Long-Acting Reversible Contraception for Adolescents

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Approximately 50 percent of women in the United States experience an unplanned pregnancy (Finer & Zolna, 2011). Of this group, adolescents and young adults under the age of 25 have the highest rate of unintended pregnancy compared with women of all other reproductive ages (Finer, 2010; Finer & Zolna, 2011). Unintended pregnancy has been associated with a low level of contraceptive knowledge and use, fear of side effects, as well as ambivalence regarding pregnancy and mistrust of government-supported family planning services (Frost, Lindberg, & Finer, 2012; Zolna & Lindberg, 2012). Currently, the Centers for Disease Control and Prevention (CDC) recommends counseling patients on the use of long-acting reversible contraception (LARC), including intrauterine devices (IUDs) and implants, as a first-line, highly effective

Abstract In 2013 and 2014, the Centers for Disease Control and Prevention (CDC) publicized its recommendations for the use of long-acting reversible contraception (LARC) (including intrauterine devices and implants) as first-line, highly effective options for pregnancy prevention. The use of LARC by adolescents has had growing support by national health and women's health organizations. Ongoing research is beginning to uncover facilitators and barriers to LARC use in adolescents. The purpose of this column is to highlight two recent U.S.-based studies in which researchers examined perspectives related to and factors associated with LARC use in adolescent and young adult women. DOI: 10.1111/1751-486X.12207

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A Second Look

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option for pregnancy prevention (CDC, 2013, 2014). Use of LARC in adolescents is supported by national organizations (American College of Obstetricians and Gynecologists [ACOG], 2012; CDC, 2013, 2014).

LARC refers to contraceptive methods that are nondaily, not intercourse-dependent and have efficacy that is not dependent on correct use or intervention on the part of the user. Currently, LARC includes IUDs and the progestin implant (Hatcher et al., 2011). Length of contraceptive benefit ranges from 3 years with the implant to 3 to 10 years depending on IUD type. Effectiveness is similar to or better than sterilization for both the implant and IUDs, and fertility returns quickly upon removal (Hatcher et al., 2011). These characteristics make LARC an ideal option for adolescents who are seeking a highly effective method while they delay pregnancy for many years.

This column takes a second look at two recent studies that examine factors associated with LARC use among adolescent and young adult women. This column provides women's health nurses an opportunity to stay up to date on emerging contraceptive science and highlights potential areas for reflection on and improvement of current practice and clinical education. In the first study, Kavanaugh, Frohwirth, Jerman, Popkins, and Ethier (2013) describe both provider and patient perspectives about LARC. In the second study, Greenberg, Makino and Coles (2013) report on adolescent health provider and practice characteristics that are associated with the provision of LARC. Both of these studies provide level III evidence (see Box 1).

First Study

The purpose of the study by Kavanaugh et al. (2013) was to explore and compare provider and patient perspectives about LARC use among adolescent and young adult women, as well as to identify strategies to facilitate the provision of LARC for young women.

Design, Sample and Data Analysis

Kavanaugh et al. (2013) utilized a qualitative design that included both direct interviews as well as focus groups to achieve the study aims. This study was conducted at several national Title X family planning health centers. Title X is a federal grant program dedicated to providing comprehensive family planning and related health services to low income women and men. This program funds approximately 4,400 health centers nationally, which include government health departments, community health centers, Planned Parenthood centers and hospital, school, private or faith-based health centers (U.S. Department of Health & Human Services, Office of Population Affairs, 2014).

Sample and data collection was as follows:

Box 1.

Levels of Evidence

The quality of evidence for a study is based on a grading system that evaluates the scientific rigor of a design, as developed by the U.S. Preventive Services Task Force. The levels are as follows:

- I: Evidence obtained from at least one properly randomized controlled trial.
- II-1: Evidence obtained from well-designed controlled trials without randomization.
- II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
- II-3: Evidence obtained from multiple time series with or without intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.
- III: Opinions of respected authorities are based on clinical experience, descriptive studies and case reports or reports of expert committees.

Source: United States Preventive Services Task Force (1996).