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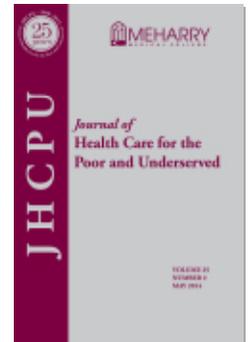
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## Disparities in Contraceptive Care

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As providers who work in Harlem, caring for many women of reproductive age, we have been troubled by the difficulties we see in our patients' efforts to succeed in using contraception. This brought us to think about *Sankofa*—the West African (Akan) symbol representing the importance of examining the lessons of our past in order to reach the full potential of our future. To eliminate health disparities in reproductive health, we must work to understand their history. In this article, we aim to investigate the social, economic, and cultural influences that affect reproductive health, and our role as providers in helping patients overcome barriers.

The cases described below provide a glimpse into two patients' lives and the varying influences on their contraception choices.

### Case #1

Ms. B.G. is a 43-year old African American woman with hypertension who came into our community health center with misgivings about her current contraceptive method. She had recently been switched from combined oral contraceptive pills to progestin-only pills because of her blood pressure. She was frustrated with the side effect of irregular uterine bleeding. The spotting bothered her and negatively affected her sex life, but she and her partner did not want to risk a late-life pregnancy. In her 20s, after the birth of her three children, she had repeatedly sought a tubal ligation as she had borne all of the children she wanted in life. Her request was denied because she was "too young." In our discussion, Ms. B.G. refused to even talk about an intrauterine device (IUD), as she was against anything that would need to be inserted into her "female parts." She and her partner had discussed a vasectomy, but he had not agreed to this. Her best friend had recently gotten the subdermal implant, Nexplanon, so she asked me [VW] for more information about it.

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### Case #2

Ms. L.S. is a 19-year-old college student in Manhattan. I [GB] met her during a group contraception visit at her school. She is a second-generation Puerto Rican American and is the first person in her family to go to college. She wants to be a lawyer. She told me that she recently started having sex with her boyfriend of three years and has never been on birth control. She comes from a big family and never wants children. She requests birth control that will not affect her periods because her mother monitors her pads at home. She heard “the IUD hurts and can rupture your uterus.” Her aunt told her that the implant in your arm is a bad idea because she had trouble getting hers removed in the past. The pastor in her church says that emergency contraception is like having an abortion. She felt very bad about having sex before marriage and definitely did not want to get pregnant.

### Reproductive Health Disparities—The Facts

The Guttmacher Institute reports wide differences in the rates of unintended pregnancy, abortion, and unplanned births based on the race and ethnicity of U.S. women of reproductive age (see Figure 1).<sup>1</sup>

Specifically, contraception care statistics demonstrate:

- 83% of Black women at risk of unintended pregnancy (i.e., having sex with men when not purposely trying to conceive) currently use a contraceptive method, in comparison to 91% of their Hispanic and White peers and 90% of Asian women.<sup>2</sup>

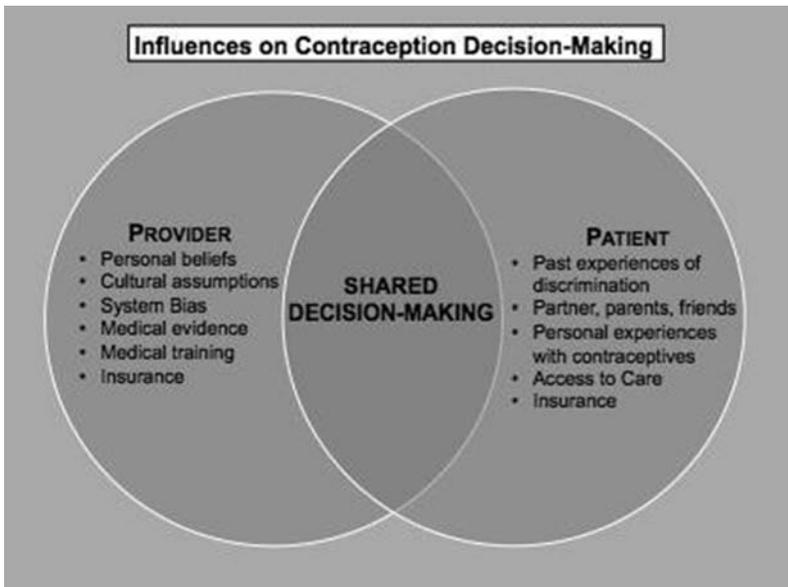


Figure 1. Influences on contraception decision-making.

- 92% percent of women at risk of unintended pregnancy with incomes of 300% or more of the federal poverty level are currently using contraceptives, compared with 89% among those living at 0–149% of the poverty line.<sup>2</sup>
- Female sterilization is most common among Blacks and Hispanics, women living below 150% of the federal poverty level, women with less than a college education, and women that are publicly insured or are uninsured.<sup>2</sup>
- Vasectomy prevalence is highest among White men (9.1%) and lower among Blacks (2.4%), Hispanics (2.1%), and men reporting themselves as belonging to another race/ethnicity (3.1%). The prevalence of vasectomy increases with income, education level, and regular access to health care.<sup>3</sup>

One concern about the racially skewed distributions of vasectomy and sterilization is that the former is safer and less expensive while tubal sterilization has higher complication rates and is more expensive.<sup>3</sup> The benefit of successful contraception throughout the reproductive years includes achieving desired family size and providing the opportunity for an individual or couple to complete educational goals and participate in the workforce, improving family income. Low-income and minority women are less likely than higher-income White women to have effective contraception. A closing of the contraception use gap can help promote societal and economic development for women and men.<sup>4</sup>

## The History of Eugenics and Forced Sterilizations

The history of reproductive health care delivery in the United States is marred by its association with the eugenics movement. In the late 19th and early 20th centuries, the eugenics movement aimed to limit the birth rate of certain groups: the poor, prisoners, immigrants, African Americans, Latinos, “promiscuous” women, and the mentally ill or “feeble-minded” through government-sponsored sterilizations.<sup>5–8</sup> Eugenacists argued that society was being overrun by these “unfit” groups, and that it was imperative to reduce their numbers so there would be a greater proportion of people who were “fit.”<sup>8</sup> By the 1930s more than half of the states had involuntary sterilization laws.<sup>7</sup> Sterilizations were often court-ordered.<sup>6</sup> These laws were part of a larger set of Progressive Era laws that were intended to eradicate social ills and improve public health.<sup>5</sup>

Involuntary sterilizations continued into the 1960s and 1970s, with the focus shifting from reducing what were seen as inferior genetic traits, to reducing welfare dependency, overpopulation, “inferior” parenting, and illegitimate births.<sup>5</sup> As a result of the Family Planning Service and Population Research Act of 1970, federally-funded family planning clinics opened with the goal of providing low-income people with family planning services, with a large proportion of these clinics opening in African American communities.<sup>5,8,9</sup> The imperative to reduce the number of welfare beneficiaries and control the fertility of women of color persists even today.<sup>6,7</sup> On the other side of the controversy, some female African American leaders welcomed the clinics as a means of freeing women from unwanted births.<sup>9</sup>

The legacy of eugenics is evident in studies that have shown that Black and Hispanic women are more likely than White women to think that the government uses

contraception to reduce minority populations.<sup>10</sup> Women who self-report experiencing personal discriminatory treatment use less effective methods of contraception than women who have not experienced discrimination.<sup>11</sup> Women of color may have a greater level of distrust in medicine in general.<sup>12</sup> Sensitivity to this historical context can help to improve contraceptive counseling.

## **Role of Economic and Insurance Disparities in Access to Contraception**

The United States remains rife with health disparities across demographic lines, including race, ethnicity, gender, socioeconomic status (SES), educational attainment, and disability.<sup>13</sup> For example, Blacks and Hispanics disproportionately carry a higher disease burden, have less access to financial resources, and consistently have less access to quality care in comparison with Whites; such disparities are often intertwined with differences in socioeconomic status.<sup>12–15</sup>

In the United States, approximately 16% of the population is uninsured,<sup>16</sup> and certain groups, such as people of color and low-income individuals, are more likely to be uninsured and face barriers to accessing quality health care than other groups,<sup>13,16,17</sup> although these numbers are now in flux due to increasingly widespread implementation of the Patient Protection and Affordable Care Act (ACA) of 2010.<sup>14</sup> Importantly, contraceptive options differ by cost: long-acting reversible contraceptives (LARC) are the most effective form of birth control, but have high up-front costs for the devices as well as fees for insertion.<sup>18</sup> One large study found that when barriers to cost were not an issue, 67% of the women in the study chose LARC as their form of birth control.<sup>11</sup>

Regarding the ACA, it is important to note that approximately half of the states opted out of creating health insurance exchanges and are not participating in Medicaid expansion; these opt-out states disproportionately house many of the U.S. poor.<sup>19</sup> While the ACA's contraceptive coverage mandate has increased access to contraceptives without a copayment,<sup>20</sup> many states have enacted refusal clauses that allow religiously-affiliated institutions not to provide this coverage.<sup>21</sup> Furthermore, the ACA does not provide insurance access to undocumented immigrants, leaving 11.7 million people to get health care with their own finances, if at all.<sup>22</sup> Thus, the promise of the ACA to bring contraceptive access to *all* US women will likely not be met.

## **The Impact of Provider and Patient Bias**

In addition to economic and insurance barriers, patients may face provider bias. Implicit bias—prejudices acted upon unconsciously—occurs in health care settings.<sup>23</sup> The Institute of Medicine's historic 2003 report revealed that provider attitudes of “bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers” contribute to health disparities.<sup>24</sup><sup>[p.8]</sup> Multiple studies have documented provider bias against African Americans and people from lower socioeconomic groups.<sup>23,25–29</sup> Dehendorf *et al.*<sup>29</sup> demonstrated disparity based on socioeconomic status, in which poor Whites were less likely to be prescribed highly effective contraception than Whites of higher socioeconomic status. Racial variation in tubal sterilization rates documented

misinformation about sterilization and limited awareness of contraceptive alternatives among African American women.<sup>30</sup> African American women were more likely to have a family member who had undergone tubal sterilization and more often thought that sterilization reversal could easily restore fertility. This degree of misinformation in a patient population can be seen as a failure of the medical community in securing informed consent for sterilization.

A legacy of abuse in the U.S. medical system, only partially discussed above, has led to continued distrust and “conspiracy beliefs” about the intentions of contraception. In recent years, a substantial number of African American women and men surveyed by Thorburn and Bogart<sup>31</sup> cited fear of genocide and government manipulation as reasons as to why they strategically avoided use of contraception, especially methods that were more dependent on insertion or delivery by health care providers.<sup>31</sup> Benkert *et al.*<sup>32</sup> found that Black patients who perceived racism in their lives were less likely to trust their physicians, which resulted in lower patient satisfaction.

### **Involving Men in Reproductive Health Discussions**

As primary care physicians who treat families, we have a unique opportunity to include men in the discussion of contraceptive options. Many women tell us that their partners influence their choice of birth control. One study done on racial and ethnic differences in men’s knowledge of contraception found that Black and Hispanic men were less knowledgeable about most forms of birth control than White men.<sup>33</sup> A meta-analysis of men’s attitudes found a very wide range of beliefs that were heavily influenced by culture and background.<sup>34</sup>

Whether or not to include the male partner in the discussion of contraception is a complex choice for many women. Among young women who are finding their way towards independent decision-making about so many aspects of their lives, coercion by partners can be a serious problem. As physicians, we do not want to reinforce dominance. On the other hand, we want our patients to be successful at contraception if they are not ready to bear children, which may require cooperation from their partner. If their partners will undermine their choices (“I need my IUD removed, my boyfriend doesn’t like it”), then perhaps participation from the partner should be sought. In the end, the contraceptive visit must be carefully tailored to each individual, and perhaps more community education with men would be a valuable approach to improving their contraception knowledge.

### **Eliminating Disparities: A Patient-Centered Approach**

Any attempt to overcome disparities must address numerous concerns, ranging across societal level, the medical system level, and the individual level. At the societal level, expanding insurance coverage and access to care<sup>12</sup> and recognizing how societal forces may contribute to patient decision-making is extremely important.<sup>6</sup> At the level of the individual, much can be gained by acknowledging and confronting providers’ own biases, both implicit and explicit.<sup>23,29</sup> This includes bias training for medical students, residents, and providers that develops culturally competent skills and individual “self-regulation

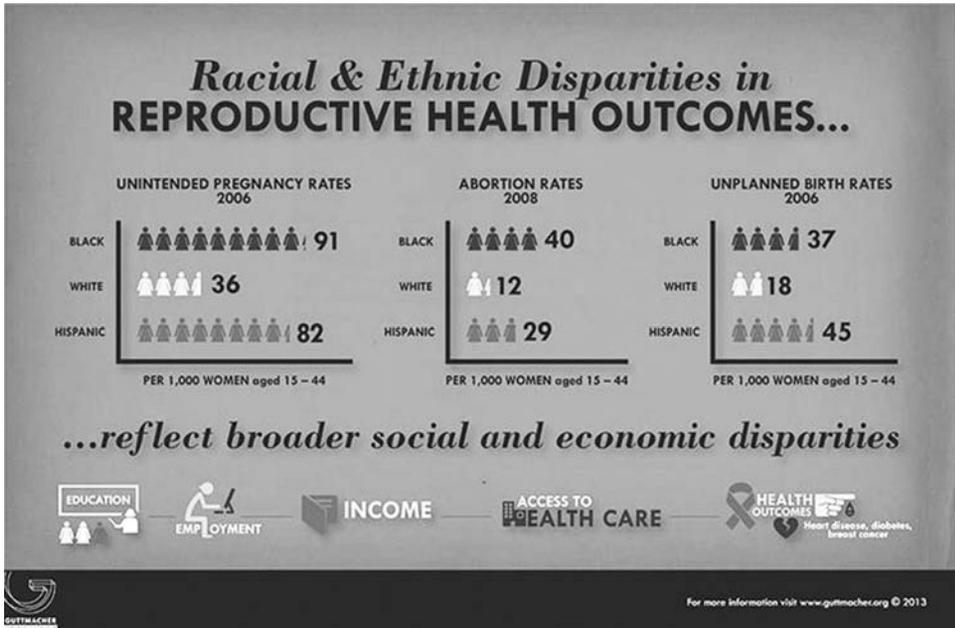


Figure 2. Racial and ethnic disparities in reproductive health outcomes.

and behavioral” skills that allow the provider to become aware of when they are being biased towards patients.<sup>23,26,28,35</sup> By doing this, providers can create a non-biased and non-judgmental environment for patients, acknowledge patient preferences, and create an individualized approach to each patient.<sup>36</sup> Suggested ways to decrease provider bias at the medical system level include increasing the diversity of the medical workforce and teaching the importance of health equity to those at the beginning of their training.<sup>23,26,35</sup> This is important because despite extensive studies proving that discriminatory practice plays a role in health care disparities, “only 55% of White physicians agree that minority patients receive lower quality of care than White patients.”<sup>23</sup> Continuing with the theme of Sankofa, providers must understand the presence, history, and impact of discrimination *before* delving into these complex conversations with patients. By confronting the past and embracing the future, we hope that disparities in contraception care can be eliminated, one shared decision at a time.

**Conclusion of Case #1**

After counseling about the side effects, including irregular periods, Ms. B.G. had a nexplanon inserted. She left the office satisfied with her choice of long-acting contraception. She actually used the word “long-acting” to describe her choice, which she felt fit her needs quite well.

## Conclusion of Case #2

Ms. L.S. and I [VW] reviewed all of the methods carefully, using a handout from the web with pictures and a brief description of the pros and cons of each method ([http://www.reproductiveaccess.org/fact\\_sheets/bc\\_choices.htm](http://www.reproductiveaccess.org/fact_sheets/bc_choices.htm)). She went back and forth between the pill and the patch (putting the ring in her vagina didn't seem like something she wanted to consider doing). I reassured her that she could try one and then come back to me or write to me through our medical record system's patient portal. She finally decided on the patch because she thought she'd be less likely to forget to change it weekly than she would be likely to forget a daily pill. I also gave her an advanced prescription for the emergency contraceptive (EC) pill, *ella*, in case she did forget to place her patch. She hoped she would not need the *ella*, especially given her pastor's view of EC, but she preferred the prospect of using it to getting pregnant. I hope our partnership will continue.

## Notes

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