

Contraceptive Use in the United States

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Contraceptive use is deemed one of the 10 greatest public health achievements of the 20th century because its benefits are universally acknowledged as a cornerstone for reducing global maternal morbidity and mortality. Current data indicates gaps in contraceptive use patterns in the US, particularly among low-income women and those from racial/ethnic and gender minority subgroups, necessitating further investigation using an ecological approach.

women

contraception

health access

United States

1. Barriers to Contraceptive Use

1.1. Individual-Level Factors

These factors are situated within the intrapersonal dimensions. Lack of knowledge, misaligned concerns, religious beliefs, and misconceptions about contraceptive safety and effectiveness are major barriers to the under-utilization or ineffectiveness of contraceptives [1][2][3]. The focus of abstinence-only education plays a role in the poor knowledge and misconception of contraceptive methods, effectiveness, and safety. In addition, it is possible that having a positive perception about contraceptives can improve understanding of and awareness of contraceptives. There are also myths surrounding the health consequences or side effects of contraceptives. For example, many women believe that IUDs or LARCs increase the risk of infection [2]. In addition to these issues, low-income women, particularly those with no or inconsistent health insurance coverage, may still experience financial burdens when removing IUDs or implants. This is because hospitals bill the removal of IUDs or implants separately from their placement despite the ACA's provision [4].

1.2. Interpersonal-Level Factors

Interpersonal level factors refer to interactions with others in formal and informal social networks and social support systems. Contraceptive use is influenced by the patient's interaction with their healthcare providers. However, provider bias determines which method of contraceptives they discuss, particularly among younger females. For example, one study found that up to 50% of pediatricians prefer an abstinence-only form of contraception for adolescents, with fewer than 20% discussing any type of IUD [5]. Moreover, the propensity of discussing IUD is higher among female and younger pediatricians [5][6]. In addition, family and friends' perspectives of contraception may influence contraceptive selection and continuation. A recent review of the impact of social networks on contraceptive use found that families were more likely to disseminate inaccurate or negative information about

LARC [7]. This highlights the importance for healthcare providers to identify strategies to dispel negative information consistently. In the same vein, cultural barriers may affect contraceptive uptake. The deviation from receiving accurate medical information and counseling about family planning may affect the effectiveness of a method. One study reported that among 321 postpartum women of Mexican origin, LARC use was predominantly low in Austin, Texas, USA (9%) and El Paso, Texas, USA (7%) [8]. This study also showed an overwhelmingly low use between intended and actual LARC use as only 8% used a LARC method compared to 52% who intended to use the same [8]. This disparate utilization supports the revelation that language barriers hinder access to immediate postpartum LARC among non-English speaking patients [9]. Moreover, healthcare providers' unfounded belief and poor knowledge about some methods of family planning services such as the IUD limit their provision of appropriate contraceptive counseling for their patients.

1.3. Institutional-Level Factors

Institutional-level factors comprise aspects and activities within the healthcare system that influence contraceptive use. Provider schedule and limited training about contraceptive counseling often act as barriers to contraceptive use. A study of 167 pediatricians from the Massachusetts Pediatric Society revealed that 53% of pediatricians did not have the time to counsel teenagers about contraceptives. Another 27% reported receiving no formal training on contraceptive counseling [5]. However, concerning IUD counseling, an overwhelming 117% of pediatricians said they had no formal training on how to do so [5]. Unfortunately, these issues are not unique to teenagers. Among certified midwives and nurse-midwives from the American College of Nurse-Midwives, 63.5% said they desired additional training for inserting immediate postpartum IUD, and 22.8% reported the same sentiments for implant insertion [10]. Indeed, the lack of formal training implies structural barriers suggesting that medical training programs and hospitals do not provide the requisite training needed for providers to enable them to discuss family planning options with patients. Other structural barriers related to contraceptive use include the lack or unavailability of standardized procedures, cost-related challenges, low reimbursement from health insurers, restrictive religious institutional policies, parental consent, or regulatory pharmacy prescription only-model that hinders offering contraceptive counseling and services [4][10][11][12].

Simultaneously, barriers such as issues with confidentiality and privacy, perceived judgment or stigma, lack of clinical space, costs, inadequate health insurance, and limited information about how to access contraceptive services are persistent institutional barriers to contraceptive use [13].

1.4. Community-Level Factors

Community-level factors comprise interactions between and within healthcare organizations, community organizations, and other informal networks that influence contraceptives. Shame and stigma related to sexuality, particularly among sexual minorities, impede contraceptive counseling and use. One study found that queer women have complicated relationships with their healthcare providers because medical professionals often assume they do not need contraceptives [14]. This coincides with results from a national survey showing that

lesbians were significantly less likely than heterosexual women to receive contraceptive counseling or prescriptions [15].

1.5. Policy-Level Factors

Policy-level factors are characterized by federal and state policies. Despite the ACA, restrictive state policies can impede access to contraceptive care. Some states declined to expand or ended their state-federal Medicaid family planning expansion programs in favor of a solely state-funded program. However, the state-funded programs exclude, for instance, abortion services. For example, 18 states have abortion-related limitations on the allocation of public funds, 15 states restrict the provision of state family planning funds, 13 states restrict the allotment of some federal and state funds on services such as STI testing and treatment and sex education, and 8 states explicitly limit the allocation of federal Title X family planning to exclude some types of providers, among other forms of restrictions [16].

2. Facilitators of Contraceptive Use

In addition to the barriers discussed above, few studies reported facilitators supporting women's contraceptive uptake. These themes are displayed in **Table 1** and are structured by the social-ecological level, with most facilitators identified at the individual level. Cited examples of facilitators for contraceptive use include peace of mind knowing that there is a minimal risk for pregnancy, trust in providers' suggestions on the best contraception methods, and same-day LARC insertions to minimize transportation and convenience barriers. Social stigma related to getting pregnant also served as a way to promote contraceptive use, especially among younger populations. Finally, laws that support pharmacists' and other providers' ability to prescribe hormonal contraception also minimize barriers for women when obtaining contraceptives. These providers provide a safe, convenient access point for women seeking contraception, and in most cases, provide greater levels of knowledge about contraception than physicians.

Table 1. Facilitators of Contraceptive Use by Social-Ecological Level.

Ecological Level	Themes
Individual	<ul style="list-style-type: none"> • Self-aspirations [17] • Personal choices to defer pregnancy [17] • Confidence in asserting their sexual wishes [14] • Peace of mind [18]
Interpersonal	<ul style="list-style-type: none"> • Supportive relationships from parents, friends, and healthcare professionals [7][17]

Ecological Level	Themes
	<ul style="list-style-type: none"> • Trust of provider [7][14]
Institutional	<ul style="list-style-type: none"> • Patient-centered contraceptive counseling [19] • Same-day LARC insertions [19] • Staff training [19]
Community	<ul style="list-style-type: none"> • Social stigma related to getting pregnant [17]
Policy	<ul style="list-style-type: none"> • Public policy allowing pharmacists to prescribe hormonal contraception [20]

References

1. Guiahi, M. Religious Refusals to Long-Acting Reversible Contraceptives in Catholic Settings: A Call for Evidence. *Am. J. Obstet. Gynecol.* 2020, 222, S869.e1–S869.e5.
2. Hall, K.S.; Ela, E.; Zochowski, M.K.; Caldwell, A.; Moniz, M.; McAndrew, L.; Steel, M.; Challa, S.; Dalton, V.K.; Ernst, S. “I Don’t Know Enough to Feel Comfortable Using Them:” Women’s Knowledge of and Perceived Barriers to Long-Acting Reversible Contraceptives on a College Campus. *Contraception* 2016, 93, 556–564.
3. Raidoo, S.; Kaneshiro, B. Contraception Counseling for Adolescents. *Curr. Opin. Obstet. Gynecol.* 2017, 29, 310–315.
4. Gomez, A.M.; Fuentes, L.; Allina, A. Women or LARC First? Reproductive Autonomy and the Promotion of Long-Acting Contraceptive Methods. *Perspect. Sex. Reprod. Health* 2014, 46, 171.
5. Wilson, S.F.; Strohsnitter, W.; Baecher-Lind, L. Practices and Perceptions among Pediatricians Regarding Adolescent Contraception with Emphasis on Intrauterine Contraception. *J. Pediatr. Adolesc. Gynecol.* 2013, 26, 281–284.
6. Akers, A.Y.; Gold, M.A.; Borrero, S.; Santucci, A.; Schwarz, E.B. Providers’ Perspectives on Challenges to Contraceptive Counseling in Primary Care Settings. *J. Women’s Health* 2010, 19, 1163–1170.
7. Mahony, H.; Spinner, C.; Vamos, C.A.; Daley, E.M. Social Network Influences on Young Women’s Choice to Use Long-Acting Reversible Contraception: A Systematic Review. *J. Midwifery Women’s Health* 2021, 7.
8. Potter, J.E.; Hubert, C.; White, K. The Availability and Use of Postpartum LARC in Mexico and Among Hispanics in the United States. *Matern. Child Health J.* 2016, 21, 1744–1752.

9. Wallace Huff, C.; Potter, J.E.; Hopkins, K. Patients' Experiences with an Immediate Postpartum Long-Acting Reversible Contraception Program. *Women's Health Issues* 2021, 31, 164–170.
10. Moniz, M.H.; Roosevelt, L.; Crissman, H.P.; Kobernik, E.K.; Dalton, V.K.; Heisler, M.H.; Low, L.K. Immediate Postpartum Contraception: A Survey Needs Assessment of a National Sample of Midwives. *J. Midwifery Women's Health* 2017, 62, 538–544.
11. Moniz, M.H.; McEvoy, A.K.; Hofmeister, M.; Plegue, M.; Chang, T. Family Physicians and Provision of Immediate Postpartum Contraception: A Cera Study. *Fam. Med.* 2017, 49, 600–606.
12. Rafie, S.; Haycock, M.; Rafie, S.; Yen, S.; Harper, C.C. Direct Pharmacy Access to Hormonal Contraception: California Physician and Advanced Practice Clinician Views. *Contraception* 2012, 86, 687–693.
13. Garney, W.; Wilson, K.; Ajayi, K.V.; Panjwani, S.; Love, S.M.; Flores, S.; Garcia, K.; Esquivel, C. Social-Ecological Barriers to Access to Healthcare for Adolescents: A Scoping Review. *Int. J. Environ. Res. Public Health* 2021, 18, 4138.
14. Higgins, J.A.; Carpenter, E.; Everett, B.G.; Greene, M.Z.; Haider, S.; Hendrick, C.E. Sexual Minority Women and Contraceptive Use: Complex Pathways Between Sexual Orientation and Health Outcomes. *Am. J. Public Health* 2019, 109, 1680–1686.
15. Everett, B.G.; Higgins, J.A.; Haider, S.; Carpenter, E. Do Sexual Minorities Receive Appropriate Sexual and Reproductive Health Care and Counseling? *J. Women's Health* 2019, 28, 53–62.
16. State Family Planning Funding Restrictions | Guttmacher Institute. Available online: <https://www.guttmacher.org/state-policy/explore/state-family-planning-funding-restrictions> (accessed on 28 September 2021).
17. FFree, C.; Ogden, J.; Lee, R. Young women's contraception use as a contextual and dynamic behaviour: A qualitative study. *Psychol. Health* 2005, 20, 673–690.
18. Campo, S.; Askelson, N.M.; Spies, E.L.; Losch, M. Preventing Unintended Pregnancies and Improving Contraceptive Use among Young Adult Women in a Rural, Midwestern State: Health Promotion Implications. *Women Health* 2010, 50, 279–296.
19. Politi, M.C.; Estlund, A.; Milne, A.; Buckel, C.M.; Peipert, J.F.; Madden, T. Barriers and Facilitators to Implementing a Patient-Centered Model of Contraceptive Provision in Community Health Centers. *Contracept. Reprod. Med.* 2016, 1, 1–9.
20. Gomez, A.M.; McCullough, C.; Fadda, R.; Ganguly, B.; Gustafson, E.; Severson, N.; Tomlitz, J. Facilitators and barriers to implementing pharmacist-prescribed hormonal contraception in California independent pharmacies. *Women Health* 2019, 60, 249–259.

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