Satisfaction, Cost Are Key in Contraceptive Use

BY ROBERT FINN

SAN FRANCISCO — Half of the 28 million U.S. women who are at risk for unintended pregnancy are not fully protected by contraception, according to a nationally representative survey.

Despite a stated desire not to become pregnant, 8% of women didn't use contraception at all during the prior year, 15% reported an at-risk gap in contraception use, and 27% reported inconsistent use.

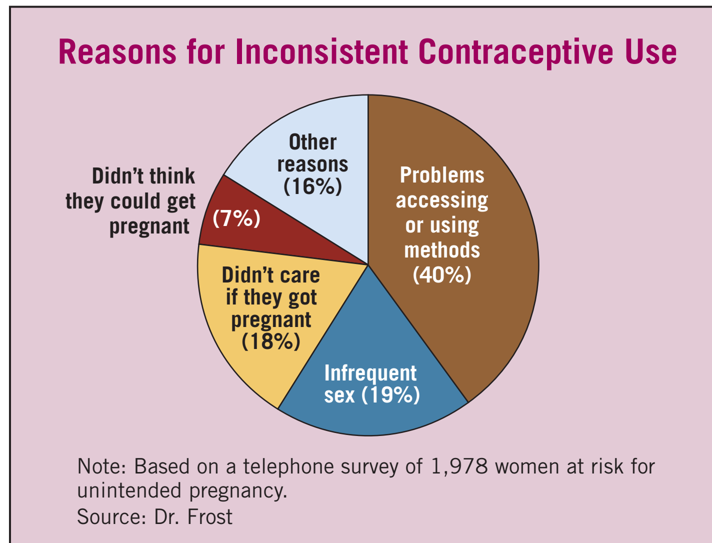
The survey identified five key factors linked to inconsistent or nonuse of contraception, Jennifer J. Frost, Dr.P.H., said at a meeting on contraceptive technology sponsored by Contemporary Forums.

Those factors were significant life changes, difficulty paying for and accessing care, low or mixed motivation to avoid pregnancy, negative attitudes and experiences with methods, and negative attitudes and experiences with health care providers.

A companion survey of public and private providers of contraception led investigators to suggest potential remedies related to each of those factors, said Dr. Frost of the Guttmacher Institute, New York.

Investigators from the institute conducted a telephone survey of 1,978 women at risk of unintended pregnancy in 2004. In 2005 they conducted a separate mail-, Internet-, and fax-based survey of 1,256 private family practice physicians, private ob.gyns., and public contraceptive care providers and community health centers, hospitals, Planned Parenthood clinics, and other sites.

"One of the great things about this research is that it expands on the evidence base supporting a more patient-centered approach to contraceptive care," Dr. Frost said. "It also suggests that such an approach may be one of the key ways to reduce unintended pregnancy in the U.S."



Reasons for Inconsistent Contraceptive Use

Note: Based on a telephone survey of 1,978 women at risk for unintended pregnancy.
Source: Dr. Frost

Among the women who used contraception inconsistently or not at all, 40% cited problems accessing or using methods as one of the reasons for nonuse, and 18% said they didn't care if they got pregnant. (See chart.)

Fully 53% of women with gaps in contraception use reported at least one major life event around the time of that gap. Twenty-six percent said they stopped or started a relationship, 22% said they moved, 21% said they started or stopped a job or school, and 22% reported some other personal crisis.

The survey of providers revealed that fewer than half discussed the disruptive effects of such life changes with women at follow-up contraceptive visits. This suggests that the impact of life changes might be lessened if more providers made regular assessments of changes in women's lives during such visits, if they counseled women about the potential impact of such life events on contraceptive use, and if they provided women with backup methods for emergency contraception.

Gaps in contraceptive use were strongly linked to a lack of education and to poverty. For example, 36% of women with less than a high school education reported gaps in use, compared with 30% of women who completed high school, 24% who attended some college, and 15% who completed college. Hispanic, black, and Asian women were more likely to have gaps than were white women (27%-31% vs. 19%).

"A few things that providers can do to reduce the impact of disadvantage in contraceptive use is to first assess a woman's ability to pay for contraceptive services and supplies and to help them choose a method that they will be able to afford over time," Dr. Frost said. "Second, [providers should] ensure that women know about and use all the available subsidized services in funding for which they may be eligible. And finally, the providers themselves [should] make sure they use all existing mechanisms for reimbursement."

The providers in public clinics were more likely to discuss pregnancy motivations with patients than were private physicians. For example, 69% of health departments reported having this discussion with patients, compared with 56% of ob.gyns. and 32% of family physicians.

Women who are unhappy with their contraceptive options often rely on less-effective methods. For example, among women who mostly like their chosen method, 46% use pills and another 22% use long-acting methods, while only 22% use condoms. Among women who say they don't like using other methods, only 24% use pills and another 11% use long-acting methods, while 49% use condoms.

The survey of providers revealed that they are far more likely to discuss the side effects of, and satisfaction with, contraceptive methods with patients than the concrete details of how to remember daily pill use. Among public clinics 87% discussed side effects and satisfaction with methods, but only 58% discussed how to remember daily pill use. Among ob.gyns. 80% discussed side effects, but only 30% discussed daily pill use.

Dr. Frost suggested that providers assess patients' motivations for choosing methods and ensure that positive choices are being made. They should review experiences and satisfaction with methods at each visit, and they should facilitate method switching to find the best option for each woman.

Finally, "although providers universally told us that women can call them if they have problems with their method . . . , women did not always report that they felt that they could call the providers with questions," Dr. Frost said. Among women who said that they could call a provider with questions, 21% had gaps in contraceptive use, compared with 39% of the women who said that they could not call their provider. And inconsistent pill use was related to low levels of patient satisfaction and continuity of care.

Among the women who were very satisfied with their provider, 34% had inconsistent pill use, compared with 47% of those who were not very satisfied. Inconsistent pill use was seen among 36% of the women who usually saw the same physician, compared with 51% of those who did not.

"Many providers might benefit from communication training that can improve client provider interactions," Dr. Frost said. "Finally, although it may appear self-evident, it is important for providers to confirm that all questions have been answered, and that clients feel that they have an easy way to contact the office of the provider with additional questions or problems with their method."

The studies were supported by grants from the National Institute of Child Health and Human Development. Dr. Frost stated that she had no conflicting commercial relationships.

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Patient survey results were published in three articles appearing in Perspectives on Sexual and Reproductive Health (2007;39:48-55, 2007;39:90-9, and 2008;40:94-104). Results of the provider survey were published in Contraception (2008;78:42-51). Links to these articles are available at www.guttmacher.org.

Ask Breast Cancer Survivors About Sexual Problems

BY HEIDI SPLETE

PENTAGON CITY, VA. — Sexual health problems in breast cancer survivors peaked about 12 months after the completion of treatment, and mental health symptoms significantly predicted these problems, according to findings from a study involving 54 female breast cancer survivors.

The findings suggest a need for providers to discuss with breast cancer patients the potential for sexual problems after therapy, and to be alert for mental health symptoms that may increase the risk for these problems, said Beth Fischgrund, a medical student at Northwestern University, Chicago.

To examine which mental health problems were associated with sexual problems and to pinpoint the peak time for these problems, Ms. Fischgrund and her colleagues, surveyed women who had completed breast cancer treatment within 24 months of study enrollment.

After their treatment was finished participants completed two surveys—one at 6-12 months and the other at 18-24 months. Each woman had been in a monogamous relationship since at least a year before her breast cancer diagnosis. The study results were presented in a poster at the annual meeting of the Society for Sex Therapy and Research.

At the time of the first survey, 40% of the women reported moderate to severe sexual problems, but this number increased to 53% at the time of the second survey. Sexual health was assessed using the Sexual Problems Scale, which measured lack of interest in sex, difficulties with arousal and orgasm, lack of pleasure during sex, and pain during sex. These components were combined to calculate a total sexual score.

The findings suggest that reports of sexual problems peaked at about 12 months post treatment, and decreased by 18-24 months. Mental health symptoms were significant predictors of sexual health problems 6 months later, the researchers said. But there were no significant differences in mental health scores between the two time periods. The strongest predictors of sexual problems were interpersonal difficulties and depression.

When asked why sexual problems didn't emerge immediately after treatment, Ms. Fischgrund suggested that during therapy, women with breast cancer are in "survival mode." At that time, they likely focus on their treatment and on beating the disease, and they don't focus as much on their sexual relationships, she theorized. The study was supported by the Lynn Sage Cancer Research Foundation. The researchers had no financial conflicts to disclose. ■