Community Women, Providers, and Contraception: A Health Needs Assessment in the Spirit of Reproductive Autonomy

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BACKGROUND

On average, ~50% of annual pregnancies in the United States are unintended. And yet, typically ~45% of women with an unintended pregnancy were some form of birth control at the time of conception. Although data shows a stable rate of unintended pregnancies each year, marked variation of who experiences these unintended events when women are subdivided based on age, socioeconomic status (SES), education level and marital status. Further, the outcomes of these unexpected pregnancies also vary based on those demographic features. For some women, while unplanned, these pregnancies ultimately become strongly desired. Others feel that termination is their best option. Importantly, however, women’s ability to make this decision varies across demographic groups. Recent rates of unintended births (versus terminations) occur more frequently in low SES women; this is likely partially related to the growing difficulty of reaching abortion services. And although unplanned births are not the sole cause of the social inequity facing poor and minority women, it is certainly a contributing factor and a consequence of the injustices they face. Therefore, addressing the numerous disparities surrounding unintended pregnancies is essential to the goal of enhancing women’s control of their reproductive lives. We feel that achieving this goal is most important for groups of women that have historically held the least amount of reproductive control: low-income; uninsured; minority; and LGBT women.

Long-acting reversible contraception (LARC) refers to two specific forms of contraception: the intrauterine device (IUD) and the hormonal implant. Both IUDs and implants are placed by clinicians and can remain in place, with no patient effort required for maintenance, for years. Further, LARC methods tout impressive rates of effectiveness that rival that of permanent sterilization. LARC, however, has the benefit of being easily reversible and allows women to increase their fertility when desired. While consistently popular with clinicians, LARC has also seen a rise in popularity among patients. Recent data shows a steady increase in total use across United States from 8.5 percent in 2009 to 11.6 percent in 2012. LARC usage among patient groups are expected to continue their upward trend as more LARC models become commercially available and financially accessible.

METHODS

Two surveys were used for data collection. The first was designed for patients that seek care at Equal Access Clinic Network. The second was designed for medical students, residents and attending physicians that provide contraceptive care at EACN. The surveys contained the following sections: Patient Survey Components

- Demographics
- Current and historical contraception use
- Exploring LARC characteristics
- Comparison to other methods
- Misconceptions about LARC
- Barriers to LARC
- Desires about future LARC options and contraception counseling process

Provider Survey Components

- Demographics
- Contraception counseling
- Exploring LARC characteristics
- Comparison to other methods
- Misconception about LARC
- Barriers to LARC
- Counseling process variability
- Patient barrier to contraception
- Specific barriers to transgender men
- Assessment of education and training

Patient surveys were collected via paper surveys at the four primary care EACN locations. Provider surveys were distributed via an online survey platform to student and department email listservs.

SELECT RESULTS

At the completion of data collection:

- 63 patient surveys were completed and analyzed
- 42 provider surveys were completed and analyzed

RESULTS CONTINUED

CONCLUSIONS

Based on preliminary analysis, we observe that educational gaps exist in both our patient and educational populations. Additionally, patients identify many barriers that prevent them from being able to access LARC. Therefore, it is not surprising to find that while over 50% of our provider offer LARC methods, LARC has only been used by 22% of patients. We hope to see more patients not only feel comfortable using LARC but also feel capable of accessing these methods in the future.

Much remains to be completed for our project. Next steps in analysis for the patient-focused component will examine responses when specifically stratifying surveys based on race and sexual orientation. This will allow us to discover trends that might vary from what we currently see in our total survey responses analysis. Next stop in analysis for the provider-focused component will examine our questions addressing reproductive care to transgendered men. Compilation of both of these next steps will bring our project closer to being better able to address the specific needs of these historically (and often still currently) disadvantaged populations. Finally, the last stage of this project will include directly altering clinical practices within EACN to best meet our patients reproductive needs. First changes currently underway include more consistent provision of education materials readily available for providers to use while counseling. We hope this will close the educational gap seen in both patient and provider groups. By doing so, we hope patients will be better informed on all options and hopefully will feel more capable to select the birth control option that is best for them.

REFERENCES

- Center for Disease Control. Effectiveness of Family Planning Method pdf, 2011.