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A missed opportunity for shared responsibility in adolescent contraception

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The American Academy of Pediatrics (AAP) Committee on Adolescence recently endorsed IUDs as the clinical contraceptive method of choice among sexually active adolescents.[1] Deference to the targeted patient groups the Committee identifies as 'adolescents' is questionable when, in actuality, the contraceptive interventions the Committee promotes are wholly intended for adolescent girls. Despite citing important empirical evidence suggesting clinical efficacy of IUDs over condom use and birth control, the policy sends a reverberating, gender-antiquated message that the onus of contraception continues to lie squarely with women, and now adolescent girls. Of the contraceptive options, only one acknowledges a male partner's role in what indisputably must be a shared contraceptive responsibility. The Committee's assertion that only condom use requires "commitment at every sex act"[1(pe1249)] mischaracterizes IUD methods as passive, and hence immune to the pitfalls of typical use. Indeed, maintaining an IUD or adorning a birth control patch reflects an active, continuous commitment young women make in contraception and towards their sexual health generally.

Surely this is not to argue that broad access to, and coverage of, contraceptive options like IUDs under the new Affordable Care Act is misplaced. Rather guidance from the Committee about how pediatricians can engage both partners equally in discussions of sexual health and pregnancy prevention is markedly absent, and reinforces gender normative assumptions that plague contraceptive discourse itself. Best practices in clinical approaches to sexual health and contraception thus cannot be divorced from wider sociocultural themes of reproduction, in which the structural oppression of women is an inescapable one. Clinical recommendations must reflect these themes if sexual health education and care delivery is to effectively meet the needs of target patient populations. Will care providers—be they pediatricians, primary care physicians or other adolescent specialists—explain the anatomical specificities and efficacy of vaginal rings with adolescent male as well as female patients, for example? If the AAP's policy statement is any indication, likely not.

Unsurprisingly, the AAP says nothing of trans/intersexed youth, nor acknowledges other genital complexities and sexual orientations many adolescents face during their sexually formative years. Yet such considerations inevitably problematize the heterosexual status quo upon which the policy statement is hitherto premised. Such exclusion has adverse implications, inviting marginalization of some young people who are left to navigate their sexual vulnerabilities alone. This threatens professional trust and, perhaps more deleterious, exposes the ignorance of healthcare providers to the realities of many of their patients vis-à-vis sexuality and sexual development.

The dawning of adolescence can moreover signal a necessary transition in care from general pediatrics to primary care. This is particularly true if pediatric patients become sexually active. Sexual healthcare therefore coincides with a poignant transition in the broader healthcare continuum for many young people, a circumstance which underscores the immediacy of triangulation in dialogue regarding contraception/sexual health between the adolescent's new healthcare provider (the primary care physician), a familiar healthcare provider (their pediatrician) and families. In this regard, the policy statement could also encourage adolescents to involve parents or other caregivers in discussions and/or decisions about such choices throughout sexual maturity and adulthood. While it is certainly plausible that circumstances may prevent some adolescents from disclosing sexual activity to their parents, they can nevertheless play important supportive and educational roles about contraceptive choices pursuant to their child's best interests; help their adolescent navigate a complicated health delivery system in order to receive the appropriate sexual healthcare they need; and ensure channels of dialogue remain open.

It is discouraging that in 2015, contraceptive methods are promoted based on clinical efficacy alone, almost exclusively intervene on female bodies and, in turn, place sole responsibility for healthy sexual activity on young women and girls. Absent strategies that promote equal responsibility for contraceptive choices among sexually active adolescents, the Committee's recommendations have far-reaching consequences, first for the future of adolescent sexual health(care), and second for the family physicians who will eventually care for them.

References

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Conflict of Interest

The author declares no conflict of interest.