JNP

Meeting Contraceptive Needs of College Students: Bringing Evidence Into Practice

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ABSTRACT

A pilot study assessed whether clinicians at an urban college health center met the reproductive needs (emergency contraception and contraception) of students. Physicians and nurse practitioners completed a 5-item survey about prescribing emergency contraception and contraception. Clinician prescribing practices varied, which may have resulted in contraceptive needs (for some students) not being met in a timely manner. Clinicians had different understandings of policies about prescribing contraceptives when on-call, when students called in, and for students who had graduated. Education and policies about handling EC and contraception requests are necessary so that clinicians meet students' reproductive health needs.

Keywords: college health, contraception, emergency contraception, reproductive needs

Meeting college students' contraceptive needs (birth control and emergency contraception) is an essential function of college health services. About 80% of college-aged students are sexually active.[1] Approximately 99% of sexually active women aged 15-44 have used at least 1 contraceptive method to prevent pregnancy. Hormonal contraceptive methods (pill, patch, implant, injectable, and vaginal ring forms), intrauterine devices (IUDs), and condoms are widely used. Hormonal methods are most commonly used.[2] However, there are still misperceptions among clinicians about when to start or refill birth control. Many clinicians adhere to older standards in which Papanicolaou tests (Pap) and breast exams are required before initiating birth control, and that blood pressure (BP) checks are necessary before refilling hormonal contraception.[3] Emergency contraception (EC) is a safe and effective strategy to prevent pregnancy. However, clinicians are often wary about prescribing EC because of their limited knowledge or negative attitudes about this form of contraception.[4]

Most sexually active women aged 15-44 have used emergency contraception after unprotected intercourse or a contraceptive failure.[5] College students at a single university campus were surveyed about their knowledge of EC. Students indicated their preferred sources to obtain information about EC were physicians (41%) and then community/campus clinics (33%).[6] However, clinician attitudes about prescribing EC may inadvertently make it difficult for women to obtain EC in a timely manner.[7] Likewise, misconceptions about EC (mechanism of action, safety of repeated use, and promoting risky behavior) contribute to prescribing barriers.[8]

Plan B One-Step (levonorgesterel [Teva Pharmaceuticals. North Wales, PA]) or ella (ulipristal acetate [Afaxis, Charleston, SC]), the "morning after pill," is taken when unprotected sex has occurred. Plan B is effective up to 3 days after unprotected sex, whereas ella is effective up to 5 days of unprotected sex (or 120 hours).[9] Plan B One-Step does not require a prescription if age 15 or older,[10] whereas ella requires a prescription regardless of age.[11] Because the 2010 Affordable Care Act mandates that contraceptive methods be covered without cost or with only a small co-pay,[12] a prescription for EC (Plan B or ella) ensures minimal cost to the patient. In addition, providing EC prescriptions with refills ensures that women can use EC in a timely manner as well as giving them control of their contraceptive and reproductive needs.

The United States Department of Disease Control and Prevention updated the *Practice Recommendations for Contraceptive Use* in 2013. These guidelines set eligibility criteria for contraceptive use. The guidelines recommend that healthy women can initiate

most contraceptive methods (hormonal oral contraception, IUD, vaginal ring, implant, and injectable) at any time. Few exams and tests are needed when initiating hormonal contraception (BP check) and inserting IUDs (bimanual exam and cervical inspection). Implant, injectable, and progestin-only pill contraception do not require any exams or tests. After beginning contraception, previously recommended routine follow-ups (3-6 months) are generally not required. Further, in circumstances that require EC, some form of continuous contraception should be started immediately after EC. The copper IUD is an effective EC method if inserted within 5 days after having unprotected sex.[13]

Knowing whether clinicians are meeting the reproductive needs of college students is necessary to ensure that students do not encounter barriers when requesting EC or other contraceptive methods. When clinicians do not prescribe EC or contraceptives, limit the number of refills, or request that students receive prescriptions in person, these women may experience unintended pregnancies or other adverse side effects.

This pilot study was undertaken to examine whether physicians (MDs) and nurse practitioners (NPs) working at a college health center prescribed EC and contraception in ways that would meet the reproductive health needs of students.

STUDY ENVIRONMENT

Students are seen for reproductive issues by MDs and NPs at a large urban college health center. Clinicians address contraceptive requests in-person, by e-mail, or by telephone. When on-call (after hours and weekends), MDs and NPs are expected to handle contraceptive matters by telephone. In addition, clinicians have remote access to electronic health records and therefore have the pertinent medical information needed to make prescribing decisions about EC and contraception requests. Clinicians are scheduled for on-call (for 1 week) approximately 3-4 times a year.

EC prescriptions are commonly requested by students. In 2010, there were 99 visits in which the diagnosis was postcoital contraception and 261 prescriptions were written for EC. In 2011, there were 85 visits in which the diagnosis was postcoital contraception, with 202 EC prescriptions written. As of February 9, 2012 (the day the survey was given to the clinicians), there were 14 EC prescriptions written.

METHODS

Design

The researcher (staff NP) developed a pilot study to determine whether clinicians were meeting the reproductive needs (EC and contraception prescriptions) of college students. The researcher developed a 5-item survey (consisting of yes-no responses and a comment section to explain responses) asking MDs and NPs about prescribing EC and contraception. The survey questions were: (1) Do you prescribe Plan B with refills? (2) Do you prescribe Plan B when condoms are the sole form of contraception? (3) Do you prescribe contraception when on-call? (4) Do you prescribe contraception when the student calls the health center? (5) Do you prescribe contraception to students who have graduated? Clinicians were asked to explain their "no" responses in the comment section (several also explained "yes" responses). The survey only asked about Plan B, because, at the time of the study, the clinic stocked this EC brand.

Participants

The sample consisted of 14 clinicians (7 MDs and 7 NPs).

Data Analysis

The yes-no responses were tabulated (frequency count). The comments were used to shed light on why MDs and NPs prescribed or did not prescribe EC or contraception. The entire comment section is provided in the Results section. Comments were edited for clarity purposes (edits are shown in brackets).

RESULTS

Plan B Prescriptions

Most clinicians (8) prescribed Plan B with refills. Most prescribed 1 refill and 1 clinician prescribed 6 refills. Clinicians who did not give refills commented:

I don't hold the above belief very strongly, but it seems that since our services here are highly accessible, patients