Addressing Disparities in Abortion & Contraception

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Disparities for Women

- Less social and economic power
- Lower income for similar work
- Shoulder higher burden of unpaid and hidden work
- Receive less preventative care for CVD
- Higher rates of depression
- Higher risk of being uninsured

- Since women’s care often split (reproductive and primary), higher risk of inadequate care.

Objectives

At the end of this talk, you will be able to:

- Help poor women navigate care for undesired pregnancies
- Choose safe methods of contraception in women with medical illness
- Utilize a shared decision-making model for contraceptive counseling
**Case**

- Young woman, post-partum
- My desire: to give her “highly effective” contraception

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**Why I'm motivated...**

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**Blacks & Hispanics have high rates of unintended pregnancy**

![Graph showing unintended pregnancies by race](Finer, LB. AJPH 2014)

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**Unintended Pregnancy with Patch-Pill-Ring vs. LARC**

![Graph showing comparison of unintended pregnancies over weeks](LARC vs PPR 2014)
Abortion rates mirror unintended pregnancy rates for ethnicity & SES

83% of abortions occur in women < 300% of FPL

Abortion stigma

“A negative attribute ascribed to women who seek to terminate a pregnancy that 'marks' them as inferior to ideals of womanhood”

Women who have abortions are often regarded as:
- Selfish
- Promiscuous
- Irresponsible
- Heartless
- Abnormal

Women hide abortion


Kumar et al 2009; Norris et al. 2011
Restrictive abortion laws disproportionately affect poor women

- Travel, childcare, time off work
- Poor girls more likely to live with one or neither parent
- Public facilities affected by restrictive laws
- Religious facilities often in poor communities
- Default enrollment

Dramatic increase in U.S. abortion restrictions

Restrictive U.S. abortion laws

- Physician-only
- Hospital-only after certain gestation
- Facilities restrictions (TRAP laws)
- Funding restrictions
- No private insurance coverage
- Parental involvement
- Waiting periods (24-72 hrs)
- State-mandated counseling of false info
- Ultrasound viewing or listen to heart

Legal status does not predict incidence worldwide

Rates per 1000 women aged 15-44

- Western Europe
- Southern Africa
- North America
- Eastern Asia
- Central America
- Southeast Asia
- Eastern Africa
- Developed regions
- Developing regions

WHO 2014 & Lancet 2012
The Hyde Amendment
- Bans federal funding of abortion
- Only 17 states use state funds to pay for abortions for women with Medicaid

Effects of funding restrictions
Evidence supports:
- Decreased rate of abortions
- Delay in access to abortion
- Fewer abortion providers
- Higher costs to gov’t social programs

Studies suggest:
- Rates of illegal abortions
- Abortion complication rates
- Pregnancy complications (PTD, low BWt)
- Child abuse rates
- Suicide rates

Henshaw et al. Restrictions on Medicaid Funding for Abortions: Guttmacher Jun 2009

Reasons for delay in 2nd-trimester patients

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t suspect pregnancy</td>
<td>34%*</td>
</tr>
<tr>
<td>In denial about being pregnant</td>
<td>21%*</td>
</tr>
<tr>
<td>Difficulty in getting to our clinic</td>
<td>63%*</td>
</tr>
<tr>
<td>Initially referred to other clinic(s)</td>
<td>47%*</td>
</tr>
<tr>
<td>Difficulty figuring out where to go</td>
<td>20%*</td>
</tr>
<tr>
<td>Difficulty with Medi-Cal, money, insurance</td>
<td>20%*</td>
</tr>
<tr>
<td>Emotional factors</td>
<td>51%</td>
</tr>
<tr>
<td>Unsure of decision</td>
<td>30%*</td>
</tr>
<tr>
<td>Afraid</td>
<td>35%</td>
</tr>
<tr>
<td>Unsupportive partner</td>
<td>19%</td>
</tr>
</tbody>
</table>

*statistically significant vs. early abortion patients, p<0.05

Drey E et al, Ob Gyn, 2006

Medi-Cal (mis)information

Calls to 30 county social services in CA:
- <21yo woman wants Medi-Cal for pregnancy
- 17% not in service or unanswered
- Frequent incorrect info:
  - 53%: Must bring ID and citizenship docs
  - 23%: Parents have to be involved
  - 17% mentioned Minor Consent for Sensitive Services

Access/WHRC Mar 2009
21 counties in CA
45 counties in NY

Case

- Young woman, post-partum
- My desire: to give her “highly effective” contraception
- Her concern: autonomy

“Are health care providers using abortion to curb the growth of the U.S. black population?”

Contraception for Underserved Women

- Safe prescribing for women with medical illness
- Shared decision-making
Low income women and women of color have higher illness burden

Higher rates of chronic diseases:
- HTN
- DM
- Obesity

Many chronic diseases:
- Worsen in pregnancy
- Have potentially teratogenic effects
- Treated using potentially teratogenic meds

PCP’s underestimate risk of unintended pregnancy

- Underestimate risks:
  - prevalence of unintended pregnancy by 23%
  - risk of pregnancy with no contraception by 35%
- Underestimate failure rates:
  - 85% underestimate failure rate of OCP’s
  - 62% for condoms
  - 16% for injectables

Parisi Contraception 2012

Contraception in women with medical illness

- Don’t forget!
- Weigh risk of pregnancy against risk of method
- Use a resource:
    - Rates methods for medical conditions
    - 1=no restriction; 4=unacceptable risk
- Search for “CDC MEC”
- Available as an App

CDC MEC for CV disease

<table>
<thead>
<tr>
<th></th>
<th>CHC</th>
<th>Prog Implant</th>
<th>DMP A</th>
<th>Cu-IUD</th>
<th>LNG-IUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple risk factors of CAD</td>
<td>3/4</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>BP systolic &gt;160 or diastolic &gt;100</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>History of DVT/PE</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Current DVT/PE</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Major surgery-prolonged immobilization</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Why do underserved women have higher rates of unintended pregnancy?

Blacks and Latinas disproportionately use lower efficacy methods

Reproductive abuse in the US

- American Eugenics movement, 1907-1960
- >100,000 sterilized
- >30 states
- California 60,000
- Norplant, 1990s
- Government aid
- Target racial/ethnic minorities

Reproductive abuse in the US

- 2006-2010, California prisons
- 150 female inmates
- 150 sterilizations between 2006-2010
**Women of color have concern about contraceptive methods**

- Focus groups of black participants
  - Changes in menstrual cycle is evidence of reproductive harm
- Majority of long-acting reversible contraception has this side-effect

Clark, Contraception 2006

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**Women of color have concern about reproductive harm**

- Cross-sectional telephone national survey of Black Americans, reproductive age
  - "Poor and minority women are sometimes forced to be sterilized..."
  - "Medical and public health institutions use poor and minority people as guinea pigs..."
- Survey black parishioners, 35 churches in Louisiana
  - Believe family planning programs are a form of genocide


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**Contraceptive features preferred by patient race/ethnicity**

- 1700 women, 13 clinics, nation-wide
- Black, Latina, White, Asian Pacific Islander
- Surveyed during family planning encounter

Examples:
- Stopping use of the method (return to fertility)*
- Ease of use
- Getting the method (cost, clinic visit)
- Side effects or health concerns
- Efficacy
- Control and privacy*

Jackson, AV unpublished data

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**Are women of color counseled differently?**

- More dissatisfied with their family planning provider, many report racial discrimination
- More likely to report being pressured to:
  - Use birth control
  - Limit their family size

Forrest, Fam Plan Perspect 1999, Thorburn Womens Health 2005
Are women of color counseled differently?

Providers more likely to:
- agree to sterilize minority and poor women
- recommend the IUD to women of color and poor women

Harrison Obsetrics and Gyn 1988, Dehlendorf AJOG 2010

Why are women of color counseled differently?

- Statistical discrimination
  - Use of group averages
- Stereotyping
  - Fixed and oversimplified image or idea
  - Not necessarily negative
  - How we organize our complex world
  - History of racism makes racial and ethnic stereotyping impossible to avoid

Implicit bias in family planning

- Young woman, post-partum
- My desire to give her “highly effective” contraception
- Her concern: autonomy
- Did I not trust her?

Implicit bias can contribute to family planning disparities

Differential pressure to control fertility can:
- Increase mistrust between patient & provider
- resistance from patient
- greater tendency to discontinue methods
- health disparities
Contraceptive decision making

**Directive Counseling**
- Promote patient autonomy
- Increase use of highly effective methods

**Consumerist Counseling**

**Shared Decision Making**
- Quality decision based on patient preferences

Does quality contraceptive counseling matter?
- Counseling influences method selection
- Quality of care associated with use of contraception and satisfaction
- Client-centered care is the right thing to do


Shared decision making in contraceptive counseling
- Elicit her preferences
  - "What’s important to you in a contraceptive method?"
  - "For some women, having a method that is easy to start or stop is important, and for others, having a method that’s totally private matters most. What kinds of things matter to you?"
- Ask clarifying questions
  - "There are methods you take once a day, once a week, once a month, or even less often than that. Is that something you have a strong feeling about?"

Use natural frequencies when explaining efficacy
- "9 out of 100 women get pregnant after a year on the Pill; less than 1 in 100 get pregnant with an IUD"

Visual aids, websites
- [www.bedsider.org](http://www.bedsider.org)

Shared decision making is an iterative process
The 2/3 of women using consistent contraception have 5% of U.S. abortions

Summary – What can we do?
- Make time for contraceptive counseling
- Use CDC MEC resource
- Ask:
  - "Do you want to become pregnant in the next year?"
  - "What is important to YOU in your contraceptive method?"
- Support Reproductive Justice

Summary – What can we do?
- Let patients know they can come to you for an unplanned pregnancy
- Do your part to reduce abortion stigma

Summary – What can we do?
- Help women who desire abortion navigate access

Ryan Programs (85 academic med centers)
NAF
National Network of Abortion Funds
Access Women’s Health (Nor Cal)
Which of the following are important considerations to inform a shared decision-making approach to contraception counseling?

A. LARC methods are low risk and significantly more effective and should be recommended first for contraception.
B. Women know what they want and are more likely to use the first method they mention.
C. Efficacy is not the top priority for all women.
D. Women of color report coercion in family planning counseling at high rates.