PERSON-CENTERED CONTRACEPTIVE CARE FRAMEWORK

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Kelsey Holt, ScD, MA
OBJECTIVES

• Describe existing landscape of initiatives designed to enhance contraceptive access
• Define a framework for future person-centered contraceptive access initiatives
• Discuss how existing efforts can incorporate lessons learned
SOME HISTORICAL CONTEXT

- In early 2000’s, excitement about IUDs (and later, implants) fueled concern about lack of access to these methods
- Led to interest by funders and public health and clinical providers in contraceptive access initiatives
- Over the past decade, initiatives have been initiated in a range of geographies
SOME HISTORICAL CONTEXT

- At the same time, evolving understanding and focus on patient-centered and human rights principles in contraceptive care
- Experience of existing and past initiatives provides an opportunity to assess where we have come from and where we should go in advancing contraceptive access
18 externally-funded city or state initiatives reviewed
FOUNDATIONAL PRINCIPLES
PATIENT-CENTEREDNESS

“Patient-centered care is care that is respectful of and responsive to individual patient preferences, needs, and values.”

- Institute of Medicine
RACE EQUITY

Use of reproduction as means of control of populations is endemic and long standing

- Nonconsensual sterilization of poor women and women of color throughout the 1900s
- Targeted marketing of Depo Provera
- 150 incarcerated women in California were coercively sterilized from 2006-2010
STRATIFIED REPRODUCTION

The fertility of some people is valued by those who dominate social discourse and the fertility of other people is not.

Formal and informal policies to limit the reproduction of some or encourage the reproduction of others.

“The thing about reproduction is that, more than anything else, it tells you how a society values people.”

-Dorothy Roberts
WHAT ABOUT REPRODUCTIVE JUSTICE?

Reproductive Justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities

- SisterSong
PREDOMINANT APPROACHES

- Overcoming barriers to same-day LARC provision:
  - Stocking
  - Provider knowledge
  - Reimbursement

- Demand generation

- Tiered effectiveness counseling
SUCCESSES

- Training providers and addressing bias and knowledge gaps around LARC
- Models for facilitating same-day and postpartum LARC access
- Increasing visibility of family planning
- Engagement of multiple sectors of the health care system
- In some states, positive impact on policy, including increased funding and changes in reimbursement for post-partum LARC
EVOLUTION OF CONTRACEPTIVE ACCESS INITIATIVES

- Increasing movement towards a focus on all methods (although primary focus on LARC methods has remained)

- More rigorous evaluation
  - Control geographies
  - External evaluators from beginning
AREAS FOR INNOVATION

1. Robust needs assessments
2. Community engagement
3. Focus on health equity
4. Rural access
5. Follow-up support for switching/removals
6. Integration with other areas of sexual and reproductive health
7. Patient-centered contraceptive counseling
Phone screening script: “One of our objectives is to be sure women are aware of all contraceptive options, especially the most effective, reversible, long-acting methods. These methods include intrauterine contraception (the IUD or IUC) and the subdermal implant called Implanon.”

Standardized contraceptive counseling script: providing information on effectiveness, advantages, and disadvantages, in order of effectiveness.
TIERED EFFECTIVENESS COUNSELING

HOW WELL DOES BIRTH CONTROL WORK?

**Really, really well**

- The Implant (Norplant)
- IUD (Skylla)
- IUD (Mirena)
- Sterilization, for men and women

*No hormones*

- Works, hassle-free, for up to...
- 3 years
- 3 years
- 5 years
- 12 years
- Forever

**Okay**

- The Pill
- The Patch
- The Ring
- The Shot (Depo-Provera)

*Expected pregnancy rate:
- 6-6 in 100 women, depending on method*

- For it to work best, use it...
- Every week
- Every month
- Every 3 months

**Not so well**

- Withdrawal
- Diaphragm
- Fertility Awareness
- Condoms, for men and women

*Expected pregnancy rate:
- 12-24 in 100 women, depending on method*

For each of these methods to work, you or your partner have to use it every single time you have sex.

What is your chance of getting pregnant?

- Less than 1 in 100 women
IS DIRECTIVE COUNSELING PATIENT-CENTERED?

• **Directive counseling** appropriate when there is one option that leads to better health outcomes
  - Smoking cessation
  - Diabetes control

• Providers can engage with patients’ preferences in patient-centered manner, while having an agenda

• **Decision support** appropriate for preference-sensitive decisions, in which there is no one best option
  - Early breast cancer treatment
  - Early prostate cancer treatment

• Helps patient to consider tradeoffs among different outcomes of treatments

Elwyn, Dehlendorf: *Ann Fam Med*, 2014
WHAT KIND OF DECISION IS CONTRACEPTIVE CHOICE?

- Different preferences relate to different assessments of potential outcomes, such as side effects.
- Also relates to different assessments of the importance of avoiding an unintended pregnancy.
“I guess one of the reasons that I haven’t gotten an IUD yet is like, I don’t know, having one kid already and being in a long-term committed relationship, it takes the element of surprise out of when we would have our next kid, which I kind of want. I’m in that weird position. I just don’t want to put too much thought and planning into when I have my next kid.”
PROBLEMATICIZING UNINTENDED PREGNANCY

- Not all unintended pregnancies are created equal
- Many women welcome unintended pregnancies
- Dimensions beyond intendedness seem to matter when thinking about the acceptability of their pregnancies: happiness, finances, social support, etc.
BUT SHOULDN’T WE GET WOMEN TO PLAN “FOR THEIR OWN GOOD”? 

Is an unintended pregnancy a universally negative health outcome?

Little data to support this commonly held belief:

▪ Many studies show no association with social or health outcomes
▪ Some studies show associations with low birth weight and preterm birth
▪ However, generally not well-designed and well-controlled
▪ Most examine only retrospective intentions

Hall: Matern Child Health J, 2017
Gipson et al., Studies in Family Planning, 2008
Shah et al., Matern Child Health J, 2011
CONCERNS WITH DIRECTIVE COUNSELING APPROACHES

Assuming women should want to use certain methods:

- Ignores variability in preferences, including around importance of avoiding unintended pregnancy
- Does not prioritize autonomy

Pressure to use specific methods can be counterproductive

- Perceived pressure increases risk of method discontinuation
- Perceiving provider as having a preference associated with lower satisfaction with method
- Negative experiences can impact longer term care seeking

Gomez; Contraception, 2017
Kalmuss, Fam Plann Perspect, 1996
Dehlendorf, Contraception, 2014
They just keep promoting these long-term methods. It’s like they’re getting a commission or something. I always wondered that. They were really, really trying to push this product…. It was like they were selling me…. Like, “You should try it.” No. I don’t want to.
“A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences….This process provides patients with the support they need to make the best individualized care decisions.”

Informed Medical Decisions Foundation
# Birth Control Method Options

### Most Effective

<table>
<thead>
<tr>
<th>Method</th>
<th>Female Sterilization</th>
<th>Male Sterilization</th>
<th>IUD</th>
<th>Implant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of pregnancy*</td>
<td>5 out of 100</td>
<td>15 out of 100</td>
<td>16 out of 100</td>
<td>16 out of 100</td>
</tr>
<tr>
<td>How the method is used</td>
<td>Surgical procedure</td>
<td>Placement inside uterus</td>
<td>Placement into upper arm</td>
<td>Shot in arm, hip, or under the skin</td>
</tr>
<tr>
<td>How often the method is used</td>
<td>Permanent</td>
<td>Lasts up to 3-12 years</td>
<td>Lasts up to 3 years</td>
<td>Every 3 months</td>
</tr>
<tr>
<td>Menstrual side effects</td>
<td>None</td>
<td>LNG spotting, lighter or no periods</td>
<td>Spotted, lighter, or no periods</td>
<td>Spotted, lighter, or no periods</td>
</tr>
<tr>
<td>Other possible side effects to discuss</td>
<td>Pain, bleeding, infection</td>
<td>Some pain with insertion</td>
<td>May cause appendicitis or weight gain</td>
<td>May have nausea and breast tenderness for the first few months.</td>
</tr>
</tbody>
</table>

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### Least Effective

<table>
<thead>
<tr>
<th>Method</th>
<th>Male Condom</th>
<th>Female Condom</th>
<th>Withdrawal</th>
<th>Sponge</th>
<th>Fertility Awareness Based Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of pregnancy*</td>
<td>12 out of 100</td>
<td>18 out of 100</td>
<td>21 out of 100</td>
<td>22 out of 100</td>
<td>12-24 out of 100</td>
</tr>
<tr>
<td>How the method is used</td>
<td>Put on penis</td>
<td>Put inside vagina</td>
<td>Put over penis</td>
<td>Put inside vagina</td>
<td>Pull penis out of the vagina before ejaculation</td>
</tr>
<tr>
<td>How often the method is used</td>
<td>Every time you have sex</td>
<td>Daily</td>
<td>Every time you have sex</td>
<td></td>
<td></td>
</tr>
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<td>None</td>
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<td>Can cause spotting for the first few months. Periods may become lighter.</td>
</tr>
<tr>
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<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Other considerations</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

*The number of women out of every 100 who have an unintended pregnancy within the first year of use of each method.


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Counsel all clients about the use of condoms to reduce the risk of STIs, including HIV infection.
NWHN-SisterSong Joint Statement of Principles on LARCs

We commit to ensuring that people are provided comprehensive, scientifically accurate information about the full range of contraceptive options in a medically ethical and culturally competent manner in order to ensure that each person is supported in identifying the method that best meets their needs.

PERSON-CENTERED CONTRACEPTIVE CARE FRAMEWORK
FRAMEWORK DEVELOPMENT

Based on an evolving understanding of person-centeredness in contraceptive care, and racial and other inequities, what opportunities are there for innovation?
Person-Centered Contraceptive Care Framework

Outreach & Trust Building
- Sexual and reproductive health information and education
- Facilitation of dialogue between community and healthcare institutions
- Awareness raising around available services and rights to high quality care
- Referral network and care coordination

Access
- Free/affordable services for all
- Flexible options for care delivery modalities
- Easy scheduling and extended hours
- Support for navigating barriers to services (e.g., via transportation and childcare)

Quality
- Patient-centered, non-coercive counseling
- Evidence-based contraceptive provision
- Implicit bias and structural competency training
- Same-day access to all methods, including emergency contraception
- Integration with other services, including referrals as needed
- Quality improvement systems that include measures of patient experience

Follow-up Support
- No cost, barrier-free LARC removal
- Facilitated method switching
- Support for side effect management
- Patient-centered pregnancy options counseling and referrals
- Protection of confidentiality in all follow-up communication
- Different formats of information delivery (app, call, text)

Community engagement in all efforts
Beyond same-day LARC access: A person-centered framework for advancing high quality, equitable contraceptive care

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Person-Centered Contraceptive Care Framework

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Community engagement in all efforts
COMMUNITY ENGAGEMENT

• Authentic community engagement along the continuum of care
• Ensure programs responsive to people they serve and do no harm
Person-Centered Contraceptive Care Framework

Outreach and Trust Building

Access

Quality

Follow-up Support
Person-Centered Contraceptive Care Framework

- Outreach and Trust Building
- Access
- Quality
- Follow-up Support

- Racism
- Sexism
- Sexuality, gender & other discrimination
- Economic injustice

- Historical, Social, Political Context
- Policy & Health Systems
- Community & Family Context

- Continuum of Care

- Availability of acceptable contraceptive methods
- Power imbalance in healthcare
- Cultural & religious biases
- Contraceptive coverage
- Government regulation
- Health care financing & infrastructure

- Stigma
RACISM AND OTHER DIMENSIONS OF OPPRESSION

- Multiple intersecting oppressions (racism, sexism, economic injustice)
- De-valuing reproduction of women of color, low-income women, and others
- Affects all aspects of reproduction and interactions with reproductive health care providers
Person-Centered Contraceptive Care Framework

Outreach and Trust Building  Access  Quality  Follow-up Support
Person-Centered Contraceptive Care Framework

Racism
- Healthcare financing & infrastructure

Sexism
- Government regulations

Sexuality, gender & other discrimination
- Contraceptive coverage

Economic Injustice
- Clinical & public health priorities

Cultural & religious biases
- Power imbalance in healthcare

Stigma
- Availability of acceptable contraceptive methods

Family & peer relationships
- Domestic & intimate partner violence

Reproductive coercion

Continuum of Care

Outreach and Trust Building  Access  Quality  Follow-up Support
Person-Centered Contraceptive Care Framework

Clinical & public health priorities

Outreach and Trust Building
Access
Quality
Follow-up Support
WHAT IS THE GOAL OF CONTRACEPTIVE CARE?
BUT ISN’T FOCUSING ON UNINTENDED PREGNANCY ALSO FOCUSING ON WOMEN?

- Dominant public health paradigm that an unintended pregnancy = a bad pregnancy
- How do women think about pregnancy in the context of their own lives?
- How can clinical services and contraceptive initiatives meet their needs within the existing context?
Person-Centered Contraceptive Care Framework

**Outreach and Trust Building**

**Access**

**Quality**

**Follow-up Support**
Person-Centered Contraceptive Care Framework

Outreach and Trust Building | Access | Quality | Follow-up Support

Availability of acceptable contraceptive methods
Person-Centered Contraceptive Care Framework

Outreach and Trust Building

Access  Quality  Follow-up Support
MOVING BEYOND DEMAND GENERATION

Public messaging has potential to enhance mistrust and contribute to stigma

Or it can engage community and facilitate relationships

Successful messaging that engages community depends on initial engagement
OUTREACH AND TRUST BUILDING

1. Sexual and reproductive health information and education
2. Awareness-raising around available services
3. Awareness-raising of the right to high quality care
4. Facilitation of dialogue between communities and healthcare institutions
5. Referral network drawing on diverse organizations
ACCESS

1. Free / affordable services for all
2. Easy scheduling and extended hours
3. Support for navigating barriers to services (e.g., through transportation and childcare)
4. Flexible options for care delivery modalities
Person-Centered Contraceptive Care Framework

Outreach and Trust Building

Access

Quality

Follow-up Support
QUALITY

1. Evidence-based contraceptive provision
2. Same-day access to all methods, including emergency contraception
3. Patient-centered, non-coercive counseling
4. Implicit bias and structural competency training for all staff
PROVIDER BIAS

• Low-income women of color more likely to report being advised to limit their childbearing than White women

• In a survey of Black women, 28% reported being pressured to start one type of method when they preferred another and 67% reported race-based discrimination

• Black patients were more likely than White patients to report having been pressured by a clinician to use contraception

Becker: Perspect Sex Reprod Health, 2008
Thorburn: Women Health, 2005
THE “PATIENTS”
Percent of Providers Recommending IUC to Low SES Women, by Race/Ethnicity
(n=173)

- Whites: 42%
- Blacks: 63%
- Latinas: 67%

P<0.05

Dehlendorf, et al., AJOG, 2010
UNDERSTANDABLE MISTRUST

• Communities of color have higher levels of distrust of medical system generally

• In family planning, this is amplified by history of coercive practices
  • Greater than 40% of Blacks and Latinas thinks that government promotes birth control to limit minorities
  • 35% agreed that medical/public institutions use poor and minority people as guinea pigs to try new birth control methods

• Women of color are more likely to have a preference for a methods that are not provider controlled

Thorburn, Health Educ Behav, 2005
Rocca, Perspectives, 2015
Bird, J Health Psychology, 2003
Jackson, Contraception, 2016
Structural competency: Theorizing a new medical engagement with stigma and inequality

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Abstract

This paper describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. It reviews existing structural...
QUALITY

1. Evidence-based contraceptive provision
2. Same-day access to all methods, including emergency contraception
3. Patient-centered, non-coercive counseling
4. Implicit bias and structural competency training for all staff
5. Integration with other services, including referrals as needed
6. Quality improvement systems that include measures of patient experience
Person-Centered Contraceptive Care Framework

Outreach and Trust Building
Access
Quality
Follow-up Support
FOLLOW-UP

1. No cost and barrier-free LARC removal
2. Facilitated method switching
I was telling the nurse how I been on my period for like 3 weeks now, and I’m having bad cramps, and I’m even having them in my back, which I never had before. And she was saying, “Just give it another month or so and see how it goes.” . . . I was mad.

I don’t know if it makes them [providers] look bad if you have an IUD removed and they’re the one who placed it, or I don’t know if they have some stat chart somewhere, like a contest board in the breakroom.
FOLLOW-UP

1. No cost and barrier-free LARC removal
2. Facilitated method switching
3. Support for side effect management
4. Patient-centered pregnancy options counseling and referrals
5. Protection of confidentiality in all follow-up communication
6. Different formats of information delivery (text, phone, app)
EVALUATION
“The quality of contraceptive programs should be based not on how many LARC methods they distribute, how many adolescent pregnancies they prevent, or how much money taxpayers save, but by how many people feel truly respected and cared for when it comes to childbearing and family formation.”
PERSON-CENTERED, EQUITY-FOCUSED EVALUATION

• Suite of outcomes
  • Conventional public health measures
  • Patient experience
  • Norms related to trust and engagement with health system
  • Reproductive autonomy / well-being

• Mixed methods research focused on process and outcome

• Stratification of findings by race and other socio-demographic variables to examine differential impact
Think about your visit with [provider] at [site] on [date of visit]. How do you think they did? Please rate them on each of the following by circling a number.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting me as a person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Letting me say what mattered to me about my birth control method</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Taking my preferences about my birth control seriously</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Giving me enough information to make the best decision about my birth control method</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
THOSE LEADING THE WAY

- The DC Family Planning Project and EverThrive Illinois are pioneering intensive, intentional community engagement processes to inform initiative development.
  - Both have integrated explicit attention to issues of racial justice and equity.
- More work integrating services, including with primary care and STI related care, in states such as Mississippi (Converge MS) and Nebraska.
- Person-centered contraceptive counseling training increasingly discussed.
- Converge is convening stakeholders to discuss best practices for person-centered and equity-focused evaluation.
APPLYING THE FRAMEWORK

- Applying all aspects of the framework will not always be feasible
  - Resources
  - Lack of evidence-based practices

- Foregrounding principles of racial equity and person-centeredness should guide selection of areas of focus and intervention components

- Recognize that there is potential for doing harm
APPLYING THE FRAMEWORK

- New initiatives should prioritize community engagement and centering equity to develop novel approaches to implementing services.

- Established programs can consider which components of initiatives are most and least aligned with framework and foundational principles, and prioritize those with most potential for improvement.
  - Community engagement can inform this assessment.

- Essential to generate new evidence about approaches to achieving goals laid out by framework.
QUESTION AND ANSWER PERIOD

Thank you!
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