



Position statement

Improving Knowledge About, Access to, and Utilization of Long-Acting Reversible Contraception Among Adolescents and Young Adults



The Society for Adolescent Health and Medicine

Many individuals initiate sexual activity during their adolescent and young adult (AYA) years and are in need of safe and effective contraceptive services. Births to adolescents aged 15–19 years account for 11% of all births worldwide, with approximately 16 million giving birth each year [1]. While the United States has the highest rate of adolescent pregnancy among developed countries, most teen births take place in low- and middle-income settings [1,2]. Compared with pregnancies in adult women, adolescent pregnancy is associated with increased maternal and neonatal morbidity and mortality, as well as poorer educational, economical, and social outcomes for teen parents and their children [1,3].

Most pregnancies among AYAs are unintended and many AYAs are at particularly high risk for inconsistent or incorrect use of contraception [4]. Adolescents aged 15–24 years are most likely to use the birth control pill, followed by condoms as contraception [5]. These methods, however, have significantly higher failure rates than long-acting reversible contraceptive (LARC) methods, which include intrauterine devices (IUDs) and contraceptive implants [5,6]. LARCs are safe, highly effective, [5–7] and particularly advantageous for adolescents because they are easier to keep confidential. In addition, LARC methods are easier to use because they do not require daily adherence or frequent visits for refills, and as a result, they are sometimes referred to as low maintenance contraception. LARC methods are also highly cost-effective [7]. Because LARCs are highly effective, reversible, and have a low risk of serious adverse side effects, many professional medical organizations in the United States and globally recommend that LARCs be among the primary contraceptive options for adolescents [8]. The World Health Organization does not place any age-related restrictions on the use of contraceptive implants and states that the advantages of using IUDs in AYAs outweigh the risks for any woman after menarche [9].

Despite significant evidence of the safety, acceptability, and effectiveness of LARC methods among AYAs, they are underutilized in this population. According to the 2011–2013 National Survey of Family Growth, only 3.2% of 15- to 19-year-olds at risk

of an unintended pregnancy in the United States were using a LARC method [10]. Globally, method-specific preference varies widely with many AYAs lacking access to the full range of contraceptive options, which restricts their ability to exercise their right to free and informed reproductive choices [11].

Barriers to LARC use among AYAs have been well documented [12] and contribute to unequal access to LARC information and services within and across countries [13,14]. These barriers can be categorized into four main areas: (1) cost, (2) access, (3) providers' knowledge and attitudes, and (4) AYA's knowledge and misconceptions. First, despite the fact that LARCs are among the most cost-effective methods over time, their upfront cost can influence a clinic's willingness to provide them. Cost can also be a burden for the consumer, especially if it is not included as a fully covered health care benefit [12]. Second, access to LARCs is a major barrier. In some states and countries, there are legal restrictions on adolescents' access to confidential, comprehensive contraceptive services [12]. Yet, even with legal barriers removed, AYAs may not have access to a clinic that offers LARCs in their community or the clinic may have limited hours or may not offer confidential, youth-centered care [12]. Some clinics find the maintenance of medical equipment required to insert IUDs to be an additional barrier [15]. Third, even when LARCs are available, health care providers' knowledge and attitudes about LARC use, especially for adolescents, can still vary. Routine training about LARC devices has not been widely available for health care providers serving AYAs. As a result, many providers lack knowledge, procedural skills, and experience to promote uptake of LARCs for AYAs [15,16]. In addition, many health care providers still have misconceptions about the appropriateness of LARCs for the AYA population [17]. Finally, AYAs often lack knowledge about LARCs and frequently have misconceptions about them. LARC methods may be perceived as newer and have, historically, been less used in this population [12,15]. In spite of these barriers, LARC methods are acceptable to many AYAs, especially when patient-centered and efficacy-based counseling is provided in an adolescent-friendly clinical setting that supports contraceptive choice and is free of coercion [18].

It is the position of the Society for Adolescent Health and Medicine that all women, including AYAs, should have equal access to the full range of contraceptive options, including LARCs.

Position Statement approved by the Society for Adolescent Health and Medicine's Board of Directors, January 2017.

Actions to reduce barriers to LARCs are crucial. At the same time, an adolescent-friendly, patient-centered approach is essential to promote contraceptive choice [18]. This involves contraceptive counseling on the full range of options and supports an individual's needs and preferences for pregnancy planning and prevention [19]. Developmentally and culturally appropriate education and counseling based on shared decision-making with particular sensitivity to noncoercion are additional components of a patient-centered approach [19]. This is especially important for younger, sexual minority, and gender nonconforming AYAs and youth with less sexual experience [20]. The Society for Adolescent Health and Medicine strongly encourages the following strategies to reduce barriers to AYAs' access to LARCs:

- I. Remove financial barriers to LARCs:
 - Make LARC methods affordable, available, and confidential for all AYAs regardless of socioeconomic status, ability to pay, race, ethnicity, or gender.
- II. Promote AYA access to LARCs:
 - Ensure LARCs are offered and are available as part of essential, comprehensive contraceptive options through education, counseling, and health care services.
 - Assess and address access gaps including, but not limited to, geographical access, clinic hours, and youth-centered clinical settings.
 - Assure confidentiality protections through policy and clinical practice.
 - Ensure that insurance companies provide adequate reimbursement to meet the cost of LARC provision.
 - Encourage health care providers who do not offer LARC insertion or removal to establish collaborative relationships with those who are available to do so in a timely manner.
- III. Improve health care providers' knowledge and skills to provide adolescent friendly, patient-centered, comprehensive contraceptive counseling that includes LARCs:
 - Familiarize providers with all available and up-to-date LARC options, their efficacy in reducing unintended pregnancy risk, side effects, and safety.
 - Integrate LARC training into professional education for all health care providers working with AYAs.
 - Provide updated LARC training and ongoing support for health care providers already in practice.
 - Adopt a patient-centered noncoercive contraceptive counseling approach to support AYAs in making their contraceptive choice that includes accurate, comprehensive information that takes into account their individual needs and preferences for pregnancy planning and prevention.
 - Include LARC methods in comprehensive sexual and reproductive health information and services that are evidence based, confidential, developmentally appropriate, and culturally sensitive.
- IV. Improve AYAs' knowledge and understanding of LARCs as part of comprehensive contraception education and counseling:
 - Provide evidence-based information to communities, families, and AYAs on the safety, effectiveness, reversibility, cost-effectiveness, acceptability, high continuation rates, and the health and nonhealth benefits of contraceptive options, including LARCs.
 - Address the pregnancy prevention needs of sexual minority and gender nonconforming youth who may be at higher

risk of pregnancy and less likely to use contraception than other adolescents.

- Encourage dual contraception including use of condoms or other barrier methods in LARC users to prevent sexually transmitted infections and HIV.

For additional information regarding implementation of adolescent sexual and reproductive health services, please see "Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine" [http://www.jahonline.org/article/S1054-139X\(14\)00052-4/fulltext](http://www.jahonline.org/article/S1054-139X(14)00052-4/fulltext) as well as the Long-Acting Reversible Contraceptives for Adolescent and Young Adults special edition of the *Journal of Adolescent Health* available at [http://www.jahonline.org/issue/S1054-139X\(13\)X0013-8](http://www.jahonline.org/issue/S1054-139X(13)X0013-8).

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