

# Barriers to Use of Long-Acting Reversible Contraceptives in Adolescents



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## KEYWORDS

• LARC • Contraception • IUD • Implant • Adolescence

## KEY POINTS

- The American College of Obstetricians and Gynecologists and American Academy of Pediatrics endorse long-acting reversible contraceptives (LARCs) as the first-line contraceptive option for adolescents because of these agents' efficacy and safety profiles.
- Provider-based barriers to using LARCs include unfamiliarity with current guidelines, lack of training in insertion techniques, and misconceptions about the risks of infection and infertility.
- Providing patients with the opportunity for same-day intrauterine device (IUD) insertion increases their access to LARCs. Pregnancy must be ruled out before insertion.
- If IUD insertional pain is a concern, providers may offer a smaller framed IUD and/or a lidocaine paracervical block.

## INTRODUCTION

In 2013 there were 448,000 annual pregnancies (43.4 per 1000 adolescents) in women 15 to 19 years old.<sup>1</sup> Despite this rate having decreased greatly over the past half century, the United States continues to have the highest rate of teen pregnancy among industrialized countries<sup>2</sup> (eg, [Fig. 1](#)). Most adolescent pregnancies are unintended.<sup>2</sup>

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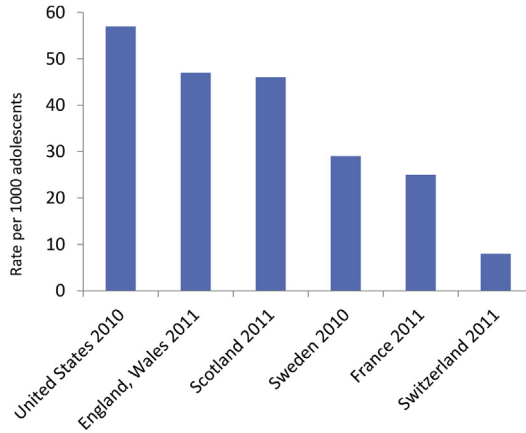
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**Fig. 1.** Rates of pregnancy per 1000 women, aged 15 to 19 years, in a sampling of developed countries.

Given that the United States has a high teen pregnancy rate and that most teen pregnancies are unintended, there is justifiable consternation regarding low rates of effective contraception use in adolescents in the United States.

The American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) both endorse long-acting reversible contraceptives (LARCs) as the first-line option when counseling adolescents about contraception<sup>3,4</sup> because of these agents' high efficacy in preventing pregnancy, superior continuation rates, and limited contraindications.<sup>3</sup> Their recommendations state that providers should first introduce LARCs before other forms of contraception, including oral contraceptive pills (OCPs), transdermal patch, vaginal ring, and the depot medroxyprogesterone acetate (DMPA) injection.<sup>3,4</sup> Even with these organizations' recommendations, LARCs continue to be underused in the adolescent population, with only 5.8% of the female adolescents who use contraception reporting the use of LARCs.<sup>5,6</sup>

LARCs include the levonorgestrel-releasing intrauterine device (LNG-IUD), the copper intrauterine device (CuT380A), and the etonogestrel single rod implant (eg, [Table 1](#)). They are the most effective forms of contraception, with pregnancy rates of less than 1% per year, similar to that of permanent sterilization.<sup>4</sup> An important distinction between sterilization and LARCs is that any LARC can be removed at the discretion of the patient; this makes LARCs an ideal contraceptive choice for adolescents who would like to delay pregnancy for an extended period of time, but not permanently.

Adolescents, who have high rates of contraceptive failure, particularly need highly effective and low-maintenance contraceptive options.<sup>7</sup> Based on the 2011 to 2015 National Survey of Family Growth, 42.43% of female teenagers and 44.2% of male teenagers have participated in vaginal intercourse at least once in their lives.<sup>6</sup> In addition, adolescents report using less reliable forms of contraception: the most common being the male condom (97.4%) followed by coitus interruptus (69.7%), and then OCPs (55.5%).<sup>6</sup> The male condom has a failure rate as high as 18% and coitus interruptus as high as 22%.<sup>3</sup>

Even when adolescents use more reliable forms of birth control such as OCPs, they often do not use them properly.<sup>3</sup> Within the first year of OCP initiation, 5% to 9% of all users become pregnant, and this failure rate is nearly doubled in women younger than

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