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IN THE LITERATURE

Seeking Causes for Race-Related Disparities in Contraceptive Use

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Rocca CH, Harper CC. Do racial and ethnic differences in contraceptive attitudes and knowledge explain disparities in method use? *Perspect Sex Reprod Health*. 2012;44(3):150-158.

About 6.5 million pregnancies occur annually in the United States. Of these, roughly half are unplanned, a percentage that has remained relatively steady for decades [1]. This is, as the American College of Obstetricians and Gynecologists (ACOG) has noted, a public health crisis [2]. Studies have suggested that unplanned pregnancy is associated with poorer maternal and infant health outcomes [3]. In addition, while unplanned does not necessarily equate to unwanted, we do know that approximately half of unplanned pregnancies end in abortion [1]. Unintended pregnancies also place a significant financial burden on the public sector: estimates regarding the birthing costs alone for unplanned pregnancy supported by public funding totaled over 11 billion dollars in 2006 [4].

Planning for pregnancy is important to optimize not only clinical outcomes, but also the context and the circumstances surrounding the pregnancy. Since the typical American couple wants to have two children, and most women are fertile for three or four decades, most women, even those who intend to have children, will spend around 30 years trying to avoid pregnancy [5]. A person's choice of contraceptive method and rates of continuation are directly related to the risk of becoming pregnant. It is not surprising that higher rates of unintended pregnancies occur among those using less effective forms of contraception or no contraception at all [6]. Physicians, therefore, have a responsibility not only to help women plan pregnancies but also to aid in the prevention of unplanned pregnancies.

Which Contraceptives Are Best?

Collectively, contraceptive-dispensing implants and intrauterine devices (IUDs) are referred to as long-acting reversible contraceptives (LARCs). LARCs offer several advantages over all other methods of contraception. Because they are placed (either in the uterus or under the skin) by a health care professional, their effectiveness does not rely on the user. LARCs have the lowest failure rates of available reversible contraceptive methods, are effective from three to ten years, and provide a quick return to fertility when discontinued [7]. Implants and IUDs are not new technologies, but current iterations have improved their side-effect profiles and made them more desirable.

The American College of Obstetrics and Gynecology recommends that physicians consider LARCs the first-line contraceptive method for most women [2]. LARCs are not right for every woman, but there are very few contraindications.

Contraceptive Use in the United States

Women are highly motivated to use contraceptives, and the great majority of women do. More than ninety-nine percent of women who have ever had sex have used a method of contraception at some point [8]. Unfortunately, despite a growing body of evidence that LARCs are safe and highly effective (with a failure rate of less than 1 percent) and can be used by almost any woman, adoption of LARCs remains low. The majority of US women using a reversible contraceptive method are using oral contraceptive pills or condoms, which have 9 percent and 18 percent typical failure rates, respectively [9, 10]. In 2009 only 8.5 percent of US women at risk of becoming pregnant reported using LARCs. The trend, however, is promising: six years earlier, only 2.4 percent of US women were using LARCs [11], and the Affordable Care Act's reduction of financial barriers to using LARCs may contribute to a significant increase in their use.

Does Race Influence Choice of Contraception Method?

Race-related disparities exist in the choice of birth control methods, with women of color generally using less effective methods. Black women are more likely than white women to report using a contraceptive method associated with lower efficacy (e.g., withdrawal, condoms) or no contraception at all [6]. They are, therefore, three times as likely as white women to experience an unintended pregnancy. Hispanic women, too, are less likely to use highly effective forms of contraception (LARCs and hormonal methods) and twice as likely to experience unintended pregnancy as are white women [12].

We do not fully understand whether or how race influences contraceptive choice and subsequently contributes to disparities in unintended pregnancy rates. If we were able to identify the factors that inform women's choices about contraception, efforts aimed at addressing those factors might significantly reduce disparities in the use of the most effective forms of contraception and thus reduce the rates of unintended pregnancy.

In 2012, researchers from the Bixby Center for Global Reproductive Health sought to investigate a possible relationship between race and contraception-related choices and summarized their work in "Do Racial and Ethnic Differences in Contraceptive Attitudes and Knowledge Explain Disparities in Method Use?" [13]. Using data collected in the 2009 National Survey of Reproductive and Contraceptive Knowledge, the authors found significant racial differences in attitudes about contraception, pregnancy, and control over one's fate (fatalism).

They found that blacks and Hispanics were more likely than whites to believe that the government encourages contraceptive use to limit minority populations and that Hispanics were more likely to report positive feelings about an unplanned pregnancy

than blacks or whites. Their study did not, however, find an association between these attitudes and contraceptive choice.

The only attitude they found that consistently influenced contraceptive choice was skepticism that the government ensures contraceptive safety. This belief was associated with decreased use of highly effective forms of contraceptive methods, but it was equally prevalent among the members of all racial groups studied. Ultimately, the findings did not suggest that racial differences in attitudes about contraception, pregnancy, and fatalism were responsible for current disparities in contraceptive use. The authors suggest there may be other race-correlated factors influencing choice of contraception that were not covered by this study.

Their study did find that, in general, less knowledge about contraceptives is associated with decreased use of the more highly effective forms. Levels of such knowledge were lower among Hispanics than among blacks and whites, and Hispanics were more likely to report a feeling of low control over the timing of their pregnancies. This suggests that improving knowledge about contraception, especially among Hispanics, could reduce some disparities in method choice.

Other Possible Factors

The authors of the study conclude that disseminating information about contraceptive methods could result in a reduction of disparities in use. Indeed, the Contraceptive Choice Project demonstrated that when patients were counseled about all forms of birth control and barriers to choice (including financial) were removed, 75 percent of patients chose the most effective forms of contraception: implants and intrauterine devices (IUDs) [14]. This suggests that, in addition to knowledge about contraception options, financial considerations impact women's choices, and financial constraints may be inequitably distributed across racial groups. Information about the distribution of financial constraints among members of various racial groups could more fully and accurately elucidate the relationship between race and contraception use.

Conclusion

As physicians, we have a responsibility to improve maternal health by helping women plan their pregnancies. Highly effective methods of contraception exist, yet the majority of women at risk for unintended pregnancy are not using these methods. Women of color are even less likely to be using these methods. It is therefore especially important when discussing contraception with women of color to provide evidence-based, comprehensive counseling and address barriers to uptake and continuation of contraception use.

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