



‘We’re kidding ourselves if we say that contraception is accessible’: a qualitative study of general practitioners’ attitudes towards adolescents’ use of long-acting reversible contraceptives (LARC)

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J PRIM HEALTH CARE

2019;11(2):138–145

doi:10.1071/HC18105

Received 26 December 2018

Accepted 29 May 2019

Published 18 July 2019

ABSTRACT

INTRODUCTION: Adolescents’ uptake of long-acting reversible contraceptives (LARCs) in New Zealand is low. We created the concept of a proactive LARC provision programme to overcome barriers to LARC uptake. Previously, this concept was discussed with adolescents and positively received. Lack of provider awareness is a barrier to LARC use identified in previous research and by adolescents.

AIM: We sought the views of general practitioners (GPs) to gauge whether LARCs and their proactive promotion for use in adolescents may be acceptable to GPs.

METHODS: Nine New Zealand GPs were interviewed about their contraception provision to adolescents and were then asked to comment on the concept of a proactive LARC provision programme. The data collected were transcribed and analysed using a general inductive approach to identify common themes and ideas. We concurrently interviewed and analysed interviews and continued to recruit GPs until thematic saturation was reached.

RESULTS: Six themes were identified from the interviews: (1) contraceptive decision making; (2) the GP role (3) sexual activity (4) social context (5) gauging adolescent understanding and (6) youth. When we proposed the concept of a proactive LARC provision programme, the GPs responded positively.

DISCUSSION: The research demonstrates that LARC uptake is affected by limited provider awareness. These findings align with other research internationally that identifies barriers to adolescent contraceptive use. The findings of this study suggest that other GPs may support a proactive LARC provision programme in New Zealand.

KEYWORDS: Access; general practice.

Introduction

Pregnancy in New Zealand (NZ) teenagers is mostly unintended,¹ suggesting a gap between the sexual reproductive health services required by adolescents and those provided. Improving access by changing the approach of contraception provision may assist in reducing the incidence of unintended pregnancy in adolescents.

Long-acting reversible contraceptives (LARCs) are a group of contraceptives that are characterised by an effective duration of ≥ 1 year, typical use failure rates very close to perfect use failure rates and they can be removed to restore full fertility.² LARCs are 22-fold as effective as the pill at preventing pregnancy,³ but in NZ LARCs are used less than other less-effective contraceptive methods.⁴ LARCs are safe for use in the adolescent population,^{5,6} but are not routinely being offered to adolescents.⁷

One way of addressing the low uptake of LARCs by adolescents could be some form of opt-out programme, with a combination of proactively offering LARCs to adolescents and individualised sexual education.^{8,9} We term this concept 'proactive LARC provision' (PLP). In such a proactive approach, health care providers would routinely offer LARCs to all adolescents. This would remove barriers for adolescents to access effective contraception. The details of how a PLP programme would be carried out have not yet been determined because the input of adolescents (the intended target population) and general practitioners (GPs; the current contraceptive providers) is needed to determine the acceptability of a PLP programme.

Before the present study, we ran a series of focus groups with female adolescents to discuss contraception, explore their opinions on sexual reproductive health services and gauge how acceptable they found the concept of a PLP programme.¹⁰ In that study, participants were accepting of the PLP programme concept. Furthermore, their experiences identified many of the same barriers to contraception that have been found in other studies of adolescent contraception access.^{11–14} These barriers include

WHAT GAP THIS FILLS

What is already known: Long-acting reversible contraceptives (LARCs) are more effective than their short-acting counterparts at preventing pregnancy, but are underused in New Zealand. Other research has shown that LARCs are a safe and acceptable contraceptive method for use by adolescents.

What this research adds: This research shows that New Zealand general practitioners (GPs) may not be aware that LARCs are suitable for use in the adolescent population. This lack of awareness may result in adolescents not having access to safe and effective contraception.

cost, misinformation, lack of adolescents awareness and lack of provider awareness.

In NZ, most contraception is provided by primary care centres.⁷ The research population in the present study was limited to GPs because GPs are gatekeepers to other health providers.^{15,16} Previous research has shown that LARC knowledge among health providers is often out-dated.^{17–21} We found no previous research reporting GPs in NZ having been consulted about their provision of contraception to adolescents. Because GPs are the main gateway to contraceptive care and key informants for adolescents, out-of-date LARC knowledge among GPs presents a potential barrier to LARC access for adolescents.

The purpose of this study was to investigate whether LARCs and their proactive promotion for use in adolescents are acceptable to GPs, in the context of their existing knowledge, opinions on LARC methods and practice regarding adolescent contraceptive provision.

Materials and methods

Participants

Using a purposeful sampling framework²² and following our study of adolescents,¹⁰ GPs from Tairāwhiti and Otago were selected for interview. Participants were purposively sampled to ensure representation of the range of characteristics shown in Table 1. Only GPs who reported

Table 1. Sampling grid of participants

Ever inserted LARC/never inserted LARC
Ethnicity Māori/ethnicity non-Māori
Gender male/gender female
MBChB in NZ yes/MBChB in NZ no
GP training in NZ yes/GP training in NZ no
Rural setting yes/rural setting no
Practicing medicine >15 years/practicing medicine >15 years
Practice targeted to adolescents yes/practice targeted to adolescents no

GP, general practitioner
LARC, long-acting reversible contraceptive
NZ, New Zealand

providing contraception were included in the study.

Procedures

Participants completed a short survey about their contraception provision and duration and scope of practice. Semistructured interviews were either face to face ($n = 8$) or conducted by videoconference ($n = 1$). The primary researcher (RD) led the interviews, following a semistructured interview guide with flexibility to explore topics as they arose. The interview began with four clinical scenarios designed to explore adolescent contraception provision, followed by broader discussion prompts informed by the adolescent focus groups, and finished with the suggestion and discussion of PLP. PLP was proposed as a programme in which adolescents would be offered a scheduled appointment to discuss LARCs with a family planning nurse or doctor, with the option to be fitted with an LARC of their choice if desired. The semistructured interview questions were guided by results from the adolescent study.¹⁰

Interviews were audio recorded and transcribed verbatim. Due to audio recording difficulties, the interview conducted by videoconference could not be transcribed. In lieu of a transcript, the data from this interview was in the form of field notes, which were reviewed and verified by the participant. When transcribing, square brackets were used to denote both non-verbal activities,

such as '[sighing]', and places where names or locations were removed and replaced with non-identifying letters. When participants asked for comments not to be included, statements were recorded as '[redacted]'.

Ethics approval was obtained from the University of Otago Human Ethics Committee (16/035).

Data analysis

Interview transcripts and field notes were analysed using NVivo qualitative data analysis software (QSR International Pty Ltd, Doncaster, Vic, Australia). The approach used a general inductive thematic analysis,²³ where key ideas were drawn from the transcripts. Transcripts were coded by one researcher (RD). Nodes and themes were reviewed by other members of the research team, and were adjusted and consolidated as necessary. The analytical process worked towards condensing the ideas to the point where key ideas were defined, described here as themes. Data analysis began while further interviews were being conducted; recruitment ceased when thematic saturation was reached (ie no new themes emerged).

Results

The demographic profile of the study participants is given in Table 2. The analysis identified six key themes: contraceptive decision making, the GP's role, sexual activity, social context, gauging adolescent understanding and youth. There was overlap between the topics covered in each theme. All themes were found in all interviews.

Contraceptive decision making

Participants discussed at length the factors they consider when they help patients decide on a contraceptive method, including factors in favour of a particular method, and factors that dissuade them from choosing methods:

If she wants to control her periods then obviously she can cycle the contraceptive pill, miss out the sugar pills, and not have a period at all which is, as far as I'm aware, a perfectly safe way of managing periods.

The COC [combined oral contraceptive pill] is the only option for good period control: everything else is not great. The depo [Depo Provera] is good to stop the periods, but I've been seeing a lot of ladies recently that have unstable endometrium from the depo.

Most GPs acknowledged that their own lack of knowledge dissuades them from offering an LARC method:

I don't know much about that. I don't think either of those things [implants or IUDs] would be top of the list of things to consider as first line options for adolescents. . . I don't know enough about the safety, tolerability, acceptability, effectiveness in that group.

The GPs role

All participants explored their role as a GP and their responsibilities to their adolescent patients. Some mentioned the way they found themselves seizing opportunities to promote safe sexual practice:

There's definitely a massive opportunity for someone to talk to people about sex, and being safe, cause they're gonna do it [have sex] anyway, so we might as well make sure they're doing it safely and that they're comfortable with what they're doing.

Others considered themselves responsible for weighing up the advantages and disadvantages of each method on behalf of their patients, in lieu of offering a wide range of options:

They come to me for my opinion and I would give them my opinion as to what I thought was best for them and let them choose out of what options I give them. . . I wouldn't necessarily give them a whole range of options, just narrow it down.

Sexual activity: GPs' conceptions and contraceptive advice

GPs conceived contraceptive use in a wide variety of ways. Some saw contraception as playing important symbolic roles in a holistic conception of a young person's sex life. In this example, the GP saw contraception as related to respect, and wider emotions:

You want whoever you're gonna have sex with to respect you. You need contraception if it's the opposite sex obviously. You want someone to

Table 2. Characteristics of the nine participants in the study

Characteristic	No. respondents (%)
Sex: female	5 (56)
Ethnicity	
NZ European	2 (22)
NZ Māori and NZ European	2 (22)
Other	5 (56)
Completed medical degree in NZ	3 (33)
Completed GP training in NZ	5 (56)
Have been practicing medicine ≤15 years	7 (78)
Practice is targeted to adolescents	6 (67)
Practice is in a rural setting	2 (22)
Provides contraceptive advice to patients	9 (100)
Years providing contraceptive advice	2 (22)
<5	4 (44)
5–10	3 (33)
>10	
Currently offers IUDs to patients	
Yes	2 (22)
No	5 (56)
Currently training to insert IUDs	1 (11)
Not personally, but recommends IUDs	1 (11)
Has ever inserted an IUD	4 (44)
Currently offers implants to patients	
Yes	3 (33)
No	5 (56)
Not personally, but recommends implants	1 (11)
Has ever inserted an implant	3 (33)

IUD, intrauterine device

have a bit of respect for you and to understand the implications of sex in terms of emotional attachments. I don't think young women quite appreciate that initially, so yeah I'd expect them to all go through bloody counselling before they have sex.

Others, although also wanting to recommend contraceptive use, were less holistic in their approach to teenage sexuality. For example, in the following case the focus is on sexually transmissible infections rather than on the wider implications for the young person of her choices:

I would also want to mention condoms to [a 15-year-old] particularly as she's only 15 and she's

probably sleeping around and she'd need the extra protection as far as protection against sexually transmitted infections is concerned.

Social context

Each interview explored the social context of their adolescent patients. Sometimes this was explicitly in regard to contraception and sometimes it was more broad:

I ask them if they've tried anything [as a contraceptive] in the past or if they know of anything that friends, family members or relatives have used that they're particularly keen on.

We do try to explore a little bit more around their relationship, around their life, like living circumstances about their guardian, about where, if anywhere, they're getting sex education, contraception education, what the relationship with their parents are like, how old is their partner. It's quite important.

Gauging adolescent understanding

In discussing PLP, GPs noted that assessing the understanding of adolescents is essential for knowing how to tailor contraception provision to them. Each GP described the challenge of gauging their adolescent patients' levels of health literacy regarding sex and contraception. Most GPs described a lack of sexual health knowledge among their adolescent patients:

So I think they know the [contraceptive] options but they don't necessarily understand how it works. I think they don't understand how their body works as well.

This lack of knowledge was seen as challenging, but also as opening up an avenue for discussion:

A lot of them will come in and be like, I only thought there was the pill, so that means you can be like great, sit down, let's talk about all these [contraceptive] options.

All the GPs explained that gauging understanding allowed them to give contraceptive advice at the level appropriate to each adolescent.

Youth

All interviews included some GP-initiated discussion of youth as a period of development and character-building experiences. Some considered the changing maturity of adolescents and how Gillick competence applies to adolescent patients. Gillick competence derives from the case of *Gillick v. West Norfolk and Wisbech Area Health Authority*, which established that people aged <16 years should be able to consent to contraception for themselves, provided they are able to demonstrate a sufficient level of competence.²⁴

I remember when I had my first 13-year-old come for a Jadelle. I freaked out a little bit, like can I do this? And I remember ringing one of my colleagues at Family Planning and they were like 'No, if that's what they want, go for it!' ... At the end of the day, she was Fraser [Gillick] competent, and she hadn't been coerced, that's what she wanted so that's what she was allowed to have.

Other GPs emphasised the particular challenges that their young patients face and how this affects contraceptive use:

You know we're all rubbish at taking medicine, especially 17-year-olds, when you're often staying round people's houses, and doing fun things.

Response to proactive LARC provision

The GPs' general response to a PLP programme was positive:

I think we're kidding ourselves if we say that contraception is accessible. Yeah I think that's [PLP] a great idea.

You're giving every kid the opportunity to have one [a LARC], because at the moment I think educated young women with expectations on them, a lot of them get contraception, but at the moment it's the low socioeconomic and far more Māori than Pākehā girls are getting pregnant. At the moment there's so much inequality in our races and I think that if you roll it out to everyone, then everyone has the opportunity and you'd have far more luck.

It would reduce the incidence of young pregnancies, teenage pregnancies and with sexually transmitted

disease information being given as well, hopefully reduce the risk of STIs at the same time.

Let me be involved!

Even when responding positively, many GPs raised specific concerns about the execution of PLP:

Nice idea, but I'd love to see this get via parents, politicians, schools because I think there probably would be an outcry.

Discussion

GP participants were enthusiastic about a PLP programme because they saw its potential for reducing health inequities,⁷ improving access to quality sexual health care and giving adolescents more control over their fertility.

Our purposeful sampling framework²² effectively identified a mixture of locally and internationally trained doctors, which matches the varied background of NZ medical practitioners.²⁵ Conducting qualitative research does not allow for a large volume of participants as with quantitative research,²⁶ so the findings of this study may need to be validated by triangulation with a quantitative research approach to ascertain the views of the wider population. Our findings, although informative, may not reflect the views of the whole GP population.

All participants responded positively to the concept of PLP. They noted that there are barriers to contraception for adolescents that align with barriers identified in other studies.^{11–14,27} The participants agreed that PLP could overcome some of these barriers, thereby improving LARC access for adolescents. There was congruence between the responses from GP participants and adolescents within the same communities.¹⁰ The study participants suggested that PLP could be met with some objections from parents and the wider public. Our research suggests that GPs and adolescents would likely accept the PLP concept, and so objections would be from other groups. Some further issues with the concept could arise from funding and logistical challenges.

Most participants in this study acknowledged a lack of LARC knowledge for use in the general

population, and more specifically in adolescents. If this reflects primary care in general, many GPs would benefit from LARC education so that they could offer LARC methods to their patients, or at least recommend them. In the relationship between an adolescent and their GP, the GP is presumed to be a comprehensive source of health information.²⁸ When GPs are unaware of LARCs as a suitable option for adolescents, these patients potentially miss out on effective contraception. Furthermore, a sound knowledge base also increases confidence in providers to provide a service.²⁸ Our findings show a gap in knowledge translation²⁹ because the information regarding LARC suitability in the adolescent population is not informing doctors' practice.^{2,5,30} This knowledge gap is consistent with findings of other studies.^{20,31}

Adolescence brings distinct, but surmountable, challenges to sexual health care.³² One of the most important components of good sexual health care is enabling adolescents to understand and gain control over their fertility. Access to sexual health care is critical, and improved access to contraception is the most effective way to improve adolescents' control over their own fertility, rather than leaving them to be controlled by their fertility.

GPs and adolescents from the same communities have similar attitudes to contraception. They all agree that it can be difficult for adolescents to access contraception and that adolescents would benefit from an initiative that proactively provided them with effective contraception methods.¹⁰ Adolescents and GPs see the current sexual health-care model as inadequate and describe many barriers that come between adolescents and effective contraception: 'we're kidding ourselves if we say that contraception is accessible'.

Conclusion

The participants in the present study found LARCs and their proactive promotion for use in adolescents to be acceptable. They support the concept of PLP. Although care was taken with participant selection, the views of the participants may not represent the views of all GPs. The

participants suggest that potential issues with this concept may come from parents, challenges in funding and logistical challenges, not from a lack of acceptance by adolescents or GPs. There is congruence between the GPs and the adolescents they serve. To address this, we believe that NZ should facilitate adoption of PLP in their reproductive sexual health framework. We need to respond to low LARC awareness with further workforce training about LARC methods and their suitability for the adolescent population.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

Competing Interests

Helen Paterson was supported by Bayer HealthCare to attend an educational conference in 2012, and published a paper supported by Bayer in 2017. No competing financial interests exist.

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