

ACCESS TO CARE

WELL WOMAN PEER-REVIEWED

Improving contraceptive care for marginalized populations

Consider the needs of marginalized patients to promote equity

by CHARISSE LODER, MD, MSC; AND LEAH MITCHELL SOLOMON, MD

Contraceptive care is an essential health service; however, inequities will persist until care provision is designed to address the needs of groups who have been marginalized. Patients who come from groups who have been marginalized, or pushed to the periphery of society, are likely to experience racism, discrimination, and overall poor health outcomes.¹ Research has uncovered disparities in contraceptive use in the United States.² Individuals who identify with groups that have been marginalized are less likely to use contraception in general, and those who do use contraception are less likely to use highly effective methods

(implant, intrauterine devices, or sterilization).² Traditionally, contraceptive care has focused on the need to prevent pregnancy and unintended pregnancy, rather than considering contraception as a tool that can improve overall health. However, it is important to expand the scope of conversations around hormonal contraception, which can be used as an instrument that both prevents pregnancy and treats a range of reproductive health conditions.³ Contraceptive use may be influenced by a number of factors, such as patient education and knowledge, insurance status, access to reproductive health services, health system factors (counseling, trust, satisfaction with provider, and access to same-day devices),

and structural factors (systemic racism, laws, policies, and economic inequality). Here, we focus on approaches to contraceptive care that can promote equity.

Obstetrician-gynecologists (ob-gyns) providing contraceptive care must understand the history of coercive reproductive health care among populations that have been marginalized and how this affects communities today. In the 20th century, thousands of individuals were coerced into sterilization based on their racial, gender, or socioeconomic identities and/or ability status.⁴⁻⁶ Even today, individuals from marginalized groups report bias in contraceptive care. According to findings from a study about contraception



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use in young individuals, participants felt pressured to use long-acting contraception and perceived provider bias regarding their contraceptive choices.⁷ Black women reported bias and coercion in data from another study about contraception in the postpartum period.⁸ It is not surprising, therefore, that patients and their families or communities may hold feelings of mistrust regarding reproductive health care. We must, then, incorporate this knowledge into our contraceptive care and use approaches to care that mitigate bias and discrimination.

How to approach contraceptive counseling

Given this historical context, ob-gyns who approach contraceptive care with attitudes aligned with reproductive justice and patient-centered approaches will be well poised to care for patients who have been marginalized. Reproductive justice supports the ability to parent or not parent and to raise children in sustainable environments.⁹ Health care providers who practice with reproductive justice values are knowledgeable about historical oppression, have skills in leveling power differentials, and work to combat barriers to reproductive autonomy. The American College of Obstetricians and Gynecologists (ACOG) supports adopting a reproductive justice approach to contraceptive care.¹⁰ To do this, health care providers must understand their own biases, which they can initiate by completing an assessment such as the Implicit Association Test and by attending unconscious bias workshops or training.¹¹

Next, providers should commit to a lifelong approach of mitigating bias that embraces self-reflection, normalizing and destigmatizing bias, and exploring

TABLE. Patient-Centered Approach to Contraceptive Counseling¹⁴

Establish values and goals	Do you think about becoming pregnant in the future? How important is it for you to prevent pregnancy? Can you share any values or beliefs that are important to you that might help me in your care?
Use good communication skills	Make eye contact Use active listening skills Use open-ended questions Summarize using patients' language
Identify best method(s)	What birth control method(s) have you used before and what did you like/not like about it/them? How often do you want to use your birth control method (daily/weekly/monthly/every few months/with each act of intercourse)? Are there adverse effects that you are concerned about? Are there desired effects that you are looking for (reduced bleeding, improvement in pain, clearer skin)?
Establish plan and conclude visit	Provide clear, balanced information Provide written resources Start contraceptive method Provide anticipatory guidance Offer follow-up visit Provide reassurance about discontinuation

the lived experiences of patients while breaking down power structures.¹² This often involves understanding one's own identity and the identities in the communities they serve, which are often multidimensional. A reproductive justice approach includes using cultural safety skills—those that acknowledge diverse beliefs by engaging patients in humble and inquisitive conversation about their needs.¹³ Finally, focusing on the patient by eliciting their goals and preferences and providing balanced information can reduce bias, establish trust, and promote reproductive justice in contraceptive care (**Table**).¹⁴

Ob-gyns who apply the concept of intersectionality to contraceptive care may improve care for marginalized communities. Intersectionality allows a provider to consider how the inequalities

that patients of various identities face can be compounded to create poor health outcomes.¹⁵ In contraceptive care, intersectionality can help health care providers understand or support contraceptive decision-making. For example, a provider may consider injectable contraception to be the best method for a patient based on the patient's preferences and medical history. However, by inquiring about their geographic location and socioeconomic and parenting status, for example, as well as their identity-based experiences, the provider may realize that the patient may not have adequate transportation to the clinic or affordable childcare, which would make it difficult for them to return for regular injections. Additionally, the patient may say that their experiences with racism contribute to their wish to avoid multiple visits to

the health center. Therefore, this broader understanding of the patient and their experiences may lead the provider to make a different recommendation regarding contraceptive methods. With the understanding that patients come from unique cultures, backgrounds, and communities, health care providers can use an intersectionality lens to provide comprehensive contraceptive care.

Creating an open dialogue

Providers who engage in conversations with community members and leaders are well placed to understand barriers and facilitators to reproductive health care and create an open dialogue for advocating for change. Several advocacy initiatives have been successful at improving access to reversible contraceptive methods for marginalized communities; these have focused on improving barriers to contraception such as lack of patient knowledge, cost, lack of provider training in provision of long-acting reversible contraception (LARC), and inability to provide same-day contraception. Contraceptive programs, such as the Contraceptive CHOICE Project, have focused on improving access to reversible contraception among communities that have been marginalized, with a goal of increasing the uptake of LARC.¹⁶ This approach has some concerns; for example, the focus on LARC may impair the patient's ability



to exercise reproductive autonomy and result in further marginalization.¹⁷ Additionally, these programs have not considered how to approach access to LARC removal to ensure that all aspects of contraception are considered with an equity lens.¹⁸

In Puerto Rico, however, the Zika outbreak resulted in the initiation of the Zika Contraception Access Network (Z-CAN) program, which advocated for increased provider training of LARC management, secured contraceptive product donations, and negotiated nominal pricing from pharmaceutical manufacturers.¹⁹ Innovative partnerships between health care workers, community leaders, and social media influencers were also used to increase

knowledge regarding availability of reversible contraceptive methods. This led to an increase in information-seeking behaviors related to contraception use.²⁰ Patients everywhere are increasingly turning to social media platforms such as TikTok, Instagram, and Twitter for information—including regarding their health.²¹ As we consider how epidemics affect contraceptive care, it will be important to use social media and engagement to improve education and access.

The Zika crisis in Puerto Rico further exemplified the gains in contraceptive access that can be made when advocacy extends beyond the individual patient-provider interaction. The Z-CAN program was able to provide contraceptive care to over 21,000 women, with over 20,000 receiving same-day provision of their contraception of choice.²² Expansion of contraceptive coverage through the Affordable Care Act (ACA) was associated with improvements in contraceptive refills and a decrease in births among commercially insured women,²³ but did not improve access for women without commercial insurance. In recent years, contraceptive coverage under the ACA has been under attack through policy changes such as the Supreme Court upholding the religious exemptions from the contraceptive mandate.²⁴ Ob-gyns are uniquely positioned to advocate on a national level and affect policy decisions that disproportionately affect marginalized populations. Presently, ACOG supports

- TAKE-AWAYS AND ACTION ITEMS**

 - Recognize the historical context of contraceptive care for marginalized individuals.
 - Understand intersectionality and how it affects shared decision-making for contraceptive care.
 - Identify personal biases through tools such as the Implicit Association Test.
 - Demonstrate patient-centered and reproductive justice approaches to contraceptive care.
 - Incorporate technological innovation into daily practice to increase contraceptive access.
 - Advocate for policy change through local and national initiatives.

continued access to both FDA-approved contraceptive options without cost sharing and OTC access to oral contraceptives without a prescription from a physician or pharmacist.

The COVID-19 pandemic accelerated innovations in telehealth and virtual care that can be used to increase access to contraception.²⁵ Though the expansion of telehealth services is a viable option to increase access to contraceptive services, it may not address issues related to cultural concerns for privacy or lack of telecommunication connectivity. Telehealth—whether conducted in real time, through interactive audiovideo communication, or asynchronously—allows patients to forgo a physical exam and reduce traveling distance and travel-related costs. This is particularly important in areas of the country that lack readily available access to contraceptive providers or where wait times for receiving care may be prohibitive. Telehealth services provide an opportunity to access a provider remotely and fill prescriptions closer to home through a local pharmacy or mail delivery service.³ Research findings have uncovered concerns about low use of telehealth for contraceptive visits among patients identifying as Black or multiracial compared with all other racial identities.²⁶ This is consistent with health service data showing lower telehealth usage for preventive care among individuals living in marginalized areas.²⁷ There are several concerns about the use of telehealth, such as inequities in accessing the necessary devices

or high-speed internet required for 2-way audiovisual communication, discrepancies in reimbursement for telehealth visits,²⁸ and lack of formal telehealth training for providers. Prior to the pandemic, reimbursements for telehealth visits by the Centers for Medicare & Medicaid Services were limited to 2-way audiovisual communication. Since the pandemic, restrictions for reimbursement of some telephone-only encounters have been waived, allowing health care providers to be compensated for visits completed via telephone.²⁹ Formal training can equip providers with tools to establish rapport in the virtual setting and education on common pitfalls encountered with telehealth.

Conclusion

Improving contraceptive access for marginalized populations is a complex and multifaceted challenge that calls for innovative approaches. It requires that ob-gyns first examine their own biases alongside the historical context of the development of contraception in the United States, which often involved coercion of marginalized individuals. Using a patient-centered framework and cultural safety approach is the first step in increasing access to contraceptive services. The role of the ob-gyn is constantly evolving and requires that we serve as advocates for our patients in the exam room and at the national level through policy changes that directly impact them. ■

FOR REFERENCES VISIT
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Updates on emergency contraception

by MICHELLE F. MEGLIN, MD; AND CHRISTINE R. ISAACS, MD

Nearly half (45%) of all pregnancies in the United States from 2015 to 2019 were unintended.¹ The majority of such pregnancies occur in patients who are not using contraception or are inconsistently using contraception. Emergency contraception is treatment to prevent pregnancy after unprotected vaginal intercourse or when there has been a contraceptive failure, and has an important role in reducing unintended pregnancy.² Unfortunately, patients are likely to receive inaccurate information about emergency contraceptive pills from retail pharmacies.³ Additionally, significant gaps exist in training and knowledge of emergency contraception among obstetrics-gynecology and family medicine residents.⁴ For these reasons, as well as the concerns stemming from anticipated changes in the legal options for reproductive health care across the United States, clinicians must remain vigilant about their knowledge being up-to-date to dispel misinformation and help patients make informed decisions (**Table 1** and **Table 2**).⁵⁻¹²

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of pregnancies in the United States from 2015 to 2019 were unintended.¹

TABLE 1. Types of Emergency Contraception⁵⁻¹²

Method	Brand names	Timing after unprotected intercourse	Efficacy	Primary mechanism of action	Access
Oral levonorgestrel 1.5 mg, single dose	Plan B One-Step Multiple generic options	Up to 72 hours (3 days)	Prevents 84% of unexpected pregnancies 2.2% pregnancy rate (unexpected pregnancy rate of 5%-8% without EC)	Delays ovulation	OTC No restrictions based on age or gender Cost: \$40-\$50
Oral ulipristal acetate 30 mg, single dose	Ella	Up to 120 hours (5 days)	1.4%-1.9% pregnancy rate	Delays ovulation	Requires prescription
Copper T 380A IUD	ParaGard	Up to 120 hours	0%-0.5% pregnancy rate	Prevents fertilization	Requires office visit for insertion Variable cost and insurance coverage
Levonorgestrel 52-mg IUD	Mirena Liletta	Up to 120 hours	0.3% pregnancy rate	Prevents fertilization	Requires office visit for insertion Variable cost and insurance coverage
Combination oral contraceptive pills: 100 µg ethinyl estradiol and 0.5 mg levonorgestrel followed by second dose in 12 hours	Yuzpe regimen	Up to 120 hours	Prevents 56%-89% of unexpected pregnancies	Delays ovulation	Requires prescription

EC, emergency contraception; IUD, intrauterine device; OTC, over the counter.

FDA-approved emergency contraception

Two FDA-approved emergency contraceptive pills (ECPs) are available in the United States: oral levonorgestrel 1.5 mg as a single dose (Plan B One-Step or generic equivalents) and oral ulipristal acetate 30 mg as a single dose (Ella).^{5,6} The 2-dose levonorgestrel regimen is no longer manufactured. ECPs are not indicated in the setting of known pregnancy, but do not harm or disrupt an existing pregnancy if inadvertently taken. A urine pregnancy test is not required prior to administration of ECPs and there are no absolute contraindications. Specifically, ECPs

are acceptable in patients with medical comorbidities such as cardiovascular disease, a history of venous thromboembolism, or a history of ectopic pregnancy. Women who are lactating may also safely take oral levonorgestrel. ECPs may be less effective in patients with obesity (> 75 kg) or a history of malabsorptive bariatric surgery, but there are no safety concerns regarding these populations.^{7,8} Both ulipristal and levonorgestrel can cause nausea; if vomiting occurs within 3 hours of taking an ECP, another dose should be administered.⁷

Single-dose oral levonorgestrel may be taken within 72 hours

(3 days) of unprotected intercourse or contraceptive failure. It is available over the counter to individuals of any age or gender without a prescription or an ID being required.⁹ The primary mechanism of action is prevention of ovulation. The drug may also alter the endometrium to inhibit implantation but is not effective once implantation has occurred. Single-dose levonorgestrel prevents up to 84% of expected pregnancies and is more effective the sooner it is taken after unprotected intercourse or contraceptive failure. It will not affect long-term fertility and patients may resume or start hormonal contraception without delay.

Levonorgestrel is typically well tolerated, but adverse effects include menstrual changes, nausea, vomiting, lower abdominal pain, fatigue, headache, dizziness, and breast tenderness.⁵

Single-dose oral ulipristal acetate is available by prescription only and may be taken up to 120 hours (5 days) after unprotected intercourse or contraceptive failure. Ulipristal acetate is a progesterone agonist/antagonist that postpones ovulation. In clinical trials, the expected pregnancy rate of 5.6% without emergency contraception was reduced to 1.9% with ulipristal acetate.⁶ When compared with levonorgestrel, the pregnancy rate was lower with ulipristal acetate (1.4% vs 2.2%).¹⁰ After taking ulipristal acetate, patients should delay initiating or resuming hormonal contraception for at least 5 days because exogenous progesterone may reduce ulipristal acetate's ability to delay ovulation. Patients should use barrier methods until their next menses.⁵ Lactating patients should be counseled to express and discard breastmilk for 24 hours after taking ulipristal acetate as its excretion in breastmilk is highest in the first 24 hours.⁷ As with levonorgestrel, common adverse effects of ulipristal acetate include headache, abdominal pain, nausea, dysmenorrhea, fatigue, and dizziness.⁶

Methods without FDA labeling for emergency contraception

The Paragard intrauterine copper contraceptive (CuT380A) and high-dose combination estrogen and progesterone regimen (Yuzpe method) have been used for many years for emergency contraception.⁷ More

TABLE 2. Benefits and Risks of Emergency Contraception⁵⁻¹²

Method	Benefits	Limitations	FDA approval for use as EC
Oral levonorgestrel 1.5 mg, single dose	Can resume or start hormonal contraceptive without delay	Decreased efficacy in patients with obesity (> 75 kg) or history of malabsorptive bariatric surgery	Yes
Oral ulipristal acetate 30 mg, single dose	Effective up to 120 hours after unprotected intercourse	Resumption or initiation of hormonal contraception should be delayed for 5 days Decreased efficacy in patients with obesity or history of malabsorptive bariatric surgery	Yes
Copper T 380A IUD	Most effective form of EC Long-term contraception	Significant barriers to timely access Many patients prefer levonorgestrel IUD over CuT380A IUD	No
Levonorgestrel 52-mg IUD	Long-term contraception	Significant barriers to timely access Limited data for use as EC	No
Combination oral contraceptive pills (Yuzpe method)		Significant nausea and vomiting	No

EC, emergency contraception; IUD, intrauterine device.

recently, there is evidence that the 52-mg levonorgestrel-releasing intrauterine system (Mirena) is effective for emergency contraception as well.¹¹ Neither method has FDA labeling for emergency contraception.

The Yuzpe method comprises a dose of 100 µg of ethinyl estradiol and 0.5 mg of levonorgestrel taken together, followed by a second dose of both hormones in 12 hours. This regimen is not sold as an emergency contraceptive product but consists of a variety of typical combination hormonal contraceptive pills. Patients using the Yuzpe method are significantly more

likely to have nausea and vomiting than those taking single-dose ECPs. This regimen prevents 56% to 89% of unexpected pregnancies.¹⁰

The CuT380A intrauterine device (IUD) has been used for emergency contraception for over 20 years. It can be inserted up to 120 hours after unprotected intercourse or, if the timing of ovulation is known, more than 5 days after unprotected intercourse if insertion occurs no later than 5 days after ovulation.⁷ Its primary mechanism is preventing fertilization by impairing sperm viability and function and it may also prevent implantation if

fertilization has already occurred. It is the most effective form of emergency contraception, with pregnancy rates of 0% to 0.5%.¹⁰ Prior to inserting CuT380A, the health care provider must be reasonably certain that the patient is not already pregnant. Other contraindications to insertion are acute pelvic inflammatory disease, uterine abnormality resulting in distortion of the uterine cavity, endometritis in the past 3 months, and known uterine or cervical malignancy. A significant benefit of this IUD is that it can remain in place for 10 years as a long-term contraceptive method.¹² However, use of the device for emergency contraception is limited by patients having to undertake an office visit for insertion within 5 days of unprotected intercourse, as well as by cost and insurance coverage; additionally, patients frequently prefer the levonorgestrel IUD over the copper IUD.¹¹

The levonorgestrel IUD is the most common IUD selected for long-acting contraception in the United States. A recent noninferiority trial randomly assigned patients to the levonorgestrel 52-mg IUD or CuT380A for emergency contraception within 120 hours of unprotected intercourse. The levonorgestrel IUD was noninferior to the CuT380A, with pregnancy rates of 0.3% and 0%, respectively. Similarly, retrospective data suggest the levonorgestrel IUD functions as emergency contraception.¹¹ To date,



- Emergency contraception is safe and effective with very few contraindications.
- Emergency contraception does not cause abortions and does not impair future fertility.
- The ParaGard intrauterine copper contraceptive is the most effective form of emergency contraception.
- Single-dose oral levonorgestrel 1.5 mg is safe and is available for purchase without any restrictions.
- Ulipristal acetate is a progesterone agonist/antagonist, available by prescription and slightly more effective than oral levonorgestrel.

the American College of Obstetricians and Gynecologists, Society of Family Planning, and the Centers for Disease Control and Prevention have not made recommendations regarding the use of the levonorgestrel 52-mg IUD for emergency contraception; in contrast, Planned Parenthood's patient education materials include it as an option.¹³ It is unclear whether use of the levonorgestrel IUD for emergency contraception will become widely accepted.

Conclusion

Several options are available for patients who are at risk for unintended pregnancy due to unprotected intercourse or contraceptive failure. Emergency contraception is safe and has very few contraindications. It does not cause abortion and does not reduce future fertility. Discussing emergency contraception should be part of all well woman preventive health care

encounters, but particularly with patients who are at risk for unintended pregnancy including those who are not using contraception, those using a less reliable form of contraception, or those who may lose access to their contraception options. Although the copper IUD remains the most effective option for emergency contraception and can be inserted up to 5 days after unprotected intercourse, single-dose oral levonorgestrel 1.5 mg is safe, has no contraindications, and is available for patients to purchase without any restrictions due to age, gender, or insurance status. ■

FOR REFERENCES VISIT
contemporaryobgyn.net/emergency-contraception



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