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Editorial

Looking inward: provider-based barriers to contraception among teens and young adults

1. Introduction

One of the signature public health achievements in the United States in recent years has been the decline in both the teen pregnancy and the teen birth rates. Between 1990 and 2004, the teen pregnancy rate declined 38% [1]; in a similar trend, the teen birth rate declined 31% between 1991 and 2006 [2]. This change was remarkably widespread; significant declines were documented in all states and among all racial and ethnic groups. Even so, it remains the case that one in three teen girls becomes pregnant at least once before turning 20, and the United States still has the highest rates of teen pregnancy and birth in the fully developed world. Most scholars agree that the decline was fueled by a combination of somewhat fewer teens reporting that they had had sex and, in particular, better contraceptive use among those who were having sex [3]. Recent vital statistics data, however, reveal a 3% increase between 2005 and 2006 in the teen birth rate — the first such increase in 15 years [2] — showing clearly that rates that go down can go back up. A new group of girls turns 13 each year and there is no room for complacency.

Less often noted is that the broader measure of unintended pregnancy in the United States, as distinct from teen pregnancy, has shown virtually no progress since 1994. According to data from the 2001 National Survey of Family Growth, half of all pregnancies in the United States at present are unintended, accounting for nearly 3 million pregnancies annually. Moreover, the rate of unintended pregnancy actually increased among women 25–29 years old between 1994 and 2001. Half of these pregnancies were among women not seeking pregnancy who nonetheless used no method of contraception in the month they conceived; the other half were among women who were using a method inconsistently or incorrectly. Significant disparities in the rate of unintended pregnancy exist among different socioeconomic, educational, ethnic and racial groups in the United States. In essence, unintended pregnancy rates are higher among women who are poorer, less-educated, and/or are black or Hispanic [4].

In response to this challenging situation, about 18 months ago, the National Campaign to Prevent Teen Pregnancy (the Campaign) expanded its mission to include an added focus on reducing unintended pregnancy (referred to by the Campaign as "unplanned" pregnancy) more generally, especially among single young adults in their 20s where the problem is concentrated. As is true for teen pregnancy, unplanned pregnancy also carries a broad array of socioeconomic and health risks to women and men, to children and to the larger community [5].

Other than some degree of actual contraceptive method failure, what lies behind these high rates of unintended pregnancy in the United States? The list of interrelated factors is remarkably long: lack of adequate sex education and a general discomfort with sexuality, the pernicious effects of poverty, improper use of specific contraceptive methods, poor communication between sexual partners, ambivalence about pregnancy, problems in obtaining access to the most effective contraceptive methods, increased public acceptance of nonmarital child-bearing, inflated fears about the side effects of certain contraceptive methods and a culture that glamorizes sex yet rarely portrays it in responsible ways.

An additional set of possible explanations centers on the training, ongoing education and practices of providers themselves — the thousands of doctors, nurses, physician assistants, nurse practitioners, pharmacists and staff in countless clinics, private offices and other settings nationwide who regularly provide family planning services to the nation's men and women, both teen and adult. For example, unintended pregnancy may, in part, reflect a lack of satisfaction among women with the care offered by providers. To that point, Frost et al. [6] found that many women experiencing problems with their contraceptive methods believe that contraceptive service providers are not readily available to answer method-related questions. A study completed by Motivational Educational Entertainment in 2004 found that among a group of urban, African-American teens in the United States, experiences with the health system (including family planning services) were among the most distressing encounters they experienced with any human services service system at all [7].

2. Provider-based barriers

In an effort to learn more about provider-based reasons behind the nation's high levels of unintended pregnancy,

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the Campaign and the Association of Reproductive Health Professionals (ARHP) — a nonprofit membership association comprised of highly qualified and committed experts in reproductive health — convened two meetings late in 2007 to explore this area. A distinguished group of reproductive, pediatric and family health clinicians was asked to explore (a) barriers to contraception centered in provider training and practices that may contribute to the nation's high levels of unintended pregnancy and (b) potential remedies for at least some of the identified barriers (summarized in the report *Providers' Perspectives: Perceived Barriers to Contraceptive Use in Youth and Young Adults*, which is available for free download at: http://www.thenationalcampaign.org/resources/pdf/BarrierstoContraception_FINAL.pdf).

Among the most important and frequently mentioned provider-based barriers identified by the group were the following:

(1) Highly variable and often insufficient provider education on family planning and contraception in many clinician training programs. For example, a recent study focused on contraceptive knowledge and attitudes among US residents suggests that while a large percentage report receiving some training about contraception, such training was often inadequate and variable across primary care specialties [8].
(2) Too little time spent in training programs on a variety of topics closely related to contraception itself, including contraceptive counseling, abortion care and sexuality, due in turn to a lack of time, competing curricular priorities, lack of trained faculty or appropriate training sites and the belief that other topics are more important [9].
(3) Insufficient opportunities for practicing providers to receive continuing education on advances in contraceptive methods and changes in contraceptive protocols, despite the clear need. For example, a 2004 survey involving qualitative, semistructured interviews with patients and clinicians in a New York City family practice clinic found that both groups had favorable attitudes toward emergency contraception (EC). Yet, in spite of there being no real evidence to support their fears, 40% of clinicians were concerned that advance prescription of EC would increase the chances that patients would engage in risky sexual behaviors [10].
(4) A general failure by providers (other than those in family planning) to initiate conversations about contraception and sexuality with patients, especially at follow-up visits, due to pressures to "keep the office on schedule," lack of interest and/or expertise, concern over low reimbursement rates for such care and counseling, and other reasons as well [11–13].
(5) A reluctance to embrace new contraceptive methods or protocols, particularly when these developments conflict with previous training and/or with more traditional beliefs and values. Examples include unnecessary delays in beginning hormonal contraceptive methods in order to rule out pregnancy, and refusing to prescribe hormonal contraception unless a patient agrees to first have a pelvic examination and Pap test, despite the fact that there is no contraception-related medical need for a routine pelvic exam or Pap test [12,14].

3. Strategies for change

The advisory group suggested a number of remedial actions that could serve as first steps in addressing provider-based barriers in the United States.

3.1. Training

Increasing the use of the most effective methods of contraception by women and couples cannot be expected if those charged with educating and caring for women needing contraception are themselves not well informed. Although basic reproductive health and family planning topics are required elements of the curricula for physician, nursing, nurse practitioner, midwifery, pharmacist, and physician assistant training programs, the actual amount of time devoted to contraception appears to vary widely from institution to institution and is not well documented. To begin understanding this area better, a formal survey should be conducted of training programs nationwide in order to ascertain precisely the level of contraceptive education being provided.

In addition, it may well be that one of the most effective ways to provide adequate contraception training in the curriculum for US medical students, in particular, is to include questions regarding these topics on national board examinations. The group also suggested that encouraging such influential people as medical school deans and departmental chairs in relevant institutions to champion the cause of including more material about contraception and related issues in the curriculum would be an effective step forward.

3.2. Continuing education

Practicing providers everywhere complain of having insufficient opportunities for continuing education on the latest advances in contraception and changes in contraceptive protocols. Sponsorship of broadly based, well-balanced and unbiased continuing education activities where practitioners could be exposed to evidence-based information in addition to practical hands-on experiences is recommended. Use of programs such as ARHP's Curriculum Organizer for Reproductive Health Education (www.arhp.org/CORE) should be encouraged, and alternative providers, particularly pharmacists, should be targeted. Building a more adequate system of continuing education in this area would be advanced by a survey of practicing reproductive health providers to ascertain the level of continuing education now being provided and to define gaps precisely. Also, a review of existing databases could help to identify and monitor who is actually providing reproductive health care.

3.3. Reimbursement

Effective contraception is of great value to individuals and their larger communities, but its value is not reflected in the reimbursement for contraception-related services, especially in the United States. Assisting providers with coding issues may alleviate some of their financial burden. However, we must actively work toward inclusion of family planning/contraception indicators in "Pay-for-Performance" quality assurance programs and others of similar type.

3.4. Social marketing

It is essential that we create a cultural environment in which contraception is considered to be not only acceptable but also highly valued. In that spirit, the group discussed the need for social marketing efforts that explain the basic rationale of contraception and its contribution to the overall health and well-being of women, men, children, families and communities. In addition, specific messaging needs to be developed about the value of long-acting reversible methods of contraception, EC, and other methods as well.

4. Summary

These suggested steps are just the starting point for a much needed discussion — provider to provider — about various ways to alleviate provider-centered barriers to contraception, particularly among the teens and young adults whose rates of unplanned pregnancy remain high in the United States.

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