

## GYNECOLOGY

# Contraceptive counseling and postpartum contraceptive use

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**OBJECTIVE:** The objective of the study was to examine the associations between prenatal and postpartum contraceptive counseling and postpartum contraceptive use.

**STUDY DESIGN:** The Pregnancy Risk Assessment Monitoring System 2004–2008 data were analyzed from Missouri, New York state, and New York City ( $n = 9536$ ). We used multivariable logistic regression to assess the associations between prenatal and postpartum contraceptive counseling and postpartum contraceptive use, defined as any method and more effective methods (sterilization, intrauterine device, or hormonal methods).

**RESULTS:** The majority of women received prenatal (78%) and postpartum (86%) contraceptive counseling; 72% received both. Compared with those who received no counseling, those counseled during 1 time period (adjusted odds ratio [AOR], 2.10; 95% confidence interval [CI], 1.65–2.67) and both time periods (AOR, 2.33; 95% CI, 1.87–2.89) had significantly increased odds of postpartum use of a more effective

contraceptive method (32% vs 49% and 56%, respectively;  $P$  for trend  $< .0001$ ). Results for counseling during both time periods differed by type of health insurance before pregnancy, with greater odds of postpartum use of a more effective method observed for women with no insurance (AOR, 3.51; 95% CI, 2.18–5.66) and Medicaid insurance (AOR, 3.74; 95% CI, 1.98–7.06) than for those with private insurance (AOR, 1.87; 95% CI, 1.44–2.43) before pregnancy. Findings were similar for postpartum use of any contraceptive method, except that no differences by insurance status were detected.

**CONCLUSION:** The prevalence of postpartum contraceptive use, including the use of more effective methods, was highest when contraceptive counseling was provided during both prenatal and postpartum time periods. Women with Medicaid or no health insurance before pregnancy benefited the most.

**Key words:** contraception, contraceptive counseling, postpartum period, prenatal care

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Nearly half of US pregnancies are unintended (UIP),<sup>1</sup> and approximately one-third are conceived within 18 months of a previous live birth.<sup>2</sup>

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UIPs have been associated with maternal substance use during pregnancy, delayed prenatal care, low birthweight, and preterm delivery.<sup>3</sup> Short interpregnancy intervals (IPIs) have been associated with small for gestational age, low birthweight, and preterm delivery.<sup>4</sup>

Postpartum contraceptive use is a primary strategy for reducing UIPs and optimizing birth spacing<sup>5</sup> yet during 2004–2006, 12% of women with a recent live birth reported not using any method of contraception and only 62% reported using highly effective methods (ie, sterilization, intrauterine device, pills, patch, ring, or shots).<sup>6</sup> Less than optimal postpartum contraceptive use highlights the need to understand associated factors, including the potential role of contraceptive counseling during the prenatal and postpartum periods.

The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics recommend

that discussion of contraceptive options and prompt initiation of a method postpartum should be a primary focus of routine prenatal and postpartum care.<sup>7</sup> Ideally, contraceptive counseling for pregnant women begins during the prenatal period because women in the immediate postpartum period are typically focused on childbirth recovery and newborn care. Contraceptive counseling during the prenatal and postpartum periods is also important because pregnancy and childbirth may change a woman's preference for contraception. In one study, 46% of postpartum women chose to use a different method postpartum than the one used before pregnancy, preferring a method that was easy to use, had long-term protection, and did not require a monthly pharmacy trip.<sup>8</sup>

Although studies have reported the effects of prenatal contraceptive counseling on postpartum contraceptive use among women<sup>9–11</sup> and adolescents,<sup>12</sup>

the effects of postpartum contraceptive counseling, independently and in combination with prenatal contraceptive counseling, have not been explored. This analysis examines the associations between prenatal contraceptive counseling, postpartum contraceptive counseling, and both prenatal and postpartum contraceptive counseling with the use of any and more effective contraceptive methods.

## MATERIALS AND METHODS

The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, population-based surveillance system that gathers information on maternal behaviors and experiences before, during, and after pregnancy from selected states in the United States and New York City. Samples of women with recent live births are drawn from state birth certificates 2-6 months after delivery.

Data are collected by mailed questionnaires; nonrespondents are contacted by telephone. The PRAMS questionnaire in each reporting area includes core questions that appear on all PRAMS surveys and area-specific questions of interest. To produce data representative of the state birth population, data are weighted for sample design, nonresponse, and noncoverage. More detail on the PRAMS methodology has been published previously<sup>13</sup> and is also available from the PRAMS web site (<http://www.cdc.gov/prams>).

We analyzed 2004-2008 data from 3 reporting areas (Missouri, New York state [excluding New York City], and New York City), the only PRAMS reporting areas that added questions on receipt of postpartum contraceptive counseling and specific contraceptive methods used postpartum to their core PRAMS surveys. Other PRAMS participating states did not collect this information.

To be included in the analyses, reporting areas must have achieved an overall weighted response rate of 65% or more for each year of data. Data were included for 2004-2008 for New York State, 2004-2007 for New York City, and 2007 for Missouri. The annual weighted response rates for these reporting areas

during 2004-2008 ranged from 65% to 73%. The PRAMS project was approved by the Institutional Review Board of the Centers for Disease Control and Prevention.

Prenatal contraceptive counseling was measured by asking, "During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos." One topic listed was birth control methods to use after my pregnancy.

Postpartum contraceptive counseling was measured by asking, "After your new baby was born, did a doctor, nurse, or other health care worker talk with you about using birth control?" To examine postpartum contraceptive use, women were asked, "Are you or your husband or partner doing anything now to keep you from getting pregnant?" and "What kind of birth control are you or your husband or partner using now to keep from getting pregnant?"

Respondents who answered no to the first question were classified as using no method and were not asked the second question, which included 13 response options for specific contraceptive methods and other. Respondents answering other were given the opportunity to write in a response; some responses were recoded into existing method options or new response options that were added (ie, implant, spermicide). PRAMS questions are cognitively and field tested prior to being included on the survey and evaluated every 3-4 years afterward.

More effective methods were defined as those with less than 10% of women experiencing an UIP within the first year of typical use based on published effectiveness rates<sup>14</sup> and included tubal ligation, vasectomy, implant, intrauterine device, shot, pill, patch, or ring; this classification was chosen to be consistent with a prior report.<sup>6</sup>

Less effective methods were those with 10% or more of women experiencing an UIP within the first year of typical use and included diaphragm, condoms, cervical cap, sponge, withdrawal, spermicide, or rhythm method.

Women reporting the use of more than 1 method were classified as using the most effective of the multiple methods consistent with prior reports.<sup>6,10,12</sup>

To focus on postpartum women at risk for UIP or short IPI, we excluded women who reported that they were currently pregnant ( $n = 70$ ), were not sexually active at the time of the survey ( $n = 675$ ), or had undergone a hysterectomy ( $n = 7$ ). We also excluded respondents who answered yes to the postpartum contraceptive use core question and either did not respond to the question about the type of contraceptive method used ( $n = 418$ ) or responded other to the question but the write-in response could not be recoded ( $n = 24$ ).

We excluded women with missing data on the outcome or exposure variables of interest ( $n = 431$ ) and women who did not receive prenatal care ( $n = 108$ ) because these women did not have the opportunity to receive prenatal contraceptive counseling. Theoretically, all postpartum women had the opportunity to receive postpartum contraceptive counseling (eg, in the hospital prior to discharge), so we did not make exclusions based on the receipt of a postpartum care visit.

Separate multivariable logistic regression models were used to examine associations between prenatal, postpartum, and prenatal and postpartum contraceptive counseling and the use of any contraceptive method (yes vs no) and the use of a more effective contraceptive method (yes vs a less effective or no method). Based on a priori considerations, we adjusted for age group, race/ethnicity, marital status, education, type of insurance before pregnancy, pregnancy intention of the most recent live birth, number of previous live births, current breast-feeding, months since delivery, reporting area, and year.

To maximize the number of observations included in multivariable analyses, control variables with more than 2% missing data were recoded to include missing as a response category. We also adjusted for postpartum contraceptive counseling (when examining the effect of prenatal contraceptive counseling)

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