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Contraceptive service needs of women with young children presenting for pediatric care

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Abstract

Objectives: The primary objective of this study is to characterize the need for contraceptive services and contraceptive method use among women with young children presenting to child health clinics. A secondary objective is to characterize the factors, including access to care and health needs, that exist in this population and to evaluate their association with contraceptive method use.
Study design: This is a cross-sectional study of women with children under age 36 months presenting to four child health practices in the Baltimore, Maryland, area. Participating women completed a survey to assess desire for pregnancy, contraceptive method use and related characteristics.
Results: A total of 238 participants (82%) were in need of contraceptive services (fertile and not desiring pregnancy). Overall, 59 (25%) of women in need were not using a contraceptive method (unmet need) and 79 (33%) were using a highly effective method (implant or intrauterine device). Factors associated with lower odds of unmet need for contraceptive services included attendance at a routine postpartum visit and visiting a healthcare provider to discuss contraception after pregnancy. Approximately half of index pregnancies were unintended and this was the only health factor associated with greater odds of using of a highly effective contraceptive method.
Conclusions: Most women presenting with young children for pediatric care indicated that they were not currently trying to become pregnant and reported current methods of pregnancy prevention that ranged from none to highly effective. Women who had not sought postpregnancy contraceptive care were more likely to have unmet need for contraceptive services.
Implications: Child health clinics may be a novel site for providing contraceptive care to women with children as part of a strategy to reduce unplanned pregnancies.

Keywords: Contraception; Family planning; Preconception health; Pediatrics; Health services

1. Introduction

Approximately half of pregnancies in the United States are intended [1]. Unintended pregnancies are associated with a number of undesirable outcomes including short interpregnancy intervals, late entry into prenatal care and low birth weight [2–4]. Healthy People 2020 goals set objectives to increase the proportion of pregnancies that are intended in the United States by 10%, to increase the proportion of pregnancies spaced at least 18 months from prior birth and to increase the proportion of sexually experienced females who receive reproductive health services annually [5]. Achievement of these objectives requires new approaches to improve pregnancy planning and reproductive health service delivery.

Use of contraception, particularly long acting and hormonal methods, has proven efficacy to reduce unplanned pregnancy and improve birth spacing. Programs in California, Missouri and Colorado that offer free or low-cost contraception in order to increase access to highly effective methods [intrauterine devices (IUDs) and implants] demonstrate significant decrease in unintended pregnancy rates and increased interpregnancy intervals [6–8].

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In contrast to funded projects where women receive equal access to all contraceptive methods at no cost, real-world provision of contraceptive services varies based on many factors, including having a usual source of care and health insurance [9–11]. Young, poor women who are statistically most likely to experience unplanned pregnancies [12] also undergo transitions in their use of health services as they move into their reproductive years [13] and are significantly less likely to have received reproductive health services in the last 12 months than women with advanced degrees [14]. Finally, underlying health conditions also influence the acceptability and availability of contraceptive methods [15].

Child health clinics may present a novel site to deliver reproductive healthcare for women, particularly those who may not be seeking care for themselves. A recent study from India, for example, suggested that child immunization clinics are a potential site of contraceptive care for mothers [16]. In the United States, pediatric guidelines recommend that child health providers discuss pregnancy planning and spacing with their patients' mothers at certain visits [17] and some recommend offering contraception [18]. To our knowledge, no US studies have assessed the extent of contraceptive service needs among women presenting with children for pediatric care and whether this has been incorporated into standard of care.

The primary objective of this study is to characterize the need for contraceptive services and contraceptive method use among women with young children presenting for care at child health clinics. A secondary objective is to characterize the factors, including access to care and health conditions, that exist in this population and to evaluate their association with contraceptive method use. Andersen's Behavioral Model of Health Services Use [19] informed the framework for this objective. The Andersen model suggests that predisposing factors that provide motivation, enabling factors that provide resources and health needs that provide actual stimulus to engage in care all influence healthcare use.

2. Materials and methods

We conducted a cross-sectional survey with a sample of women bringing children for care to four child health clinics in the Baltimore, Maryland, area. We selected clinics to include a variety of practice types (academic, community, private practice) and facilitate recruitment of low-income, minority (African-American and Latina) women at risk for poor birth outcomes and limited access to healthcare. Providers of pediatric care at the clinics were primarily pediatricians, but they also included combined internal medicine-pediatric physicians and pediatric nurse practitioners.

Women were eligible to participate in the survey if they had a child aged 36 months or younger who was a patient in one of the participating practices. We excluded women who did not speak English or Spanish or who were not the biological mother of the child. Research assistants approached women in the clinic waiting room or in examination rooms after introduction by clinic staff, to assess interest in participation and eligibility. After informed consent, women completed a 30- to 45-min survey either in person or by phone depending on their preference and space availability in the clinic. Participants received a US$25 gift card for completing the survey. Study procedures were approved by the Johns Hopkins Hospital Institutional Review Board.

The primary outcome measure of interest was "in need of contraceptive services," defined as not currently pregnant or planning pregnancy in the next 6 months and neither she nor her partner was sterile [20]. The secondary outcome was effectiveness of contraceptive method used. We classified effectiveness as Tier 1 (IUD, implant), Tier 2 (injectable or combined hormonal method), Tier 3 (barrier methods, fertility awareness) or Tier 4 (withdrawal, spermicides) [21]. If a woman reported use of more than one method (e.g., condoms plus hormonal method), we used the most effective method for classification. We defined unmet need for contraceptive services as women classified as in need but not currently using a contraceptive method.

Drawing on the Andersen model [19] and prior literature [9,11], we included the following covariates as "predisposing factors" for contraceptive service use: age (years), race, Hispanic ethnicity, level of education (coded as high school or less vs. more than high school) and relationship status (coded as married or living with partner vs. single or not living with partner). We also included obstetric history, including parity and time since last birth (months).

Enabling resources considered for our analysis included current insurance coverage/type; whether respondent had a usual source of healthcare (yes/no) and location of usual source (coded as clinic, doctors office, urgent care/emergency room); attendance at a routine postpartum visit (coded as yes/no); preventive care visit in the 12 months prior to the survey, excluding care related to their pregnancy (coded as yes/no); and healthcare visit to discuss contraception after their pregnancy (coded as yes/no).

We evaluated several health needs that might provide stimulus to engage in care. Women indicated their perceived health status by response to the question "How would describe your own health? Would you say: Excellent, Very Good, Good, Fair or Poor?" Responses were coded as "Fair/Poor" vs. "Excellent/Very Good/Good." Chronic health conditions included self-reported asthma, high blood pressure, depression/anxiety and diabetes. Body mass index (BMI) was calculated as kilograms per squared meter (kg/m^2) based on self-reported height and weight. We classified women as being obese if they had a BMI ≥ 30 kg/m^2.

The final health factor we evaluated as a potential stimulus for seeking contraceptive care was intendedness of the index pregnancy. We assessed intendedness with two questions: "Thinking back to just before you got pregnant with your most recent child, how did you feel about becoming pregnant? Did you want to be pregnant…" with