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Access to long-acting reversible contraception among US publicly funded health centers

Marta Bornstein[a,*,1], Marion Carter[b], Lauren Zapata[c], Loretta Gavin[d,1], Susan Moskosky[d]

[a]Oak Ridge Institute for Research and Education, Centers for Disease Control and Prevention, Division of STD Prevention, Atlanta, GA
[b]Centers for Disease Control and Prevention, Division of STD Prevention, Atlanta, GA
[c]Centers for Disease Control and Prevention, Division of Reproductive Health, Atlanta, GA
[d]Department of Health and Human Services, Office of Population Affairs, Washington DC

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Abstract

Objectives: Access to a full range of contraceptive methods, including long-acting reversible contraception (LARC), is central to providing quality family planning services. We describe health center-related factors associated with LARC availability, including staff training in LARC insertion/removal and approaches to offering LARC, whether onsite or through referral.
Study Design: We analyzed nationally representative survey data collected during 2013–2014 from administrators of publicly funded U.S. health centers that offered family planning. The response rate was 49.3% (n=1615). In addition to descriptive statistics, we used multivariable logistic regression to identify health center characteristics associated with offering both IUDs and implants onsite.
Results: Two-thirds (64%) of health centers had staff trained in all three LARC types (hormonal IUD, copper IUD, implant); 21% had no staff trained in any of those contraceptive methods. Half of health centers (52%) offered IUDs (any type) and implants onsite. After onsite provision, informal referral arrangements were the most common way LARC methods were offered. In adjusted analyses, Planned Parenthood (AOR=9.49) and hospital-based (AOR=2.35) health centers had increased odds of offering IUDs (any type) and implants onsite, compared to Health Departments, as did Title X-funded (AOR=1.55) compared to non-Title X-funded health centers and centers serving a larger volume of family planning clients. Centers serving mostly rural areas compared to those serving urbans areas had lower odds (AOR 0.60) of offering IUD (any type) and implants.
Conclusions: Variation in LARC access remains among publicly funded health centers. In particular, Health Departments and rural health centers have relatively low LARC provision.
Implications: For more women to be offered a full range of contraceptive methods, additional efforts should be made to increase availability of LARC in publicly-funded health centers, such as addressing provider training gaps, improving referrals mechanisms, and other efforts to strengthen the health care system.

Keywords: Long-acting reversible contraceptives LARC; Contraceptive methods; Title X; Training

1. Introduction

In 2014, the CDC and the Office of Population Affairs published recommendations for the provision of quality family planning services. In these recommendations, the need to offer the full range of contraceptive methods onsite or by referral, including long-acting, reversible contraception (LARC), which include hormonal and copper intrauterine devices (IUDs) and hormonal implants [1,2], is highlighted. Recommendations by the American Congress of Obstetricians and Gynecologists are similar. LARCs are highly effective methods, with failure rates of <1% [3] Women in the United States are increasingly choosing LARC methods, although prevalence remains relatively low. According to national population-based data, just over 7% of women were using a LARC method in 2011–2013, an increase from 3.8% in 2006–2010 [4].

A recent study partly attributed the decline of unintended pregnancies in 2008–2011 to the use of LARC methods [5]. Additional studies show that reducing barriers to LARC can

* Corresponding author.
E-mail address: Martabornstein@gmail.com (M. Bornstein).
[1] At time of writing.

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lead to increased LARC use among women and, in turn, decreased rates of unintended pregnancy [6,7]. In Colorado, providing LARC methods at no charge to teens was associated with increased use of those methods from under 3% to 25% in 6 years and a reduction in teen pregnancy by between 4.6 and 7.9% [8]. In St. Louis, with more education on LARC and free LARC provision, 72% of teen girls enrolled in the study chose a LARC method, which was associated with significantly lower pregnancy, birth, and abortion rates compared to national averages [9]. Although the St. Louis project focused on teens and adult women, data regarding unintended pregnancy were studied more extensively in teens.

Despite the effectiveness of LARCs, numerous barriers to LARC use for both teens and adult women remain. These include lack of knowledge about LARC among clients and providers, ongoing misconceptions about the safety of LARC, gaps in provider knowledge and training, and cost and insurance coverage barriers [10]. For example, a national survey of obstetricians-gynecologists found that nearly all respondents reported offering IUDs, but most required two or more visits; and only 51% received residency training on contraceptive implants [11]. A survey of providers in California's Family PACT program found that only 41% of sites offered the implant onsite and about one fifth would not recommend IUDs for teenagers or nulliparous women, contrary to United States Medical Eligibility Criteria for contraceptive use [12–14].

Characterizing such barriers is essential to addressing them and making LARC more accessible. Using nationally-representative data from publicly-funded health centers that offer family planning, we describe health center approaches to providing LARC, whether onsite or by various types of referral arrangements, with a focus on factors associated with onsite provision of both LARC methods (IUDs and implants).

2. Methods

2.1. Data

From June 2013–May 2014, surveys were sent to a stratified, random sample of 4000 health centers identified from a Guttmacher Institute database of all publicly-funded family planning health centers nationwide [15]. Primary aims of the survey were to provide baseline data for implementation of the Recommendations for Providing Quality Family Planning Services and to compare health centers who received funding from the Title X federal family planning program to health centers that did not receive Title X funding. Therefore, by design, the sample was stratified into recipients and non-recipients of Title X funding. Within each of those strata, 2000 centers were randomly sampled, with further stratification by health center type (Health Department, Planned Parenthood, Community Health Center, hospital-based center, other) to ensure proportional representation of health center type within the sample. At each sampled health center, an administrator was asked to complete a survey.

We calculated the response rate by assuming that the proportion of health centers eligible in the unknown eligibility subgroup was the same as the proportion in the known eligibility subgroup. After excluding ineligible health centers (i.e., closed by the time of data collection), the overall response rate was 49.3% (n=1615). Response rates did vary by Title X funding status (61.0% for Title X health centers and 37.6% for non-Title X health centers) and health center type (ranged from 37.9% for Community Health Centers to 63.5% for Health Departments). As the project was determined to be non-research, public health practice by the CDC, Institutional Review Board approval was not needed.

2.2. Measures of LARC Access

The survey asked if all, any, or no clinical staff were ever trained in inserting/removing each of the following LARC methods: hormonal IUD, copper IUD, and implant. Administrators also were asked how their health center offered IUDs (any type) and implants, separately, with the following response options: (1) offered the service onsite, (2) co-located with providers who offered the service or their parent organization offered it, (3) had a contract or other written agreement with an organization that provided the service, (4) had informal relationships with providers who offered the service, or 5) had a referral-only partnership. We categorized responses 2 and 3 as "formal" arrangements, and responses 4 and 5 as "informal" arrangements for this analysis.

2.3. Analytic strategy and independent variables

We present estimates of health center approaches to offering LARC overall and by three health center characteristics: (1) receipt of Title X funding (yes/no); (2) health center type (Health Department, Planned Parenthood, Community Health Center, hospital-based health center, or other); and (3) area served (mainly rural, mainly urban/suburban, or combination of rural and urban/suburban). We used chi-square tests to identify significant differences in these distributions.

We also conducted multivariate logistic regression to identify health center characteristics associated with providing LARC onsite. In addition to the characteristics described above, we included the approximate annual client volume (6 categories ranging from <500 clients to 50,000+ clients), annual family planning client volume (5 categories ranging from <500 clients to 10,000+ clients), and geographic region (Northeast/Mid-Atlantic, South/Southwest, Mid-west, and West) as independent variables. Both total and family planning client volume were included because they had significant associations with onsite provision in bivariate