

PROVIDERS' PERSPECTIVES

PERCEIVED BARRIERS TO CONTRACEPTIVE USE IN YOUTH AND YOUNG ADULTS

FINAL REPORT
MARCH 2008

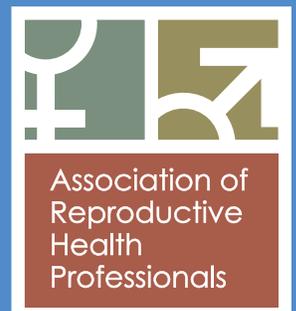


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Background

- The National Campaign to Prevent Teen and Unplanned Pregnancy (NC), founded in 1996 to work on teen pregnancy prevention in the United States, has recently expanded its mission thanks to a generous grant from the William and Flora Hewlett Foundation. Beginning in 2007 and beyond, the NC is working to improve the well-being of children, families, and society not only by reducing teen pregnancy but also by decreasing unplanned pregnancy among young adults in their 20s.
- The NC has partnered with the Association of Reproductive Health Professionals (ARHP), a non-profit membership association comprised of highly qualified and committed experts in reproductive health, to learn more about providers' perspectives of unintended pregnancy and barriers to more effective contraceptive use.
- As a key component of this learning effort, the NC and ARHP convened two meetings in late 2007 with an advisory group of reproductive, pediatric, and family health clinicians to explore (A) the barriers faced by providers and their patients related to preventing unintended pregnancy and using contraception consistently, and (B) potential real-life solutions to overcome these barriers that might be carried out by the NC/ARHP.
- In preparation for these meetings, an extensive literature search was also conducted, with a focus on determining the extent of contraceptive training that health care providers receive at all levels of their education and on providers' perceptions of why adolescents and young adults do not use contraception successfully and risk unplanned pregnancy.

Project Goal

- Identify a set of concrete action steps that the NC/ARHP can work on to help prevent unintended pregnancy.

Overview of Final Report

- This report outlines five key barriers and potential action steps that might be taken by the NC/ARHP as identified at the two advisory group meetings and echoed in the literature search.
- It is important to note that this set of barriers and action steps is not intended to represent the entire constellation of challenges or solutions needed to promote more effective contraception. Rather, it is the set of barriers and action steps that pertain most to the provider community and seem most actionable—barriers that include, for example the lack of provider training and ongoing education, outdated protocols, restrictive reimbursement procedures, lack of social marketing that promotes contraception and inadequate reproductive health services for men.

- One of the most sweeping barriers discussed by the advisory group—that is, that the lives of many women and poor women in particular are chaotic and not conducive to careful family planning—is not among the five barriers summarized below. This is because the advisory group rightfully recognized that it is beyond the grasp of the provider community to change these circumstances and foster regular family planning visits among these women. The group instead emphasized that providers need to capitalize on every visit as though it may be the only visit. Nearly all the potential action steps listed below, from providing better educational materials, to changing protocols for more rapid delivery of contraceptives, to greater social marketing regarding contraception, would serve to help women in these circumstances seek out and obtain the family planning services they need.

CURRENT STATISTICS AND INFORMATION ABOUT SEX, CONTRACEPTION, AND UNPLANNED PREGNANCY AMONG YOUNG ADULTS AND TEENS

Unplanned Pregnancy Overall. Half of all pregnancies in the United States are unintended, accounting for nearly 3 million pregnancies.¹ The rate of unintended pregnancy has remained stable among young women in their 20s and, in 2001, the rate of unintended pregnancy among women ages 18-24 was twice that of other age groups (more than one unintended pregnancy for every 10 women). The rate of unintended pregnancy increased among women 25-29 between 1994 and 2001.¹

Ambivalence about contraception and pregnancy, method side effects, difficulties using methods, and lack of satisfaction with or availability of providers are among the reasons cited for the limited success with contraception.²⁻¹¹ For instance, in an oft-cited paper, Rosenberg et al found that women who stop using oral contraceptives (OCs) due to side effects often either fail to substitute another method, or they adopt a less-reliable method.¹² The authors estimate that over 1 million unintended pregnancies a year are related to OC use, misuse, or discontinuation.

Significant disparities in the rate of unintended pregnancies exist between different socioeconomic, educational, ethnic, and racial groups in the United States: Women whose incomes exceed the poverty line, those with at least a high school education, and those who are white have lower unintended pregnancy rates than women who are poorer, are less-educated, or are black or Hispanic.¹

Poverty and chaos in women's lives may predispose them to a cycle of unintended pregnancy after unintended pregnancy. Ambivalence toward contraception and avoiding pregnancy, as well as "magical thinking" about the likelihood of pregnancy as a result of unprotected intercourse, may also lead to nonuse of birth control. In 2004, Frost et al surveyed a nationally representative sample of 1,978 women at risk for unintended pregnancy.² They found that contraceptive nonuse and gaps in contraceptive use were strongly associated with ambivalence about avoiding pregnancy.

Other significant predictors of inconsistent or nonuse of birth control included having less than a college education, being black, being 35-44 years old, having infrequent sexual intercourse, not being in a current relationship, being dissatisfied with one's method, and believing that contraceptive service providers were not available to answer method-related questions.

Outcomes for Teens. Given that the rate of unplanned pregnancy is highest among people just entering adulthood, one naturally looks to the teen years to see whether it is simply part of a continuum of risky reproductive behaviors. Not surprisingly, the statistics on teen pregnancy and teen births in the U.S. are discouraging. Among developed countries, the United States has one of the highest adolescent pregnancy rates.¹³ Nearly half (46%) of 15- to 19-year-olds in the US have had sex at least once and by age 19, 70% have had sexual intercourse.¹⁴ After nearly two decades of declines,

the birth rate increased 3% among teens 15-19 years old in the United States in 2006.¹⁵ CDC officials said it is unclear whether the increase represents a new trend or is just an aberration, but said the increase was significant enough to warrant concern.¹⁶ Prior to that time, the US teen birth rate had declined over the past 15 years, largely due to improvements in contraceptive use and, to a lesser degree, an increase in sexual abstinence.^{16,17}

Some teens receive limited or no sex education in schools, so the onus falls on parents and health care providers to educate teens more comprehensively about contraception, sexually transmitted infections (STIs), and other sex-related issues. According to 2002 data, for instance, one-third of teens have not received any formal instruction about contraception—impacting them not only in their teen years but in their 20s.¹⁸ A fifth have received abstinence-only education with no instruction in birth control methods.

In addition, some research suggests that social support programs and cultural values may subtly condone teen pregnancy, blinding teens to the negative ramifications of unplanned pregnancies.¹⁹ Surveys indicate that US teens are more likely to desire motherhood than teens in other countries.²⁰

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Barrier 1. While the amount of contraceptive education that providers receive is not totally clear, it appears to be insufficient.

During both meetings, the advisory group noted that we lack a clear picture of the amount of didactic and hands-on experience health care providers receive in contraception and family planning during their training. Although basic reproductive health and family planning topics are required elements of the curricula for physician, nursing, nurse practitioner (NP), midwifery, pharmacist, and physician assistant (PA) programs, the actual amount of time devoted to contraception appears to vary widely from institution to institution and is not well documented. In addition, although the Accreditation Council for Graduate Medical Education (ACGME) requires training in family planning and contraception as part of the core curriculum for internal medicine, pediatric, family medicine, and obstetrics/gynecology residents, structured teaching on these topics is not necessarily part of the residency curricula.¹

The little evidence that does exist suggests that, in many cases, training in contraception is insufficient. An editorial published in *Contraception* reports that lack of training is the primary reason cited by health care practitioners for not taking a sexual health history from patients on a routine basis, followed by clinician embarrassment and a belief that sexual health is not relevant to the patient's visit.²

Another study, focusing on contraceptive knowledge and attitudes among residents, suggests that while a large share of residents report receiving contraceptive training, it was often inadequate and variable across primary care specialties.¹ A cross-sectional survey of 74 primary care medical residents in obstetrics/gynecology, (ob/gyn), internal medicine, pediatrics, and family practice programs) in Allegheny County, PA, found that nearly all residents (93%) believed contraception to be an important component of preventive health care for women of reproductive age. Seventy-three percent said they had received formal training in contraception in their residencies and 74% felt well-trained to counsel patients about contraception. Yet the study found a mean score on contraceptive knowledge of 54%. Furthermore, only 43% of providers felt competent to prescribe emergency contraception (EC) and only 16% felt adept at inserting IUDs. Not surprisingly, ob/gyn residents performed consistently better on the knowledge index than did other residents.

In another example, a 1999 study of Maryland residents found that 20% of ob/gyn residents and 50% of family medicine residents had never inserted an IUD, 16% and 43%, respectively, had never inserted a contraceptive implant, 16% and 37% had never prescribed EC pills, and 20% and 30% had never fitted a diaphragm.³ A 1993 survey of ob/gyn residency program directors and chief residents by Westhoff et al found that most residents reported experience prescribing OCs and performing tubal ligations, but had little experience with other contraceptive methods.⁴ Of graduating chief residents, 38% said they had never inserted an IUD. The residents reported less clinical experience than was estimated by the program directors.

Reasons for the apparently small amount of training time spent on contraceptive counseling, abortion care, and sexuality include a lack of time, competing curricular priorities, lack of trained faculty or appropriate training sites, and the belief that training on these issues is less important than training in other areas. A review and commentary published in the *Journal of Sexual Medicine* seconds the findings in this editorial, stating that “In all countries, medical students, house staff, and practicing physicians currently receive variable, nonstandardized, or inadequate training in sexual history taking and sexual medicine assessment and treatment. There remain significant physician-patient barriers to discussing sexual issues; and patients feel that their physicians are reluctant, disinterested, or unskilled in sexual problem management. There is a knowledge gap between developments in sexual medicine and the clinical skills of practicing physicians.”⁵

The format of contraceptive teaching (interactive vs. standard didactic lecture) does not appear to impact on knowledge gain, satisfaction, or long-term retention of medical students.^{6,7}

Potential Action Steps

(1) Conduct a formal survey of training programs nationwide.

An informal email survey of ob/gyn residency programs nationwide conducted as part of the literature search revealed how widely contraceptive education varies just within the specialty most concerned with family planning: Among the limited number of respondents to this survey, several indicated that contraception is not specifically included in the ob/gyn curriculum, but is believed to be covered as part of family planning lectures and rotations. In addition, there may be little hands-on training in IUD insertion and abortion procedures.

This preliminary research and providers’ input demonstrates a definitive need for a formal survey to be conducted of ob/gyn programs, as well as other providers’ educational programs—family physicians and other primary care providers, pediatricians, nurses, NPs, midwives, pharmacists, and PAs.

In addition, a formal survey of practicing ob/gyns, pediatricians, primary care physicians, nurses, NPs, midwives, pharmacists, and/or PAs might be conducted to ascertain the extent of continuing education that practicing clinicians receive in contraception.

(2) Perform a comprehensive review of existing databases (e.g., Kaiser Permanente or pharmacy databases) to identify and monitor who is actually providing reproductive health care.

An advisory group member suggested that there is a need to clearly identify who is providing family planning services in different settings across the United States, as well as how the landscape is changing—for instance, in some rural areas, internists or family practice providers may be providing more contraceptive care than ob/gyns. Identifying the true providers of contraceptive care can help the NC/ARHP craft appropriate educational vehicles and messages.

(3) Advocate for the inclusion of contraceptive requirements on medical school board examinations and in medical school and resident curricula.

An advisory group member noted that one of the most effective ways to get adequate contraception training into the curriculum for medical students is to insert questions regarding these topics on the national board examinations, specifically population- and epidemiology-based questions rather than medical-based questions. The group also suggested that finding persons—perhaps even chairs and deans—on the faculty of each medical school and program to champion the cause for the inclusion of contraception in the curriculum would be an effective measure for the NC/ARHP to pursue.

The group members noted that two programs are currently in place that train providers in contraception: The Ryan Residency Program and the New Family Planning Program. Both programs are in need of expansion and might be appropriate partners for the NC/ARHP in this effort. Likewise, Medical Students for Choice, a group started about 15 years ago and numbering about 1,000 members with chapters at over 300 medical schools, is a target audience for training efforts and/or partnership.

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Barrier 2. Practicing providers have insufficient opportunities for continuing education on advances in contraceptive methods and changes in contraceptive protocols.

Over and over again during the advisory group meetings, panelists observed that many practicing providers are reluctant to embrace new contraceptive methods or protocols, particularly when these developments conflict with more traditional beliefs and values. This reluctance is exacerbated by a lack of continuing education on contraceptive issues and methods. These comments were echoed by the findings of the literature review.

One example of outdated protocols that are still common is delayed initiation of contraception to rule out pregnancy. Clinicians may hesitate to provide OCs to a patient because they fear she may be pregnant and wrongly believe that hormonal contraception can be teratogenic or have adverse effects on a fetus when administered during the luteal phase of a cycle in which a woman has conceived.¹ They may insist she have a pregnancy test and return to the office 2 weeks later for contraceptive prescription—during which time the patient may likely have unprotected sexual intercourse. Likewise, providers may refuse to prescribe hormonal contraception unless a patient agrees to have a pelvic examination and Pap test—despite the fact that there is no contraception-related medical need for a pelvic exam or Pap test.^{1,2} Clinicians may also hesitate to prescribe certain methods of contraception due to outdated notions of risk—for instance, a perception (recently disproved) that the IUD is only appropriate for women who have had children and are in mutually monogamous relationships.¹ Primary care physicians, pediatricians, and non-ob/gyn specialists are likely to only consider the birth control pill when prescribing contraception.

The advisory group felt that addressing the lack of continuing education around contraception could facilitate greater adoption of new technology and protocols in a number of ways. For example, greater continuing education could bring providers up to date on the growing number of contraceptive methods and thus better enable them to do contraceptive counseling. Appropriate contraceptive counseling when initiating a method and if side effects are encountered leads to higher rates of contraceptive continuation.^{1,2} It has also been demonstrated that women are most successful with a method when they receive their contraceptive of choice.³

Continuing education could also help address the lack of hands-on training in insertion techniques for the IUD or the single-rod implant (Implanon).¹ Similarly, it could address the lack of knowledge about the timing for EC or the pros and cons of the 40-something pill brands on the market. A survey of pediatricians in Washington, DC, conducted by Sills et al found that lack of knowledge about FDA approval of EC and the timing of EC administration, rather than attitudes about EC, were associated with low rates of prescription of EC to teens.⁴

The panel also cited the need for better education and more accurate information concerning the risks of birth control and appropriate contraindications. For example, OC risks are described for the whole class of drugs and don't differentiate progestin-only

from combination formulations.¹ Labeling also doesn't reflect the dramatic lowering in estrogen dose over the past 40 years. Breastfeeding is listed as a contraindication to combination OCs, even though there is no high-level evidence to demonstrate a harmful impact of birth control pills on breastfeeding. Finally, OC labeling does not include any information on use of pills for emergency contraception. Similar labeling issues have limited use of IUDs and injectable depot medroxyprogesterone acetate (DMPA). Continued education on these issues could eventually help foster a move toward less restrictive labeling and more appropriate contraindications.

In addition, continuing education could introduce a more fact-based foundation to inform practitioners' values, beliefs and attitudes toward contraception. For example, a 2004 survey involving qualitative, semi-structured interviews with patients and clinicians in a New York City family practice clinic found that while both groups had favorable attitudes toward EC, 40% of clinicians had concerns about advance prescription of EC, fearing that such practice would increase the chances that patients would engage in risky sexual behaviors.⁵ Yet, there is little evidence that this is the case. Thus, practitioners may feel more willing to embrace new methods and practices if more information was available to help dispel myths or help them reconcile traditional ideas with new developments.

Similarly, Haley and colleagues reported the results of an anonymous mail survey of general practitioners and ob/gyns practicing in Quebec, Canada.⁶ Although most clinicians asked about contraception during a general medical examination of a teen, they did not routinely discuss condom and barrier contraceptive use to prevent STIs; nor did they often ask patients about the number, gender, or STI risk of partners. The major reasons for not doing so were an assumption that patients were not at risk for STIs and a perception that patients were uncomfortable talking about sexual issues. Likewise, Bull et al found in a study of 208 service providers in a variety of privately and publicly funded clinics that providers asked patients about their number of sexual partners and contraceptive history half the time, but only asked about their STI history a third of the time.⁷ The providers cited patient discomfort (46%) and their own discomfort (13%) as barriers to eliciting this information. Continuing education for providers on these topics and how to discuss them with their patients could bolster providers' comfort and enable them to be much more effective in promoting more effective contraception.

Potential Action Steps

(1) Sponsor broad-based continuing medical education (CME) and continuing education (CE) activities for health care professionals.

The advisory group suggested that the best way to educate practicing clinicians about contraception is to offer well-balanced, unbiased, non-pharmaceutical-affiliated, CME- and CE-accredited programs bundled with free dinners, which are appealing to providers because they enjoy the meals and find the events convenient to attend.

The advisors suggested that such activities should:

- Review all contraceptive methods, including EC

- Educate attendees about evidence-based, off-label methods of using contraceptives, such as the Quick Start method of initiating hormonal contraceptives (where a woman can start the pill, patch, and ring at any time during the month rather than having to wait for the menstrual period), and use of IUDs by nulliparous women (which is on-label for ParaGard but off-label for Mirena)
- Cover noncontraceptive health benefits of methods

Ideally, these educational activities should be interactive and tie into real-life opportunities for IUD and Implanon insertion training.

(2) Train and offer speakers to health care professional and other organizations and continue to promote ARHP’s CORE program.

Several of the advisory group members suggested offering expert family planning speakers to organizations of health care professionals, such as those servicing PAs, NPs, nurse-midwives, pharmacists, pediatricians, family physicians, and others (e.g., the Centers for Disease Control), with the goal of putting family planning on the front burner for these groups. These speakers could emphasize cutting-edge, evidence-based, best practices—e.g., offering hormonal contraception without the requirement of a Pap test or pelvic examination; offering contraception and EC with every pregnancy test and after every abortion; offering the IUD to nulliparous women; and offering more than just the birth control pill. The talks could utilize and emphasize the availability of ARHP’s Curricula Organizer for Reproductive Health Education (CORE) program (www.arhp.org/core), an interactive, open-access (free), online tool featuring peer-reviewed, evidenced-based materials on numerous reproductive health topics such as contraception, abortion care, menstruation, sex and sexuality, and STIs. It contains thousands of individual PowerPoint slides and complete presentations, case studies, learning activities, test questions, and other handouts for learners. CORE is a unique resource for anyone involved with educating health professionals, from undergraduate and graduate settings to in-service trainings and CE programs.

(3) Target alternative providers, particularly pharmacists, for CE and study.

The advisory group also noted the need to expand the reach of contraceptive education beyond physicians to alternative providers who have the authority to prescribe drugs in many states, such as NPs, midwives, PAs, and pharmacists. The panel singled out pharmacists as a particularly important group to target because they serve as gatekeepers for Plan B, the emergency contraceptive that is available without a prescription for consumers 18 years and older but only with a prescription for those under age 17. The panel noted that there have been numerous instances of pharmacists refusing to fill prescriptions for Plan B, because they perceive it to be an abortifacient rather than a contraceptive. There have also been instances of pharmacists refusing to fill prescriptions for hormonal methods for the same reason.

One advisory group member suggested designing and conducting a study with pharmacists in a state that is friendly to provision of birth control and might allow pharmacists to prescribe the contraceptive pill, patch, or ring (e.g., Oregon or Washington

state, both of which allow pharmacists to prescribe EC). The project could focus on how pharmacists could be empowered to safely prescribe hormonal birth control, with an emphasis on the type of screening (e.g., blood pressure reading, completion of a self-screening questionnaire) that would need to be done prior to prescription of the contraceptive and the type of training and affiliation with a physician that would be required. In fact, this study could build on the results of the University of Washington's School of Pharmacy pilot study called the Direct Access Study conducted in 2004 with 8 pharmacies in the Seattle area (<http://uwnews.org/article.asp?articleid=26207>).⁸ This successful feasibility study found that women who were already using a hormonal method or had in the past were mostly likely to turn to their pharmacist for contraception. A subsequent study, the Bridging Study, is currently ongoing and seeks to find out if women with recent contraceptive prescriptions that have expired would be interested in receiving contraceptives directly from a pharmacist to bridge the gap until a future doctor's visit.⁸ "We can't change reimbursement of physicians to provide them with an incentive to counsel more about birth control," this panelist said, "so we should look at alternative providers for whom there is reimbursement."

(4) Update and widely and creatively distribute existing contraceptive information for both providers and patients.

The advisory group suggested that a variety of educational materials are needed for distribution to providers and patients. These materials need to be formatted for a diverse variety of platforms, including the Web, email, PDA downloads, and conventional paper vehicles. The group noted that it is critical that these materials be updated and reformatted on a continuous and consistent basis to maximize their usability and validity.

The literature search emphasized the need for patient education materials to rely on simplified, graphic messages rather than text-heavy, medically dense explanations. Text should be written at a level that most consumers can comprehend—i.e., around a 5th grade reading level. Studies suggest that internet materials should contain graphics and flash technology, be interactive, and should allow consumers to remain anonymous and offer instant incentives for participating in online research.^{9,10}

Specifically, the following steps might be taken by the NC/ARHP:

- Update ARHP's existing patient education tool on choosing a birth control method. Add noncontraceptive health benefits to the current chart. Continuously update this information and restyle it for different platforms. Make it interactive for use on the Web, since the NC's research shows that teens and young adults expect online tools and communities to be interactive.
- Create and continuously update reference materials on all methods of contraception for providers in a variety of formats—posters, PDA downloads, monographs, books, etc.—and for a variety of platforms (e.g., Up to Date, Emedicine, etc.).
- Create and distribute a document for providers listing common fallacies and misperceptions about contraception—e.g., that you need to perform a Pap test to prescribe hormonal birth control or that nulliparous women can't have an IUD

inserted—and for added value, place a contraceptive coding key on the bottom of the page.

- Create and distribute a questionnaire/algorithm for providers to follow when counseling and prescribing contraception to improve efficiency and reduce the amount of time providers need to spend with the patient.

(5) Develop contraceptive case studies and put them on the ARHP website.

Advisory group members suggested the need to create contraceptive case studies for use in educational programs. These cases should focus on clinical issues, as well as reimbursement issues (coding strategies for linking procedures—e.g., an abortion and an IUD insertion, a delivery and a tubal ligation, or an HPV vaccine and contraceptive visit), ethical issues, and real-life scenarios (e.g., a young woman who is drunk and has unintended sex; a young woman who breaks up with her partner and stops using her birth control but then has unintended sex).

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Barrier 3: High cost, difficult reimbursement and lack of quality assurance measures can sometimes discourage providers from offering contraception.

In addition to dealing with medical issues, health care providers must have a basic understanding of billing codes to describe diagnoses, services, procedures, and drugs (including contraceptives) to obtain reimbursement and comply with complex insurance regulations. If bills are incorrectly coded, they must be recoded and resubmitted, at the health care provider's cost, for reimbursement. Currently, there are some 9,000 CPT (Current Procedural Terminology) and 17,000 ICD (International Classification of Diseases) codes as well as HCPCS (Healthcare Common Procedure Coding System) codes.^{1,2} Many clinicians and their billing and coding specialists may not be familiar with coding strategies that allow patients easier access to contraception and/or offer greater reimbursement. During the advisory group meetings, providers repeatedly cited a lack of reimbursement for certain procedures, particularly when combined together (e.g., delivery and tubal ligation or abortion and IUD insertion), as a major barrier to contraceptive success. The literature also cites the high cost of certain methods (e.g., the IUD and other long-term methods), lack of or low level of reimbursement from Medicaid and Title X for these methods, and insurance prohibitions against dispensing more than a 1-month supply of a contraceptive as other economic barriers.^{3,4}

This echoed comments of some advisory group members, who stated that in many cases the reimbursement they received for inserting an IUD was not even sufficient to cover the cost of the device itself, much less any of their time. Others commented that some contraceptive methods were so expensive they could not be kept on the shelves, particularly in public family planning clinics. A Guttmacher Institute survey of 627 publicly funded family planning agencies found that while the number of contraceptive methods available to women increased between 1995 and 2003 and agencies reduced barriers to providing OCs and EC (by liberalizing their policies for provision), more than half of agencies did not stock certain methods because of cost.⁴ In addition, key funding sources had declined. The proportion of agencies receiving Medicaid funding fell from 91% to 80%, and the proportion of clients who paid full fees for contraceptive services fell from 19% to 14%. In addition, agencies that waived fees for adolescents declined from 66% in 1995 to 44% in 2003.

Like insurance reimbursement coding, quality assurance measures being implemented under Pay-for-Performance programs can similarly discourage contraceptive care. These Pay-for-performance programs are being initiated by third-party payers as a means to improve the quality of medical care and patients' well-being,⁶ and they offer providers a financial incentive to seek measurable improvements in their patients' health. Members of the advisory group members noted that pay-for-performance programs are expanding nationwide and that, while many payers are looking for reproductive indices to include in the programs, measures of reproductive care have not yet been widely incorporated.

Potential Action Steps

(1) Create an easy-to-reference coding document. As a service to clinicians, the advisory group members suggested that the NC/ARHP create a small handbook for family planning providers listing contraceptive and reproductive health reimbursement codes, for easy and convenient reference. They also suggested providing coding information in other educational materials—for instance, listing HCPCS “J” codes for contraceptives at the bottom of educational materials. While coding structures governing reimbursement from insurance companies were felt to be rather restrictive, several members of the advisory group indicated that creative strategies exist that can increase a provider’s ability to obtain reimbursement.

(2) Actively work to get family planning/contraception indicators into quality assurance programs—e.g., Pay for Performance programs.

The panelists suggested that the NC/ARHP meet with the Health Insurance Association (the organization for all insurers) and the Hospital Joint Commission to get the conversation started on including family planning as part of the Pay for Performance format. Suitable reproductive indices might include “Have you offered contraception to every woman who walks into your clinic?” and “Are you offering EC to all patients?”

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Barrier 4: Consumers receive little in the way of broad-based messages and information on the importance of contraception and the methods available

The literature review and the advisory group meetings both highlighted a lack of awareness of important contraceptive issues among consumers, as well as a lack of true understanding of contraception, pregnancy, and sexual function. Indeed, the recent 3% rise in teen birth rates reported by the Centers for Disease Control may be due to a sense of complacency surrounding consumer education thanks to years of success in reducing the teen pregnancy and birth rates.¹ Members of the group expressed concern that while education and understanding pertaining to sex, pregnancy and contraception have declined and unrealistic sexual content in the media has increased, there have been few countervailing social messages to promote better understanding regarding the importance of contraception and the methods available.

A 2007 survey of 500 girls age 13-18, sponsored by *Seventeen* magazine and The Candie's Foundation, found that nearly half think it is possible they might become pregnant in the next 5 years; 70% say if guys played more of a role in using birth control it would help prevent unplanned pregnancy; 67% have friends who are or became pregnant as teenagers; and two-thirds are more worried about STIs than an unplanned pregnancy.² Seventy percent of the teen girls said that having a plan for the future would help prevent unplanned pregnancies.

Consumers, particularly young men and women in their teens and 20s, live in a highly charged, sexually confusing era. Sexual content in media is pervasive and often presented out of context to its risks (e.g., pregnancy and STIs).³ In some schools, abstinence-only programs focus solely on the risks of using birth control methods,² and there has been much less education about the benefits of contraception in preventing pregnancy, STIs, and preserving health (noncontraceptive benefits). In addition, the risks and side effects of contraception are often presented in contrast to the risks of not using birth control, rather than more realistically to the health and social risks of pregnancy. One survey found that a third of teens have not received any formal instruction about contraception, according to 2002 data—impacting them not only in their teen years but in their 20s.⁴ A fifth have received abstinence-only education with no instruction in birth control methods.

There are also many myths and fallacies circulating about the so-called dangers of IUDs and other methods. Similarly, consumers may simply have poor awareness of highly efficacious, long-term methods of contraception such as the IUD and Implanon, or hormonal alternatives to the pill such as the vaginal ring and patch (which are replaced monthly and weekly, respectively, rather than taken daily as the pill must be). Teens age 15 to 17 surveyed for the Kaiser Family Foundation in 2004 reported they are concerned about their sexual health, whether they've had sex yet or not.⁵ Most have a fairly high degree of awareness about various methods, but have significant gaps in their knowledge. They were most familiar with condoms (85%) and birth control pills (77%). Many teens underestimate the effectiveness of birth control options, particularly newer methods.

They are even more confused about STI protection than about pregnancy prevention, and one quarter did not know that OCs do not protect against STIs. Similarly, although awareness of EC has improved over the past few years, significant misperceptions still exist that can foster political, social, and economic, barriers to more widespread use.³

A low level of medical literacy and difficulty understanding labeling instructions may contribute to consumer's lack of information about contraception. A UK study found in a population of 505 women 16-35 years of age attending a family planning clinic that 44% had a reading age between 12 and 14.⁶ Those in the lower literacy group were more likely to have been under the age of 16 when they first had sexual intercourse and they were significantly more likely to have knowledge gaps around basic reproductive and contraceptive facts. A 2007 health literacy study found that patients need to have at least a high school reading level to understand instructions for over-the-counter (OTC) condoms, spermicides, and EC pills.⁷ "Very little has changed in the past decade regarding readability of OTC contraceptive patient instructions, despite calls to simplify written instructions," according to these authors.

Potential Action Step

(1) Create a continuing social marketing campaign(s) emphasizing long-term methods, EC, general family planning/contraception, and the role of men in preventing pregnancy and STIs.

Key points for an IUD campaign might include:

- Do you know about the IUD?
- It's the most effective form of birth control
- Have you talked to your friends about it?

Key points for an EC campaign might include:

- Have you ever forgotten to take a pill?
- Have you ever been late for a Depo shot?
- Have you ever wished you had EC in your medicine cabinet?

Key points for a general family planning and contraception campaign might include:

- Contraception has many health benefits in addition to preventing pregnancy and STIs
- You might need a different contraceptive method at different stages of your life
- Find the best one for you now
- Side effects can be managed and often overcome
- Talk to your health care provider who is an expert in contraception

Key points for a male-focused campaign might include:

- Birth control isn't just a woman's job or problem
- Contraception can lead to better sex
- Contraception reduces the risk of pregnancy and STIs

The campaigns could utilize poster (for bar restrooms, college dorms, clinics, etc.), television and magazine advertisement, Web, and other repetitive formats for delivering these messages and should make the methods seem appealing to young women and men. Men might be targeted at NASCAR, Superbowl, and other sporting events and in bars. Both sexes might be educated in school-based programs.

Pertinent examples of effective marketing campaigns include the television advertisements for the birth control pill Yaz and the HPV vaccine, as well as the anti-drug campaign (“This is your brain...this is your brain on drugs”) and the anti-smoking campaigns launched by the American Heart Association and the American Lung Association.

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Barrier 5: Traditional gender roles are shifting rapidly with respect to sex, leaving men potentially confused about expectations, yet with the same limited access to reproductive health services as in the past.

Some members of the advisory panel commented that today's young men are inundated with openly sexual content from the media and are sometimes interacting with young women who follow a more aggressive but more ambivalent set of sexual norms than in the past. The lack of traditional expectations or clear signals may make it difficult for young men to know how to behave sexually and what their role is in decision making with their partners. These changing dynamics could further undermine efforts to promote better contraception among men—a task that, in the opinion of the advisory group, is already made difficult by the fact that many men view contraception as a woman's problem, that they lack understanding of their partner's or their own sexual response, and that they generally do not engage with health services on a regular basis.

In general, on-going health services for men are not prevalent and most men only seek health care when they are ill. In addition, few reproductive services are available to men and men aren't aware that they should seek these services. In one study using data from the 2002 National Survey of Family Growth, it was found that only 48% of 3,611 men 20-44 who had ever had sex with a woman reported receiving sexual and reproductive health services in the past year.¹ In another study, a 1999 survey of publicly funded agencies that administer family planning clinics, researchers found that 87% of clinics served some male contraceptive or STI clients (a mean of 255 men and a median of 50) in 1998—and most were interested in serving more.² The most commonly reported barriers to serving men were a lack of awareness among men that services were available to them and inadequate agency funding.

Furthermore, men are often not welcome in the gynecologist's office and are made to feel uncomfortable by health care providers who are not comfortable talking about sexuality with them, according to one advisory panel member. This is true in spite of research showing that when women consult their partners about contraception and men participate in contraceptive decision-making, successful use of a birth control method is more likely than if a woman pursues contraception on her own.³⁻⁵ Despite this evidence, few interventions target couples to prevent unintended pregnancy.⁶

The advisory group suggested that clinicians may need help in realizing that when it comes to contraception, they are treating not only the woman, but also her partner and the relationship. This is critical because research indicates that when male partners become involved with contraceptive decision-making, women are more likely to use the most effective methods and to continue with those methods. For instance, a study of 202 Latina women at increased risk for HIV found that those who were involved in the decision-making about contraception or who had discussed contraception with their partner were twice as likely to use an effective method.⁷ In another study of 213 predominantly Hispanic women who requested the pill from an urban family planning clinic, women who reported that their partner was unaware of their planned pill use had significantly higher odds of discontinuing pill use than women who had disclosed their planned pill

use to partners.⁸ The researchers suggested that “male partners” awareness of planned pill use may be a marker for the level of communication and commitment in the relationship.” In a third study conducted in the early 1990s, women with more than one partner in the preceding year were less likely than women with just one partner to report use of an effective contraceptive method.⁹ The study enrolled 291 unmarried, predominantly black, low-income women presenting for prenatal care at the Johns Hopkins obstetric clinic. A third of the respondents indicated that both partners shared equally in decisions about contraceptive use; joint decision-making was more common among condom than pill users.

Potential Action Steps

(1) Develop a cohesive plan for reaching out to men to educate them about contraception, sexuality, and reproduction.

The advisory group emphasized the need to target men to foster among them a sense of responsibility for contraception, unintended pregnancy, and STIs, and to help them feel more comfortable in the health care setting. Several group members cited the importance of reframing men as heroes in the contraceptive equation rather than as perpetrators or pigs, as the media often does. This outreach effort might be in the form of a social campaign (see barrier 4 and action steps).

(2) Sponsor and develop a male health conference(s).

An advisory group member reported on the success of a male health conference, held as a joint project between providers and the Urban League in Rhode Island. Based on this and the success of a radio call-in show, this panelist suggested that men are very interested in learning about contraceptive and reproductive topics but often don’t know where to turn for information. Advisory group members championed the idea of peer-to-peer communication as an effective technique for reaching teens and young adults, an idea that was also echoed in the literature review and that might be incorporated into a conference setting.

(3) Encourage the establishment of male reproductive clinics such as the one run at Columbia University in New York City.

While members of the advisory group heartily endorsed the idea of conducting a social marketing campaign directed toward young men, one member also reported a need for one-on-one encounters with men. “It is not clear that family planning or Planned Parenthood clinics are the places for them to go,” the member said. “The problem is that men are getting information without context, which creates anxiety for them. They need someone to put that information into context for them—and clinicians are really the best sources for that.” This member suggested partnering with ob/gyns to set up 4-hour male clinics in their offices during times when the ob/gyns are in surgery. Hospitals and abortion suites are another setting for male clinics.

(4) Establish an award for innovation for reaching out to men.

The NC/ARHP could offer a reward or financial incentive for innovative ideas and programs reaching out to young men in health care and other settings.

(5) Encourage prominent providers to write editorials and submit to male consumer publications.

For instance, a panelist or other expert could be enlisted to write an editorial for *Esquire* on a contraception topic to reach a male audience. Since it is difficult to obtain placement of articles in consumer magazines, the purchasing of an advertorial for this material might also be considered.

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