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Reproductive Life Plan Counseling and Effective Contraceptive Use among Urban Women Utilizing Title X Services

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A B S T R A C T

Background: Although the Centers for Disease Control and Prevention and the U.S. Office of Population Affairs recommend inclusion of reproductive life plan counseling (RLPC) in all well-woman health care visits, no studies have examined the effect of RLPC sessions on the decision to use effective contraception at publicly funded family planning sites. RLPC could be a particularly impactful intervention for disadvantaged social groups who are less likely to use the most effective contraceptive methods.
Methods: Using data from 771 nonpregnant, non–pregnancy-seeking women receiving gynecological services in the Cincinnati—Hamilton County Reproductive Health and Wellness Program, multinomial logistic regression models compared users of nonmedical/no method with users of 1) the pill, patch, or ring, 2) depot medroxyprogesterone acetate, and 3) long-acting reversible contraception (LARC). The effect of RLPC on the use of each form of contraception, and whether it mediated the effect of race/ethnicity and education on contraceptive use, was examined while controlling for age, insurance status, and birth history. The interaction between RLPC and race/ethnicity and the interaction between RLPC and educational attainment was also assessed.
Findings: RLPC was not associated with contraceptive use. The data suggested that RLPC may increase LARC use over nonmedical/no method use. RLPC did not mediate or moderate the effect of race/ethnicity or educational attainment on contraceptive use in any comparison.
Conclusions: In this system of publicly funded family planning clinics, RLPC seems not to encourage effective method use, providing no support for the efficacy of the RLPC intervention. The results suggest that this intervention requires further development and evaluation.

The United States experiences higher rates of unintended pregnancy than nearly every other nation of similar economic status (Finer & Zolna, 2011; Singh, Sedgh, & Hussain, 2010). These high rates are partly owing to high rates of unintended pregnancy among historically disadvantaged populations (Mosher, Jones, & Abma, 2012). An analysis of the 2006–2010 National Survey of Family Growth showed that never married women, younger women, and African-American women were at greater risk for unintended pregnancy than other women, in part because they used effective contraception less often (Jones, Mosher, & Daniels, 2012). Unintended pregnancy is a public health concern that disproportionately burdens individuals in marginalized social locations. With the recent increase in state-level restrictions on abortion access, it is increasingly important that women seeking to avoid pregnancy be empowered to choose from among the most effective contraceptive methods (Medoff, 2012).

Reproductive life plan counseling (RLPC) is a conversation between a medical service provider and a patient about how control of reproduction fits into a patient's future life plans (Centers for Disease Control and Prevention [CDC], 2006; Files et al., 2011). This discussion is meant to disambiguate pregnancy intention and render contraceptive decision making a discrete action with concrete risks and benefits. Thus, the RLPC session is meant to cultivate knowledge of pregnancy intention in the patient in an effort to guide the patient toward choosing

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the most effective contraceptive method for themselves. Although both the CDC and the U.S. Office of Population Affairs recommend that RLPC sessions should be a component of every well-woman visit, evaluation of the effectiveness of this intervention is lacking (Gavin et al., 2014).

In this article, we assess the effectiveness of RLPC among patients covered by Title X services in one Midwestern, U.S. city. Specifically, we examined whether the use of effective forms of contraception is associated with having received RLPC and whether RLPC decreases the education gap or the gap between Black and Latina women and White women in effective contraceptive use. Because federal and state agencies recommend RLPC, our analyses address an important policy question.

Effective Reversible Contraceptive Methods

There are currently numerous effective reversible contraceptive methods available to women in the United States. These methods can be categorized into three broad classes according to estimates of their typical use efficacy and mode of administration: 1) hormonal oral contraceptives, transdermal patches, and vaginal rings—requiring daily, weekly, or monthly maintenance, 2) depot medroxyprogesterone acetate (DMPA), an injectable contraceptive that must be administered every 3 months, and 3) long-acting reversible contraception (LARC), including the intrauterine device (IUD) and the subdermal implant, which last between 3 and 10 years after insertion, depending on the device. LARCs are the most effective reversible contraceptive methods available currently for women. These methods have typical use efficacy rates that are similar to female sterilization, and they can be easily reversed with rapid return to fertility (Hatcher et al., 2011). In addition, LARC methods have far fewer contraindications than many other types of contraceptive methods (American College of Obstetricians and Gynecologists, 2011).

Population estimates of the use of effective contraceptive methods, including all three classes mentioned, differ by race/ethnicity and socioeconomic status. Jacobs and Stanfors' (2013) examination of the 2006–2010 National Survey of Family Growth found that Black, and to a lesser degree Latina, women were less likely than White women to utilize effective hormonal contraception. Examining factors affecting contraceptive use from the 2006–2010 National Survey of Family Growth, Dehlendorf et al. (2014b) found that women with at least some college education had significantly higher odds of choosing any effective contraceptive method over no contraceptive method when compared with women who had less than a high school diploma. Additionally, Jones et al. (2012) found that a lower percentage of women at risk of unintended pregnancy with less than a high school diploma chose IUDs when compared with more highly educated women. It is important to note that racial/ethnic differences exist in patterns of contraceptive use among methods of relatively equivalent efficacy as well. For example, Dehlendorf et al., (2011) found that Black and Latina clients in California's family planning program for low-income women were less likely to use oral contraceptives, vaginal rings, and LARC methods than White women, but more likely to choose patches and DMPA. Despite variation in patterns of individual method use, this body of research suggests that disadvantaged racial/ethnic status and low educational attainment is generally associated with women using nonmedical methods or no contraception at all.

Racial and socioeconomic status differences in contraceptive use patterns can be attributed to social, cultural, and economic processes that influence contraceptive choice. First, knowledge about the availability, safety, and reliability of effective contraceptive methods depends on a potential user's relationships with other women who have used or continue to use these methods and the potential user's level of social support for the use of these methods (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006; Teal & Romer, 2013). Second, as with other medical interactions (Shim, 2010), contraceptive counseling over effective method use requires negotiation between the provider and patient to develop shared understandings about efficacy and uses for these complex technologies. Thus, provider–patient interactions play a critical role in an individual's decision to use an effective contraceptive method (Dehlendorf, Kimport, Levy, & Steinauer, 2014a; Kavanaugh, Frowirth, Jerman, Popkin, & Ethier, 2013). Finally, because effective contraceptive methods can have prohibitively high up-front costs, economic capital is an important factor in considering certain methods over others (Dennis & Grossman, 2012; Trussell, Hassan, Lowin, Law, & Filonenko, 2015).

Public health interventions designed to increase usage of effective contraceptive methods focus on two domains: reducing economic barriers and cultivating knowledge of the benefits of effective contraceptive use through patient education. Interventions that reduce the cost of contraception have been successful in increasing use of effective contraceptive methods (Foster et al., 2011; Secura et al., 2014). The helpfulness of efforts to cultivate knowledge of contraceptive methods is less clear. One route to improve knowledge of contraceptive options is through the process of RLPC in the provider–patient interaction. During RLPC, providers attempt to take a life-course perspective toward the reproductive health of their patient. The patient is asked to think about pregnancy intention, future life goals, and the role of reproduction in those life goals. The results of this conversation allow for the provider to suggest medical and nonmedical interventions to either facilitate a healthy pregnancy or prevent pregnancy from occurring. If the patient is not seeking pregnancy, the provider is expected to discuss various contraceptive options starting from the most effective methods that do not have medical contraindications (usually LARCs) and going down the list of methods based on 1-year typical use efficacy estimates. The effectiveness of RLPC is unknown.

Social factors may impede or improve the effectiveness of RLPC. First, the race and class of a patient has an effect on what happens in the doctor–patient interaction. Racial/ethnic minorities and less educated patients often report worse experiences than White and highly educated patients in health care interactions (van Ryn et al., 2011). In addition, patients are less likely to adopt medical technologies, particularly newer ones, when they lack social and cultural knowledge of the services being offered (Phelan, Link, & Tehranifar, 2010). Additionally, given the unjust racial history of public family planning efforts in the United States (Roberts, 1997), contraceptive counseling interactions with health care providers may be interpreted differently depending on the race/ethnicity of the patient or provider.

We are aware of no study that describes how RLPC from health care providers influences effective contraceptive use, whether it has similar effects for all racial/ethnic and education groups, and whether it decreases racial/ethnic and educational differences in contraceptive use. Our sample from a publicly funded health system that minimizes the cost of contraceptive access allows an analysis that focuses on the effect of counseling free from of economic barriers.