



Closing the Gap between Need and Uptake: a Case for Proactive Contraception Provision to Adolescents

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Abstract

In New Zealand, there are adolescents who are at risk of pregnancy and who do not want to become pregnant, but are not using contraception. Cost and other barriers limit access to contraception. To address the gap between contraceptive need and contraceptive access, this paper puts forward the concept of proactive contraception provision, where adolescents are offered contraceptives directly. To strengthen the case for proactive contraception provision, this paper addresses a series of potential objections. One is that such a programme would cause harm; another that such a programme would not have sufficient benefit. In rebutting these objections, the conclusion is reached that proactive contraception provision is a model worth pursuing as a means of meeting the needs of the New Zealand adolescent population and may be of interest more widely.

Keywords Adolescent · Access to contraceptives · Contraception · New Zealand

Introduction

Contraception is considered by the World Health Organisation (WHO) to be an essential medicine (WHO 2015), but not all of those who are at risk of pregnancy are using it (United Nations 2015). Worldwide, in the countries with data available, only 25% of women have ever used a contraceptive method by age 19 (Blanc et al. 2009). Given that the majority of adolescent pregnancies are unintended (Mermelstein and Plax 2016), there is evidence of unmet contraceptive need in this population.

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Proactive contraception provision for adolescents could close this gap between population need and contraceptive uptake. This paper approaches a proactive contraception provision programme in the context of New Zealand (NZ), a country in which adolescents are entitled to access contraception, but face barriers to access (Miller 2016). Some of the points in the following in favour of this approach may be valid globally, but others only apply to NZ. Within Australasia, NZ and Australia are most similar to each other in attitudes toward and access to contraception (Bateson et al. 2017), whereas Asian countries approach these areas differently (Petta et al. 1996).

In this paper, I defend proactive contraception provision against some potential objections, to demonstrate this concept is worth pursuing. The objections can be divided into two classes: the first class of objection is that proactive provision in a programme aimed at adolescents will in fact increase harm. The second class of objections claims that the benefits are erroneous—that in fact neither is choice increased and nor is harm prevented. The first class of objection will be dealt with first: it will be argued that the feared harms of such a programme are illusory. But this would still not justify the programme, as it must do recognisable benefit to be justified. Therefore, the second class of objection has to be rebutted. As the harms are either illusory or easily managed, and the benefits are real, there is a case for proactively offering contraceptives to all female adolescents within the NZ context.

A Proactive Contraception Provision Model

This section outlines the key features and intended advantages of a proactive contraception provision model.

The Model

Contraception provision in this model entails contraceptive counselling, including a discussion between a provider and a consumer regarding the different contraceptive methods, the efficacy of each method, and the advantages and disadvantages of each method, the offer of a consumer's preferred method(s), and the prescription or administration of the method(s) chosen (ACOG 2012).

Contraceptive options in NZ include condoms, combined oral contraceptive pills (OCPs), progestogen-only contraceptive pills (POPs), progestogen injection (Depo-Provera), copper intrauterine devices (IUDs), levonorgestrel intrauterine systems (LNG-IUSs) and progestogen implants and the emergency contraceptive pill (ECP) (Family Planning 2015, n.d.). The pricing and availability of each method differs around the world (PHARMAC n.d., 2016; Family Planning NSW 2013). Condoms are relatively inefficient at pregnancy prevention, with a 13% typical use failure rate (Sundaram et al. 2017). In the same study, OCPs and POPs had a 7% typical use failure rate, injectables (such as Depo-Provera) had a 4% typical use failure rate and LNG-IUSs and IUDs (known collectively as long-acting reversible contraceptives (LARCs)) had a typical use failure rate of 1%, making them much more effective than the other methods (Sundaram et al. 2017). LARC methods have previously been considered unsafe for adolescents due to fears of pelvic inflammatory disease and increased expulsion (Russo et al. 2013), but it has been established that these methods should

be considered first line in this population (Shoupe 2016; ACOG 2012; Smith 2015). LARC methods can be removed whenever a patient no longer wishes to have the device, and fertility will resume (Russo et al. 2013). While it has been established that LARCs are under-utilised, efficacious and acceptable for use in adolescents (Shoupe 2016; Moreno 2016; ACOG 2012); this paper focuses on the provision of all contraceptive methods, so that adolescents are able to choose the method that suits them best.

The model proposes proactive provision of this service, that is, offering the service before it is needed or before the consumers seek this themselves. Currently most health services, including contraception, are reactive, allowing patients to seek services as required. The benefits of a proactive model avoid many of the problems related to service access and/or when the service provided is preventative rather than curative (WHO 2019). For example worldwide, human papilloma virus (HPV) vaccines are shown to reach more individuals when proactive provision is implemented to overcome compromised access (Gallagher et al. 2018). In NZ, HPV vaccines are offered proactively to adolescents, often in the high school setting (Ministry of Health 2019).

The majority of contraceptive methods are preventative, requiring use prior to sexual activity. Condoms are used at the moment of sexual activity, and the ECP and the copper IUD can be used within 5 days of sexual activity to prevent pregnancy. The programme is aimed at the adolescent population, as in NZ, this has inadequate contraceptive coverage, evidenced by the majority of adolescent pregnancies being unintended (Mermelstein and Plax 2016). In practical terms, such a programme would involve adolescents being given a contraceptive counselling appointment at their school, with an offer of the adolescent's chosen method. Every adolescent would receive contraceptive counselling, and those that requested contraception would be provided with their chosen method. This is what "proactive contraception provision" entails in this paper.

The choice to propose such a programme in the high school setting is based on NZ's history of offering immunisation programmes through schools (Ministry of Health 2019; WHO 2019). The role of high schools as an avenue for healthcare provision differs globally, and even within NZ, there is the chance that the religious beliefs of different schools may make high schools a poor choice of venue.

Possible Advantages

Contraception is suited to a model of proactive provision, particularly in the adolescent population. Adolescent access to contraception in the current model is not adequate, due to barriers such as time, cost and stigma (Lawton et al. 2016). Poor contraceptive counselling and lack of knowledge are also barriers to adolescent contraceptive access (Duncan et al. 2019; Lawton et al. 2016), and proactive contraception provision (with tiered contraceptive counselling) could address some of these barriers. Furthermore, the universal approach (where all adolescents were offered services regardless of need) could reduce stigma, as adolescents would not have to identify themselves as needing contraception. These factors, compromised access in a reactive system and a preventative service, make the proactive provision of contraception a suitable model to consider.

Proactive contraception provision also has the potential to enhance the autonomy of most recipients. In general, use of effective contraception can increase choice by giving

a young woman control over her options, e.g. reducing the risk of unintended pregnancy (which might force certain choices and outcomes on her) and the risk represented by the harms of unintended pregnancy. Some young women describe contraceptive decision-making as facilitating agency and moral importance, thereby enhancing their autonomy (Wigginton et al. 2016). This power can be given to a greater number of young women by taking it to them proactively.

With the premise of proactive contraception established, it follows to address the objections to the concept. These objections largely fit as either feared harms or insufficient benefits. The harms will be explored and addressed, and then I will review the extent of the benefits.

Addressing the Feared Harms of Proactive Provision of Contraception

If our goal is to above all else not harm others, some say that providing contraception before coitarche should give us a pause (Edelman 2015). Harms that have been alleged are the physical harms of contraceptives themselves (e.g. side effects) and harms associated with sexually transmitted infections (STIs) and with risk of sexual violation, over and above what occurs in the absence of proactive contraception provision. These harms can be classed as either evidenced or unsupported.

Evidenced Harms of Proactive Contraception Provision

Physical Harms of Contraceptives

Proactive contraception provision could be objected to on the grounds that contraceptives themselves cause harm. There is a complex relationship between contraceptives and side effects, some of which may be considered harmful. A real, but potential, harm of proactive contraception provision is that contraceptives currently available are imperfect, unpredictable, and without the individual benefit of pregnancy prevention, proactivity could cause more harm than good. Any contraceptive has the potential to cause harm. Individuals who experience harmful side effects from contraception and who are not sexually active will not experience adequate benefit to justify the harm (Paul 2015) from the proactive provision of contraception.

However, some alleged harms have limited evidence to support them (Lebow 1999), whereas other harms are misinterpreted from existing evidence (e.g. oral contraceptive use is associated with increased prescription of antidepressants (Skovlund et al. 2016)—this is often assumed to be evidence of the oral contraceptive pill causing depression, but this correlation is not necessarily causal).

There are some side effects that are well evidenced. Some individuals may never experience side effects and will never be harmed by them, and in those that do experience side effects, the harms can be greatly reduced by ongoing consultation. The picture is complex, with some side effects considered to be beneficial (e.g. amenorrhoea with a levonorgestrel intrauterine system (Patseadou and Michala 2017)) and other side effects being disruptive (e.g. irregular bleeding with levonorgestrel implants, which can be managed with addition of oral contraceptives (Hoggart and Newton 2013; Roke et al. 2016)). Most of these harmful side effects can be resolved by cessation of the contraceptive method, so do not result in permanent harm (Roke et al. 2016).

Increased Risk of STIs

A possible further concern about proactive contraception provision is decreased condom use due to increased access to more effective methods, resulting in increased STI infection. In the USA, for example, LARC use has been associated with reduced condom use (Steiner et al. 2016). The suggested explanation for this is that the much higher typical use efficacy of LARC methods (Winner et al. 2012) prompts users to trust them completely, and therefore not using condoms as a “back up” for less effective methods as a method of pregnancy prevention. While condoms have typical use failure rate of 13% (Sundaram et al. 2017), they are the most commonly used contraceptive method to provide protection from some sexually transmitted infections (STIs).

The possibility of reduced condom use is a valid concern. While there is a risk of reduced condom use when more effective contraceptive methods are favoured, thorough contraceptive counselling would recommend dual use, i.e. using a condom in addition to a non-barrier method of contraception, to reduce the risk of STI transmission. Proactive contraception provision would entail contraceptive counselling recommending dual use.

Unsupported Claims of Harms of Proactive Contraception Provision

Contraceptive Uptake as a Risk Factor for Sexual Violation

One suggested harm of proactive contraception provision is the increased risk of males coercing females into having sex with them as a result of their contraceptive use (Paul 2015): “Even if it did not affect young women’s decisions, knowing that girls are routinely made infertile may well affect the behaviour of men”. This claim that proactive contraception provision would make males more likely to coerce females into having sex (a form of sexual violation (Crimes Amendment Act 2015)) is not supported by evidence—there are no data of contraceptive availability in relation to sexual violation. It has not been shown that increased contraceptive use in a population is associated with an increase in the incidence of sexual violation. In addition, a claim such as this appears to be closely aligned with victim-blaming culture (Grubb and Turner 2012), in the way that it suggests that the victims of sexual violation have some power over whether a perpetrator chooses to sexually violate them or have some responsibility for this. But victim blaming of this sort should not be considered a valid reason not to pursue proactive contraception provision.

The potential for unnecessary harms (Edelman 2015; Paul 2015) is important to consider, but not enough to wholly negate the potential benefits of proactive contraception provision. While proactive contraception provision may not be entirely non-maleficent, the benefit and autonomy (if real) offered may outweigh the potential harms.

Validity of the Benefits of Proactive Contraception Provision

This section argues that the benefits of proactive contraception are real. A series of objections to the validity of these benefits is considered and countered. One form of benefit is the prevention of real harm, and another is the

provision of a good. This section focuses on the effects of proactive contraception provision on a single generation, rather than multi-generational effects, though these may also exist. Proactive contraception provision would result in greater benefits for some individuals compared with others, as the lives of adolescents are varied. Each adolescent exists within their own social context, and this hugely influences their needs and priorities.

Unintended Pregnancy as a Potential Harm

A desired outcome of proactive contraception provision is a decrease in the harms caused by unintended pregnancy. Whether proactive contraception provision is beneficial, therefore, rests on whether unintended pregnancy is a harm. It is not known the frequency of which an unintended pregnancy is also an unwanted pregnancy. The unwantedness of a pregnancy may drive these negative effects, but this relationship has not been explored. Increased contraception uptake decreases the incidence of unintended pregnancy, and so if unintended pregnancy is a harm, proactive contraception provision is beneficial.

Unintended pregnancy has a large impact on the lives of parents and has been associated with a greater risk of depression (Abajobir et al. 2016; Kavanaugh et al. 2017). Adolescent mothers in particular are at greater risk of negative outcomes such as mental health disorders and substance abuse (Thompson, Canadian Paediatric Society and Adolescent Health Committee 2016). Unintended pregnancy has four potential short-term outcomes: abortion, miscarriage, stillbirth or live birth. If a pregnancy is carried to term and live birth is the outcome, the baby can be adopted or raised by the biological mother. Raising a child has a significant impact on the time, freedom, future education opportunities and finances of an individual (Williamson 2012). When pregnancies are unintended, the extent of the ability of individuals to determine their own fate is likely to be reduced. Proactively providing contraception could, therefore, increase the autonomy of young women by reducing their risk of unintended pregnancy, giving them, to this extent, the ability to decide their own fate, and plan their future with or without a child to raise.

What is not clear, however, is how much of these negative outcomes are directly associated with unintended pregnancy and how much is due to the context in which the unintended pregnancy occurs. This context extends from the social and cultural situation of the mother to the structure of the healthcare system and includes many other factors. It is possible that unintended pregnancy could be entirely separated from an increased risk of negative outcomes, if the context were different. The complexity is realised in the multiple possibilities for social change, which could focus on social welfare reform or campaigning to reduce the social stigma surrounding teenage pregnancy.

However, short of changing the cultural landscape, unintended pregnancy is a key preventable risk factor in this scenario. While it is possible that in an improved context, unintended pregnancy need not be associated with negative outcomes, in the current context, unintended pregnancy puts mothers at risk of negative outcomes (Mollborn 2016). With this in mind, unintended pregnancy can be considered a harm, and so prevention of this can be considered a benefit.

Extent of Benefit Achieved from Proactive Contraception Provision

Prevention of Pregnancy

An objection to proactive contraception provision is that the population risk of unintended pregnancy is not large enough to justify the cost. If the aim of proactive contraception provision to adolescents is a reduction in unintended pregnancy, we must consider whether the potential benefit is adequate to justify such provision. It seems that the perceived harms of proactive contraception provision are not valid, so any benefit will outweigh this. What is essential now is to consider whether the potential benefit justifies the financial cost of the programme itself. The amount of potential benefit may not be sufficient. The rates of adolescent pregnancy (measured in births and abortions) are already declining (University of Waikato 2013; MacPherson 2017; Watson 2018). In the USA, only 33% of 16-year olds report ever having had sex and 82% of those adolescents report using contraception at first sex (Finer and Philbin 2013). In NZ, only 24% of adolescents aged 12 to 19 report ever having had sex and of those 60% report always using contraception (Clark et al. 2013), so it is possible that proactive contraception provision may only benefit a small portion of the adolescent population. This may be too small a benefit to justify wide-scale proactivity.

However, although 60% of sexually active NZ adolescents report using a contraceptive method, the methods favoured by adolescents are the oral contraceptive pill and condoms (Clark et al. 2013), methods which are markedly less effective than LARC methods (Winner et al. 2012). These contraceptive-using adolescents would benefit from contraceptive counselling, as a LARC method could further reduce their risk of unintended pregnancy. Effective contraceptive counselling emphasises the effectiveness of each method, highlighting the superior efficacy of LARC methods, resulting in higher LARC use and reduced unintended pregnancy (Birgisson et al. 2015). Tiered contraceptive advice does not entail LARC methods being pushed regardless of patient preference; it simply requires providers to mention all methods available and their efficacy, from most to least effective.

Furthermore, when the data are explored, we see that amongst NZ adolescents aged 16 to 19, 41% report ever having had sex (Clark et al. 2016). In the US study mentioned previously, a further finding was that although 82% of 16-year olds (who have had sex) reported using contraception at first sex, for younger individuals this proportion is lower—only 52% of 12-year olds used contraception at first sex (Finer and Philbin 2013). The proportion of adolescents who have had sex increases with each year of age. The proportion of adolescents who have had sex is important because these are the adolescents who are at risk of pregnancy. Therefore, these adolescents who report being sexually active would benefit from the pregnancy prevention offered by the proactive contraception provision. Nevertheless, the aim of proactivity is to capture individuals before they need a service, rather than after they need it, so more adolescents would benefit than those who are already sexually active. If younger adolescents are less likely to use contraception at coitarche, then they would benefit from proactive contraception provision.

Non-contraceptive Benefits

In addition to the prevention of pregnancy, proactive contraception provision would also offer increased health literacy and non-contraceptive benefits. One major benefit of proactive contraception provision would be the educatory role of contraceptive counselling, as it would increase contraceptive health literacy. When patients are aware of health options available to them, how they work and the potential harms and benefits of each option, they are deemed to have a sufficient level of health literacy (Adams 2010). Patients who have higher levels of health literacy have better health outcomes—they are better at self-management, and interventions can be more effective (Adams 2010). Sexuality education in NZ does not fulfil the contraceptive education needs of adolescents, as it only briefly touches on contraceptive education in the wider context of sexuality (Education Review Office 2018).

Further, non-contraceptive benefits of some contraceptive methods include reduction of painful periods (dysmenorrhoea), control of menstrual cycle and reduced risk of some cancers (Glasier 2006; Bahamondes et al. 2015). Many contraceptive methods have uses that go beyond pregnancy prevention. These non-contraceptive uses include treatment of acne and treatment of heavy menstrual bleeding or irregular periods (Glasier 2006; Bahamondes et al. 2015). These are conditions present amongst the general population, and so proactive contraception provision could offer management of these conditions in addition to the benefit of reproductive control.

Proactive Provision of Contraception does not Support Choice

When a proactive contraception provision programme centred around long-acting reversible contraceptives (LARCs) was discussed (Pickering et al. 2015), one criticism of such a concept was that proactive provision, in this case referred to as “opt-out”, is a form of coercion (Paul 2015). In contrast to the suggestion that proactive contraception provision would increase autonomy by bringing the choice to the adolescent, perhaps proactivity would put too much pressure on the adolescent obliging them to accept contraception they do not truly want—thereby coercing the adolescent.

Furthermore, it was suggested that to implement such a programme would reduce the status of adolescents to “simply vessels for pregnancies that must be prevented” (Paul 2015). This suggests that by taking the decision to seek contraception away from adolescents, adolescent autonomy would not be respected, and that prevention of unintended adolescent pregnancy is not a valid justification for doing this.

While the autonomy of adolescents should be protected and respected, I do not think that proactive contraception provision would be automatically coercive. Any healthcare provider working within NZ’s legislation would not be allowed to coerce patients (Care of Children Act 2004; Health and Disability Commissioner 1996). In adolescent care, we can and do respect autonomy, and this has been outlined in a variety of ways. The Medical Council of New Zealand (2011) recommends treating adolescents as fully informed and capable of making their own decisions until a provider is given reason to believe otherwise; and the General Medical Council (2008) in the UK emphasises that the decision-making ability of adolescents should be determined by their understanding of the options at hand, rather than solely by age, and recommends involving children and young people in decisions about their care. In the NZ context, adolescents are

encouraged to make their own decisions about healthcare and sexuality, and they are encouraged to be involved in the decision-making process even if they cannot make full decisions themselves.

In addition, according to the Medical Council of New Zealand (2011), consumers aged 16 years or more should be treated as adults, in terms of competency to make decisions, and all consumers requiring termination (i.e. abortion) services, regardless of age, will be treated as adults. The Contraception, Sterilisation and Abortion Act (1977) in NZ states no minimum age for receiving contraceptive services. In the USA, the American Medical Association (n.d.) states that individuals below the age of majority are not assumed to have the capacity to make health decisions on their own, but in some jurisdictions they have the right to confidential services relating to contraception and other reproductive healthcare. Globally, the Convention on the Rights of the Child determined that children have the right to express their opinion in matters that impact them and to have their views respected (UNICEF 1989). There is no global standard that determines the rights of adolescents to contraception, but practise is often informed by the case of *Gillick v. West Norfolk and Wisbech Area Health Authority*, which recommends that if a provider considers an adolescent to adequately understand the implications of the contraceptive decision they are making, and that there is a chance of the adolescent having unprotected sex if they do not provide the contraception, there is no requirement to gain parental consent, and the adolescent can make an informed choice (*Gillick v. West Norfolk and Wisbech Area Health Authority* (1986) AC 112). If the right to be fully informed (Health and Disability Commissioner 1996) is respected and contraception provision entails full information, explanation and written information if required, then it can be assumed that any adolescent receiving a proactive contraception provision service would be free to make an informed choice, and their autonomy would be respected. In NZ, proactive contraception provision could be offered to adolescents younger than 16, as there are adolescents younger than 16 who are sexually active (Clark et al. 2016), and adolescents are expected to be included in medical decision-making (Medical Council of New Zealand 2011).

Along with this belief that proactive contraception provision could be done in a way that respects the autonomy of adolescents, it is important to use concerns to inform practise. The concerns over provider coercion of adolescents into choosing the methods with highest efficacy (when this may not be the best option for the adolescent) should be considered, and so I suggest that in implementing a programme, effectiveness should not be measured solely by the number of contraceptives given, as seen historically in other contraception provision programmes (Brown and Moskowitz 1997). Instead, success could be measured by appreciating the benefit of increasing health literacy and asking participants to evaluate the experience.

An important caveat needs to be added here. In NZ, and in some other culturally similar countries, the extension of choice to adolescents is regarded as a good. It is part of the NZ culture to construct young people as decision makers, and in some cases, to see their decision-making as highly individual, taking place without the support, indeed in some cases without the knowledge, of the closer or wider family. But not all societies see the development of adolescent individualistic autonomy as a goal to be pursued; indeed, individual adult decision-making may also not be seen in a wholly positive light. Autonomy, it is sometimes said, is relational (Stoljar 2011). That is to say, its extent and nature and the value put upon it is determined to some degree by the society

in which people grow up and live. It is then unclear how far the extension of choice which the programme seeks to effect, would be valued or possible, in other cultural/societal contexts.

The Proposed Programme is a Vehicle for Control and Oppression

Today's society is one of liberty of the individual, and so although a goal of proactive contraception provision would be greater control over one's own fate, it is imperative that we consider the potential for such a concept to be perceived as a means of control over women's bodies. A major consideration is the historical objection to programmes, which are either to the perceived control of women's bodies or over-reproduction in certain groups (Steinbock 1995; Petta et al. 1996; Brown and Moskowitz 1997; Gomez et al. 2014). There is an enduring concern that in this particular area of medicine, proactive provision of contraception repeats agendas of control and oppression of women, and in particular, of women of colour, women from indigenous communities and from socioeconomically deprived groups (Steinbock 1995; Gomez et al. 2014).

These concerns are valid and should inform the design of a proactive contraception provision concept, but they need not be a cause to throw away the concept entirely. With respect to the fear of control over women's bodies, fully informed consent and genuine choice should be essential to any contraception provision. While the process of contraception provision is consultative, the provider should not make the final decision. Furthermore, practise in NZ is bound by the Privacy Act (1993) and Privacy Commissioner—health information is to remain confidential unless there are reasonable grounds to believe that releasing the information is necessary to prevent or lessen a serious threat to public health or public safety, or to prevent or lessen a serious threat to the life or health of an individual; or there are reasonable grounds to believe that releasing the information is necessary to avoid prejudice to the maintenance of the law by a NZ public sector agency (Privacy Commissioner n.d., 2017). The Privacy Act in NZ would thereby still protect the health information of adolescents involved in a proactive contraception provision programme.

Fears of targeting certain population groups can be allayed by a universal provision approach. Proactive contraception provision should be offered to all adolescents, irrespective of socioeconomic status, ethnicity, disability or any other factor—this universality would be a step away from historic efforts to suppress the fertility of specific population groups. The final component that separates this concept from historical oppressive movements is the NZ setting. While NZ has a history of colonialism, racism and oppression, Te Tiriti o Waitangi (The Treaty of Waitangi) has established an expectation of consultation with indigenous groups when enacting policy (Barrett and Connolly-Stone 1998). This has extended to wider public consultation, for example the Advisory Committee on Assisted Reproductive Technology's (ACART) call for public opinion when developing policy regarding posthumous sperm and embryo donation (Advisory Committee on Assisted Reproductive Technology 2018). Proactive contraception provision could not be implemented nationwide without consultation with relevant groups, including Māori communities.

A Population Model may not Best Serve Individuals

In addition, such a programme may appear to have a strong heteronormative feel to it (Jackson 2006) and fails to acknowledge the 8% of NZ adolescents who do not identify as heterosexual (Clark et al. 2013). Such a programme should account for this group, by offering an opportunity to discuss any matters of sexuality and safe sex, regardless of sexual orientation. These adolescents may not have any need for pregnancy prevention, but they may benefit from provision of barrier methods to reduce STI transmission.

All contraception provision must first and foremost address the needs and concerns of the patient at hand. While a proactive contraception provision model would improve access, great care needs to be taken to treat each individual with care and respect—the ultimate decision to accept or decline a contraceptive method is best made by the adolescent. While there are consequences at the population level (i.e. teenage pregnancy rates) of an adolescent's contraception decision, the decision to use or not to use contraception has direct impact on the adolescent and is a decision best made by the adolescent themselves (Babcock 2016). It may seem contradictory to advocate individualised healthcare within the scope of a public health intervention, but if participants are each allocated a one-on-one consultation with a healthcare provider, there should be sufficient time for providers to work alongside adolescents in deciding the most appropriate contraceptive for them. Global access and patient-centred care are not mutually exclusive concepts.

Cost of a Proactive Contraception Provision Model

There are clear benefits to a programme that offers effective contraception advice and access to adolescents. Further consideration of such a programme leads us to look at the costs involved. What would be the cost of running the service, educating parents and communities and providing the contraceptives? Furthermore, what would the opportunity cost of this programme be? The resources used to run such a programme may deplete the available resources for other health issues, and the time taken away from students' class time may be disruptive. To show that a programme is cost-effective, one has to ask whether the costs of a proactive provision programme outweigh the costs of not proactively providing contraception. The financial costs of such a programme are beyond the scope of this paper.

Conclusion

There is a gap between the contraceptive needs and the uptake of contraception in the adolescent population—not all of those who need contraception are accessing it. Proactively providing contraception could work to close this gap. In the NZ context, we aim to facilitate autonomous decision-making in adolescents, encompassing the range in maturity between different adolescents.

Increasing adolescents' access to contraception is not only respectful of their autonomy, but a way to increase their autonomy. Providing adolescents with control

over their fertility allows them to determine their own fate, and does not restrict future opportunities. Proactive contraception provision would promote benefit, and potential harms are either illusory or easily managed. It is on these grounds that I present proactive contraception provision as a suitable model.

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