

Recent Contraception Literature

Not only did the 2022 *Dobbs v. Jackson Women's Health Organization* decision lead to the implementation of abortion restrictions in some states, but it also affected clinician and patient behavior in the realm of contraception due to access to these services being inextricably linked. In states which have enacted the most restrictive bans post-*Dobbs*, there are concerns that contraceptive restrictions will also be enacted, especially on emergency contraception (EC). Many family planning clinics have closed in these 26 states, eliminating a source of contraceptive access that approximately one in ten women rely on.¹ Others fear that clinicians will pressure or coerce patients to adopt their preferred methods in contraceptive counseling.² The Ethical and Religious Directives (ERDs) echo the Catholic Church's prohibition of contraceptives utilized with the purpose "either as an end or a means, to render precreation impossible," because this violates the inseparability of the unitive and procreative facets of the marital act.³ ERD 52 states: "Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning." It may appear, therefore, that restrictions on contraception have no effect on the provision of Catholic healthcare services. However, the ERDs note two instances in which the use of contraception is permissible. First, in ERD 36, the USCCB outlines the licit usage of

medications which "prevent ovulation, sperm capacitation, or fertilization" for women who are victims of sexual assault. Although it is impermissible to remove, destroy, or interfere with the implantation of a fertilized ovum, the provision of "compassionate and understanding care" may call for the use of contraceptives as a form of defense against conception following rape. In ERD 54, "procedures that induce sterility" can be licit via the doctrine of double effect, under which "the direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." Legal shifts affecting the availability of contraceptives, therefore, may impact the ability of Catholic healthcare systems to provide adequate medical care. The articles reviewed below capture trends in oral and emergency contraceptive use post-*Dobbs*, as well as changes in clinician counseling of adolescents following the landmark decision.

Qato, Dima M., Rebecca Myerson, Andrew Shooshtari, Jenny S. Guadamuz, and G. Caleb Alexander. "Use of Oral and Emergency Contraceptives After the US Supreme Court's *Dobbs* Decision." *JAMA Network Open* 7, no. 6 (June 26, 2024): e2418620. <https://doi.org/10.1001/jamanetworkopen.2024.18620>.

Qato et al. examined the effects of the *Dobbs* decision on monthly fill rates of oral contraceptive pills (OCPs) and emergency contraceptives (ECs), comparing states which implemented full abortion bans (12 states) following the decision with comparison states (14 states), which maintained a consistent

level of restrictions pre- and post-*Dobbs*. Using IQVIA's National Prescription Audit, PayerTrak, and the 2021 American community survey, the authors calculated the monthly rates of pharmacy-dispensed oral contraceptive fills per 100,000 women of reproductive age during four time periods: pre-*Dobbs* oral arguments, between the *Dobbs* oral arguments and the announcement of the decision, the first year post-*Dobbs*, and more than one year after the decision.

142.8 million prescriptions for OCPs and 904,269 prescriptions for ECs were filled nationally at pharmacies between March 2021 and October 2023, spanning the duration of the study. The monthly fill rate declined 25.6% nationally between these time points, dropping from 6784 to 5049 fills per 100,000 women. Fill rates for non-oral hormonal contraceptives also declined steadily over this time span. When examining EC rates, the authors found that the period during which *Dobbs* was under review witnessed an increase from 33.3 to 40.5 fills per 100,000. This number peaked at 52.6 following *Dobbs* in July 2022, but declined to reach pre-*Dobbs* levels (32.9/100,000) and fell even lower in the most restrictive states.

When examining the states which became the most restrictive with comparison rates, the authors found that states which implemented full abortion bans experienced a 4.1% decline in OCPs (285.9/100,000 fewer fills) in the year following the decision. Past the one year mark, the most restrictive states underwent an additional 5.6% decline (386/100,000 fewer fills) compared to comparison states. While EC fills increased in both groups of states in the first year following the decision, the most restrictive states saw a 65% decrease

in EC fills (13.2/100,000 fewer fills) after the one-year mark. At the same time point, levonorgestrel and ulipristal fills had declined by 48% (5.8/100,000 fewer fills) and 89.9% (7.4/100,000 fewer fills) in these states, respectively. Using a sensitivity analysis, the authors determined that declines in oral contraceptives were not offset by increases in use of other contraceptive methods.

The authors attribute these results to the closure of family planning clinics, one-third of which provide contraceptive prescriptions – both OCPs and ECs – to be filled at pharmacies. Supporting this claim is the fact that “post-*Dobbs* declines in ECs were greatest in the most restrictive states that had closed a larger share of their family-planning clinics”. They also hypothesize that confusion regarding the legal status of ECs may have led to the decline in fills of ECs following the decision; recent policies such as “the exclusion of ECs from contraceptive coverage mandates, the lack of Medicaid coverage for over-the-counter ECs, and policies that allow pharmacists to refuse to dispense contraceptives due to moral, ethical, or religious objections” may be contributing factors to the decreased rates in the most restrictive states. The authors conclude by pointing to the need for further research on changes in the use of long-acting and permanent contraception post-*Dobbs*.

Bullington, Brooke W., Emily S. Mann, Madeline Thornton, Joline Hartheimer, Kavita Shah Arora, and Bianca A. Allison. “Clinician Perspectives on Adolescent Contraceptive Counseling Following *Dobbs v. Jackson*: Implications for Young People’s Contraceptive Autonomy.” *Journal of Pediatric and Adolescent Gynecology* 38,

no. 1 (February 2025): 75–78. <https://doi.org/10.1016/j.jpap.2024.10.007>.

Bullington et al. hypothesized that, post-*Dobbs*, clinicians prescribing contraception to adolescents may prioritize pregnancy prevention and pressure patients to adopt specific methods over their preferences or to utilize contraception against their wishes. The authors attribute this pressure to worries about the consequences of unintended pregnancy and efforts to maintain the national public health goal of preventing adolescent pregnancy.

After conducting semi-structured interviews with 16 clinicians (15 physicians and one nurse practitioner, all of whom see adolescent patients) sampled from an American Academy of Pediatrics conference, three themes emerged. First, participants spoke of an increased focus on pregnancy prevention in counseling, with one participant noting, “I like [pregnancy] prevention rather than [abortion] so, if we can just avoid it altogether, it would be ideal.” Second, participants spoke of using the *Dobbs* decision to promote long-acting reversible contraceptive (LARC) methods – such as one respondent who noted they are “pushing IUDs much, much more and much earlier”. One participant said, “Oh, [the *Dobbs* decision] is actually helping me, because I’m saying, listen, I don’t know what else they would do [if they got pregnant]”, as well as how the Supreme Court decision “added a talking point to [their] push for LARC”. Another explained that they advised caution for a patient who was moving to a state with limited abortion access for college, skewing their recommendation towards LARC. The third and final theme identified

was that location of practice and the state’s abortion legislation influenced the counseling provided, with some counseling not changing significantly in areas unaffected by *Dobbs* and some counseling becoming highly influential following abortion restriction.

In their discussion of the results, the authors note that physicians must be aware of the potential biases created and amplified by the *Dobbs* decision, which inhibit adolescent autonomy and act as barriers to achieving the national recommendations of “person-centered, impartial contraceptive counseling.” Clinicians must examine their values and beliefs and ensure that they are not emphasizing their priorities and public health goals at the cost of excluding patient preferences and needs. The authors call for a change in practice to include “comprehensive contraceptive care provision, provider training in unbiased and affirming contraceptive counseling, and continued refinement of developmentally tailored contraceptive decision aids” so that reproductive care does not come to constitute an assault on reproductive justice.

RECENT NATURAL FAMILY PLANNING (NFP) LITERATURE

Natural family planning refers to the use of knowledge of “natural biologic markers to estimate a woman’s fertile phase within her menstrual cycle” in order to avoid or achieve pregnancy.⁴ Catholic proponents of NFP claim that this practice, incorporating periodic abstinence, maintains the proper expression of conjugal love, as opposed to the use of contraception, which stands in opposition to the virtue of chastity.⁵ Non-religious proponents claim that the use of

NFP can strengthen marriage by facilitating a greater understanding of fertility, as well as increasing communication, self-mastery, intimacy, appreciation for intercourse, and spiritual well-being; others raise concerns of detriment and stress caused by NFP due to challenges in implementation, lack of spontaneity, and fear concerning pregnancy. Either way, there has been an increase in the number of women who wish to manage their fertility through non-hormonal methods (from 1.1% use of fertility-based awareness methods in 2008 to 3.2% use in 2015), such as through applications which chart and track the menstrual cycle, due to hormonal contraception's side effects.⁶ Considering the effects of *Dobbs* on contraceptive use behaviors and attitudes towards contraception, we should examine the effectiveness and effects of NFP methods, which require no prescription but need education and consistency to be effectively implemented. The articles below detail a study of the effectiveness of the Marquette NFP Method and the effects of NFP on marital relationships to determine whether NFP can serve as a suitable alternative to prescription contraceptives.

Mu, Qiyang, Richard J. Fehring, and Thomas Bouchard. "Multisite Effectiveness Study of the Marquette Method of Natural Family Planning Program." *The Linacre Quarterly* 89, no. 1 (February 2022): 64–72. <https://doi.org/10.1177/0024363920957515>.

The use of NFP and other fertility-based awareness methods for contraception raises concern among healthcare providers; these methods are not deemed effective due to

"worries and concerns of user inappropriateness, lack of accurate knowledge of female fertility and of NFP methods, and clinical time constraints to teach the method." Modern NFP incorporates more advanced technology, but still presents a typical use failure rate between 2 and 23 percent depending on the method. The Marquette Method, developed in 1998, uses urine hormonal monitoring technology to estimate the cycle's fertile window. Traditional aspects of NFP like mucus monitoring and temperature taking may also be incorporated, and the method must be taught by a teacher who has been trained with a theory course, practicum course, and medical applications course.

Mu et al.'s study was a retrospective and longitudinal investigation over the course of 12 months, using the teaching records of ten Marquette Method teachers in the United States and Canada. This group of teachers was comprised of professional nurses, advanced practice nurses, a family practice physician, and a physician assistant. The average woman receiving the education was 29.63 years old, and of these women, 32.9% had regular cycles, 60.7% were postpartum and breastfeeding, and 5.6% had irregular cycles. The 1,221 women used a variety of indicators, with women using basal body temperature, cervical mucus monitoring (CMM), electronic hormonal fertility monitoring (EHFM), luteinizing hormone urine monitoring (LH test), or a combination of these. The majority (61.8%) used a combination, with the most popular choice being the use of the LH test with either CMM or EHFM (38.6%), followed by EHFM only (27.2%), then the combination of CMM and EHFM (23.2%), and finally, the use of CMM alone (9.3%).

Correct-use unintended pregnancies (pregnancy resulting despite avoidance of intercourse in the fertile window) are contrasted from incorrect-use unintended pregnancies (pregnancy resulting from intercourse in the fertile window or an incorrect calculation of the fertile window). A total of 42 unintended pregnancies were reported in this study, with 11 of these marked as correct-use unintended pregnancies. The overall typical use pregnancy rate was calculated to be 6.7 per 100 women over the course of 12 months; when examining each subgroup, the rates are 2.8, 8.0, and 4.3 pregnancies per 100 women for the regular cycle group, the postpartum and breastfeeding group, and the irregular cycle group, respectively. When examining pregnancy rate by method, the rates were 4.1 per 100 women who used LH with CMM or EHFM, 8.1 per 100 women who used EHFM alone, 14.1 per 100 women who used CMM and EHFM in combination, and 15.6 per 100 women who used CMM alone.

These findings are consistent with previous research on the Marquette Method's effectiveness. The Marquette Method is also comparable to other NFP methods, and the unintended pregnancy rates are close to that of the hormonal contraceptive pill (8/100 unintended pregnancies in a 12-month period) and the male condom (12/100 unintended pregnancies in a 12-month period).

The authors note several limitations of the current study: the retrospective design does not allow for the calculation of correct-use pregnancy rates by correct months of use, and the data set lacks demographic information

about religion, economic status, race, ethnicity, marital status, and level of motivation for avoiding or achieving pregnancy (once motivation levels fall below 8 on a 1-10 scale, there is a significant increase in unintended pregnancies). Despite these limitations, this study demonstrates that "healthcare providers who completed the Marquette Method teacher training program can successfully teach women and couples NFP and achieve consistent results comparable to those of previous effectiveness studies."

Fehring, Richard J., and Michael D. Manhart. "Natural Family Planning and Marital Chastity: The Effects of Periodic Abstinence on Marital Relationships." *The Linacre Quarterly* 88, no. 1 (February 2021): 42–55. <https://doi.org/10.1177/0024363920930875>.

Fehring et al. set out to examine the influence of contraception and the use of NFP on divorce, separation, and cohabitation rates in women of reproductive age. They begin with a review of the current literature surrounding NFP and periodic abstinence (PA), concluding that the majority of male and female users of NFP report that the practice has helped their marriages despite some difficulty adhering, and these individuals may even demonstrate higher self-esteem, higher levels of intellectual, relational, and sexual intimacy, and greater spiritual well-being when compared to contraceptive users. Small sample size and convenience sampling present limitations in this literature, but one cited study shows that 62% of couples using NFP reported that the practice improved their relationship, while 1.4% stated it worsened their relationship. When examining contraception, the same study

found that 12.5% of contraceptive-using couples felt it improved their relationship, while 22.5% reported that use worsened their relationship. The authors' review of the literature led them to conclude that there was no significant difference in frequency of intercourse between NFP and contraceptive users. Finally, they present the strong claim that ever-use of family planning methods like sterilization, vasectomy, OCPs, condoms, and abortion were all associated with increased odds of divorce when compared with women who had never used these methods in one study; however, they point out the very small sample size of women who have ever-used NFP and that many other factors (such as religiosity) could lead to or prevent divorce.

Fehring et al.'s study hypothesized greater odds of divorce and cohabitation for women who ever-used the aforementioned contraceptive methods when compared to those who never-used those methods, as well as lower odds of divorce for frequently church-going women who have ever-used NFP and report religion's import in their lives. They used the data set from the National Survey of Family Growth, including interviews with 2,582 women who had ever been married. Of these women, 70.8% were married, 19.7% divorced, 7.8% separated, and 1.7% widowed. 51.4% of women were Protestant, 20.5% were Catholic, 17.9% reported no religious affiliation, and the remaining 10.1% were of other faith systems.

Results of this study showed that the most common method of contraception was sterilization; comparatively, only one percent of women reported current NFP use. Divorce and separation rates were 39.4% for women

who had ever-used sterilization, 27.7% for those who had ever-used condoms, and 14% for those who had ever-used NFP. As demonstrated, "women who had ever-used NFP had lower odds of divorce compared to those women who never-used NFP." Ever-use of oral contraceptives increased the odds of divorce or separation by 40%, and sterilization did so by 60%; ever-use of NFP decreased the odds by 31%, and church attendance did so by 49%. Cohabitation, which religiosity significantly protected against, was also associated with a 2.4 times increase in the odds of divorce or separation compared to women who had never cohabitated. This finding ties into the study because the ever-use of sterilization, OCs, and condoms is associated with between a 1.7 times and 3 times increase in the odds of cohabitation when compared to women who never-used these methods. These findings are limited by the low number of NFP users and the investigation of ever-use of NFP as opposed to consistent use, but the results indicate that the use of periodic abstinence as a component of NFP serves to strengthen the marital relationship.

CONCLUSION

Evidently, the historic overturning of *Roe v. Wade* did not only impact abortion access in the United States. Another study investigating the differences pre- and post-*Dobbs* in four states found a decline in sexual activity, a decrease in the reception of high-quality contraceptive care, an increase in barriers to contraceptive access, and an increase in condom use.⁷ The ripple effects of shifting abortion legislation on contraception decisions are merely beginning to be investigated, and the reproductive landscape will continue to shift as states continue

to deliberate their abortion services and provision of reproductive care service. These shifts make it critical to devote attention to changes in contraceptive access, the efficacy of different contraceptive methods, and the effects of different contraceptive means on relationships, as well as to craft policy that mitigates the effects of abortion restrictions on reproductive autonomy in the realm of contraception. Evidence suggests that the inaccessibility of abortion may lead to a greater push, both by women and their healthcare providers, for contraceptive use. Although increased utilization of NFP techniques – performed while the couple remains open to procreation – stands in alignment with the teachings of the Catholic tradition, contraceptive use which disrespects the marital act by separating union from procreation does not. In light of these shifts, Catholic healthcare systems may need to emphasize and clarify the Church’s position on contraceptives while continuing to provide compassionate and understanding care to women who seek contraception, for reasons both licit and illicit.✚

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ENDNOTES

1. Qato, Dima M., Rebecca Myerson, Andrew Shooshtari, Jenny S. Guadamuz, and G. Caleb Alexander. “Use of Oral and Emergency Contraceptives After the US Supreme Court’s Dobbs Decision.” *JAMA Network Open* 7, no. 6 (June 26, 2024): e2418620. <https://doi.org/10.1001/jamanetworkopen.2024.18620>.
2. Bullington, Brooke W., Emily S. Mann, Madeline Thornton, Joline Hartheimer, Kavita Shah Arora, and Bianca A. Allison. “Clinician Perspectives on Adolescent Contraceptive Counseling Following Dobbs v. Jackson: Implications for Young People’s Contraceptive Autonomy.” *Journal of Pediatric and Adolescent Gynecology* 38, no. 1 (February 2025): 75–78. <https://doi.org/10.1016/j.jpag.2024.10.007>.
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6. Mu, Qiyan, Richard J. Fehring, and Thomas Bouchard. “Multisite Effectiveness Study of the Marquette Method of Natural Family Planning Program.” *The Linacre Quarterly* 89, no. 1 (February 2022): 64–72. <https://doi.org/10.1177/0024363920957515>.
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