Pulling back the curtain on trends in contraceptive use in recent years: what can we predict for the future?

In this issue, Kavanaugh and Pliskin provide the most recent information about contraceptive method use in the United States based on a secondary analysis of two rounds (2013–2015) and (2015–2017) of the National Survey of Family Growth (NSFG) (1). They report increases in the utilization of both contraceptive implants (particularly by adolescent women) and intrauterine devices, and decreases in the use of oral contraceptives and permanent contraception. They also report that the percentage of sexually active women who use no method remained stubbornly unchanged at 12%.

The overall 4% increase in use of intrauterine devices (IUDs) and implants seen in this study from 2013 to 2017 extends the 3.1% increase seen from 2009 to 2012. It would be reasonable to ask if these trends predict future increases in women's use of these highly effective and safe methods. However, analyzing the forces that were responsible for this observed growth, one wonders if these rates might actually represent a high-water mark.

Enthusiasm for IUDs and implants clearly grew in the wake of the CHOICE study, which demonstrated high rates of acceptance of IUDs and implants, their superior pregnancy protection, and their high continuation rates. Three-fourths of the subjects chose IUDs or implants. It was suggested that if their efficacy-based structured counseling approach were adopted elsewhere, uptake of these methods would significantly expand. About that same time, the Affordable Care Act progressively removed many of the financial barriers to long-acting methods, which measurably increased IUD use by privately insured women (2). Professional organizations, such as the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics, endorsed IUDs and implants as first-line choices for adolescent and nulliparous women "because of their efficacy, safety, and ease of use." Hands-on training programs ramped up.

While emphasizing that each woman should be offered the full array of contraceptive options for which she is medically eligible, in 2014 the companion document to the Centers for Disease Control and Prevention (CDC)'s U.S. Medical Eligibility Criteria entitled "Providing Quality Family Planning Services—Recommendations from CDC and the U.S. Office of Population Affairs" emphasized the importance of efficacy in patient counseling: "Providers are encouraged to present information on potential reversible methods of contraception by using a tiered approach (i.e., presenting information on the most effective methods first, before presenting information on less effective methods)" (3).

Many studies of the time catalogued challenges that women faced in receiving their IUDs and implants, and new innovative programs sprang up to solve those problems. For example, early demonstration projects studying the safety, acceptability, and continuation rates of IUDs and implants placed immediately after delivery before discharge home were highly successful. Women who were provided those devices in hospital were far more likely to still be using them 6 months postpartum compared with women who delayed their initiation until the 6-week postpartum visit. In relatively short order, the Medicaid programs in dozens of states started reimbursing hospitals and providers for postpartum provision.

Enthusiasm for implants and IUDs was palpable. Every study that resulted in increased utilization of these methods was hailed a success. At one point, family planning programs were debating what usage percentages should be adopted as targets. The thought was that "appropriate counseling" could be documented if a greater percentage of patients in a clinic chose these "top-tier" methods.

But so very much has changed since then. Funding sources are drying up. The Supreme Court granted universities and employers exemption to ACA requirements if they object to including contraception in their benefits packages; this will shift the full cost to the women who are covered by such policies. Millions of women unemployed by the Covid-19 pandemic have lost all employer-based coverage. Many traditional family planning programs have had to forego all Title X funding; others will soon have their funding shared with programs that do not have to offer any modern methods of contraception as a result of the new Final Rule regulations.

At a more fundamental level, though, many thought leaders have progressively moved away from structured counseling that stressed efficacy as the most important variable in method selection. They saw that it did not promote patient autonomy and had begun to rekindle distrust with the medical system. What has emerged to replace that model is the person-centered framework for high-quality, equitable contraception care (4). This approach does not merely focus on reducing unintended pregnancies, but adds prioritizing the individual's well-being and promoting positive experiences with care. From a utilitarian viewpoint, the idea is that women who choose the methods they want to use, based on their own preferences and priorities, will be more successful users.

Echoes from the history of some family-planning experiences seem to be heard today around IUDs and implants. Studies have shown that these more effective methods may not meet the preferences of many people of color. The mistrust of the medical system becomes even more important when women must rely on clinicians not only to place the device but also to remove it on demand. Enthusiasm that clinicians express for IUDs and implants may be interpreted as pressure, which violates a woman's autonomy. And when women's requests for removal are resisted or delayed, clinician-patient relationships are jeopardized and the appeal of the method is undermined (5). Whether it is related to these concerns or not, calls for women-controlled methods are increasing. Some new methods, such as the 13-cycle EE/segestrel vaginal ring and vaginal pH regulators for contraception still require clinicians to prescribe them, but their use is controlled by the

woman. Newer apps and biometric devices that can be used for fertility awareness methods may appeal to some women precisely because they require no interaction with the medical system.

The Covid-19 pandemic has also accelerated the introduction of nontraditional avenues to contraception. Telemedicine has enjoyed a huge jump start that enables women access to contraception without needing an office visit. In many states, pharmacists can both prescribe and dispense pills, patches, vaginal rings, and injections. By increasing easier access to these methods, we may be biasing the choices women make. Similarly, increasing the number of cycles of pills, patches, and rings dispensed at once further enhances the convenience (and effectiveness) of those methods but may well inhibit the use of methods that require office visits (and procedures) with a clinician. Over-the-counter access to hormonal methods has been endorsed by ACOG and other groups to diminish access barriers, which may further diminish relative attractiveness of IUDs or implants. Although women may be able to remove their own IUDs, they cannot place them themselves.

Finally, the critical ongoing problem that Kavanaugh and Pliskin remind us of in their article is the persistently high proportion (12%) of sexually active women who use no method of birth control even though they do not desire to become pregnant. Studies show that this 12% contributes disproportionately to the number of unintended pregnancies, abortions, and unintended births. We still do not seem to understand what motivates these women. It is apparently not a problem with the survey tool; the NSFG specifically asks about traditional methods of contraception, such as fertility awareness and coitus interruptus, that other surveys often neglect. It is quite conceivable that some of these women rely on abortion as their method of family planning where the procedure is safe, legal, and available. But there are clearly other forces at work. Indifference and ambivalence about both pregnancy and contraception are common. It may not be socially acceptable for a woman to admit that she wants to become pregnant when she does not have the social and financial resources to support a child. Traditional women's roles may call for them to view the pregnancy as a gift or at least as something to accepted. Perhaps these women should be given ongoing preconception care to ensure that they are ready for pregnancy when they conceive. Some may need education: Surveys show that by a 3-to-1 margin, women rate oral contraceptives as being more hazardous to a woman's health than pregnancy. But all these possibilities cycle back to the concept that to be effective, contraceptive choice must be put into a comprehensive personal and societal context.

As a clinician and a researcher, I always feel deep satisfaction when a woman who was new to a method returns singing its praises. As a former economist, it may pain me to "waste money" discontinuing early a method a woman had thought she wanted to try but did not like, but that is clearly the price of doing business. We must go back to the basics. Make certain women know about all their options and their associated benefits and risks so that they can make informed choices. Live up to our pledge that each woman will maintain control of her method. Of course, we cannot know what those risks and benefits for each woman are unless we know her not only as a medical being but also in the social context within which she lives. Contraception may be a leader in implementing person-centered counseling because women have so many choices, but counseling around other disease states and health promotions will soon follow. This may be the person-to-person value we human clinicians can add to AI's big database.

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