EDITORIAL AND COMMENT

Integrating Family Planning into Primary Care—a Call to Action

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Maternal health indices in the USA are shameful. Not only are US women more likely to die from pregnancy-related causes than women in any other developed country, but only in the USA is the rate of maternal mortality rising (Fig. 1).¹ Moreover, the racial disparity in this rate is staggering, with Black women experiencing maternal death at 3 to 4 times the rate of White women, independent of income or education.^{2, 3} The reasons underlying this disparity are complex and multifactorial, including long-standing social and structural inequalities; institutional, interpersonal, and internalized racism; differential experiences with the healthcare system; and higher rates of chronic medical conditions among Black women (likely due, in part, to the first three factors listed). Chronic medical conditions (e.g., obesity, hypertension, diabetes), in fact, are becoming more prevalent across the entire US population and are supplanting traditional causes of pregnancy-related complications and death, such as hemorrhage.⁴ This shift in the etiologies of poor maternal outcomes squarely positions primary care providers to be part of the solution, especially as the majority of maternal deaths are deemed to be preventable and optimizing medical conditions before pregnancy may be one key to prevention.

The greater contribution of chronic medical conditions toward maternal morbidity and mortality further underscores the importance of access to patient-centered family planning care, which includes assessment of reproductive goals as well as provision of preconception, contraception, and abortion care services. Women with chronic medical conditions need information about both how their disease (and any related medications) could impact the health of their pregnancy and how pregnancy might impact their disease state so that they can make informed decisions about family formation and pregnancy timing. For those who want to avoid or delay pregnancy, access to the full range of contraceptive methods and abortion services is essential, especially since unplanned pregnancies can increase the risk of adverse pregnancy outcomes by precluding

optimization of health and medications before conception. In this issue of JGIM, Gawron et al. explore the prevalence of and relationship between chronic medical conditions and contraceptive use among women of reproductive age. Nearly a third of all women in their sample had at least one chronic medical condition known to increase the risk of adverse pregnancy outcomes. Their findings also highlight the relatively low use of highly effective methods (intrauterine devices, implants, and sterilization) among women with medical conditions (7.6%). With regard to long-acting reversible methods specifically, which have few medical contraindications and thus are safe for most women with chronic disease, use was low and did not increase with multi-morbidity (5.8% among women with 1 condition vs. 3.2% among women with 5 or more conditions).

While access to family planning services is essential to health and well-being, it is currently delivered through a fragmented system. This may be particularly problematic for women with chronic medical conditions who are mostly likely to see primary care providers (or subspecialists) for their health management, but are then typically referred elsewhere (or simply expected to seek care elsewhere) for their contraception needs. Accessing abortion services may require yet another transition of care. This fragmentation causes unnecessary hurdles to receiving comprehensive reproductive health care and leads to health needs going unmet, perhaps contributing to the higher rates of unintended pregnancy observed among women with medical and mental illness.^{5, 6} It may also impede women's ability to integrate considerations about their medical or mental health conditions into pregnancy and contraception decision-making.

This already fragmented system is facing additional constraints due to widespread political efforts to curtail abortion access for ideological purposes. The new regulations for the Title X federal family planning program (referred to as the “gag rule”) block funding to family planning providers that provide abortion services and also prohibit Title X sites from referring pregnant patients to abortion providers. In addition to Planned Parenthood sites nationally, numerous other Title X grantees and subrecipient clinics that provide a range of sexual and reproductive health services have withdrawn from the Title X program (thus far 23% of sites that previously received Title X funding will no longer do so).⁷ While it is still too early to fully determine the impact of the new regulations, the loss of

Fig. 1 Maternal deaths per 100,000 births. Graph from <https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world>

funding will likely cause many of these clinics to close or sharply curtail their services, significantly reducing access to family planning care for the four million people who rely on Title X-funded services each year.

Rising rates of maternal mortality, greater attribution of chronic medical conditions to maternal morbidity and mortality, and erosion of access to publicly funded reproductive healthcare services demand that we revisit reproductive health service delivery in this country. Primary care physicians, including internists and pediatricians, who have not traditionally engaged in family planning care need to take up the gauntlet if they are truly committed to advancing whole person health and person-centered care. Reproduction and family formation are core elements of the human condition for most people, and emerging qualitative data indicate that patients strongly desire for their primary care doctors to engage in family planning conversations with them.⁸

To facilitate conversations about pregnancy goals and desires, several “pregnancy intention” screening models have been recommended for use in primary care, including One Key Question® (*Would you like to become pregnant in the next year?*) and the PATH questions (*Would you like to have (more) children at some point? If so, have you thought about when? How important is it to you to avoid pregnancy until then?*).⁹ These patient-centered questions aim to non-judgmentally query people’s thoughts and feelings about future childbearing and, importantly, can accommodate ambivalent or mixed feelings about pregnancy, which are common (as high as 30–40% of women) and associated with subsequent pregnancy. Counseling that engages with the full spectrum of orientations toward pregnancy, including ambivalence, can help support individuals in both optimizing health in the event of pregnancy and selecting a contraceptive method that aligns with their values, preferences, and needs. To be effective, implementation of these screening questions should be embedded in larger system-level efforts that support family planning provision, including training providers in patient-centered counseling and shared decision-making in

contraceptive method selection, employing emerging provider and patient-facing decision support tools in family planning care, and establishing champions in practices that are proficient in LARC and/or robust referral pathways to facilitate timely access to these contraceptive services. Finally, expanding the scope of primary care practice to include medication abortion provision would help to further de-fragment reproductive healthcare, offset the continually increasing restrictions on abortion access, and counter the ideologically driven and false separation of abortion from other family planning care.¹⁰

While family planning care has traditionally been the domain of obstetrics and gynecology, increasing recognition that social and medical determinants of maternal health exist long before and after the index pregnancy underscores that primary care physicians are obligated to participate in ensuring the reproductive health of their patients. This means integrating family planning care into primary care practice, supporting efforts to tackle the deep social and structural inequalities that give rise to racial disparities in reproductive outcomes, and firmly advocating for reproductive rights and autonomy so that all people have the ability to build the families and lives they desire.

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