



## Impact of having a high-risk pregnancy on future postpartum contraceptive method choice



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### ABSTRACT

**Background:** To compare the knowledge and preference of preconceptional contraception to future postpartum contraceptive method choice in high-risk pregnancies.

**Research question:** Does a high-risk pregnancy condition affect future postpartum contraceptive method choice?

**Method:** Women hospitalised at the High Risk Pregnancy unit of a tertiary research and training hospital were asked to complete a self-reported questionnaire that included demographic characteristics, presence of unintended pregnancy, contraceptive method of choice before the current pregnancy, plans for contraceptive use following delivery and requests for any contraceptive counselling in the postpartum period.

**Findings:** A total of 655 pregnant women were recruited. The mean age, gravidity and parity of the women were  $27.48 \pm 6.25$  years,  $2.81 \pm 2.15$  and  $1.40 \pm 1.77$ , respectively. High-risk pregnancy indications included 207 (31.6%) maternal, 396 (60.5%) foetal and 52 (7.9%) uterine factors. All postpartum contraceptive choices except for combined oral contraceptives (COCs) usage were significantly different from preconceptional contraceptive preferences ( $p < 0.001$ ). High-risk pregnancy indications, future child bearing, ideal number of children, income and education levels were the most important factors influencing postpartum contraceptive choices. While the leading contraceptive method in the postpartum period was long-acting reversible contraceptive methods (non-hormonal copper intrauterine device Cu-IUD, the levonorgestrel-releasing intrauterine system (LNG-IUS) (40%), the least preferred method was COCs use (5.2%) and preference of COCs use showed no difference between the preconceptional and postpartum periods ( $p = 0.202$ ). Overall 73.7% of the women wanted to receive contraceptive counselling before their discharge.

**Conclusion:** A high-risk pregnancy condition may change the opinion and preference of contraceptive use, and also seems to affect the awareness of family planning methods.

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## 1. Introduction

The aim of preconception care for all pregnancies is to reduce the risk of adverse health effects for the woman, foetus, or neonate by optimising the woman's health and knowledge before planning and conceiving a pregnancy.<sup>1</sup> Therefore, the timing of a pregnancy is of great importance for improving pregnancy outcomes not only for healthy couples, but also those with medical disorders.

High-risk pregnancies are associated with increased morbidity and mortality, either for the mother or the foetus, or both. Risk assessment of a pregnant woman should be part of her routine prenatal care. This risk assessment should be also noted soon after her labour and at the postpartum period. Many risk factors, including socioeconomic, medical and pregnancy related problems – preexisting, antepartum, or intrapartum-, may cause deterioration of pregnancy outcome.<sup>2,3</sup> Maternal or foetal health problems that rise during pregnancy might alter patients' view about future pregnancies. Although these pregnant women, having a high-risk condition in their pregnancies, are closely followed during the antenatal period and have more antenatal visits than other

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healthier counterparts and are even mostly hospitalised for long periods; they do not have better counselling for future family planning methods.<sup>4</sup>

When pregnancies are “too early, too late, too many, and too close”, maternal and neonatal outcomes are negatively affected.<sup>5</sup> The risks of childbirth are known to vary with the mother’s age and may also be linked to her parity and to the interval since the previous birth.<sup>6</sup> Despite the improvement in postpartum family planning programmes and contraceptive technology, still unintended and high-risk pregnancies occur frequently. The connections between contraceptive use, unintended pregnancies and women with a recent preterm delivery have been reported.<sup>7–9</sup> Women having unintended pregnancies unfortunately report not using contraceptives, or inconsistent and ineffective method use.<sup>10</sup>

Though clinicians are assisted by the American College of Obstetricians and Gynecologists (ACOG) and the US Centers for Disease Control and Prevention (CDC) guidelines about contraceptive preferences for women with medical comorbidities, there is still lack of knowledge and usage of contraceptive methods.<sup>4</sup> It should be kept in mind that family planning and consistent contraceptive use is an important key to achieve maternal and infant health.<sup>11</sup>

Our hypothesis in this study was that pregnant women followed as having “high-risk pregnancy” would be more inclined to use contraceptive methods after delivery and their current situation may create awareness about planning the future pregnancies. We evaluated and compared the knowledge and preferences of preconceptional contraceptive methods and future plans for postpartum contraceptive usage and analysed the requests for any contraceptive counselling in the postpartum period.

## 2. Subjects and methods

The study was conducted at the High-Risk Pregnancy Clinic of a tertiary research and training hospital. The Institutional Local Ethics Committee and Institutional Education and Planning Committee approvals were obtained and each patient gave a signed informed consent for recruitment to the study. From January 2009 to May 2011, face-to-face interviews were carried out with 655 pregnant women with pregnancies greater than 20 weeks of gestation who were admitted for at least one high-risk obstetric indication and who were between the ages of 16 and 48. A high-risk pregnancy was defined as a pregnancy affected by a pre-existing or a pregnancy-related condition that leads to increased risk of morbidity or mortality before or after delivery for the mother, foetus, or neonate. Patients who were not in a stable medical condition and who could not fill in the questionnaire without help were not included in the study.

Each patient was asked to complete a questionnaire that included 25 questions related to demographic characteristics, presence of unintended pregnancy, educational and economic status, prior contraceptive use and postpartum plans for contraceptive use following delivery. Prior contraceptive use and future plans for contraceptive use following delivery were assessed with multiple-choice questions. The questionnaire also contained questions about the source of contraceptive knowledge and whether the individual wanted to get counselling on contraception before discharge. All responses to the questions are the basis for the findings.

### 2.1. Patient classification

High-risk conditions were classified as maternal, foetal and uterine factors. Maternal factors included diabetes mellitus (gestational or pregestational), hypertensive disorders (preclampsia, eclampsia, chronic hypertension and gestational

hypertension), obesity, grandmultiparity, pregnancy and other factors (anaemia, infections, other systemic diseases). Foetal factors consisted of foetal growth disorders, disorders of amniotic fluid volume (AFV), postterm pregnancies, preterm delivery, multifetal gestation, foetal anomalies. Uterine factors included previous uterine surgery (repeated caesarean section or myomectomy), abnormalities of the placenta, umbilical cord and membranes (placenta previa, placenta accreta, – increta or – percreta), and cervical incompetence.

### 2.2. Questionnaire variables

**Sociodemographic characteristics.** Age, gravidity, parity, induced abortion, marital status, education levels, working status, family income, and the presence of health insurance were noted. Induced abortion was defined as surgically or medically terminated pregnancies by the request of parents without any medical necessity. Education levels were considered as primary school for 5 years education, secondary school for 8 years education, high school for 12 years education. Women who had never been to school or had learned how to read and write but not able to finish the school, were accepted as no education. Family income equal or lower than minimum wage was considered as low, up to twice of the minimum wage as moderate and higher than twice of the minimum wage was evaluated as high-income level.

**Pregnancy intention.** Participants were asked if they had any demand for another pregnancy and when they would prefer to become pregnant again. They were also asked for the ideal number of children.

**Contraceptive use.** Participants were asked “What kind of birth control were you or your husband or partner using before getting pregnant?” for their prior contraceptive use. To assess future plans for contraceptive use following delivery, they were asked “Are you or your husband or partner going to use a method to prevent pregnancy?” The ones who responded “yes” to the question were asked “What kind of birth control are you or your husband or partner planning to use?” Participants were also approached if they knew or had heard about all contraceptive methods available in Turkey (barrier methods, copper intrauterine device (Cu-IUD), the levonorgestrel-releasing intrauterine system (LNG-IUS), combined oral contraceptives (COCs), combined monthly injection, combined vaginal ring, depot-injection, mini-pill, progesterone implant) by choosing “Yes, I have heard.”, “No, I have not heard before.”. Traditional methods of contraception included withdrawal (coitus interruptus) and periodic abstinence.

SPSS (Statistical Package for the Social Sciences) version 17.0 was used to record and statistically analyse the data. Normally distributed data were expressed as means  $\pm$  standard deviation and data that were non-normally distributed was expressed as the median for descriptive statistics. Chi-square test was used and statistical significance was defined as  $p < 0.05$ .

## 3. Results

### 3.1. Participants’ demographics

Of the 692 questionnaires distributed, 655 were returned. The response rate was 94.6%. The mean age, gravidity and parity of the patient group were  $27.48 \pm 6.25$  years (range 16–48 years),  $2.81 \pm 2.15$  (range 1–12) and  $1.40 \pm 1.77$  (range 0–11) respectively. Of 655 pregnant women, 29.2% were nulliparous. Approximately two thirds of the participants lived in Ankara, the capital city of Turkey, and the vast majority of them (96.2%) had health insurance.

In the study population, while 80.2% of the women reported that the current pregnancy was desired, one-fifth (19.8%) of them reported the current pregnancy as unintended with a concomitant

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