

Editorial

## Beyond a prescription: strategies for improving contraceptive care

LJ, a 24-year-old graduate student, sat in our clinic room nervously pleating the corner of her shirt waiting to receive the medication to initiate her medical abortion. While I was reviewing her procedure and choice of contraception, LJ stated she that was planning to go back on Yaz<sup>®</sup>, a popular brand name oral contraceptive (OC), which she was using before she got pregnant. When queried about her insurance status, she told me she had no coverage. I wondered aloud about her choice of pills since she was paying out of pocket for the expensive patented medication. She told me her physician had started her out with sample packs from the office and given her a prescription. There had been no discussion about her insurance status or alternative pills. The month LJ could not afford to buy her pills is the month she had an unintended pregnancy.

In the United States, by the time a woman reaches age 45, more than half will have had an unintentional pregnancy [1]. Among the 3.1 million unintended pregnancies that occur each year, 52% are to women who used no contraceptive method during the month in which they became pregnant; 43% are to women who used a contraceptive method either inconsistently or incorrectly; and only 5% of unintended pregnancies can be attributed to women who used their method perfectly, but the method failed [2,3].

These statistics may tempt one to lay the blame for unintended pregnancies almost entirely on women. However, a woman's ability to successfully initiate, continue and consistently use contraception is influenced by manifold and diverse factors. For example, the health care system, society, and cultural and personal attitudes can all create barriers that prevent a woman from achieving her pregnancy goals. In addition, the failure to achieve these goals must also be shared by the providers whom women look to for guidance and care during their reproductive years as well as by societal and health system barriers. Reproductive health providers can effectively identify and moderate several of these barriers and improve their patients' contraceptive outcomes by adopting a patient-centered care model.

The Institute of Medicine defines patient-centered care as providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensures that patients' values guide all clinical decisions [4]. Several studies of this approach reinforce its value in

improving patient satisfaction and compliance [5–11]. A recent analysis demonstrates the connection between the quality of the provider–patient interaction and contraceptive use: OC users who were dissatisfied with their provider were more likely to be taking their pills inconsistently [12]. Continuity of care — an element of patient-centered care — is also related to continuity of contraceptive use. Women who typically do not see the same clinician at contraceptive visits or who do not feel they can call their provider with follow-up questions were more likely to have had gaps in contraceptive use, even though they were not trying to get pregnant [13]. Other important components of a patient-centered approach that providers must consider include a patient's cultural or religious beliefs that can affect her choice or use of contraception.

We suggest the following four patient-centered strategies that reproductive health care providers can implement to eliminate unnecessary barriers and improve the quality of contraceptive care they provide.

### **1. Provide opportunities to discuss pregnancy planning and changing contraceptive needs at every visit**

Make contraception an essential component of preventive health care. For each patient, collect a reproductive health history and plan (in addition to a medical history) to guide patient care and contraceptive choices. Update the history at every visit, as your patient's needs and circumstances will likely change over time. Time constraints may limit a detailed discussion, so assess if her contraceptive needs have changed or she has been unable to adhere to her previous chosen contraceptive and ensure she returns for a follow-up visit. Such issues are important to explore regardless of her sexual orientation. Women who identify as lesbians may at times have sex with men and need to know about condoms and emergency contraception or may be interested in becoming pregnant.

Providers should not assume that all patients seeking contraception have similarly strong motivations to avoid pregnancy; many women have mixed or ambivalent feelings about becoming pregnant. Among sexually active women who were not trying to become pregnant, more than one in

five reported that they would be very pleased to learn they were pregnant and 18% reported that avoiding pregnancy was only a little or not important [12]. Such women have been found to be at elevated risk for pregnancy, even while using contraceptives, and could be empowered by receiving increased information about their personal risk of pregnancy as well as information about preconception care (planned pregnancies are healthy pregnancies).

A reproductive health history and plan should also explore lifestyle issues that impact adherence. Ask questions that seem pertinent, such as whether a woman can remember to take a pill every day; what her previous experience with a particular contraceptive has been; whether her partner is receptive to using barrier methods every time they have intercourse; whether she can afford the contraceptive method; and whether there are insurance barriers.

## 2. Acknowledge the challenges of using methods effectively and help patients find solutions that work in the context of their lives

Even after choosing a method, two factors that challenge a woman's ability to use contraception effectively are her level of satisfaction with her method(s) and her ability to use the selected method(s) consistently and correctly over the decades-long period in which she is fertile. Acknowledging these challenges directly with patients may lead to more in-depth discussion about different methods and how to achieve effective contraceptive coverage over time and at different life stages.

Many women are simply dissatisfied with their contraceptive options. In a recent study, 38% of women using reversible methods chose their current method primarily because they did not like any other method [12]. Nearly 40% of women reported not being completely satisfied with their current contraceptive method, citing reasons such as reduced sexual pleasure, actual or anticipated side effects, difficulties in use and worry about effectiveness. Providers should be aware that the women who are not completely satisfied with their method tend to have gaps in use and to use methods incorrectly or inconsistently, putting themselves at increased risk for unintended pregnancy [14]. Addressing patient concerns about method safety and side effects may help to reduce dissatisfaction and improve use.

The prolonged time periods for which women need to use contraception also present a huge challenge to effective use. About half of those taking any medication do not take it as prescribed. Even people taking medications for life-threatening conditions fail to do so consistently. Long-acting contraceptive methods can help to address this issue. Improving patient understanding of the benefits of long-acting methods and making them more easily available and covered through family planning reimbursement and insurance programs could have a significant impact on reducing unintended pregnancy [15,16]. Counseling women about the

situations that lead to gaps in contraceptive coverage over time (such as changes in relationships, work or insurance coverage) and suggesting strategies for addressing those gaps can also help to achieve more effective coverage.

## 3. Update your knowledge and skills to eliminate unnecessary barriers to access

In recent years, a number of reproductive health specialists have argued persuasively that many of the current practices related to contraceptive provision present unnecessary barriers to care [17–19]. They have championed an evidence-based approach to care — one that bases prescribing practices on the accumulation of research about the benefits and risks of various contraceptive methods — as a way of ensuring that patients can receive contraceptive care both safely and quickly. Some of the common practices that impede access to contraceptives include:

- Limitations on who can receive an IUD: Despite the longstanding practice of inserting IUDs only for parous women in monogamous relationships, evidence suggests that they can be safely used by both nulliparous and nonmonogamous women [20–22]. They also can be inserted mid-cycle [23].
- Requiring a pelvic exam before starting hormonal methods: The World Health Organization (WHO), Planned Parenthood Federation of America and the American College of Obstetricians and Gynecologists (ACOG) support unbundling services such that provision of contraception is not required to be linked with a pelvic exam, Pap smear and/or STI screening [23]. In fact, pelvic exams are not a requirement for initiating hormonal contraception [17].
- Requiring women to wait until menses to start methods: Having women wait until the Sunday after menses before starting OCs or having them wait for a follow-up visit before IUD insertion is not necessary [23]. The Quick Start method enables women to start contraception immediately and can be used with OCs, IUDs, the patch, ring, injection or implant. It significantly improves the rate of women continuing OCs [24]. In addition, it has been shown that there is better compliance at 3 months in adolescents using the Quick Start method [25].
- Limiting DMPA use due to concerns about bone health: Depo-Provera (DMPA) has a “black box” warning that prolonged use may result in the loss of bone density. The US Food and Drug Administration (FDA) approved this warning despite a lack of evidence that prolonged use of DMPA causes an increase in fracture or has an effect on postmenopausal bone health [23]. Experts in family planning have called for the FDA to rescind the black box warning, and both ACOG and WHO support long-term use of DMPA for contraception in women 18 to 45 years of age [23,26,27].

Although it can be challenging to keep pace with these evolving evidence-based clinical recommendations and to offer a full range of contraceptive options, doing so allows providers to meet patients' needs with greater convenience and more effective contraceptive coverage.

#### 4. Help patients navigate the complex systems that create barriers to contraceptive access

Accessing and paying for contraception can be a major barrier to patients. Providers and members of the health care team can support women to find feasible ways to access and pay for contraceptive methods by offering information about relevant local, state and federal resources. For example, providers can educate themselves about less expensive generic drugs that could reduce costs for their patients and mention cost-saving options to patients, such as using a mail-order pharmacy to get a 3-month supply. Receptionists can keep a list of local pharmacies that stock emergency contraception and refer women to these locations when they call for information. Staff can also educate themselves about free or low-cost services in the community and how their state Medicaid program covers contraception, passing this information on to women who need it.

While patient-centered care could mitigate some barriers, our society and health care system create many other hurdles to a woman's ability to successfully use contraception. On the societal front, both the media and an inadequate sex education have a significant influence on sexual health and behavior. A Kaiser Family Foundation study of US television programming in the 2004–2005 season found that 70% of 959 general audience TV shows included sexual content. Of the 675 shows with sexual content, an average of five scenes per hour involved talking about sex or sexual behavior [28]. Only 14% of the television shows with sexual content include any messages about the real-life risks and consequences of having sex [29]. In the United States, the national sex education agenda focuses on abstinence-only rather than comprehensive programs, leaving girls and women with both inadequate and inaccurate information about their bodies and how to avoid pregnancy.

Barriers in the health care system include protocols that delay initiation of contraception, inappropriate contraindications and lack of insurance coverage for contraception [23]. The high cost of contraceptive methods is also a barrier. For example, even women with private insurance paid approximately 60% of the total cost of OCs [29].

While advocacy groups and others work diligently to address these systems barriers, reproductive health care providers can make an equally important contribution by providing patient-centered contraceptive care. This means listening to and talking with patients about a very personal and important part of life, helping them understand their pregnancy risks and helping them learn about and access contraceptive methods that meet their needs at different times in their lives.

It is an ongoing process that changes as a woman moves through her reproductive life. By giving women more than just a prescription for contraceptives, providers can play an integral role in helping women achieve their reproductive goals.

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#### References

- [1] Henshaw SK. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998;30:24–9, 46.
- [2] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspect Sex Reprod Health* 2006; 38:90–6.
- [3] Kost K, Singh S, Vaughan B, Trussell J, Bankole A. Estimates of contraceptive failure from the 2002 National Survey of Family Growth. *Contraception* 2008;77:10–21.
- [4] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
- [5] Houle C, Harwood E, Watkins A, et al. What women want from their physicians: a qualitative analysis. *J Women's Health* 2007;16:543–50.
- [6] Stewart M, Brown JB, Donner A. The Impact of patient-centered care on outcomes. *J Fam Pract* 2000;49:796–804.
- [7] Kindersley P, Stott N, Peters TJ, Harvey I. The patient-centredness of consultations and outcome in primary care. *Br J Gen Pract* 1999;49: 711–6.
- [8] Cecil DW, Killeen I. Control, compliance, and satisfaction in the family practice encounter. *Family Med* 1997;29:653–6.
- [9] Henbest RJ, Stewart M. Patient-centredness in the consultation: 2. Does it really make a difference? *Fam Pract* 1990;7:28–33.
- [10] Roter DL, Hall JA, Katz NR. Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. *Med Care* 1987;25:437–51.
- [11] Stewart MA. What is a successful doctor-patient interview? A study of interactions and outcomes. *Soc Sci Med* 1984;19:167–75.
- [12] Frost JJ, Darroch J. Factors Associated with contraceptive choice and inconsistent method use, United States, 2004. *Perspect Sex Reprod Health* 2008;40:94–104.
- [13] Frost JJ, Singh S, Finer LB. Factors associated with contraceptive use and nonuse, United States, 2004. *Perspect Sex Reprod Health* 2007;39:90–9.
- [14] Guttmacher Institute. *Improving contraceptive use in the United States*. In Brief. 2008 Series; 2008. New York: No. 1, April.
- [15] Trussell J, Wynn LL. Reducing unintended pregnancy in the United States. *Contraception* 2008;77:1–5.
- [16] Speidel J, Harper C, Shields W. The potential of long-acting reversible contraception to decrease unintended pregnancy. *Contraception* 2008; 78:197–200.

- [17] Stewart FH, Harper CC, Ellertson CE, et al. Clinical breast and pelvic examination requirements for hormonal contraception: current practice vs evidence. *JAMA* 2001;285:2232–9.
- [18] Foy R, Crilly M. Evidence-based reproductive health care: getting evidence into practice. *J Fam Plann Reprod Health Care* 2004;30:17–20.
- [19] Goodman S, Hiendlish SK, Benedict C, et al. Increasing intrauterine contraception use by reducing barriers to post-abortion and interval insertion. *Contraception* 2008;78:136–42.
- [20] Otero-Flores JB, Guerrero-Carreno FJ, Vazquez-Estrada LA. A comparative randomized study of three different IUDs in nulliparous Mexican women. *Contraception* 2003;67:273–6.
- [21] Suhonen S, Haukkamaa M, Jakobsson T, Rauramo I. Clinical performance of a levonorgestrel-releasing intrauterine system and oral contraceptives in young nulliparous women: a comparative study. *Contraception* 2004;69:407–12.
- [22] MacIsaac L, Espey E. Intrauterine contraception: the pendulum swings back. *Obstet Gynecol Clin North Am* 2007;34:91–111.
- [23] Leeman L. Medical barriers to effective contraception. *Obstet Gynecol Clin North Am* 2007;34:19–29.
- [24] Westhoff C, Kerns J, Morroni C, et al. Quick Start: novel oral contraceptive initiation method. *Contraception* 2002;66:141–5.
- [25] Lara-Torre E, Schroeder B. Adolescent compliance and side effects with Quick Start initiation of oral contraceptive pills. *Contraception* 2002;66:81–5.
- [26] ACOG practice bulletin. Cervical cytology screening. Number 45, August 2003. *Int J Gynaecol Obstet* 2003;83:237–47.
- [27] World Health Organization. WHO statement on hormonal contraception and bone health. Available at [http://www.who.int/reproductive-health/family\\_planning/bone\\_health.html](http://www.who.int/reproductive-health/family_planning/bone_health.html). Accessed September 16, 2008.
- [28] Kunkel D, Eyal K, Finnerty K, et al. *Sex on TV 4*. Menlo Park (Calif): Kaiser Family Foundation; 2005.
- [29] Espey E, Cosgrove E, Ogburn T. Family planning American style: why it's so hard to control birth in the US. *Obstet Gynecol Clin North Am* 2007;34:1–17.