

Making the Case for a ‘Contraceptive Convenience’ Agenda

By Sneha Barot

Breakthroughs in contraceptive technology, expanded government funding and evolving public health policies over the past 50 years have dramatically changed women’s ability to control their fertility and to better care for their reproductive health. This progress is reflected in part by the fact that the overwhelming majority of women at risk of unintended pregnancy in the United States—some nine in 10—are practicing contraception any given year.

Yet, the fact remains that nearly one-half of all U.S. pregnancies are unintended at the time of conception. By age 45, nearly half of all women will have experienced an unintended pregnancy, and nearly one-third will have had an abortion. These statistics may not be as surprising as they seem, considering that the typical American woman who wants two children spends only a few years of her life pregnant or trying to become pregnant, but some 30 years trying to avoid a pregnancy.

It is a tremendous challenge to successfully practice contraception over the span of three decades. Research identifies many reasons why women find it difficult to use contraceptives consistently, correctly and effectively, ranging from concerns regarding side effects to disruptions to one’s life (see box). In turn, the argument increasingly is being made that the primary ways in which contraceptives are made available in our society are no longer grounded in the reality of current scientific advancements or modern women’s lives—in short, that contraceptive access today is artificially and unnecessarily hard, and that it can and should be made easier.

In response, an expanding movement of advocates is urging the case for “contraceptive convenience,” to better integrate contraception into the everyday lives of women and to simplify women’s access to it. Although many reproductive health providers have already implemented changes in their practice to make contraceptive use more convenient and sustainable for women, advocates are proposing bolder and potentially transformative changes in the way contraception is accessed in this country. At its heart, their proposition seeks to strip away layers of medical intervention or requirements deemed outmoded or immaterial and that impede access and inhibit use. Aspects of this agenda have raised serious concerns among some stakeholders. Advocates argue, however, that “demedicalizing” contraception, by removing requirements such as pelvic exams and even the requirement of a prescription for many hormonal contraceptives, would increase women’s access, lower discontinuation rates, decrease financial and logistical hurdles for women, and ultimately reduce rates of unintended pregnancies.

Historical Underpinnings

The forces of history, politics and medicine have squarely placed contraception where it is today—tightly woven into the institutional medical infrastructure of this country. Except for condoms, spermicides and most recently emergency contraception, access to most modern contraceptive methods requires the intervention of a health care provider. Compelling reasons had created this class of medical gatekeepers to contraception. For example, legal restrictions on birth control sales and information, such as in the Comstock Act of 1873, fueled the desire to legit-

Understanding Contraceptive Gaps and Nonuse

A 2004 Guttmacher Institute study examined contraceptive use patterns of U.S. women aged 18–44 at risk of unintended pregnancy over the course of one year. It found that half of all women at risk are not fully protected from unintended pregnancy because of nonuse of contraceptives, inconsistent or incorrect use, or gaps in use of one month or longer (see chart). For example, 38% of pill users have missed at least one pill in the prior three months. This pattern may reflect women’s struggles with using methods that require daily application. Among those who use condoms, 61% have used the method inconsistently or incorrectly in the last three months, indicating the even greater difficulty associated with consistent use of methods that must be used during every act of sex.

A number of across-the-board reasons emerge for why women who do not want to get pregnant do not use or inconsistently use contraceptives (see chart, page 13). At the top of the list are problems women face accessing or using methods, which include dissatisfaction with available methods, concerns about side effects, lack of time for medical visits and difficulties in paying for methods. Women’s satisfaction with their method has a strong bearing on their method use. Those who are dissatisfied with their method are more likely to skip a pill or use

condoms inconsistently. Dissatisfaction with providers is another aspect of this complex web, as women’s interactions with their provider impact their contraceptive use. For instance, women who feel that they cannot call their provider with questions or do not see the same provider each time are less likely to use contraceptives consistently.

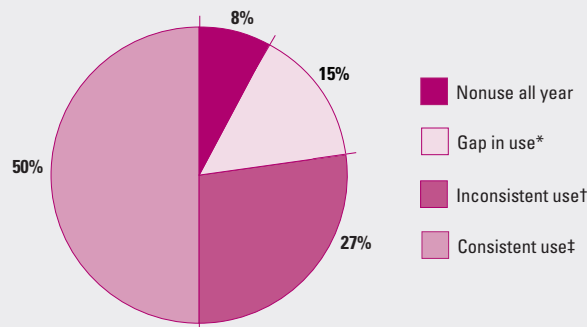
Dissatisfaction can also play a role in method switching. Method dissatisfaction prompts switching of method types in more than one-quarter of women who have used contraceptives over the previous year. Whereas 8% switch to a more-effective method type, 19% switch to a less-effective method or stop using a method.

Nonetheless, a certain amount of method switching should be

viewed as a normal occurrence. It is expected that women will need to explore among options to find a suitable contraceptive method, because the first choice may not always be the right choice. Problems arise when women face hurdles in switching from one method to another. This challenge persists even as women get older, because method switching will also continue through different life transitions. These patterns occur because some forms of contraception are more appropriate than others at different points throughout one’s life. For example, younger women, those in less-stable sexual partnerships or those in shorter-duration relationships are more likely than others to switch methods. In contrast, uninsured women are less likely than those with insurance to

PATTERNS OF CONTRACEPTIVE USE

Half of adult women at risk are inadequately protected from unintended pregnancies.



28 million women at risk of unintended pregnancy

*Of one month or longer. †For pills, denotes one or more missed pills in past three months; for barrier methods or withdrawal, denotes nonuse at one or more acts of intercourse in past three months. ‡Includes the IUD, implant, injectable and patch; the category also includes 5% of respondents with no data on consistency of use. Note: Women at risk of unintended pregnancy include those who are sexually active, not pregnant nor seeking pregnancy, and not infertile nor sterilized. Source: Guttmacher Institute, 2007.

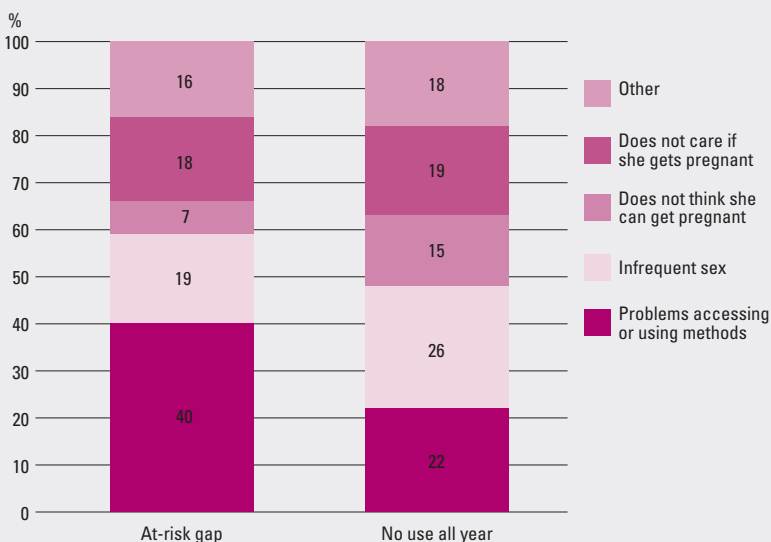
switch, perhaps because of lack of coverage or resources to do so—suggesting that they may face some of the biggest impediments in trying new methods.

Important life changes play a considerable role in women’s use of contraceptives. For example, half of women who experience a gap of at least one month in contraceptive use report experiencing an important life event during that time, such as a job change, move to a new home, start or demise of a relationship or personal crisis. There are countless ways in which disruptions to women’s lives or their changing circumstances affect their ability to maintain contraceptive use. Such difficulties and fluctuations point to the need to make methods easier to obtain.

Women identify infrequent sexual activity as another major reason for nonuse or inconsistent use of contraceptives. Women who do not have sex often could be averse to taking long-term hormonal contraceptive methods or to signing up for methods such as the pill that require a daily commitment—reflecting a need for a broader array of contraceptive choices. These women may not find current contraceptive methods apt for their level of sexual activity. This gap signifies an acute need to develop new non-hormonal as well as postcoital methods that address the concerns of women who may not

WHY CONTRACEPTIVES ARE NOT USED

Women commonly cite method problems or infrequent sex as reasons why they have gaps in contraceptive use or do not use contraceptives at all.



Source: Guttmacher Institute, 2007.

engage in regular sexual activity. These individuals may also fall under the significant minority of women who fail to use contraceptives because they incorrectly believe that they are not at risk of pregnancy.

Although it is important to uncover the reasons why women are not using available contraceptive options, these factors must be understood in the context of other health issues—such as diet, exercise, chronic illnesses or unhealthy habits—that persist throughout a lifetime and require a commitment that may be unrealistic to adhere to on a regular or daily basis. Indeed, according to a 2003 World Health Organization

report, adherence to treatments of chronic illnesses such as heart disease medication averaged only 50% in developed countries. Interestingly, the report noted that increasing the rates of adherence was perhaps more important and cost-effective than advancements in medications or technology.

imize contraception under the mantle of physician care in the early years of the 20th century. With doctors acting as gatekeepers, reproductive health advocates were able to reform birth control policy and law to permit contraceptive access for individuals and couples. The development and approval of oral contraceptives in 1960 and the widespread use of and concern over first-generation, high-dose pills and their side effects were additional reasons for continued pressure to keep health professionals involved.

Soon afterwards, in the late 1960s and 1970s, the federal government began subsidizing contraceptive services for low-income women. For political reasons, and on the medical and social merits, contraceptive service delivery was firmly embedded in the larger national preventive health agenda. Contraception was considered highly controversial at the time: Its potential to improve the lives of women and families was acknowledged, but there were also legitimate concerns about the impact of this new technology on women's health and about the potential for coercion of poor and minority women to limit their childbearing. These were the very women who often also lacked access to basic health care. Thus, family planning clinics were mandated to provide and were promoted for providing not just contraceptive supplies, but also Pap smears, breast and pelvic exams, and screening and treatment for STIs—all of which were deemed necessary for responsibly dispensing contraceptives and further entrenched contraceptive access within the clinical setting.

Reform Efforts Underway

Today, health care advocates and providers are challenging the notion of gatekeepers for certain contraceptive methods. Some advocates and providers are already taking modest but significant steps in pursuit of a contraceptive convenience agenda. One simple step is the offering of expanded office hours by most providers to accommodate patients during evenings and weekends. Another is "quick-start," which allows women to begin using hormonal contraceptives on the day that they visit their provider's office, instead of waiting until a certain point in their menstrual cycle.

These types of measures go far in assisting women who are trying to prevent pregnancies; however, a large number of providers have simply failed to take many of the basic, minimal and effective steps suggested to promote convenience and use. For example, a 2004 Guttmacher Institute survey of organized family planning providers found that although 78% of Planned Parenthood clinics have offered quick-start for contraceptive pills, smaller proportions of other providers have done so: 47% of public health departments, 38% of obstetrician-gynecologists, 27% of other clinics and 13% of family physicians. In the same vein, advance provision or prescription of emergency contraception is now widely recommended as a pregnancy prevention measure. Nonetheless, only about 38% of health departments and other public clinics take this step, compared with 93% of Planned Parenthood clinics.

As long ago as 1993, the Food and Drug Administration revised the package labeling for oral contraceptives to permit deferral of physical exams, allowing providers to dispense birth control pills without requiring an initial physical or pelvic exam of the patient. Planned Parenthood Federation of America has widely embraced this strategy, now practiced by 86% of its affiliates. Furthermore, some of its affiliates have expanded upon this protocol in its HOPE (hormonal options without pelvic exam) program by allowing women to forgo the exam altogether. In contrast, only about half of obstetrician-gynecologists (49%), family physicians (56%), health departments (54%) and other public clinics (56%) offered a deferred-exam protocol for hormonal contraceptive users in 2004.

Other innovative strategies to increase convenience and use include programs to provide advance supplies of contraceptives, so that women do not need to face the continual hassle, time and cost of filling a prescription every month. At a minimum, prescriptions for oral contraceptives could be filled for 90 days at a time, instead of for one month, as often required by insurance companies. In addition to the many family planning centers in the public sector that have distributed supplies months in advance,

many other clinics are now developing programs to provide longer supplies of hormonal contraceptives to prevent gaps in use or promote longer-term use. For example, Planned Parenthood's Easy Scripts Program mails birth control pills or the contraceptive patch to patients' homes every month so that they need not run to the pharmacy or a clinic for their refill. Women need only come to the office for their initial exam, and the prescription and mail-delivery program lasts for a year until their next annual exam. This program has been especially beneficial for women in rural areas, who may find it difficult to get to a distant clinic.

Another successful strategy has been Planned Parenthood's Pills Now Pay Later program. Women take home an advance 13-month supply of pills at their annual or HOPE exam, but then are billed automatically for a month supply once a month over the course of the year. According to an evaluation of this program, women experienced fewer gaps in contraceptive use than women with shorter supplies, and were 28% more likely than women with a three-month supply to continue use beyond 15 months.

Internet access is another new mode of service delivery that makes it possible to reach more groups of women. It allows certain family planning clinics to offer contraceptive services by screening women through an online health assessment and a follow-up call. For example, some Planned Parenthood affiliates permit clients to fill out a health history form and choose a contraceptive method online. In a subsequent telephone call to the client, a nurse answers questions and reviews the health history. Thereafter, the supplies are delivered to the woman's home, a prescription is called into a pharmacy or the supplies can be picked up in person at a health center. In addition, these women can refill their prescriptions online.

Breaking Barriers

The contraceptive convenience movement gained a major victory and took an important step forward when emergency contraception was approved for over-the-counter use in 2006. This move implicitly acknowledged the basic safety of

hormonal contraception, as well as the costs of the increased risk of unintended pregnancy created by time delay and the role of convenience in women's ability to contracept effectively. The gold standard for many advocates of contraceptive convenience, however, is untying prescriptions from "regular" oral contraceptive use and making pills available directly from a pharmacy—either entirely over-the-counter or "behind-the-counter," whereby a pharmacist could dispense pills after a basic client screening.

Needless to say, certain contraceptive methods, such as IUDs, will always require the intervention of a medical provider. Advocates argue, however, that because oral contraceptives are safe and efficacious, and have well-known benefits and low risks, conditions justify a move toward further demedicalization. They point to research showing that women can self-diagnose for risks, and point out that requisite testing for hypertension—the one clear contraindication for oral contraceptive use—could be accomplished by simpler means than a visit to a clinic or physician's office, such as at self-administered kiosks at pharmacies or by pharmacists themselves. The advantages would include lower costs from eliminating the expenses of a visit to a clinician, time-savings and convenience, and perhaps higher uptake and continuation rates.

Over-the-counter status, of course, would require an attendant revolution in product labeling, another area that is ripe for reform. Package labels often contain information based on either outdated data or concerns over litigation. The tendency to list all potential complications of a product undermines the need to highlight the most common or serious complications for patients. Moreover, labeling may not reflect the most recent medical advances for a product. Moving a product so that it is directly accessible to the consumer, without the benefit of instructions from a doctor, would necessitate that labels be made simple, comprehensible and accurate, as was done for emergency contraception. User-friendly product labels are essential instruments for reforming contraceptive service delivery so that contraceptives are more accessible, understood and used.

Anticipating Consequences

The demedicalization agenda is gathering steam, but it is not without serious concerns within the women's health community. Many fear that women of color, low-income women, young women and first-time contraceptive users might suffer under such moves. A strong fear is that removing the prescription requirement for oral contraceptives could make pills unaffordable for poor women, if it also resulted in the removal of private insurance and Medicaid coverage. Any efforts to push for over-the-counter status would need to resolve the cost issues that marginalized populations would be facing.

Eliminating the need to go to doctors or family planning clinics for oral contraceptives could also jeopardize access to other preventive health services normally provided to women during their visits as part of the family planning "package." This consequence could disproportionately affect minority communities, where rates of ethnic and racial disparity in illnesses and treatment could be further aggravated. In the same vein, concerns linger about self-screening for hypertension, which is found at higher rates among some minority populations. Dislodging contraception from an institutionalized network of family planning and preventive health care programs could create a whole new set of problems and disparities.

There is also a fear that an important opportunity for counseling and checking-in with patients will be lost by providers. Such concerns skirt a larger problem with how counseling is generally conceptualized and delivered, and provoke a need for health care providers to develop an alternative approach to patient counseling—one that views it as a continual process rather than a one-time event. Visiting a health care provider and choosing the right contraceptive method is just the first and perhaps easiest step in practicing contraception. Providers need to offer more support to women who are trying to adhere to a long-term regimen of contraceptive use. According to Guttmacher research, although most providers discuss a range of topics during an initial patient visit, substantially less counseling occurs as part of standard patient protocol

for second or later visits. For example, at subsequent visits, only 41% of family physicians and 58% of obstetrician-gynecologists discussed correct and consistent method use, and fewer than half of providers always discussed life changes or difficulties with their patients. However, as evidenced by research, women's contraceptive needs and methods are constantly evolving, and such fluctuation necessitates additional and sustained attention to counseling of patients.

Demedicalization is not an either/or proposition, whereby counseling should be sacrificed in the process of tearing down unnecessary medical walls. Rather, women need ongoing support from their doctors, and this counseling is one of many support mechanisms that should be available to women throughout their lifetimes.

Redefining Responsibility

While much of the current debate surrounding contraceptive convenience focuses on tearing down medical barriers, this movement carries a bigger agenda. There are indeed a slew of non-medical measures that need to be pursued to truly make contraceptives easier for women to obtain and easier for them to use. One of the most important of these is to create a fundamental shift in societal attitudes toward contraception, so that users will face fewer restrictions—and more support.

Because some may criticize the notion of "convenience" in this context, it is worth emphasizing that making access and use easier is not trivializing an important reproductive health issue or promoting irresponsible attitudes or behavior—quite the opposite. By collectively making contraceptives simpler to obtain and use, society also makes it easier for women to better manage and care for their reproductive health in the face of a multitude of reasons and challenges that obstruct their ability to effectively and consistently practice contraception over their lifetime. Convenience in the area of contraception would be real, meaningful and practical support, which would enable women to avoid unwanted pregnancies, improve their health and better plan and pursue their lives. www.guttmacher.org