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Original article

Use of Long-Acting Reversible Contraception Among Adolescent and Young Adult Women and Receipt of Sexually Transmitted Infection/Human Immunodeficiency Virus–Related Services

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A B S T R A C T

Purpose: Long-acting reversible contraceptive (LARC) methods do not require annual clinic visits for continuation, potentially impacting receipt of recommended sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) services for young women. We assess service receipt among new and continuing LARC users versus moderately and less effective method users and non-contraceptors.

Methods: Using 2011–2015 National Survey of Family Growth data from sexually active women aged 15–24 years (n = 2,018), we conducted logistic comparisons of chlamydia, any STI and HIV testing, and sexual risk assessment in the past year by current contraceptive type.

Results: Less than half of respondents were tested for chlamydia (40.9%), any STI (47.3%), or HIV (25.9%); 66.5% had their sexual risk assessed. Differences in service receipt between new and continuing LARC users as compared with moderately effective method users were not detected in multivariable models, except that continuing LARC users were less likely to be tested for HIV (adjusted prevalence ratio [aPR] = .52, 95% confidence interval [CI] = .32–.85). New, but not continuing, LARC users were more likely than less effective method users (aPR = 1.35, 95% CI = 1.03–1.76) and non-contraceptors (aPR = 1.43, 95% CI = 1.11–1.85) to have their sexual risk assessed, although both groups were more likely than non-contraceptors to be tested for chlamydia (new: aPR = 1.52, 95% CI = 1.08–2.15; continuing: aPR = 1.69, 95% CI = 1.24–2.29).

Conclusions: We found little evidence that LARC use was associated with lower prevalence of STI testing. However, new, but not continuing, LARC users, as compared with those not using a method requiring a clinic visit, were more likely to have had their risk assessed, suggesting that initiating LARC may offer an opportunity to receive services that does not persist.

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IMPLICATIONS AND CONTRIBUTIONS

This study extends what is known about the STI/HIV prevention implications of LARC use among young women. Ongoing monitoring of differences in service receipt by contraceptive type may inform strategies for integrating STI/HIV prevention with efforts to increase awareness of and access to LARC methods.

Disclaimer: The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Unintended pregnancy, human immunodeficiency virus (HIV), and other sexually transmitted infections (STIs) are distinct, but interrelated health concerns. Given that each occurs in the context of sexual behavior, many have argued for an integrated prevention approach [1,2]. National guidelines for providing quality family planning services recommend comprehensive delivery of sexual and reproductive health prevention and care services, including STI/HIV testing and counseling [3]. Integration is especially salient for adolescent and young adult women: nearly half of the 20 million new STIs reported each year, including HIV, are among young people aged 15–24 years, and the proportion of pregnancies that are unintended is higher among adolescents (75%) and young adults (59%) compared with older women (31%–42%) [4,5].

Increasing use of long-acting reversible contraceptive (LARC) methods [6,7], namely intrauterine devices and implants, has renewed attention to the challenge of integrating unintended pregnancy and STI prevention, particularly among young people. Professional medical organizations recommend LARC methods as a highly effective pregnancy prevention option for all women of reproductive age, including adolescents [8–10]. Yet because they confer no STI/HIV prevention benefits, family planning guidelines suggest LARC users should also use condoms if they are not in a mutually monogamous relationship [3]. However, recent evidence shows condom use is low among adolescent LARC users and suggests they may be less likely to use condoms than users of moderately effective methods (e.g., birth control pills, injectables, patch, and ring) [11,12].

The implications of LARC use for STI/HIV prevention may also extend beyond condom use to health services. Specifically, LARC users may be less likely to receive recommended STI/HIV-related services, given the long-acting nature of these methods and young women's care-seeking patterns and preferences. Whereas moderately effective methods must be refilled or administered by a provider at least annually, LARC methods remain effective for up to 3–10 years, depending on the method, and require less clinical interaction for continuation. Fewer family planning visits may mean fewer opportunities for testing, given that 75% of women receiving STI-related services report receiving them from obstetricians/gynecologists or family planning providers [13]. Moreover, many women intend to be tested for STIs at family planning clinics [14], which are the only source of care for a substantial proportion of women [15].

Limited research has explored associations between LARC use and receipt of health services. Although two prior studies examined use of clinical services, including STI testing, among young female LARC users, neither was conducted in the context of the current health-care system—one took place in the early 1990s and the other used home-based STI testing as part of study follow-up [16,17]. Using nationally representative data, we assess whether sexually active adolescent and young adult LARC users are less likely to receive STI/HIV services compared with users of moderately effective contraceptive methods that typically involve annual clinic visits. Given that new LARC users are inherently interacting with the health-care system at the time of insertion, we distinguish new and continuing LARC users. We also compare new and continuing LARC users to users of less effective methods that do not require regular clinical interactions for continuation and non-contraceptors. A more nuanced understanding of whether LARC use is related to receipt of STI/HIV services can inform strategies for integrating STI/HIV prevention with efforts to increase awareness of and access to LARC methods.

Methods

Data source and procedures

We used data from the 2011–2015 National Survey of Family Growth (NSFG) implemented by the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC). Details of the survey methodology are documented elsewhere [18]. Briefly, this continuously administered survey (with interviews conducted over 48 weeks each year) employs a multistage probability design that yields a nationally representative sample of women and men aged 15–44 years in the U.S. household population. Computer-assisted personal interviews (CAPI) are used to collect self-reported information about family life, marriage and divorce, pregnancy, fertility, contraceptive use, health behaviors, and outcomes. Additional sexual health-related indicators are assessed via audio computer-assisted self-interviews (ACASI).

Study sample

For this analysis, the sample was restricted to sexually active female adolescents (15–19 years) and young adult women (20–24 years) at risk of unintended pregnancy ($n = 2{,}018$). Participants were considered to be sexually active and at risk of unintended pregnancy if they had vaginal sex with at least one male sex partner in the prior year and were not currently pregnant, seeking pregnancy, postpartum (completed pregnancy ≤2.5 months before interview), infecund, or using sterilization as their current method of contraception.

Measures

The independent variable of interest was type of contraceptive method currently used. We first used a recoded variable to determine the most effective method used during the month of the interview (if any), based on estimates of contraceptive effectiveness with typical use [19]. For users of highly effective LARC methods, we then used a calendar history of contraceptive use to assess whether the method was initiated within or before the past 12 months. The final categorical indicator distinguished (1) new LARC users (initiated ≤12 months prior); (2) continuing LARC users (initiated > 12 months prior); (3) current users of moderately effective methods, including oral contraceptives, Depo-Provera, the patch, and ring; (4) current users of less effective methods, including condoms, diaphragm, withdrawal, morning-after pill, foam, sponge, suppository, jelly or cream, periodic abstinence, or other methods (not specified); and (5) non-contraceptors.

Outcomes included dichotomous variables for chlamydia testing, any STI testing, HIV testing, and STI-related risk assessment in the past year, given existing recommendations for these services. The U.S. Preventive Services Task Force, CDC, and American College of Obstetricians and Gynecologists recommend annual chlamydia and gonorrhea screening for all sexually active women <25 years of age, and routine HIV screening starting at age 15, with recommended screening intervals for HIV varying based on risk [20]. The American Academy of Pediatrics also recommends risk assessment for sexually active individuals based on condom use, partner characteristics, participation in transactional sex, and prior STI treatment as part of quality, annual preventive care visits for young people [21].

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