Original Study

Barriers to Long-Acting Reversible Contraceptive Uptake Among Homeless Young Women

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A B S T R A C T

Study Objective: To identify barriers to long-acting reversible contraception (LARC) uptake among homeless young women.
Design: In this mixed methods study surveys and guided interviews were used to explore women's contraceptive and reproductive experiences, interactions with the health care system, and their histories of homelessness.
Setting: All surveys and interviews were conducted at a homeless drop-in center or shelter.
Participants: Fifteen women between 18 and 24 years of age with a past year history of homelessness.
Interventions: None.
Main Outcome Measures: Perceived barriers to contraceptive use, including knowledge and access barriers and interactions with the health care system around reproductive health.
Results: Confusion about the possibility of early termination of LARC, and the perception that providers deliberately withhold selective information about contraceptive options to bias contraceptive decision-making, were 2 key new findings. Women also reported interest in visual aids accompanying verbal contraceptive counseling. Pregnancy attitudes and history of reproductive and sexual coercion also influenced contraceptive decision-making and reported interest in LARC methods.
Conclusion: Comprehensive counseling about all contraceptive options, including LARC, are important for targeting the perceived gaps in contraceptive education and care among homeless young women.
Key Words: Contraception, LARC, IUD, Implant, Homelessness, Mixed-methods

Introduction

Unintended pregnancy occurs disproportionately among poor and low-income women, women aged 18-24 years, and women of color.[1,2] Pregnancy rates are also much higher among women who are homeless compared with women who are housed.[3] Unintended pregnancy can be particularly burdensome among homeless women because an unintended pregnancy might negatively influence women's ability to move out of homelessness.[3] Addressing unintended pregnancy among homeless young women remains a significant public health challenge.

A number of factors are associated with contraceptive use among homeless youth. Pregnancy ambivalence, defined as unresolved or contradictory feelings about whether or not one wants to conceive a child at a particular moment, has been identified as a prevalent attitude among homeless youth. Homeless youth who are ambivalent have lower rates of contraceptive use than nonambivalent homeless youth.[4] Education level, receipt of contraceptive services, and negative attitudes toward pregnancy are also positive predictors of contraceptive use among homeless youth.[5] Thus, social context and pregnancy attitudes might be important factors to consider for improving uptake of effective contraception among young homeless individuals who seek to prevent pregnancy.

Long-acting reversible contraceptives (LARCs), specifically intrauterine devices (IUDs) and implants, are highly effective contraceptive methods, yet are used less commonly than other methods, including the pill and condom, in the United States.[6] Recent estimates indicate that approximately only 5% of teens and young women aged 15-24 years use LARCs.[7] Barriers to IUD uptake include lack of knowledge, misconceptions about LARCs, and access-related issues.[8–10] In a recent study that made all contraceptive options available to women at no cost, two-thirds of women chose either the IUD or implant after being educated about all options.[11,12] This study highlights the potential effect of contraceptive education and removing financial barriers on LARC uptake.

No studies have assessed barriers to LARC education and services among homeless young women. The type, content,

The authors indicate no conflicts of interest.

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1083-3188/$ - see front matter
http://dx.doi.org/10.1016/j.jpag.2015.07.003

and quality of family planning education and services, particularly for LARC methods is unclear. Moreover, other barriers to contraceptive use such as exposure to sexual coercion and exploitation remain largely unexplored in this population. We conducted a mixed methods study to explore barriers to LARC use among young women ages 18-24 years who were currently homeless or had experienced recent homelessness to inform improvements in reproductive health service delivery to better meet the needs of this highly vulnerable population.

Materials and Methods

Recruitment

In this descriptive, mixed methods study a purposive sampling strategy was used to recruit young women (n = 15) aged 18-24 years who were currently homeless or had experienced recent homelessness within the past 12 months. Because there is no current standard definition for homeless youth, and because homeless and marginalized youth generally transition in and out of unstable housing situations often, homelessness was defined broadly as the occurrence of 2 or more nights within the past 12 months when a woman did not have a home, was told to leave her home, or was otherwise unable to stay at her home and forced to stay elsewhere.[13] We recruited through community organizations, health clinics, and snowball sampling. Community organizations working with homeless women distributed flyers with information about the study to the young women they served during the study period. Women were also informed of the study by their health care provider at outpatient clinical locations that serve homeless youth and young adults in the Pittsburgh region.

Interested women contacted the principal investigator (M.D.) to be screened. Screening consisted of a 5-item survey to assess eligibility on the basis of age, history of homelessness, and ever having had vaginal intercourse with a man. Eligible women were then asked to provide verbal consent to participate in the study. Participants received a $20 gift card as remuneration for their time and effort.

Study Design

Each participant completed a computerized survey followed by in-person interview. All surveys and interview procedures took place in a private room at a daytime community drop-in center for homeless youth in downtown Pittsburgh. Participants completed a 47-item computerized survey. Survey items were adapted from previous contraceptive decision-making studies[14,15] or developed de novo using input from medical experts and researchers on young women's reproductive health and contraception. Interviews were conducted by the principal investigator using a semistructured interview guide with probes.

Measures

Survey

The 47-tem survey overed 11 domains (Table 1). The survey was used to assess demographic characteristics, current and past contraceptive use, pregnancy intention within the next 12 months, self-reported knowledge about LARCs, sources of information about LARCs, and experiences with reproductive and sexual coercion. Five items assessed patient trust in health care providers, which were adapted from the Wake Forest Physician Trust Scale.[16] Concern about possible side effects and complications were included in survey items based on common myths and misconceptions around LARC identified in a previous qualitative study.[17] Participants who indicated previous LARC use were asked whether a provider had offered LARC or not, and if so, whether they decided to get LARCs as a result of provider counseling. If they indicated discontinuation of LARCs, reason for removal was assessed, along with possible side effects or complications that prompted removal. For participants who indicated no previous LARC use, items were used to assess whether or not she had ever been offered any LARC method by a provider, and the likeliness of starting an IUD or implant if her provider recommended it. Because youth experiences of homelessness often include frequent transitions in and out of homelessness, their lifetime and

Table 1
Survey Domains

Domain	Description of Items
1. Past and current contraceptive use	All methods ever used, duration of current method, if any
2. Previous LARC use	If used before, was it a result of a provider recommendation
3. Reasons for LARC discontinuation	If previous LARC use indicated by earlier responses
4. Self-perceived knowledge about LARC	Heard about IUD or implant, where she heard about it, self-perceived knowledge about how it works
5. Interactions with health care providers around LARC	Previous LARC offered by provider, LARC mechanism explanation from provider
6. Attitudes toward health care providers	Trust in health care provider, likelihood of getting IUD or implant based on hypothetical LARC offer by provider
7. Concerns about starting a LARC method	If LARC nonuse was indicated by earlier responses
8. Pregnancy history	Currently pregnant, ever pregnant, number of pregnancies, planning on becoming pregnant in next 12 months, likelihood of becoming pregnant in next 12 months
9. Intimate partner violence	Physical harm, force, or threats to have sex Recent (<3 months ago) or previous (>3 months ago)
10. Reproductive and/or sexual coercion	Forced pregnancy, forced to not use birth control, threatened to leave if she did not get pregnant, hreatened to take away birth control, threatened to get her pregnant Recent (<3 months ago) or previous (>3 months ago)
11. Positive partner experiences around contraceptive and pregnancy decision-making	Ever encouraged use of birth control, family planning services, wanted to talk openly about birth control or pregnancy

IUD, Intrauterine device; LARC, Long-acting reversible contraceptive