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# Differences in contraceptive use between family planning providers and the U.S. population: results of a nationwide survey

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**Abstract**

**Objectives:** To describe contraceptive use among U.S. female family planning providers and to compare their contraceptive choices to the general population.

**Study design:** We surveyed a convenience sample of female family planning providers ages 25–44 years, including physicians and advanced practice clinicians, via an internet-based survey from April to May 2013. Family planning providers were compared to female respondents ages 25–44 years from the 2011–2013 National Survey of Family Growth.

**Results:** A total of 488 responses were eligible for analysis; 331 respondents (67.8%) were using a contraceptive method. Providers' contraceptive use differed markedly from that of the general population, with providers significantly more likely to use intrauterine contraception, an implant, and the vaginal ring. Providers were significantly less likely to use female sterilization and condoms. There were no significant differences between providers and the general population in use of partner vasectomy or the pill. Long-acting reversible contraception (LARC) use was significantly higher among providers than in the general population (41.7% vs. 12.1%, $p<.001$). These results were consistent when stratifying by variables including self-identified race/ethnicity and educational level.

**Conclusions:** The contraceptive choices of this sample of female family planning providers differed significantly from the general population. These findings have implications for clinical practice, patient education, and health policy.

**Implications:** Family planning providers report higher use of LARC than the general population. This may reflect differences in preferences and access. Providers might consider sharing these findings with patients, while maintaining patient choice and autonomy.

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## 1. Introduction

For three decades, it has been widely cited that female physicians choose intrauterine contraceptives (IUCs) at a higher rate than the general population [1,2]. A 2012 international study of physicians and midwives generated similar findings, with 36.9% reporting use of an IUC [3]. Various factors, including contraceptive access and knowledge, have been suggested to explain providers' higher use of these methods.

Since previous U.S. provider surveys were conducted, new contraceptive methods — including the vaginal ring, the patch and two levonorgestrel IUCs — have become available. Long-acting reversible contraception (LARC), consisting of IUCs and implants, has also received considerable attention in recent years. More evidence about the efficacy and safety of LARC methods has been generated; clinical guidelines have changed; and the use of these methods has increased [4,5]. The makeup of the medical field has also changed; Over 70% of obstetrician-gynecologist residents are now female, and a broader range of providers, including nurse practitioners, nurse-midwives and physician assistants, deliver contraceptive care [6–9]. In light of these intersecting trends, this study aimed to update

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previous research findings and incorporate additional types of providers.

Research also suggests that women may be receptive to clinician self-disclosure of her personal contraceptive method in some circumstances, and patients commonly ask their provider what method she is using [10,11]. The present study seeks to fill a gap in current knowledge about providers' own contraceptive preferences. We describe contraceptive use among a nationwide sample of family planning providers, including physicians, advanced practice clinicians and others who deliver contraceptive care. Findings are compared to data from the most recent National Survey of Family Growth (NSFG), a nationally representative survey [12]. We hypothesized that family planning providers would report higher use of LARC methods than women in the general population.

## 2. Materials and methods

We conducted an anonymous online survey between April and May 2013. Data collection and reporting followed the checklist for reporting results of internet e-surveys (CHERRIES) and the guidance of the ACCADEMY group [13,14]. The study protocol was reviewed by Asentral Institutional Review Board and determined to be exempt.

Survey questions were designed to mirror those asked in the NSFG. Prior to distribution, the survey instrument was pilot tested among 15 female family planning providers. The survey was programmed in the secure Qualtrics electronic survey platform (Qualtrics, LLC, Provo, UT). Adaptive questioning and branching were utilized; depending on a participant's responses, questionnaire length ranged from 12 to 26 pages, with 1–6 questions per page. Most respondents completed the survey in less than 10 min.

Eligible participants included female family planning providers ages 25–44 years who had ever used contraception and were willing to complete the survey. Sample size calculations were performed a priori. We calculated that a sample size of 500 was sufficient to detect a 10% difference in LARC use between providers and the general population with 95% power. We employed purposive sampling to target family planning providers [14]. The survey was distributed by e-mail to lists maintained by the Fellowship in Family Planning, the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning, the National Association of Nurse Practitioners in Women's Health, the National Clinical Training Center for Family Planning, Planned Parenthood Federation of America and the Society of Family Planning. These lists were chosen to reflect a broad group of family planning providers across the U.S., incorporating physicians and advanced practice clinicians and ranging from trainee to expert level. Together, these e-mail lists included approximately 4000 e-mail addresses. The survey was also made available at a kiosk at the 2013 National Abortion Federation annual meeting. Eligible participants received a $25USD gift card for completing the survey.

All data were encrypted, both during transmission and at rest. Algorithms built into the survey platform ensured that data were internally consistent and that no required data elements were missing. Additionally, the survey platform determined that each site visitor was a unique participant and required a combination of unique respondent identifiers to minimize duplicate responses. We stopped data collection once the required sample size was reached in order to preserve the predetermined level of statistical power.

We used univariate statistics to describe the demographic and professional characteristics of the study population. We calculated the proportion of family planning providers who currently used a contraceptive method. Among these current contraceptive users, we calculated the proportions that used each of the following methods: implant, IUC, partner vasectomy, female sterilization, contraceptive pills, patch, 3-month injectable, vaginal ring, condoms, natural family planning and other (e.g., withdrawal, diaphragm). Respondents could indicate use of multiple contraceptive methods. For those using two or more methods ($n$=39), we assigned the most effective method using published contraceptive failure rates [15]. We used chi-square tests and multivariable logistic regression to examine the associations between select provider characteristics and use of LARC.

We used population-weighted data from the 2011–2013 NSFG to estimate current contraceptive use in the general population. Detailed methodology for the NSFG data collection has been previously published [16]. To maximize comparability with our sample, we restricted NSFG respondents to those ages 25–44 years.

We further examined contraceptive method use among family planning providers and the general population within strata of race/ethnicity, advanced degree (graduate, doctoral or professional degree vs. college degree or less), age, parity and completion of childbearing. We focused on LARC and two other contraceptive methods with the most substantial differences in use between family planning providers and the general population (female sterilization and the vaginal ring). We used two-sample tests of proportions to assess differences in contraceptive method use between family planning providers and the general population and calculated prevalence ratios (PRs). Due to the distinct designs of our survey (convenience sampling) and the NSFG (complex survey sampling) that necessitated the application of sampling weights to NSFG data only, we did not conduct pooled multivariable analysis. We used two-tailed tests of significance; $p<.05$ was considered significant. State SE version 13 (StataCorp LP, College Station, TX) and IBM SPSS 21.0 (IBM Corporation, Armonk, NY) were used to perform the analyses.

## 3. Results

A total of 1699 participants completed eligibility screening. Of those, 1082 did not meet inclusion criteria: 70% were outside of the target age range or did not provide a valid age, 24% did not identify as a family planning provider

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