



Review article

Access Barriers to Long-Acting Reversible Contraceptives for Adolescents



Natasha Kumar^{a,*}, and Joanna D. Brown, M.D., M.P.H.^b

^a Warren Alpert Medical School of Brown University, Providence Rhode Island

^b Department of Family Medicine, Warren Alpert Medical School of Brown University, Providence, Rhode Island

Article history: Received January 20, 2016; Accepted March 28, 2016

Keywords: Delivery of health care; Health services accessibility; Adolescent health; Intrauterine device

 A B S T R A C T

The United States continues to have the highest adolescent birth rate of any industrialized country. Recently published guidelines by the American Academy of Pediatrics create a new consensus among professional organizations around the suitability of long-acting reversible contraceptives as first-line contraception for adolescents. Through a narrative review of U.S. studies published after 2000, this study seeks to summarize existing access barriers to long-acting reversible contraceptives for adolescents and highlight areas that warrant further intervention so that the recommendations of these professional organizations can be effectively integrated into clinical practice. Existing barriers include costs for institutions providing contraceptive care and for recipients; consent and confidentiality for adolescent patients; providers' attitudes, misconceptions and limited training; and patients' lack of awareness or misconceptions. Systemic policy interventions are required to address cost and confidentiality, such as the Affordable Care Act's mandate that contraceptive coverage be a part of essential health benefits for all insurance providers. Individual-level access barriers such as providers' misconceptions and gaps in technical training as well as patients' lack of awareness can be addressed directly by professional medical organizations, health care training programs, and other interventions.

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IMPLICATIONS AND CONTRIBUTION

After the recent consensus by professional medical organizations around long-acting reversible contraceptives (LARC) as first-line contraception for adolescents, this review consolidates literature on existing access barriers to LARC for adolescents to foster thoughtful interventions that ensure this shift in guidelines leads to increased utilization of LARC.

Rates of unintended pregnancy in the United States are approximately twice that of many other developed countries, and adolescents are at particularly high risk [1,2]. In 2010, the teen pregnancy rate in the United States was 57.4 pregnancies per 1,000 teen girls [3]. Although this rate has sharply decreased from 1990 to 2010, the United States continues to have the highest adolescent birth rate out of any industrialized country [4], estimated as 26.5 births per 1,000 teens in 2013 [5]. In 2006,

82% of adolescent pregnancies were unintended, compared to 48% for women in general [6]. Meanwhile, adolescents are less likely to adhere to short-term contraceptives, such as oral contraceptive pills, than their adult counterparts [7].

Long-acting reversible contraceptives (LARC), specifically the intrauterine device (IUD) and the implant, are the most effective reversible contraceptive methods currently in existence. While much of contraceptive failure is attributed to lack of adherence by patients—for example, accidentally missing a daily dose of oral contraceptives—the efficacy of LARC is not user dependent. The one-time insertion is conducted by a trained medical provider and the methods last at least 3 years and do not require the users' actions to maintain [8]. Thus, the difference between perfect use and typical use of these contraceptive methods is

Conflicts of Interest: The authors declare that there are no real or perceived conflicts of interest.

* Address correspondence to: Natasha Kumar, Box G-9999, Brown University, Providence, RI 02912.

E-mail address: natasha_kumar@brown.edu (N. Kumar).

virtually nonexistent and the chances of an unintended pregnancy are close to nil. This is reflected in the failure rates of LARC, which are less than 1% [9]. LARC, for adolescents, provide an ideal option for user-independent pregnancy prevention.

Within the medical community, guidelines have been rapidly shifting to support LARC as ideal for adolescents. In 2012, the American Congress of Obstetricians and Gynecologists (ACOG) recommended that LARC be used as first-line methods for nulliparous adolescents [10]. In October 2014, the American Academy of Pediatrics (AAP) published new guidelines that aligned with ACOG, synchronizing best clinical practices by obstetrician gynecologists and pediatricians, two of the specialties likely to provide reproductive care or counseling to adolescents [11]. Given the efficacy of LARC relative to other methods, the recommendations by the AAP and ACOG are undoubtedly steps in the right direction to support optimal sexual health and prevent pregnancy among adolescents in the United States.

However, utilization of LARC by adolescents is extremely low relative to short-acting methods [12]. Only 3% of adolescents ages 15–19 who had intercourse at least once used an IUD in 2011–2013 compared to 6.4% of the total population of women ages 15–44 [13,14]. Meanwhile, 2% of adolescents who had intercourse at least once reported using the implant compared with .8% of women ages 15–44. Although adolescents' use of the implant appears to be higher than that of the overall population of reproductive-aged women, their use of either implants or IUDs is far less prevalent than their use of shorter acting methods. Ninety-seven percent of adolescents who had intercourse at least once had used a condom and 54% had used the pill [14]. Updated, consistent guidelines should help to shift this trend in a positive direction, but numerous barriers impeding adolescents' access to IUDs and implants persist within the existing health care system. Through a narrative review of U.S. studies published after 2000, this study seeks to summarize existing access barriers to LARC for adolescents to highlight areas that merit further attention and intervention from physicians so that the new consensus of AAP and ACOG recommendations can be effectively integrated into clinical practice.

Access Barriers to LARC for Adolescents

Multiple factors influence adolescents' access to resources for sexual health in the United States. Although federal laws afford some level of universality of access to LARC for this age group, research has documented barriers at both the institutional and the individual level of care provision, including but not limited to financial constraints, unclear or confusing legal frameworks around confidentiality for minors, providers' attitudes toward and misconceptions about LARC, and limited patient awareness of LARC.

Cost (insurance coverage and institutional burden)

IUDs and implants alike, while more cost-effective than other contraceptives in the long term, have significant upfront costs, which can be a barrier for patients whose insurance will not cover contraceptive expenses or for patients who are uninsured. The total bill for a patient to initiate LARC generally exceeds \$1,000 [15]. Currently, almost all insurance plans cover prescription drugs (i.e., oral contraceptive pills), but only 28 states mandate insurance coverage of all Food and Drug Administration

(FDA)-approved contraceptives, including IUDs and implants. Of the 28 states with contraceptive mandates, 17 require insurance coverage of related outpatient services. Although the Affordable Care Act (ACA) has guaranteed insurance coverage of FDA-approved contraceptives, including the IUD and implant, the act allows older plans to be grandfathered into the new health care system under their existing coverage plans. Eventually, many older plans will be forced to comply with the new mandates as cost sharing and benefit structures change, but this process will take several years, according to estimates by the U.S. Department of Health and Human Services [16]. In addition, recent legislation has also allowed for religious exemptions from the ACA for certain employer-based plans, which limits the potential number of women who will benefit from complete insurance coverage of contraceptives, including LARC.

Within the literature, several studies point to the cost of IUDs and implants as a significant concern for clinic administrators in providing contraceptive services to adolescents and young adults [17]. In one study, key informant interviews of clinic staff attributed uptake of long-term methods by adolescents to grant funding for IUDs and implant provision that provided these methods free of charge [18]. Meanwhile, interventions such as the Contraceptive CHOICE Project in Missouri (Project CHOICE), the Taking Charge intervention in school-based health centers in Seattle, and the Colorado Family Planning Initiative have demonstrated impressive increases in use of LARC when these methods are provided to patients free of charge, thus removing cost as a barrier to access [19–21]. In Project CHOICE, the elimination of the cost to patients, as well as effective counseling, resulted in 62% of adolescents aged 14–20 (69% of 14–17 year olds and 61% of 18–20 year olds) utilizing LARC, proving that cost as well as accurate clinical information are significant determinants of access to IUDs and implants [22].

Another constraint for clinic administrators was the institutional burden of LARC provision, which can incur additional costs for institutions and patients. A survey of family planning clinic directors found that providing IUDs and implants required increased time from physicians compared to other methods, including more extensive counseling, an insertion procedure and follow-up visits, which can be a constraint on LARC provision [18]. A 2008 study shows that maintaining the medical equipment required to insert IUDs also introduces an additional burden on clinical practices [23].

Consent and confidentiality

Consent and confidentiality for minors seeking sexual health resources are challenging ethical and legal issues. The opportunity for independent consent by minors is an essential component of effective contraceptive care, as is the opportunity for that care to be confidential if needed. Patient confidentiality from parents is a key determinant of utilization of contraceptive care for adolescents [17]; in a 2002 study of adolescents receiving care at a family planning clinic, only 1% would stop having vaginal sex but 59% would stop receiving all services at the clinic if parental notification of contraceptive care was mandatory [24]. Of note, a study of parental acceptability of contraceptive methods indicates that parents are most comfortable with oral contraceptives and least comfortable with IUDs. While on one hand, this points to the importance of increased parental awareness and education about LARC for teens, it also highlights

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