HORMONAL IUD
Access Group

January 2026

Scientific Evidence

For Hormonal IUD Introduction

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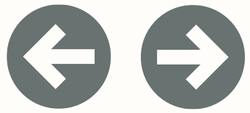
Navigating the Evidence Package

Core Function Buttons

The Home icon will take you to the **main menu**

The Return icon will take you to the **page you were last on**



The Arrow icons will take you to the **previous** or **next** page

The Define icon will take you to the **abbreviation list**

Section Navigation & Indicators

Introduction

Use the menu bar to navigate between sections. The active section will be grey.

Therapeutic Indications

On Label Indications

Use the menu to navigate between subsections. Within each section, the active subsection will be green.

The Globe icon indicates when a slide is supported by evidence from low- and middle-income countries.

The Question Mark icon indicates that a topic is being actively researched in low- and middle-income contexts.

About the Hormonal IUD Evidence Package

The Hormonal IUD Evidence Package provides a supportive evidence base for family planning trainers and service delivery organizations, Ministry of Health leadership, and family planning providers interested in or actively pursuing introduction of the 52mg hormonal IUD.

This resource summarizes more than 50 years of hormonal IUD research and learning in both HICs and LMICs. It can be used as a standalone reference document or can be used to build out evidence-informed method trainings, introduction plans, and provision guidelines.

The Evidence Package was developed through a comprehensive literature review, inclusive of both peer reviewed and grey literature, and has been validated by experienced hormonal IUD providers and clinical trainers.

Suggested Reference

Hormonal IUD Access Group. *Scientific Evidence for Hormonal IUD Introduction.* 2026.

About the Hormonal IUD Evidence Package

There are a number of hormonal IUD products available in the global market. Of these, two commercial products have been approved by WHO Listed Authorities, a process which confirms their safety, quality, and efficacy:

- **AVIBELA**™ – A 52mg-releasing IUD developed and supplied by Medicines360 through its wholly owned subsidiary Impact RH360
- **MIRENA**® – A 52mg-releasing IUD developed by the Population Council, owned and supplied by Bayer AG

In addition, the ICA Foundation donates unbranded 52mg-releasing hormonal IUD units to NGOs and health service delivery organizations. This document will refer to the unbranded product as "**LNG-IUS**". The LNG-IUS has received approval from WHO Listed Authority but is not available commercially or for national procurement.

This evidence package focuses exclusively on evidence pertaining to these three 52mg-releasing hormonal IUD products though hormonal IUD products of smaller doses and non-quality-assured 52mg hormonal IUDs are available in limited markets.

Using the Evidence Package

This resource can be used as either a complete set or users can extract slides to build custom evidence packs or provide focused evidence on one topic.

To extract slides in PowerPoint:

- In the slide thumbnail tab, on the left side of the PowerPoint window, select the slide(s) you want to save.
- On the Home tab select Copy.
- Select File > New, then select Blank Presentation.
- On the **Home tab** select **Paste** to open the drop-down menu and select the **Keep Source Formatting** button. This will paste the slide into your new presentation as the second slide.

To extract slides in PDF:

Exact process will vary by PDF reader application. General steps may include:

- Select the slide(s) you want to save.
- Navigate to your PDF organization tools. In most applications, these will be labeled as Organize or “Organize Pages”
- Select “Extract” and confirm that the pages you’d selected are indicated in the extraction options

Evidence Structure

Main Idea

The “main idea” section will share the most essential piece of information related to the topic.

Additional Information

The “additional detail” section will provide supporting evidence and insights on the topic, including visualizations when needed.

Key Resources

The “key references” section includes essential resources, including publications, product labels, and tools to support the evidence and allow users to learn more.

Abbreviations

AIDS - Acquired Immunodeficiency Syndrome
API - Active Pharmaceutical Ingredient
CDC - US Centers for Disease Control
CIP - Costed Introduction Plan
CYP - Couple Year of Protection
FDA - US Food and Drug Administration
FP - Family Planning
GnRH-a - Gonadotropin-Releasing Hormone Agonists
HIC(s) - High-Income Country/Countries
HIUD - Hormonal Intrauterine Device
HIV - Human Immunodeficiency Virus
HMB - Heavy Menstrual Bleeding
HMIS - Health Management Information System
HRT - Hormone Replacement Therapy
ICA Foundation - International Contraceptive Access Foundation
IUD - Intrauterine Device
IUS - Intrauterine System
LARC - Long-Acting Reversible Family Planning
LMIC(s) - Low- or Middle-Income Country/Countries
LMIS - Logistics Management Information System
LNG - Levonorgestrel
MEC - Medical Eligibility Criteria
mg - Milligram
mL - Milliliter
mm - Millimeter
µg - Microgram
NGO - Non-Governmental Organization
NSAID - Non-Steroidal Anti-Inflammatory Drug
PID - Pelvic Inflammatory Disease
QoL - Quality of Life
STI - Sexually Transmitted Infection
UNFPA - United Nations Population Fund
WHO - World Health Organization

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Hormonal IUD Characteristics & Method Provision

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Hormonal IUD Characteristics & Method Provision

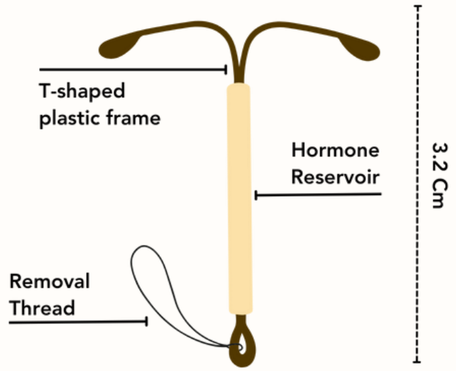
Method Characteristics

Product Description

Main Idea

The Hormonal IUD is a small, plastic device shaped like a T. It has a narrow reservoir that contains and releases the hormone levonorgestrel.

Additional Information



The 52mg levonorgestrel-releasing intrauterine system consists of a T-shaped plastic frame with a cylindrical reservoir containing the method's active pharmaceutical ingredient. The T-shaped frame is 32mm x 32mm, or approximately the size of two stacked dice. A polyethylene removal thread is attached to a loop at the end of the vertical stem of the frame. After insertion, the thread extends out of the cervix and into the vagina, where it is clipped to approximately 3cm in length for user comfort.

Key Resources

MIRENA Prescribing Information. Bayer AG. (2022)

AVIBELA Prescribing Information. Impact RH360. (2022)

Active Pharmaceutical Ingredient

Main Idea

The hormonal IUD's active pharmaceutical ingredient is levonorgestrel, a progestin also used in contraceptive pills and implants.

Additional Information

Levonorgestrel has been used in pharmaceutical products since 1970 both alone and in combination with estrogen. It's most commonly known as the active ingredient in many emergency contraceptive pills (at a much higher dose than the hormonal IUD) and in the two-rod implant Levoplant.

It is not associated with common estrogenic side effects, like loss of bone mineral density or blood clotting.

As a progestin, levonorgestrel is an agonist of the progesterone receptor and a weak agonist of the androgen receptor, with no other significant hormonal activity.

Key Resources

Levonorgestrel (C21H28O2). PubChem. (2025)

Results of a controlled study employing d-norgestrel and ethinyl estradiol. Apelo & Velosa. (1970)

Pharmacology of estrogens and progestogens: influence of different routes of administration. Kuhl. (2005)

Mechanism of Action

Main Idea

The hormonal IUD prevents sperm from reaching the egg by thickening the cervical mucus and thinning the uterine lining.

Additional Information

Based on evaluation of the pharmacodynamics of the hormone levonorgestrel, HIUD's active ingredient, the hormonal IUD is believed to have three main mechanisms of action:

- Thickening of the cervical mucus to limit passage of sperm into the uterus
- Inhibition of sperm function and movement in the uterus
- Inhibition of the thickening of the uterine lining.

The hormonal IUD does not consistently inhibit ovulation, and this is not considered to be a primary mechanism of action for the method.

Because the method prevents fertilization and implantation, it is not considered an abortifacient.

Key Resources

How Does Liletta Work? Abbvie & Medicines360. (2025)

Mirena IUD Mechanisms of Action. Bayer. (2025)

Luukkainen T, Lahteenmaki P, Toivonen J: Levonorgestrel-releasing intrauterine device. Ann. Med. 22(2), 85–90 (1990)

Distinct Method Attributes

Main Idea

The hormonal IUD does not significantly impact ovulation, acts locally within the uterus, limits heavy menstrual bleeding, and can be used discretely.

Additional Information

The hormonal IUD has four attributes that make it different from other available methods:

Ovulation - Unlike implants, pills, patches, or injectables, hormonal IUDs do not significantly impact ovulation. Most users will continue to ovulate while they use the method.

Local Effect - Most of the hormone the hormonal IUD releases is absorbed directly into the uterus, and only a small amount enters the blood stream. This limits systemic side effects.

Thinning Uterine Lining - The hormonal IUD limits the growth of the uterine lining. As a result, most users experience substantially reduced menstrual bleeding or paused bleeding over time.

Discretion - Many users see the hormonal IUD as more discrete than implants, which leave visible scars, and copper IUDs, which often cause heavy bleeding.

Key Resources

Effect of levonorgestrel-releasing intrauterine device on hormonal profile and menstrual pattern after long-term use. Xiao et al. (1995)

Contraceptive and therapeutic effects of the levonorgestrel intrauterine system: an overview. Jensen. (2005)

Heavy Menstrual Bleeding Treatment With a Levonorgestrel 52-mg Intrauterine Device. Creinen et al. (2023)

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Hormonal IUD Characteristics & Method Provision

Dosage

Dosage Form and Release Rate

Main Idea

The HIUD contains 52mg of LNG, released at a rate of 20µg per day from a silicone-based reservoir.

Additional Information

The hormonal IUD's silicone-based hormone reservoir is loaded with 52 milligrams of the hormone levonorgestrel which excretes through the silicone structure and coating. Immediately following insertion, the hormone is released at a rate of approximately 20 micrograms per day. In contrast, the single-rod contraceptive implant releases levonorgestrel at a rate of approximately 60-70 micrograms per day immediately following insertion.

The release rate for the hormonal IUD slows over time, releasing approximately 11 micrograms per day after five years of use and 7 micrograms per day after eight years of use. This slowed release does not impact the method's efficacy – the method remains equally effective at up to eight years of use.

Key Resources

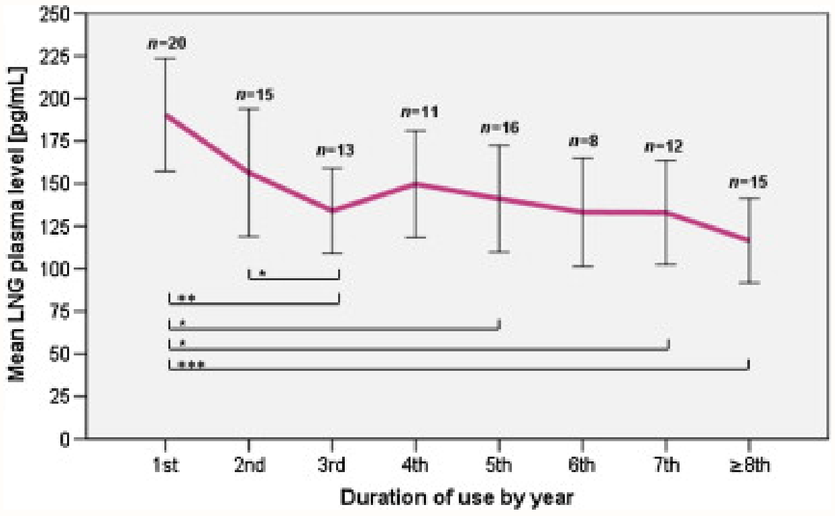
Extended use of LNG-IUS 52 mg: A population PK approach to estimate in vivo LNG release rates and systemic exposure including comparison with two other LNG-IUSs. Jensen et al. (2023)

Release Considerations

Main Idea

Blood plasma concentrations for LNG are low, and display slow, steady decline over time.

Additional Information



Plasma concentrations of levonorgestrel for hormonal IUD users are lower than those seen for levonorgestrel-releasing contraceptive implants and oral contraceptives, and unlike oral contraceptives, plasma concentrations do not display peaks and troughs. User-to-user variation in levonorgestrel concentration is likely associated with individual variation in metabolic clearance rates.

Key Resources

Extended use of LNG-IUS 52 mg: A population PK approach to estimate in vivo LNG release rates and systemic exposure including comparison with two other LNG-IUSs. Jensen et al. (2023)

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Hormonal IUD Characteristics & Method Provision

Method Provision

Post-Partum and Post-Abortion Insertion

Main Idea

The HIUD can be provided post-partum and post-abortion. Providers should carefully assess patients for risk of infection or method expulsion.

Additional Information

As long as infection is not present, the hormonal IUD can be inserted:

- Immediately (within 48 hours) after a first- or second-trimester surgical abortion, completed medical abortion, or miscarriage
- Immediately (within 48 hours) after the expulsion or removal of the placenta following birth
- After the uterus has returned to its pre-pregnancy size and shape following birth, abortion or miscarriage, a process that typically takes 4-6 weeks

Risk of uterine perforation is moderately increased for breastfeeding users or users who have recently given birth. Risk of expulsion is moderately increased with insertion immediately after delivery or second trimester abortion.

Key Resources

Intrauterine Device Expulsion After Postpartum Placement: A Systematic Review and Meta-analysis. Jatlaoui et al. (2018)

Intrauterine contraceptive insertion postabortion: a systematic review. Steenland et al. (2011)

Insertion Processes

Main Idea

The HIUD is inserted vaginally, through the cervix, and into the uterus using a sterile inserter.

Additional Information

The insertion process for the hormonal IUD has six primary steps:

1. Preparation of the client for insertion
2. Opening the sterile HIUD package
3. Loading the HIUD and setting the flange
4. Inserting the HIUD into the uterus
5. Releasing the HIUD and withdrawing the inserter
6. Trimming the removal strings below the cervix

Full insertion processes vary by product and by inserter type. For additional detail, view the insertion steps for Avibela™, Mirena®, and LNG-IUS. Aseptic technique and sterile equipment must be used throughout the insertion to minimize risk of infection.

Key Resources

Inserting the LNG-IUD. *Family Planning: A Global Handbook for Providers*. (2019)

Inserter Evidence & Experiences

Main Idea

Some providers may prefer a single-handed inserter over a two-handed inserter for convenience. There is no known difference in user experience.

Additional Information

Two-Handed Inserter

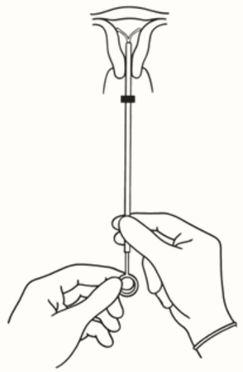

Image Credit: ICA Foundation

Single-Handed Inserter

Image Credit: Bayer

Limited quality evidence is available regarding user or provider preference for single- or two-handed inserters. Three studies have evaluated provider perception of single-handed inserters in high income contexts; each found highly favorable perception, referencing ease of use and consistency of IUD placement. However, these studies did not ask that providers compare single-handed inserters to other IUD inserter types.

Key Resources

Exploring IUD Inserter Interchangeability: Qualitative Insights from Healthcare Providers and Policy Makers in Nigeria. Burke et al. (2025)

Feasibility study of a single-handed inserter for levonorgestrel 52 mg intrauterine device placement. Eisenberg et al. (2023)

Insertion Pain

Main Idea

Pain during insertion is common. When available, providers should offer NSAIDs or lidocaine to minimize pain.

Additional Information

In studies conducted in the US, Europe, and Latin America, the majority of users experienced moderate to severe pain during insertion.

Younger, nulliparous or nulligravid IUD users who have experienced painful periods in the past are more likely to experience severe pain, but all clients should be counseled on the potential for pain and on the options their provider can offer for pain management during and after insertion.

WHO Selected Practice Recommendations

Oral NSAIDs (e.g., naproxen sodium) should be offered if available.

Either topical or injectable lidocaine applied to the cervix may reduce insertion pain.

If NSAIDs or lidocaine aren't available, providers **should still provide** clients with HIUD, with their informed consent.

Key Resources

Selected practice recommendations for contraceptive use, 4th Edition. World Health Organization. (2025)

Assessment of pain and ease of IUD placement according to type of device, parity, and mode of delivery. Lopes-Garcia et al. (2023)

Anticipated pain as a predictor of discomfort with intrauterine device placement. Dina et al. (2018)

Insertion Difficulty & Failure

Main Idea

Difficulty inserting the HIUD is somewhat common and is typically addressed by re-attempting or dilating the cervix. Failing to insert the HIUD is rare, occurring in fewer than 1 in 100 insertions.

Additional Information

Insertion failure (an inability by the provider to place the IUD resulting in a terminated insertion) occurred in 1% or fewer insertion attempts across multiple study settings.

Difficulty inserting, most commonly the result of encountering resistance at the cervix, is more common. 10-20% of insertions could be expected to have some degree of challenge. In most cases, simply re-attempting (while remaining mindful of client pain and preference) results in a successful placement, though occasionally, cervical dilation using dilator devices or misoprostol is required to complete the insertion.

Key Resources

Ease of intrauterine contraceptive device insertion in family planning settings. Harvey et al. (2012)

Assessment of pain and ease of intrauterine device placement according to type of device, parity, and mode of delivery. Lopes-Garcia et al. (2023)

Removal Processes

Main Idea

The HIUD is removed by grasping the removal strings with blunt forceps and gently withdrawing the device through the cervix.

Additional Information

In order to remove the HIUD, a trained provider will use blunt forceps to grasp the removal strings and slowly pull them. As the HIUD is pulled through the cervix, the arms will bend up.

In extremely rare circumstances, the HIUD may be embedded in the uterine wall or the removal strings may no longer be visible. These events require more complex intervention, including ultrasound to locate the HIUD and/or cervical dilation to access the uterus. These complications do not occur often.

Note: Some clients may be interested in self-removal. There is limited evidence on the safety of this practice. If clients express interest to their provider, providers should encourage them to return to the clinic for removal.

Key Resources

Removing the Intrauterine Device. Family Planning: A Global Handbook for Providers. (2019)

Client Eligibility

Main Idea

HIUDs have very broad eligibility criteria. Clients with unresolved pelvic infection, uterine distortion, or breast cancer are not eligible.

Additional Information

Hormonal IUDs have very broad medical eligibility and are generally considered to be safe and effective for most clients who may be interested in HIUD adoption. Individuals who are **not eligible** include:

- Clients who have not yet had their first period
- Clients over the age of 65
- Clients with evidence of unresolved reproductive system infection or breast cancer
- Clients who are suspected to be pregnant
- Clients who have distortion of the uterus (due to congenital or acquired uterine abnormalities) or no uterus

Important: Adolescents, clients older than 40, unmarried clients, clients who have not had children, and clients who are breastfeeding **are all eligible** to use hormonal IUDs and can do so safely.

Key Resources

Medical Eligibility Criteria for Contraceptive Use, 6th Edition. World Health Organization. (2025)

Provision to Adolescents

Main Idea

HIUDs can be used safely and effectively by adolescents who are not married and have not yet had children. Attention should be given to insertion pain management and accurate uterine sounding.

Additional Information

National FP guidance for IUD provision to adolescents varies, but clinical evidence proves that HIUDs can be inserted safely and used effectively in post-menarcheal adolescents for both HMB treatment and contraception. Acceptability and continuation are high among this population. Focus groups with girls aged 15-19 in Nigeria and Zambia found high interest in HIUD use for treatment of HMB, but concern about the potential for paused bleeding and about the insertion process.

Special Considerations

- Adolescents may be marginally more likely to expel the HIUD. Accurate assessment of uterine depth and careful fundal placement lower this risk.
- Nulliparous HIUD adopters are known to experience elevated pain during insertion. Providers should speak to all clients about pain management.

Key Resources

Intrauterine device use is safe among nulligravidas and adolescent girls. Bahamondes & Bahamondes. (2021)

Usage of the levonorgestrel-releasing intrauterine system (LNG-IUS) in adolescence: what is the evidence so far? Patseadou & Michala. (2016)

Provision to People Living with HIV

Main Idea

The HIUD is safe to initiate with people living with Stage 1 or 2 HIV. Use can be continued at any stage, including Stage 3 (AIDS).

Additional Information

Use of the hormonal IUD does not contribute to increased viral load or susceptibility to opportunistic infections. It has no known interactions with HIV therapy or preventative drugs.

Use of the hormonal IUD does not protect against HIV, but the method does not contribute to risk of HIV transmission or infection.

IUDs have been found to be highly acceptable to individuals receiving HIV treatment, due to their convenience and ease-of-use.

Key Resources

Safety and continued use of the levonorgestrel intrauterine system as compared with the copper intrauterine device among women living with HIV in South Africa. Todd et al. (2020)

Acceptability of intrauterine contraception among women living with HIV. Kakaire et al. (2016)

Contraindications

Main Idea

The HIUD is contraindicated with conditions that increase the likelihood of reproductive system infection or that are likely to lead to uterine perforation or expulsion.

All Contraindications		
Pregnancy or suspicion of pregnancy	Distortion of the uterus from uterine anomaly, or absent uterus	Acute pelvic inflammatory disease (PID) or history of PID without subsequent intrauterine pregnancy
Postpartum endometritis or infected abortion in the past 3 months	Known or suspected uterine malignancy	Known or suspected breast cancer or other progestin-sensitive cancer
Uterine bleeding of unknown etiology	Unresolved acute lower genital tract infections	Severe decompensated cirrhosis, hepatocellular adenoma, and/or malignant hepatoma
Increased susceptibility to sexually transmitted infections	Previous unremoved IUD	Hypersensitivity to any component of the HIUD

Key Resources

MIRENA Prescribing Information. Bayer AG. (2022)

AVIBELA Prescribing Information. Impact RH360. (2022)

Use as Emergency Contraception

Main Idea

Hormonal IUDs have not yet been clinically proven to be effective emergency contraceptives, but evidence suggests this indication may be possible in the future.

Additional Information

Small studies on the potential to use the hormonal IUD to prevent conception following method failure or unprotected sex suggest the method may be equally effective to the copper IUD, which is currently the most effective emergency contraceptive option. Clinical evaluation for this indication is now underway in the United States.

As the method has not yet received a regulatory approval or WHO recommendation for use as EC, using it for this purpose would be off-label.

Key Resources

Levonorgestrel vs. Copper Intrauterine Devices for Emergency Contraception. Turok et al. (2021)

Levonorgestrel 52 mg IUD for Emergency Contraception and Same-Day Start [Clinical Trial Record]. Clinicaltrials.gov. (2022)

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Safety & Side Effects

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Safety & Side Effects

Safety Considerations

Expulsion and Perforation

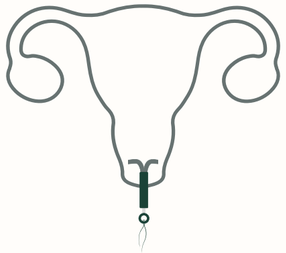
Main Idea

Expulsion occurs in roughly 3-6% of users and perforation occurs in roughly 0.1% of users. Risk is higher for users who are post-partum and/or breastfeeding.

Additional Information

Expulsion

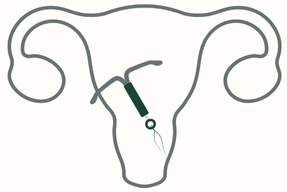
IUD partially or fully exits the uterus through the cervix



Frequency: 3-6% of users in the first 12 months
Risks: Immediate post-partum insertion, nulliparity
Treatment: Removal of partially expelled devices

Perforation

IUD embeds in or exits the uterus through the uterine wall



Frequency: 0.1% of users
Risks: Breastfeeding, insertion <36 weeks post-partum
Treatment: Ultrasound, outpatient or inpatient removal

Key Resources

Comparison of two cohorts of women who expulsed either a copper-intrauterine device or a levonorgestrel-releasing intrauterine system. Simonatto et al. (2016)

Intrauterine contraception: incidence and factors associated with uterine perforation—a population-based study. Kaislasuo et al. (2012)

Infection

Main Idea

Risk of pelvic infection is low and is concentrated in the period immediately following insertion.

Additional Information

In large cohort studies among HIUD users, pelvic infection was generally found to be:

Limited to Immediate Post-Insertion

Infection rates are just under 1% within the first 20 days, with risk falling to baseline thereafter and no increase with prolonged use.

Not Associated with HIUD

Most infections were pre-existing infections (STIs, BV, yeast) that had not been identified during counseling or insertion.

Readily Treatable

Infection is treated with antibiotics or antifungals (with follow-up at 48-72 hours) and most cases resolve without HIUD removal.

Pre-insertion pelvic exams to identify existing infection and adherence with aseptic technique during insertion significantly limit risk of infection during HIUD use.

Key Resources

Levonorgestrel 52 mg intrauterine system efficacy and safety through 8 years of use. Creinin et al. (2022)

Contraceptive efficacy and safety of the 52-mg levonorgestrel intrauterine system for up to 8 years: findings from the Mirena Extension Trial. Jensen et al. (2022)

Cancer Risk

Main Idea

The hormonal IUD does not increase absolute cancer risk, and is protective against reproductive cancers.

Additional Information

Protective Effect

Approx. 20-30% reduction in risk for development of endometrial cancer. Modest reduction in risk for development of abnormal cervical cells.

Relative Risk

Moderate increase in *relative* risk of breast cancer diagnosis, largely in older women (40+) with existing risk factors.

No Effect

No increase in *absolute* risk of breast cancer in general population of HIUD users. No known effect on any form of non-reproductive cancer.

For most users, this risk profile is extremely favorable, given the strong protection against endometrial proliferation. Additional counseling may be warranted for clients at already-elevated risk of breast cancer due to age, family history, obesity, or other significant risks.

Key Resources

Meta-Analysis of Breast Cancer Risk in Levonorgestrel-Releasing Intrauterine System Users. Silva et al. (2021)

Meta-Analysis of Intrauterine Device Use and Risk of Endometrial Cancer. Beining et al. (2008)

Levonorgestrel intrauterine system and breast cancer risk. Heting et al. (2023)

Pregnancy During Use

Main Idea

Pregnancy during HIUD use is very rare - less than 0.2% in the first year. HIUD use may increase risk of ectopic pregnancy or miscarriage.

Additional Information

If pregnancy occurs with an IUD in place, the likelihood that it is ectopic is higher than in the general population. Studies estimate that **27–53% of pregnancies conceived with the IUD in utero are ectopic**. For intrauterine pregnancies with an IUD in situ, risks of miscarriage (including septic abortion), chorioamnionitis, and preterm birth are increased. Removing the IUD early reduces—but does not eliminate—these risks, and removal itself can precipitate miscarriage.

Management typically includes ultrasound to confirm IUD location and ectopic evaluation; if strings are visible or the device is in the cervix and pregnancy continuation is desired, early removal is recommended. Fetal exposure to a retained hormonal IUD has not been shown to increase the risk of birth defects.

Key Resources

Comparative contraceptive effectiveness of levonorgestrel-releasing and copper intrauterine devices: the European Active Surveillance Study for Intrauterine Devices. Heinemann et al. (2015)

Pregnancy outcomes with an IUD in situ: a systematic review. Brahmi et al. (2012)

Breastfeeding

Main Idea

The hormonal IUD is safe to use while breastfeeding, with no impact on infant health or milk quality.

Additional Information

Only 0.1% of the maternal dose of levonorgestrel (or about 0.02 micrograms/day) enters breastmilk, and clinical evaluation has determined that **this dose is not associated with any negative effect to infant growth or development**, or with reduced milk quality or quantity.

Breastfeeding is associated with a modestly increased risk of uterine perforation during or following insertion, as it contributes to a thinned endometrium. Careful uterine sounding and compliance with all insertion steps reduces this risk.

Key Resources

A comparative study of the levonorgestrel-releasing intrauterine system Mirena versus the Copper T380A intrauterine device during lactation: breast-feeding performance, infant growth and infant development. Shaamash et al. (2005)

The safety of intrauterine devices in breastfeeding women: a systematic review. Berry-Bibee et al. (2016)

Return to Fertility

Main Idea

Fertility returns shortly after HIUD removal, and former HIUD users conceive at the same rate as the general population.

Additional Information

80%+

Portion of former HIUD users seeking to become pregnant who conceive within 12 months of IUD removal. This is the **same rate as conception in the general population**, indicating very limited or no impact on fertility.

Why is return to fertility consistent?

Most of the HIUD's effect is localized inside the uterus and cervix, and the method doesn't significantly impact ovulation or the hormonal menstrual cycle. When the HIUD is removed, most of its effect ends and any remaining LNG in the body is quickly metabolized.

Key Resources

Levonorgestrel 52 mg intrauterine system efficacy and safety through 8 years of use. Creinin et al. (2022)

Contraceptive efficacy and safety of the 52-mg levonorgestrel intrauterine system for up to 8 years: findings from the Mirena Extension Trial. Jensen et al. (2022)

Sexually Transmitted Infections

Main Idea

HIUD use does not increase risk of acquiring STIs, including HIV. HIUD use also does not increase risk of transmitting STIs.

Additional Information

People with elevated potential for exposure to HIV can safely use hormonal IUDs without impacting their risk of infection.

Additionally, WHO guidance indicates that hormonal IUDs can be safely initiated with individuals with Stage 1 and Stage 2 HIV, and that use can be continued if their condition advances to Stage 3 HIV (AIDS). HIUD use does not increase genital shedding of the disease. Clients with active bacterial infections (e.g., chlamydia, gonorrhea, syphilis) cannot initiate use of HIUD, and infections should be fully resolved prior to insertion.

HIUDs do not protect against STIs, including HIV, and clients at risk should continue to use condoms or other preventative products.

Key Resources

Medical Eligibility Criteria for Contraceptive Use, 6th Edition. World Health Organization. (2025)

Use of Intrauterine Devices and Risk of Human Immunodeficiency Virus Acquisition Among Insured Women in the United States. Marcus et al. (2019)

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Safety & Side Effects

Side Effects

Frequency & Duration of Common Side Effects

Main Idea

Side effects are common immediately after insertion, usually improve within 3-6 months, and are rarely serious.

Common ↕ Uncommon

Possible Side Effects	More Info
Pain and cramping immediately following insertion	Most post-insertion pain resolves on its own within a week of insertion. If it suddenly becomes severe, it may be a sign of perforation or PID.
Changes in bleeding patterns, including lighter, irregular, infrequent or no monthly bleeding	In the first 3-6 months of method use, irregular or more frequent bleeding is common. After this adjustment period, most users experience substantially reduced menstrual bleeding.
Upset stomach, tender breasts, mild mood changes, headaches, dizziness, acne, weight gain	Side effects associated with the hormone levonorgestrel typically get better or go away completely in the first 6 months of use.
IUD expulsion or uterine perforation, benign ovarian cysts & significant changes in mood like anger or depression	Expulsion, perforation, and significant mood changes are very rare and warrant rapid intervention. Cysts are typically asymptomatic and go away on their own.

Key Resources

Managing Side Effects. Family Planning: A Global Handbook for Providers. (2019)

Levonorgestrel-releasing IUD as a method of contraception with therapeutic properties. Luukkainen & Toivonen. (1995)

Bleeding Patterns

Main Idea

Bleeding irregularity and longer bleeding is common in the first 3-6 months of HIUD use. Over time, bleeding volume and frequency reduces substantially, and may be paused entirely.

Additional Information

Short Term Changes

In the first 3-6 months following insertion, clinical evidence suggests that bleeding irregularity, more frequent bleeding, or longer bleeding is common. These changes generally begin to resolve into more regular bleeding patterns within several months of insertion.

Long Term Changes

Most users begin to experience a significant reduction (>90%) in menstrual blood volume by 6 months post-insertion. In the first 12 months of HIUD use, 20% of users will experience paused monthly bleeding (or no bleeding for at least a 90-day window), and about 40% will experience paused bleeding in the first 24 months. If established bleeding patterns suddenly change, it may indicate a method complication.

Key Resources

Menstrual bleeding and spotting with the Levonorgestrel Intrauterine System (52 mg) during the first-year after insertion: a systematic review and meta-analysis. Maldonado et al. (2020)

Levonorgestrel intrauterine system associated amenorrhea: a systematic review and metaanalysis. Sergison et al. (2019)

Other Menstrual Changes

Main Idea

Cramping and pain is normal immediately following HIUD insertion. As bleeding volume lessens or bleeding pauses, many users experience significantly reduced cramping and pain.

Additional Information

Key Resources

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Therapeutic Indications

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Therapeutic Indications

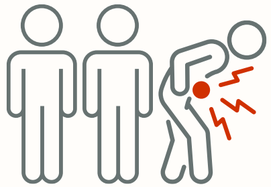
On-Label Indications

Heavy Menstrual Bleeding: Definition

Main Idea

Heavy menstrual bleeding is bleeding that negatively impacts a person's physical, emotional, and/or social quality of life due to its volume and associated pain.

Additional Information



Global evidence suggests **30-50%** of women will experience HMB

As a global average, **15%** of girls and women report missing work, school, or social activities due to bleeding or pain

Women with HMB consistently score lower on measures of quality-of-life than women without HMB

Why use a person-centered definition?

Experiences with menstrual bleeding are highly subjective. Person-centered definitions for HMB, like the definition above, help to ensure that clients feel comfortable and confident in seeking care, and that they receive appropriate intervention regardless of whether their experiences directly align with clinical criteria.

Key Resources

Prevalence of HMB and associations with physical health and wellbeing in LMICs. Sinharoy et al. (2023)

Epidemiology of menstrual-related absenteeism in 44 LMICs. Starr et al. (2025)

Review of quality of life: menorrhagia in women with or without inherited bleeding disorders. Shankar & Kadir. (2007)

Heavy Menstrual Bleeding: Causes

Main Idea

Causes of HMB may be structural (e.g., fibroids or polyps) or nonstructural (e.g., ovulatory dysfunction) and are classified using the FIGO-developed mnemonic PALM-COEIN.

Additional Information

	Structural		Nonstructural
P	Polyps	**C**	Coagulopathy
A	Adenomyosis	**O**	Ovulatory Dysfunction
L	Leiomyoma	**E**	Endometrial
M	Malignancy	**I**	Iatrogenic
		N	Not Yet Classified

Essential Note

While the hormonal IUD is a highly effective treatment option for heavy menstrual bleeding and menstrual pain, it **cannot cure clients** of the conditions that cause HMB.

Key Resources

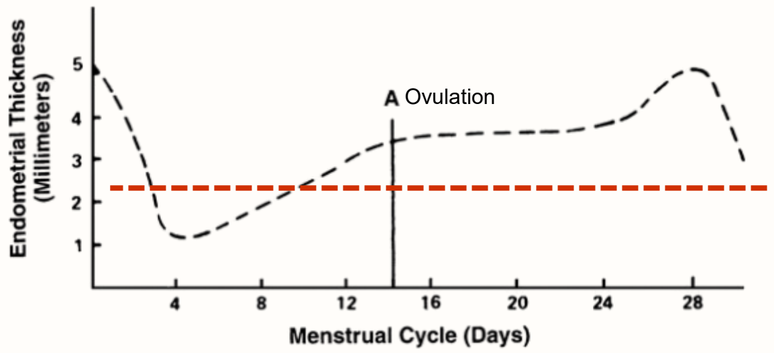
FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. Munro et al. (2011)

Heavy Menstrual Bleeding: HIUD Mechanism

Main Idea

The hormonal IUD represses the hormonal changes that would trigger endometrial growth, which reduces the accumulation of blood and tissue in the uterus over the course of the menstrual cycle.

Additional Information



Typical Endometrial Growth Pattern

Avg. Maintained Thickness During HIUD Use

Over the course of a typical menstrual cycle, the endometrium (or uterine lining) thickens and fills with blood to prepare for potential implantation and pregnancy. This process is caused by cyclical hormonal changes within the uterine tissue. Should no implantation take place, the body releases the accumulated tissue and blood, which is seen as a monthly period.

The hormonal IUD slowly releases the progestin levonorgestrel, which over time (3-6 months) represses the hormonal changes in the uterine tissue that would typically cause endometrial growth and blood accumulation, leading to substantially reduced menstrual blood volume.

Key Resources

Endometrial effects of intrauterine levonorgestrel. Guttinger & Critchley. (2007)

Serum levonorgestrel levels and endometrial thickness during extended use of the levonorgestrel-releasing intrauterine system. Hidalgo et al. (2009)

Heavy Menstrual Bleeding: HIUD Efficacy

Main Idea

The hormonal IUD typically reduces monthly menstrual blood loss by >90%, making it among the most effective and least-invasive treatment options for heavy menstrual bleeding.

Additional Information

In systematic reviews and meta-analyses, the 52mg HIUD was found to **reduce menstrual blood loss more than other medical treatments** (e.g., oral contraceptives, NSAIDs, tranexamic acid).The method was also found to provide comparable or better client outcomes than endometrial ablation (surgically removing endometrial tissue) or hysterectomy while preserving fertility, with fewer complications and lower resource use.

In clinical evaluation, most hormonal IUD users experience **a reduction in bleeding volume of over 90% within six months** of insertion. However, this is often proceeded by several months in which bleeding is more irregular as the body adjusts to the device.

Key Resources

Hormonal contraception as treatment for heavy menstrual bleeding: a systematic review. Uhm & Perriera. (2014)

Interventions for heavy menstrual bleeding; overview of Cochrane reviews and network meta-analysis. Bofill Rodriguez et al. (2022)

Progestogen-releasing intrauterine systems for heavy menstrual bleeding. Bofill Rodriguez et al. (2020)

Heavy Menstrual Bleeding: Safety of Paused Bleeding

Main Idea

Reduced or paused menstrual bleeding during use of the hormonal IUD is safe, and does not cause accumulation of blood or waste products in the uterus.

Additional Information

Because the hormonal IUD interrupts and ultimately restricts the processes that trigger tissue growth in the uterus over the course of the menstrual cycle, only small amounts of tissue and blood accumulate after ovulation. These are released normally during the HIUD user's monthly period. If there is no bleeding in a given month, it indicates that so little tissue or blood has accumulated that the body has nothing to release. Extensive evaluation has found that **there is no negative effect associated with paused menstrual bleeding while using a hormonal IUD**. When the HIUD is removed, a user's normal bleeding patterns return.

Regular menstruation does not carry out toxins or waste, as the uterus is not a blood-filtering organ; these materials will continue to be collected by the liver, kidneys, and other filtering organ systems and excreted out as sweat, urine, and feces.

Key Resources

Menstrual suppression: current perspectives. Hillard. (2014)

Levonorgestrel intrauterine system associated amenorrhea: a systematic review and metaanalysis. Sergison et al. (2019)

Health effects of long-term use of the intrauterine levonorgestrel-releasing system. Rönnerdag & Odlind. (1999)

Hormone Therapy

Main Idea

HIUDs can be an effective part of hormone therapy for pre- and postmenopausal women, largely used to protect endometrial overgrowth while taking estrogen supplementation.

Additional Information

Some women are prescribed estrogen therapy to control the physical effects of hormonal changes occurring as the body approaches menopause or following menopause. Estrogen supplementation is known to cause overgrowth of the endometrium as a side effect. This overgrowth is associated with a higher risk of developing endometrial, uterine, and cervical cancers. The **hormonal IUD can be prescribed *alongside* estrogen therapy** to repress endometrial growth, allowing clients to continue to get the benefits of supplemented estrogen without raising their risk of cancer development.

Important: Use of the hormonal IUD for this purpose is not approved in all countries where the method is available, and providers should check the label of their hormonal IUD products before prescribing.

Key Resources

Effects of the levonorgestrel-releasing intrauterine system plus estrogen therapy in perimenopausal and postmenopausal women: systematic review and meta-analysis. Somboonporn et al. (2011)

Use of hormonal contraceptives in perimenopause: A systematic review. Guerin et al. (2022)

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Therapeutic Indications

Potential Off-Label Therapeutic Uses

Treatment of Leiomyomas/Fibroids

Main Idea

Hormonal IUDs do not remove, shrink, or cure fibroids, but they are an effective option for managing bleeding and pain associated with uterine fibroids.

Additional Information

What are leiomyomas?
Leiomyomas, also known as uterine fibroids, are non-cancerous growths that develop in the smooth muscle of the uterus.

Impact of the hormonal IUD
Most women with uterine fibroids are likely to experience reduced menstrual blood loss and increased serum levels of hemoglobin, hematocrit, and ferritin following the insertion of an HIUD, despite occasional irregular bleeding. The HIUD may also help menstrual cramping associated with fibroids. HIUDs cannot shrink fibroids or cure clients of the condition.

Important: Large fibroids can distort the shape of the uterus, which may interfere with IUD placement and raise risk of IUD expulsion.

Key Resources

Intrauterine device use among women with uterine fibroids: a systematic review. Zapata et al. (2010)

Levonorgestrel-releasing intrauterine system use in premenopausal women with symptomatic uterine leiomyoma: a systematic review. Jiang et al. (2014)

Treatment of Adenomyosis

Main Idea

HIUDs are an effective first-line treatment for adenomyosis, reducing the severity of symptoms like pain and bleeding. They're most effective when paired with GnRH agonist medications.

Additional Information

What is adenomyosis?
Adenomyosis is a condition in which the tissue that lines the uterus grows into the muscular wall of the uterus, causing an enlarged uterus, heavy menstrual bleeding, and pain.

Impact of the hormonal IUD
HIUD use effectively reduces the severity of symptoms, uterine volume and endometrial thickness, and improves laboratory outcomes. Studies have shown that the 52mg hormonal IUD combined with gonadotropin-releasing hormone agonists (GnRH-a) is more effective than the hormonal IUD alone, providing benefits in reducing dysmenorrhea, menstrual bleeding, uterine volume, endometrial thickness, and adverse events. HIUD use cannot cure clients of adenomyosis, however.

Key Resources

The role of levonorgestrel intra-uterine system in the management of adenomyosis: A systematic review and meta-analysis of prospective studies. Abbas et al. (2020)

The role of different LNG-IUS therapies in the management of adenomyosis: a systematic review and meta-analysis. Zhang et al. (2025)

Treatment or Prevention of Anemia

Main Idea

The hormonal IUD consistently increases hemoglobin levels and boosts irons stores in users, making it a potential preventative or treatment for iron-deficiency anemia.

Additional Information

What is iron-deficiency anemia?
Anemia is a chronic health condition characterized by low hemoglobin. In approx. 70% of people with anemia, the condition is caused by low blood iron. Iron-deficiency anemia is commonly associated with fatigue, shortness of breath, bruising, and high heart rate.

Impact of the hormonal IUD
Heavy menstrual bleeding is a significant risk factor for developing iron-deficiency anemia or worsening the symptoms of existing anemia. Use of an HIUD to limit menstrual blood loss is associated with significantly higher hemoglobin and iron levels. However, it is not yet know how effective the hormonal IUD may be as a routine treatment option for clients with mild-to-moderate iron-deficiency anemia; clinical research is underway in Kenya.

Key Resources

Hemoglobin and serum ferritin levels in women using copper-releasing or levonorgestrel-releasing intrauterine devices: a systematic review. Lowe & Prata. (2013)

Use in Oncological Regimes

Main Idea

HIUDs can be used alone or in combination with other treatments to control early-stage endometrial cancer, and can be used to limit the negative side effects of breast cancer treatments

Additional Information

Endometrial Cancer
HIUDs have been confirmed as effective options for conservative management of early-stage endometrial cancer and atypical endometrial growth, leading to high regression rates and low rates of hysterectomy. They are even more effective when paired with other early-stage treatments, like oral MPA, GnRH agonists, or uterine resection.

Breast Cancer
HIUDs can be used alongside tamoxifen (an oral treatment for early and secondary breast cancers) to reduce the risk of endometrial polyps and overgrowth, both common side effects.

Key Resources

LNG IUS-based therapies for early-stage endometrial cancer. Wei et al. (2023)

Comparative effects of progestin-based combination therapy for endometrial cancer or atypical endometrial hyperplasia. Cui et al. (2024)

LNG IUS for endometrial protection in women with breast cancer on tamoxifen. Romero et al. (2020)

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User Satisfaction & Continuation

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User Satisfaction & Continuation

Method Acceptability

User Satisfaction

Main Idea

User satisfaction for HIUD is high in both HICs and LMICs, with approx. 90% of users indicating that they're satisfied or very satisfied with their method after 12 months of use.

Additional Information

Prospective, multi-center clinical trials and cohort studies have found 1-year method satisfaction at 90-95% of users, and pilot studies conducted in Ghana, Nigeria, Kenya, Zambia, and Madagascar show similar results, with **80-95% of users indicating that they were "very satisfied"** with their method.

For those choosing to continue use of the method past 12 months, satisfaction appears to increase over time.

Adopters consistently show strong interest in recommending the HIUD to others, and providers report less-frequent early removals and post-insertion counseling than for other LARCs.

Key Resources

What Have We Learned? Implementation of a Shared Learning Agenda and Access Strategy for the Hormonal Intrauterine Device. Rademacher et al. (2022)

Expanding long-acting contraceptive options: a prospective cohort study of the hormonal intrauterine device, copper intrauterine device, and implants in Nigeria and Zambia. Brunie et al. (2021)

Quality-of-Life Indicators

Main Idea

Hormonal IUDs are associated with reduced healthcare burden, reduced menstrual bleeding, and limited negative side effects.

Additional Information

Use of any modern family planning method is associated with general quality-of-life improvements, like reduced maternal mortality and unsafe abortion, greater ability to engage in work and school, and strengthened relationships. In addition to these benefits, HIUD has several unique QoL impacts:

Reduced Healthcare Burden

The 8-year duration of use requires fewer health visits, leading to lower transport costs and reduced life disruption

Reduced Menstrual Bleeding

HIUD users require fewer menstrual products, take less time off work or school, and have greater ability to participate in life activities.

Limited Systemic Side Effects

Only 10% of the HIUD's hormone enters the blood stream, leading to fewer side effects than other modern FP methods.

Key Resources

The Levonorgestrel Intrauterine System: Reasons to Expand Access to the Public Sector of Africa. Hubacher. (2015)

Long-acting intrauterine systems: recent advances, current challenges, and future opportunities. Fanse et al. (2023)

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User Satisfaction & Continuation

Method Adoption & Continuation

Motivations for Method Adoption

Main Idea

Potential users are interested in the method's impact on bleeding, high efficacy and long duration.

Additional Information

In both high-income and LMIC contexts, users reference the hormonal IUD's long duration and high effectiveness (along with related attributes like "convenience") as their primary motivations for selecting the method.

Interest in the method's impact on bleeding also plays a significant role in method adoption. In Kenya, Nigeria, and Malawi, **15-32% of adopters listed menstrual changes as their primary reason for choosing the method**, above efficacy or duration. Of those adopters, almost all indicated that they wanted less bleeding, paused bleeding, or more manageable menstrual side effects.

Key Resources

SHINE Study Quantitative Results. Burke et al. (2026)
Not Yet Published, Contact Access Group for Data.

What Have We Learned? Implementation of a Shared Learning Agenda and Access Strategy for the Hormonal Intrauterine Device. Rademacher et al. (2022)

Method Continuation

Main Idea

HIUD continuation at 12 months is typically 80-90%, higher than implant continuation and equal to or slightly higher than copper IUD continuation. Most new users intend to keep the method for 3-5 years.

Additional Information

Hormonal IUD continuation rates vary by setting but are generally comparable to or slightly above those of other LARCs. The method's **1-year continuation rates are typically 80-90%**, and 3-year continuation rates are typically 60-75%. In a "real-world" service delivery context in Brazil studying continuation for 5 years, approximately 60% of adopters continued to use the method at the 5-year mark.

In pilots for the method conducted in Nigeria, Zambia, and Madagascar, 1-year continuation was 81-95% depending on country and study. In pilot studies that compared HIUD to copper IUD and implants, HIUD continuation was minimally higher or equal to copper IUD continuation but significantly higher than implant continuation.
Hormonal IUD continuation past 2 years has not been evaluated in low- and lower-middle income contexts. 5-year continuation research is active in Nigeria, Kenya, and Malawi.

Key Resources

Three-year Continuation of Reversible Contraception. Diedrich et al. (2017)

Expulsion and continuation rates of LNG IUS was similar among nulligravid and parous users. Brull et al. (2022)

What Have We Learned? Implementation of a Shared Learning Agenda and Access Strategy for the Hormonal Intrauterine Device. Rademacher et al. (2022)

Motivations for Method Discontinuation

Main Idea

Discontinuation in the first year of use is typically associated with irregular bleeding and pain in the 3-6 months following insertion. After the first year, discontinuation is more often from a desire to get pregnant.

Additional Information

In non-clinical studies, **the most commonly referenced reason for removing the HIUD in the first year of use is pain/cramping and bleeding irregularity**, both of which are common side effects that generally resolve within 6 months of method insertion. After the first year, reasons for discontinuation shift away from side effects; clients discontinuing after 12 months are more likely to reference a desire to get pregnant, method inconvenience, or partner disapproval.

Comprehensive method counseling may help clients decide whether the method's transient side effects align with their needs and may reassure adopters that their side effects are normal and likely temporary when experienced.

Key Resources

Discontinuation rates of intrauterine contraception due to unfavourable bleeding: a systematic review. Costescu et al. (2022)

Levonorgestrel 52 mg intrauterine system efficacy and safety through 8 years of use. Creinin et al. (2022)

Switching & Interchangeability

Main Idea

Between half and two-thirds of new HIUD users had previously used short-acting methods or no FP method, indicating that HIUD introduction can attract new users to highly effective, reversible FP methods.

Additional Information

Pilots conducted in LMICs definitively concluded that clients see HIUD as non-equivalent to copper IUD and implants and that the method attracts users who had previously used no family planning method or less-effective FP options. **More than 50% of HIUD adopters** in pilots had previously used a short-acting method or no method, and these findings are supported by active real-world introduction research in Nigeria, Kenya, and Malawi.

This finding is significant, as it signals that introduction of the hormonal IUD attracts new users to modern FP and moves some clients to more-effective methods, a change which substantially lowers rates of unintended pregnancy.

Key Resources

SHINE Study Quantitative Results. Burke et al. (2026)
Not Yet Published, Contact Access Group for Data.

What Have We Learned? Implementation of a Shared Learning Agenda and Access Strategy for the Hormonal Intrauterine Device.
Rademacher et al. (2022)

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LMIC Health Systems Experience

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LMIC Health Systems Experience

Cost-Effectiveness

Commodity Cost

Main Idea

While upfront cost for HIUD is very high, the method has a low commodity cost per Couple Year of Protection due to its long duration of use and dual indication for treatment of HMB

Additional Information

4.8

Updated HIUD CYP per Unit

This CYP indicator factors in HIUD's long duration and high continuation rates. This is the **highest CYP indicator of any non-permanent FP method**, and it suggests substantial cost efficiencies.

Considering Upfront Cost vs Cost-Over-Time

Hormonal IUDs have the highest average upfront cost of any contraceptive, at **10.90 USD from UNFPA**. However, because the method is both extremely long acting, has two indications (contraception and HMB), and continuation is high, its cost-over-time is minimal.

Key Resources

Couple-Years of Protection Indicator: New Global Guidance for Updating Existing Methods and Adding New Methods. Lebetkin et al. (2024)

52mg Hormonal IUD [Catalogue Record]. UNFPA. (2026)

Service Delivery Cost

Main Idea

HIUDs have similar service delivery expenses to copper IUD and implants. Weighing all costs and the method's duration, HIUDs are more cost effective over time than injectables, COCs, and internal condoms.

Additional Information

The healthcare system or the client may be responsible for the following costs:

- Consumable supplies (e.g., gloves, drapes, antiseptic solution)
- Instruments per client visit (e.g., tenaculum, scissors, uterine sound),
- Direct labor for counseling, insertion, removal, and resupply, as applicable

Some costs are spread over a number of products/insertions/injections and therefore must be allocated accordingly. Total estimated service delivery cost for HIUD is similar to that of copper IUD and implants. When balanced against duration of use and CYPs, the method's service delivery expenses are more cost-effective than those of short-acting or on-demand FP methods.

Key Resources

Expanding Access to a New, More Affordable Levonorgestrel Intrauterine System in Kenya: Service Delivery Costs Compared With Other Contraceptive Methods and Perspectives of Key Opinion Leaders. Rademacher et al. (2016)

The cost of maternal health services in low-income and middle-income countries from a provider's perspective: a systematic review. Banke-Thomas et al. (2020)

Cost Effectiveness Over Time

Main Idea

When factoring in the HIUD's high contraceptive efficacy, high continuation, and long duration, the method is more cost-effective over a 10-year period than implants or injectables.

Additional Information

Over a 10-Year Period in select LMIC settings, the HIUD:

- Has lower incremental cost compared to implants and injectables
- Has higher incremental cost compared to copper IUDs
- Averts more unintended pregnancies than any other contraceptive option, including copper IUDs

What does cost-effectiveness analysis include?

Analysts factor in the full impact on the healthcare system and society resulting from averted unintended pregnancies. They calculate an "incremental cost-effectiveness ratio" of different FP methods by comparing the cost of each unintended pregnancy averted for each method and the downstream impacts of averted pregnancy.

Key Resources

Cost-effectiveness of including the hormonal IUD in the contraceptive method mix in Nigeria and Zambia. FHI 360. (2021)

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LMIC Health Systems Experience

Stakeholder Perspectives

Healthcare Provider Perceptions

Main Idea

Providers see the HIUD as filling gaps in the FP method mix and appreciate its potential as a treatment option for HMB. They note structural barriers, like limited time for counseling and stock-outs, as challenges.

Additional Information

Provider perspectives vary by study setting. The following summarizes common themes from qualitative research conducted in Nigeria, Kenya, Zambia, India, Ghana, Bangladesh, and Malawi:

Provider-Perceived Positives

- Offers clients a highly-effective treatment option for HMB and other conditions
- The long duration of the method allows for cost-savings and lowered health system burden
- Can be used for birth spacing or as a long-term method for clients whose families are complete
- Client satisfaction is high, and providers report fewer clients requiring post-insertion follow-up

Provider-Perceived Negatives

- HIUD's are seen as more complex than other methods, requiring additional counseling time
- Maintaining adequate stock of sterile or single-use insertion equipment is challenging
- Method awareness is extremely limited, and many providers don't have regular opportunity to insert
- Clients have mixed opinions on spotting in initial post-insertion period + later paused bleeding

Key Resources

SHINE Study Qualitative Results. Burke et al. (2026)
Not Yet Published, Contact Access Group for Data.

What Have We Learned? Implementation of a Shared Learning Agenda and Access Strategy for the Hormonal Intrauterine Device. Rademacher et al. (2022)

Assessing acceptability & feasibility of introducing LNG IUS in nat. FP program in Bangladesh. Pathfinder. (2023)

Policymaker Perceptions

Main Idea

Policymakers in introducing countries believe HIUD introduction supports strategic FP and menstrual health objectives, but requires significant investment and support to reach its full potential.

Additional Information

Limited evidence is available for policymaker perspectives on HIUD in LMICs. The following summarizes findings from qualitative interviews conducted in Nigeria, Kenya, and Malawi.

Preliminarily, key informants noted that uptake has increased with mobilization, awareness, and free product availability, but sustainability depends on more trained providers, consistent supplies, additional service points, and continued community engagement. Supply chain issues and stockouts/method redistribution remain a major concern, particularly following the closure of USAID's Global Health Supply Chain program, which was responsible for national-level logistics coordination for the method in a number of countries.

With few exceptions, policymakers in actively introducing countries or countries preparing to introduce are supportive of HIUD, even given the above-referenced challenges. As their costed introduction plans for the method prove, substantial thought was given to the method's unique attributes, its potential for individual and systems-level cost savings over time, and the role it may play in achieving national-level FP aims. However, policymakers note their concern about resource mobilization for both introduction activities and commodities; should the hormonal IUD be moved off of the UNFPA's New and Lesser-Used fund, the upfront cost of the product may be unattainable.

Key Resources

SHINE Study Qualitative Results. Burke et al. (2026)
Not Yet Published, Contact Access Group for Data.

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LMIC Health Systems Experience

Enablers & Barriers

Enablers of Method Uptake

Main Idea

Political will, catalytic procurement strategies, and integration of HIUD alongside other FP methods support successful scale-up and method adoption.

Additional Information

Political Will and Supportive Authority
Ministry of Health ownership of the hormonal IUD introduction process, and Ministry-led partner coordination and communication ensure sustainable method scale-up and effective use of resources.

Catalytic Procurement Funding
UNFPA-funded procurement during initial product introduction stages enables countries to build method awareness and health system capacity for HIUD without impacting procurement of other FP products.

Health System Integration
Positioning HIUD alongside other FP methods and including it in routine FP programming in communities and at facilities supports client decision-making and reproductive autonomy, and supports sustainable introduction.

Key Resources

Contraceptive Method Introduction to Expand Choice: A Strategic Planning Guide. FP HIPs Partnership. (2022)

Hormonal IUD Introduction & Scale-Up Catalytic Opportunity Fund. Clinton Health Access Initiative. (2025)

SHINE Study Qualitative Results. Burke et al. (2026)
Not Yet Published, Contact Access Group for Data.

Barriers to Method Uptake

Main Idea

Low method awareness, limited trained providers, and high upfront commodity cost limit HIUD scale-up and method adoption.

Additional Information

High Upfront Cost
HIUD's high unit cost - 10.90 USD - is challenging for many governments to include in routine FP procurement. While the method is extremely cost-efficient over time, upfront expense may eliminate it from consideration for the public sector in some geographies.

Low Method Awareness
Many introduction plans place heavy emphasis on provider training and facility readiness, and deprioritize awareness building and orientation of community health workers. This significantly limits demand for the method at the facility level.

Limited Trained Providers
Single-provider-per-facility training targets and routine provider rotation between facilities limits the availability of trained providers, particularly in rural regions or regions with fewer health centers.

Key Resources

SHINE Study Qualitative Results. Burke et al. (2026) *Not Yet Published, Contact Access Group for Data.*

What Have We Learned? Implementation of a Shared Learning Agenda and Access Strategy for the Hormonal Intrauterine Device. Rademacher et al. (2022)

Common Areas of Concern

Main Idea

Inaccurate or incomplete information about the method's impact on fertility, potential therapeutic uses, removability, duration, and potential for migration appear common in both HICs and LMICs.

Additional Information	
Impact on Fertility **Concern**: Long-term use of HIUD will limit future fertility. **Evidence**: Regardless of duration of use, former HIUD users conceive at the same frequency as non-users.	**Therapeutic Uses** **Concern**: HIUD can cure users of fibroids or adenomyosis. **Evidence**: HIUD can limit the symptoms of these conditions, but cannot cure them.
Removability **Concern**: Removal before the HIUD's full duration is dangerous. **Evidence**: HIUDs can be safely removed any time.	**Duration** **Concern**: HIUDs are only effective for 3-5 years, like implants. **Evidence**: 52mg HIUDs have been proven effective for up to 8 years.
Migration **Concern**: HIUDs can migrate up towards the heart and be fatal. **Evidence**: Less than 1 in 10,000 insertions results in perforation. There has never been a case of migration out of the lower abdomen.	**Use in Adolescents** **Concern**: HIUD use is dangerous or inappropriate in adolescents. **Evidence**: HIUDs have been proven to be safe, effective, and highly acceptable to adolescents and young women.

HORMONAL IUD
Access Group

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For additional information:

Contact info@hormonaliud.org or visit www.hormonaliud.org