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Unmet demand for highly effective postpartum contraception in Texas☆,☆☆

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Abstract

Objectives: We aimed to assess women's contraceptive preferences and use in the first 6 months after delivery. The postpartum period represents a key opportunity for women to learn about and obtain effective contraception, especially since 50% of unintended pregnancies to parous women occur within 2 years of a previous birth.
Methods: We conducted a prospective cohort study of 800 postpartum women recruited from three hospitals in Austin and El Paso, TX. Women aged 18–44 who wanted to delay childbearing for at least 24 months were eligible for the study and completed interviews following delivery and at 3 and 6 months postpartum. Participants were asked about the contraceptive method they were currently using and the method they would prefer to use at 6 months after delivery.
Results: At 6 months postpartum, 13% of women were using an intrauterine device or implant, and 17% were sterilized or had a partner who had had a vasectomy. Twenty-four percent were using hormonal methods, and 45% relied on less effective methods, mainly condoms and withdrawal. Yet 44% reported that they would prefer to be using sterilization, and 34% would prefer to be using long-acting reversible contraception (LARC).
Conclusions: This study shows a considerable preference for LARC and permanent methods at 6 months postpartum. However, there is a marked discordance between women's method preference and actual use, indicating substantial unmet demand for highly effective methods of contraception.
Implications: In two Texas cities, many more women preferred long-acting and permanent contraceptive methods (LAPM) than were able to access these methods at 6 months postpartum. Women's contraceptive needs could be better met by counseling about all methods, by reducing cost barriers and by making LAPM available at more sites.

Keywords: LARC; Female sterilization; Postpartum contraception; Hispanic; Texas

1. Introduction

Although much is known about the mix of contraceptive methods in use in the United States (US), it is unclear whether the current distribution actually reflects women's preferences. Many women who intend to limit their fertility or delay childbearing continue to rely on methods with relatively high typical-use failure rates such as oral contraceptives, condoms and withdrawal. While use of long-acting reversible contraception (LARC) has increased over the last decade [1,2], it has been argued persuasively that unintended pregnancy rates could be reduced if more women relied on highly effective methods [3,4].

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Yet low utilization of LARC may not reflect the true underlying demand for the intrauterine device (IUD) and implant. Several demonstration projects, particularly the Contraceptive CHOICE Project in St. Louis, have shown a dramatic uptake of LARC when there is supportive counseling and the methods are provided at no cost [5,6]. Demand for male and female sterilization may not be fully met either due to a variety of access barriers [7–13].

According to the most recent cycle of the National Survey of Family Growth (NSFG), approximately half of all pregnancies in the US are unwanted or mistimed, and 61% of all unintended pregnancies and 75% of unwanted births occur to women who have already had at least one live birth [14,15]. Furthermore, despite the improved access to health care and insurance coverage in the immediate postpartum period and the increased motivation to prevent pregnancy, over half of unintended pregnancies occur within 2 years following delivery [16]. In this paper, our objectives are to describe contraceptive method preferences in the postpartum period among women in two cities in Texas and to determine whether women are able to access their preferred methods.

2. Materials and methods

This study was conducted shortly after the Texas state legislature drastically reduced funding for family planning, and many providers of subsidized family planning services had experienced substantial cuts in their budgets [17]. Participants were recruited after delivery at one hospital in Austin and two in El Paso chosen to obtain a mix of publicly and privately insured participants and socioeconomic groups. We aimed to enroll 400 women in each city: 300 who were publicly insured and 100 who were privately insured at the time of delivery. Eligible participants were aged between 18 and 44 years, did not want more children for at least 2 years at the time of recruitment, delivered a healthy singleton infant whom they expected would go home with them upon discharge, spoke English or Spanish, and lived in the US within 50 miles of the hospital of recruitment. After obtaining signed informed consent from participants, we administered a 20-minute face-to-face baseline interview. Recruitment took place between April and July 2012 in Austin and between July and November 2012 in El Paso. Follow-up interviews were conducted by telephone at 3, 6 and 9 months postpartum. We offered a $30 incentive for completing the initial interview and $15 for completing each of the telephone interviews.

The initial baseline questionnaire collected information on demographic and socioeconomic variables including age, parity, relationship status, ethnicity, education, insurance status and income. Insurance status, future childbearing intentions and contraceptive use were assessed at baseline and in each of the three succeeding interviews. Intentions were assessed using the question “Do you plan to have more children in the future?” Those who did want more children were asked a follow-up question to assess the desired timing. In the baseline interview, participants were asked if they had had a tubal ligation or if an IUD or subdermal implant had been inserted while they were in the hospital. At each successive interview, the contraceptive use questions referred to the full range of methods with a prompt for use of methods that might not be thought of as birth control such as abstinence or a method that a spouse or partner was using. The very small number of women who stated that they were using two methods together was classified as using the more effective of the two methods [18].

To track participants’ contraceptive preferences, we designed a panel of questions asked over the course of the first three interviews (Fig. 1). At the 3-month postpartum interview, we asked about the birth control method participants wanted to be using at 6 months postpartum. We chose 6 months since, by that time, most women have resumed sexual relations and will no longer be relying on exclusive breastfeeding as a contraceptive. This interview also included a prompt asking for any method that the participant might have left out because it was too expensive or not covered by her insurance. At the 6-month interview, women who had not mentioned LARC in response to any previous question were also asked, “Would you consider using an IUD if it was offered free or for a small fee?” The same question was also asked about the implant. To ensure demand for sterilization was fully captured, women who had not previously expressed a desire for tubal ligation or vasectomy, and who did not want any more children or who did not know if they wanted more children in the future were also asked, “Would you like to have had a tubal ligation in the hospital right after you had your new baby?” Finally, these same participants were asked, “Would you like your husband/partner to get a vasectomy?”

We distinguished between a participant’s preferred contraceptive method given in response to the direct method preference question and any method that was mentioned as a response to any of the method preference prompts, terming the latter a “latent preference.” We then classified the unprompted preference and the latent preference into a tiered hierarchy constructed according to method efficacy based upon that detailed in *Contraceptive Technology*[19]. The lowest tier, which we term “less effective methods” (LEM), includes condoms, withdrawal, spermicides, sponges, fertility-based awareness methods (including the rhythm method) and abstinence. The second tier, which we term “hormonal methods,” includes combined and progestin-only contraceptive pills, injectables, the vaginal ring and the patch. The third tier, LARC, includes the implant, Copper-T IUD and the levenorgestrel-releasing intrauterine system. We also distinguished a fourth tier for permanent methods: female sterilization and vasectomy. If a participant expressed a latent preference for more than one method, her preference was categorized based on the most effective method mentioned. Women who had obtained a tubal ligation or whose partners or spouses had obtained a vasectomy were classified as having a preference for a permanent method.