.

    - Topical Anesthetics: Lidocaine-prilocaine cream and lidocaine spray have limited effectiveness for cervical pain during IUD insertion, primarily helping with tenaculum discomfort.[24]

- **Oral Analgesics:** Pre-procedural naproxen (Aleve) is commonly recommended to decrease post-insertion cramping and discomfort, and is usually taken 40 to 120 minutes prior to IUD placement.[25]

- **Methoxyflurane (Penthrox):** This inhaled analgesic offers quick-acting pain relief for minor procedures, though it remains less studied specifically for IUD insertions.[26] The Vancouver Island Women's Clinic offers Penthrox as part of its menu of pain management options, noting additional appointment time may be required.[27]

- **Oral Anxiolytics:** Medications like lorazepam (Ativan) can reduce procedure-related anxiety, indirectly aiding in pain management by decreasing tension and improving the overall experience.[28] While not directly analgesic, anxiety reduction can significantly improve patient comfort during the procedure. This can be prescribed, and some clinics may have it on hand for patients.

For patients with specific needs who have severe anxiety, trauma history, or other medical indications, advanced pain management options may be considered:

- **Procedural Sedation:** In exceptional cases, this IV medication can help patients feel relaxed during IUD insertion. This option is extremely limited in BC and requires specialist referral.[29] Patients interested in this option can discuss it with their primary care provider or gynecologist, who may refer them to a specialist authorized to provide IV sedation for IUD insertion. It may also be helpful to ask clinics about their referral process or if they maintain a waiting list.

- **Anesthesiologist-Administered Sedation and General Anesthesia:** These options are rarely indicated for standard IUD insertions and are typically only available when combined with other gynecological procedures. They may be considered in highly specific clinical circumstances for patients with severe trauma or medical complications.

Guidelines Informing IUD Insertion Practice in British Columbia

IUD insertion protocols in BC rely primarily on national clinical guidelines and position statements, implemented through provincial training initiatives and health policy frameworks. In the absence of BC-specific clinical guidelines for IUD insertion procedures, healthcare providers reference authoritative documents from national organizations, particularly the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the College of Family Physicians of Canada (CFPC).

The *Canadian Contraception Consensus* (CCC) serves as the primary national framework for contraceptive care.[30] Despite its comprehensive coverage of eligibility eligibility criteria and method selection, it notably lacks adequate guidance on pain management during IUD insertion. Rather, the document referenced a study that reported minimal discomfort, without disclosing that 93% of participants received lidocaine.[31] This significant omission mischaracterizes the evidence base, and has generated concerns that the guideline insufficiently addresses pain management considerations, potentially contributing to inconsistent practices across Canadian healthcare settings.[32]

In 2022, SOGC published a statement on IUD pain management that, while acknowledging insertion pain, remains separate from the core CCC guidelines, positioning pain management as optional rather than essential.[33] The statement minimizes pain by suggesting only ‘some’ patients experience discomfort, normalizing procedural pain instead of promoting proactive management. Despite listing interventions like NSAIDs, anesthetics, and trauma-informed approaches, these were presented as mere suggestions without integration into primary clinical guidelines.

The College of Family Physicians of Canada (CFPC) has also addressed IUD pain management through recommendations published in the *Canadian Family Physician* journal. A 2020 review by Whitworth highlighted how local anesthetics remain underutilized and advocated for standardizing lidocaine spray, EMLA cream, and paracervical blocks in insertion protocols.[34] While this publication reinforces the need for preemptive, individualized pain management approaches, neither organization provides standardized expectations, creating a regulatory void where analgesia remains optional rather than standard for this invasive reproductive procedure. This stands in stark contrast to literature synthesizing the academic community’s recommendations. [35]

In BC, clinical practice patterns are significantly influenced by Continuing Professional Development (CPD) educational initiatives, most notably those developed by the University of British Columbia (UBC). The UBC Contraception Management curriculum provides healthcare practitioners with training in trauma-informed care methodologies, analgesic intervention strategies, and evidence-based IUD insertion techniques. These educational programs incorporate contemporary national guidance, including recommendations from both the SOGC and CFPC, and have emerged as a fundamental mechanism for guideline dissemination and clinical knowledge translation throughout BC.[36]

In 2023, BC implemented precedent-setting legislation establishing universal coverage for prescription contraception, encompassing IUD devices and insertion procedures. This policy initiative, while primarily addressing financial barriers rather than clinical practice standards, substantively impacted IUD insertion protocols by increasing accessibility and utilization. A recent study published in the *BMJ* found "that after 15 months of the implementation of universal, no-cost, first-dollar contraception coverage policy, LARC dispensations increased by 49%, equating to an additional 11,375 individuals."[37] However, enhancing IUD availability without concurrently addressing procedural pain management and provider practice variability potentially undermines equitable healthcare delivery. Although the provincial government has not established independent clinical standards regarding pain management during IUD insertion, there is increasing recognition among institutional stakeholders regarding the necessity of provincial alignment with SOGC pain management recommendations. Recent advocacy efforts have successfully secured a new fee code for cervical blocks performed by family physicians, where none previously existed. This development, which incentivizes the use of effective pain management techniques during IUD insertions, demonstrates how targeted advocacy can improve clinical practice. However, additional systematic improvements remain necessary.

Systemic Limitations in British Columbia

Despite British Columbia's implementation of universal no-cost contraception policy, significant systemic limitations persist that undermine equitable access to prescription contraception in the province. While direct costs may have been removed, there are still a wide range of indirect costs, including time off work or school for appointments, transportation costs, and in some cases, cost for pain management. As well as persistent stigma and taboo around sex and sexual and reproductive health, access to reliable, up-to-date, judgement free information about options, etc. These limitations manifest across regulatory, infrastructural, educational, and cultural domains, and disproportionately affect women and gender-diverse individuals, particularly those from living in rural or marginalized communities, and those living in rural or remote areas.

What Needs To Be Done

We are asking the government of BC to:

1) Adopt province-specific clinical guidelines for addressing pain management planning for IUD insertions.
2) Implement appropriate MSP billing mechanisms for pain control interventions.
3) Work with post-secondary and training institutions to implement mandatory training requirements for practitioners.
4) Implement strategies for equitable access to pain management during IUD insertions across all regions.

Lack of Provincial Standards

BC lacks formalized provincial guidelines governing these protocols. Consequently, clinicians must rely on national documents, including the *SOGC Canadian Contraception Consensus* (2016), which notably omits comprehensive pain control strategies, and the 2022 SOGC position statement, which provides guidance but is not formally integrated into standardized clinical practice. This regulatory gap results in inconsistent/inequitable access to care across the province. These gaps are particularly concerning as British Columbia expands scope-of-practice parameters to include IUD insertions by nurse practitioners, midwives, and naturopaths. In British Columbia, there isn't a province-wide system to ensure all healthcare providers inserting IUDs have the same training. This means the quality of care can vary depending on a provider's individual training, even though midwives, nurse practitioners, and naturopathic doctors have their own certification programs.[38]

Therefore, we call on the government to:

1) Develop and implement BC-specific clinical guidelines for IUD insertions that standardize pain management protocols, establish mandatory competency-based training requirements for all practitioners (including those with expanded practice scope), and address the cultural minimization of gynecologic pain.

Financial Barriers to Quality Care

While the Medical Services Plan (MSP) framework previously lacked designated fee codes for essential pain control interventions during IUD insertions, recent advocacy efforts have successfully secured a new fee code for paracervical blocks performed by family physicians. However, challenges remain with other pain management approaches like topical, oral, and inhaled analgesics, where billing mechanisms are still insufficient. As a result of current billing practices, clinicians often have limited time with patients, which means that comprehensive pain management, proper education about the procedure, and addressing individual concerns are sacrificed to meet productivity metrics.

Therefore, we call on the government to:

2) Implement appropriate MSP billing mechanisms for pain control interventions during IUD insertions, remove structural disincentives for quality care, and ensure equitable access to pain management regardless of geographic location or provider.

Training and Education Gaps

No mandatory, competency-based educational framework exists for IUD insertion in British Columbia that comprehensively addresses analgesia administration or trauma-informed care principles. Educational approaches remain predominantly informal and heterogeneous across medical schools, residency programs, and continuing professional development initiatives.[39] This educational deficiency results in

practitioners performing IUD insertions without adequate training in pain control methodologies.

Therefore, we call on the government to:

3) Work with educational institutions to develop and implement standardized, competency-based training for all practitioners who perform IUD insertions. This training should include pain management techniques, trauma-informed approaches, and cultural sensitivity. Make this training mandatory across all healthcare disciplines authorized to perform IUD insertions.

Inequities in Pain Management

Access to procedural pain mitigation is substantially determined by provider discretion and geographic location. While some patients in urban centers have access to lidocaine administration or enhanced supportive care, many urban providers still offer only NSAIDs, similar to their rural counterparts. This creates a stratified system where pain management is determined by location rather than clinical need.[40] Similarly, patients in rural or remote communities may experience prolonged wait times and limited provider availability, particularly regarding practitioners trained in trauma-informed insertion techniques or comprehensive pain management approaches.[41] Many patients must travel significant distances to access reproductive health services that provide adequate care, further exacerbating existing inequities,[42] not to mention costs.

Therefore, we call on the government to:

4) Implement strategies for equitable access to pain management during IUD insertions across all regions by: establishing standardized provincial protocols (ask #1) that make pain management options mandatory rather than discretionary, increasing funding for underserved areas, deploying mobile health services to reach remote communities, and providing telemedicine support to help local providers deliver consistent pain management.

Costs to Reproductive Healthcare

These systemic deficiencies reflect broader patterns of misogyny within medical systems. The omission of comprehensive analgesia recommendations from guidelines, absence of training mandates, and failure to standardize care reinforce historical marginalization of women and individuals with uteruses, treating their pain as secondary or inevitable.

Provincial and national medical culture continues to normalize pain during gynecologic procedures, with clinicians frequently reassuring patients that 'discomfort is normal' without acknowledging that such pain could be mitigated through appropriate management strategies. This normalization of suffering is reinforced by national guidelines that cite studies utilizing analgesia without transparent disclosure.[43]

Additionally, an increasing prevalence of patients have publicly shared traumatic IUD experiences, highlighting pain, inadequate consent processes, and provider dismissal. These testimonials reflect broader systemic deficiencies and have contributed to diminished trust in reproductive healthcare services, particularly among young, racialized, or trauma-affected populations.[44]

Clinicians providing trauma-informed IUD insertions, including extended counseling, local anesthetic administration, or extended appointment durations, lack structural or financial support. In certain contexts, they may experience penalties for reduced productivity, reinforcing a system that prioritizes throughput over patient-centered care approaches.

In the absence of standardized rights or protocols, responsibility for securing adequate pain relief frequently falls upon patients. Many must explicitly request anesthesia, conduct independent research regarding clinical options, or advocate during appointments – placing disproportionate burden on those least equipped to navigate clinical hierarchies effectively.[45]

Without systematic reform, British Columbia's reproductive healthcare infrastructure will continue to perpetuate structures in which gynecological pain remains inadequately acknowledged, undertreated, and institutionally normalized.[46]

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