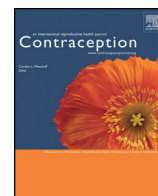




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Original research article

# Video compared to conversational contraceptive counseling during labor and maternity hospitalization in Colombia: A randomized trial☆☆☆

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## ABSTRACT

**Objective:** Assess if video-based contraceptive education could be an efficient adjunct to contraceptive counseling and attain the same contraceptive knowledge acquisition as conversation-based counseling.

**Study design:** This was a multicenter randomized, controlled trial examining contraceptive counseling during labor and maternity hospitalization regarding the options of immediate postpartum contraception. At two urban public hospitals, we randomized participants to a structured conversation with a trained counselor or a 14-min video providing the same information. Both groups received written materials and were invited to ask the counselor questions. Our primary outcome was to compare mean time for video-based education and conversational counseling; secondary outcomes included intended postpartum contraceptive method, pre- and postintervention contraceptive knowledge, and perceived competence in choosing a method of contraception.

**Results:** We enrolled 240 participants (conversation group=119, video group=121). The average time to complete either type of counseling was similar [conversational: 16.3 min, standard deviation (SD)  $\pm 3.8$  min; video: 16.8 min, SD  $\pm 4.6$  min,  $p=.32$ ]. Of women intending to use nonpermanent contraception, more participants intended to use a long-acting reversible contraceptive (LARC) method after conversational counseling (72/103, 70% versus 59/105, 56%,  $p=.041$ ). Following counseling, mean knowledge assessment scores increased by 2 points in both groups (3/7 points to 5/7 correct). All but two participants in the video group agreed they felt equipped to choose a contraceptive method after counseling.

**Conclusions:** Compared to in-person contraceptive counseling alone, video-based intrapartum contraceptive education took a similar amount of time and resulted in similar contraceptive knowledge acquisition, though with fewer patients choosing LARC.

**Implications:** Video-based contraceptive education may be useful in settings with limited personnel to deliver unbiased hospital-based, contraceptive counseling for women during the antepartum period.

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## 1. Introduction

There is limited research investigating how contraceptive counseling is provided, for example, through conversations with clinicians, written materials or audiovisual techniques. Few studies have assessed counseling for postpartum contraception, and most investigated postpartum counseling, missing an opportunity for patients to initiate long-acting reversible contraceptive (LARC) methods or permanent contraception, as their provision within the childbirth period is time-

sensitive [1,2]. Prior studies have shown that video-based contraceptive education can result in increased LARC uptake [3,4]. Others demonstrated increased knowledge gain and satisfaction, especially when paired with clinician counseling [2,5].

In a 2015 survey of Colombian women who were sexually active or in relationships, only 61% were using contraception regularly [6]. Of women using contraception, 8% reported using a LARC method, the copper intrauterine device (IUD) or contraceptive implant, and 23.6% reported use of permanent contraception [6]. In our baseline assessment of three public hospitals, 7.3% of women had undergone a tubal ligation procedure prior to hospital discharge. Many women in Colombia rely on permanent contraception due to limited access to LARC and cultural beliefs about contraception; however, a recent survey found that 16% of women utilizing permanent contraception regretted this decision at the time surveyed, of which 79% stated that they desired more children [6].

Since many women do not receive prenatal care at the facility in which they deliver, decisions about family planning prior to labor are not easily communicated to hospital staff. Given staffing limitations, it is challenging to provide individualized contraceptive counseling. Furthermore, contraceptive counseling is currently not incorporated into routine prenatal care. In this study, we sought to demonstrate that video-based contraceptive education could be an efficient adjunct to counseling and attain the same level of family planning knowledge as conversation-based counseling.

## 2. Material and methods

### 2.1. Study population

This was a randomized controlled trial of patients admitted to a hospital for childbirth conducted in 2015–2016 at two public, urban, high-risk maternity care hospitals in Colombia. Participants enrolled in this study were simultaneously enrolled in the “Colombia: Maternidad Segura” (COMSE) study, a multicenter cohort study investigating postpartum LARC uptake and continuation. The first site, “Unidad Hospitalaria de Manrique” (UHM) in Medellín, Antioquia, has approximately 4000 deliveries per year and has single-payer insurance. The second site, “E.S.E Clínica de Maternidad Rafael Calvo” (CMRC) in Cartagena, Bolívar, has approximately 9000 deliveries per year. We followed the CONSORT reporting guidelines. The Institutional Review Board at Oregon Health & Science University (OHSU) in Portland, OR, USA, Metrosalud in Medellín, the Ethics Committees at the “Universidad de Antioquia” in Medellín and the Ethics Committees at each hospital approved all research protocols. Participant inclusion criteria were hospital admission for anticipated delivery with a live pregnancy at least 20 weeks of gestation. We excluded participants if they rated their level of pain higher than 8 on the Wong–Baker FACES® pain rating scale at the time of enrollment as most of our participants were expected to be in labor during the intervention [7].

### 2.2. Study procedure

Study personnel approached eligible maternity patients to participate in this study. We enrolled most participants during early labor, but participants were also enrolled during admission for high-risk pregnancies and prior to scheduled cesarean delivery. At UHM, eligible patients only included those admitted for a planned vaginal delivery due to a physical separation of surgical and vaginal delivery wards in the hospital. At CMRC, we recruited patients admitted for vaginal or cesarean delivery. After signing informed consent, we randomized participants to two groups using 1:1 randomization and sequentially numbered sealed opaque envelopes. Randomization was computer-generated by the primary investigators ([www.randomization.com](http://www.randomization.com)) using blocked randomization and completed separately for each of the two study sites. Block sizes allowed for a few more participants to be randomized in each group than planned, in order to allow for dropout.

The *conversation group* participated in a structured, face-to-face conversation with a trained counselor. The *video group* watched a video of a young, female Colombian nurse reading a script of the same information provided by conversational counseling, followed by an invitation to engage in a dialog about their contraception options and ask questions of the counselor. Participants and study personnel were not blinded. Study personnel conducted all interactions in Spanish.

Both groups underwent counseling in a variety of locations, including private and shared patient rooms, which occurred immediately after randomization. We administered a contraception knowledge questionnaire before and after the counseling. This study was complete after they completed the postcounseling questionnaire.

### 2.3. Counseling intervention

We developed the counseling protocol based on an evidence-based counseling technique called the “GATHER” method, also used in Project CHOICE [8]. We included information about methods that were available in the Colombian public health plan and considered safe during breastfeeding in order of decreasing effectiveness, including tubal ligation, copper IUD (380-A, Jai Pharma, Mumbai, India), subdermal implant (Jadelle implant®, Bayer AG, Berlin, Germany), progestin injection, progestin-only pills and condoms. All of these methods were available during the study prior to hospital discharge or by prescription. Typically, prescriptions or preauthorization for services (tubal ligation, IUD, implant) is provided through primary care sites, and all methods are covered by the public health plan. Information about lactational amenorrhea, the withdrawal method and cycle timing was also provided. We provided both groups with written materials and a chart of relative contraceptive effectiveness adapted from the World Health Organization [9]. Study personnel answered questions for both groups.

We used the same video for both sites, which lasted 13.75 min. Study coordinators showed the video on a small, portable DVD player that could be brought to the participant's hospital bed. Several health care professionals at both hospitals reviewed and approved all materials used in the counseling. We pilot-tested the counseling content with a sample of patients and made adjustments to terminology as needed for clarity.

### 2.4. Measures

Our primary outcome of interest was to compare the mean time for video-based contraceptive education with additional questions and answers versus conversational contraceptive counseling alone. For the conversational group, counselors measured time with stopwatches as the total duration from the beginning of counseling to the completion of participant questions answered by the counselor. For the video group, time was recorded from video start until the completion of participant questions answered by the counselor. Both were inclusive of possible interruptions.

We assessed family planning knowledge and preferences for postpartum contraception through a seven-question written test, which was administered both before and after the counseling. Questions were true/false or multiple choice and covered topics including contraceptive method effectiveness, fertility and basic definitions. Our secondary outcomes of interest included postcounseling knowledge scores assessed as mean total correct answers to seven multiple-choice questions and the change in the contraceptive method participants intended to use after counseling stratified by tier of effectiveness compared to their reported intention before receiving counseling. The top tier of effectiveness included copper IUD, subdermal implant and permanent contraception; the middle tier included progestin injection and progestin-only contraceptive pills; and the lowest tier included condoms or no method. We also compared the actual LARC uptake prior to hospital discharge by group.

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