Challenges to contraceptive counseling: Health disparities in family planning

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Outline for today’s presentation

- Overview of racial and ethnic disparities in unintended pregnancy and contraceptive use
- Potential explanations for observed disparities
- General principles for patient-provider interactions to ensure quality and equity

Disclosures

- Nothing to disclose

Objectives

- Recognize that stark disparities in unintended pregnancy and contraceptive use exist
- Identify some of the patient, provider, and system factors that contribute to observed disparities
- Appreciate principles for effective contraceptive counseling

Unintended pregnancy

- Over half of all pregnancies in the US each year are unintended

Unintended pregnancy is associated with adverse health consequences

- Delayed or inadequate prenatal care
- Higher prevalence of smoking and drinking
- Higher rates of depression and IPV
- Poorer perinatal infant outcomes
- Lower likelihood of breastfeeding
Disparities in rates of unintended pregnancy (per 1,000 women)

- **White**
- **Black**
- **Hispanic**

Percentage of poverty level

Disparities in contraceptive use

- Compared to whites, black and Hispanic women:
  - Are less likely to use any method
  - Use less effective methods
  - Even when using the same methods, more likely to have inconsistent or incorrect use

Disparities in abortion rates (per 1,000 women)

- **White**
- **Black**
- **Hispanic**
### Potential determinants of disparities

**PATIENT-LEVEL**
- Knowledge and attitudes
- Pregnancy intention
- Relationship context
- Mistrust
- Perceived susceptibility to pregnancy

**CONTRACEPTIVE USE**

**PROVIDER-LEVEL**
- Training and skills
- Knowledge and attitudes
-bias and stereotyping

**SYSTEM-LEVEL**
- Access to healthcare
- Costs

### System level factors

- Women across racial/ethnic groups equally likely to access family planning services

<table>
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<th>Service</th>
<th>White</th>
<th>Black</th>
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<td>24.2</td>
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<td>Condom services</td>
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<td>1.00</td>
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**Social, Cultural, Historical Context**

- The fertility of some people is valued by those who dominate social discourse and the fertility of other people is not
- Nonconsensual sterilization of poor women and women of color in the 1960s-70s
- Legislative proposals in the 1990s to make receipt of welfare benefits contingent upon Norplant use
### Perceived low susceptibility to pregnancy

- "Didn’t think I could get pregnant" commonly cited reason for not using contraception
  - 42% of women who engaged in unprotected intercourse
  - 31% of 15-19 year olds with unintended pregnancy (27% of whites, 32% of blacks, and 42% of Hispanics)
  - 43% of low-income, pregnant women in our ongoing study reported they thought they could not get pregnant (45% of blacks vs 33% whites)

- Disconnect between what we tell them and what they experience: "It only takes one time…"
  - 92% of women overestimated the risk of pregnancy from 1 act of unprotected intercourse
  - Women had 18 acts of unprotected intercourse before conception

  Participant: "I personally thought I couldn’t, not that I couldn’t conceive but just I wasn’t fertile."
  Interviewer: "Why? What gave you that thought?"
  Participant: "Cause I had sex unprotected before, and just the fact that I’ve never been pregnant." (AA woman who is not using contraception)

### Male partner reproductive coercion

- Of the 66 participants in our study, 25 (38%) described experiences with reproductive coercion
  - Black women reported these experiences more commonly: 59% vs 20%, respectively
  - Black women were also more likely to attribute a current or prior pregnancy to reproductive coercion (n= 8 vs 1)

  "Before my fiancé got locked up he wanted a baby and I had birth control pills... he threw them away, yeah, he bought ovulation kits and a four-pack of pregnancy tests... he was serious... I didn’t want no baby... I didn’t want one but I was confused. But now he’s not around and I don’t want no baby." (AA woman, age 19)
Knowledge and attitudes

- Racial differences in awareness of, knowledge about, and attitudes toward contraception exist—especially among men
- For women, such differences do not appear to be a major driver of disparities in contraceptive use
- Ensure that preferences are not shaped by inaccurate knowledge

Provider bias

- Numerous studies showing that providers treat patients differently based on their race/ethnicity
- Low-income women of color more likely to report being advised to limit their childbearing than were middle-class white women
- A survey of family planning clients found blacks were more likely than whites to report having been pressured by a clinician to use contraception

Mistrust

- Conspiracy beliefs are common in minority communities
  - 34% agreed that whites want to keep the number of black people down
  - 37% agreed that medical/public institutions use poor and minority people as guinea pigs to try new birth control methods
- Conspiracy beliefs associated with lower likelihood of using provider-dependent methods

Provider bias

- In a survey of AA women, 28% reported being pressured to start one type of method when they preferred another
- 1988 study found that older age, multi-parity, and black race were the most significant factors in a gynecologist’s willingness to perform sterilization
- More recent study found that providers more often recommended IUDs to black and Hispanic women of low SES

Perceived discrimination

- Perceived discrimination also common:
  - 67% of survey participants reported experiencing race-based discrimination when obtaining family planning services
  - 52% reported experiences that reflect stereotypes of AA women (e.g., doctor or nurse assumed they had multiple sexual partners)
- Can shape contraceptive attitudes and perhaps method choice

Correcting bias

- Social categorization is automatic and ubiquitous
- Enhanced by features of the health care setting (e.g., fatigue, work overload) that decrease cognitive capacity
  - These conditions more common in settings that treat minorities
- Awareness of particular scenarios in which marginalized populations are subjected to discriminatory care can motivate providers to examine and correct their own behavior
Potential determinants of disparities

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**SYSTEM-LEVEL**
- Access to healthcare
- Costs

**CONTRACEPTIVE USE**

Health communication strategies

- **Informed choice**
  - Emphasizes patient autonomy
- **Directive approach**
  - Promotes use of highly effective methods

What we know

- Patient-reported quality of care associated with satisfaction with method and contraceptive continuation
- Women like an intimate, friend-like interaction in which providers participate in decision making in a way that emphasizes women’s values and preferences
- Blacks and Latinas more likely to feel that providers should only share their opinion if it is elicited by a patient or if they make their rationale clear to the patient

What are our goals?

- Help women and couples clarify and achieve their reproductive goals
- For those who do not desire pregnancy, help them find a method that they can use consistently and correctly over time
- Increase the proportion of pregnancies that are consciously desired and planned
- Close the racial gap in unintended pregnancy and abortion rates
General principles for counseling

- Ask women about their pregnancy intentions and reproductive goals, consider system-level interventions to activate women and/or providers (e.g., reproductive life plan or contraceptive vital sign).
- Explore inconsistencies between intention and behavior; counsel women about their personal risk for pregnancy and information about benefits of planned pregnancy.
- Ask about male partners’ fertility intentions and consider screening for reproductive coercion; provide discreet methods (implant, injection, IUD without strings) if needed.

Don’t make assumptions about what is important – ask women about their perspectives and tailor counseling: consistent with patient-centered care and will help establish rapport.

Provide meaningful information: use relative effectiveness for different contraceptive methods and consider a tiered approach.

Acknowledgment of the challenges of using methods effectively and address barriers to adherence and continuation: Anticipatory guidance for side effects, contingency planning, dispensing more months of supply.

Seize opportunities to educate men about the full range of contraceptive methods; men are interested in participating in decisions and influence women’s contraceptive use.

Communicating effectiveness

Use of highly effective methods (IUD, female and male sterilization) by age and race/ethnicity


Pregnancy coercion and birth control sabotage survey items

- "Has someone you were dating or going out with ever:
  - told you not to use any birth control (like the pill, shot, ring, etc.)?
  - said he would leave you if you did not get pregnant?
  - told you he would have a baby with someone else if you did not get pregnant?
  - hurt you physically because you did not agree to get pregnant?
  - tried to force or pressure you to become pregnant?

- "Have you ever hidden birth control from a sexual partner because you were afraid he would get upset with you for using it?"

- "Has someone you were dating or going out with ever:
  - taken off the condom while you were having sex so that you would get pregnant?
  - put holes in the condom so you would get pregnant?
  - broke the condom on purpose while you were having sex so you would get pregnant?
  - taken your birth control (like pills) away from you or kept you from going to the clinic to get birth control so that you would get pregnant?
  - made you have sex without a condom so you would get pregnant?"