Contraception

Contraception 92 (2015) 268–275

Original research article

Intimate partner violence and postpartum contraceptive use: the role of race/ethnicity and prenatal birth control counseling

Susan Cha[a,*], Derek A. Chapman[a], Wen Wan[b], Candace W. Burton[c], Saba W. Masho[a]

[a]Department of Family Medicine and Population Health, Division of Epidemiology, Virginia Commonwealth University, School of Medicine, Richmond, VA 23298, USA
[b]Department of Biostatistics, Virginia Commonwealth University, School of Medicine, Richmond, VA 23298, USA
[c]Department of Family and Community Health Nursing, Virginia Commonwealth University, School of Nursing, Richmond, VA 23298, USA

Received 6 January 2015; revised 23 March 2015; accepted 22 April 2015

Abstract

Objectives: Intimate partner violence (IPV) is a major problem that could affect reproductive decision making. The aim of this study is to examine the association between IPV and contraceptive use and assess whether the association varies by receipt of prenatal birth control counseling and race/ethnicity.
Study design: This study analyzed the 2004–2008 national Pregnancy Risk Assessment Monitoring System (PRAMS) that included 193,310 women with live births in the United States. IPV was determined by questions that asked about physical abuse by a current or former partner in the 12 months before or during pregnancy. The outcome was postpartum contraceptive use (yes vs. no). Multiple logistic regression analyses were conducted to assess the influence of experiencing IPV at different periods (preconception IPV, prenatal IPV, both preconception and prenatal IPV, preconception and/or prenatal IPV). Data were stratified to assess differential effects by race/ethnicity and receipt of birth control counseling.
Results: Approximately 6.2% of women reported IPV, and 15.5% reported no postpartum contraceptive use. Regardless of the timing of abuse, IPV-exposed women were significantly less likely to report contraceptive use after delivery. This was particularly true for Hispanic women who reported no prenatal birth control counseling and women of all other racial/ethnic groups who received prenatal birth control counseling.
Conclusions: IPV victimization adversely affects the use of contraceptive methods following delivery in women with live births. Birth control counseling by health providers may mitigate these effects; however, the quality of counseling needs further investigation. Better integration of violence prevention services and family planning programs is greatly needed.
Implications: Consistent with national recommendations by the U.S. Preventive Service Task Force, clinicians and public health workers are strongly encouraged to screen for IPV. Health providers should educate women on effective contraceptive options and discuss long-acting reversible contraceptives that are not partner dependent within the context of abusive relationships.

Keywords: Intimate partner violence; Family planning; Contraception; Birth control; PRAMS

1. Introduction

Intimate partner violence (IPV) is a major problem in the United States [1,2]. One in four women experience some form of IPV in the course of their lives, creating potentially dangerous situations for pregnant women and infants [3]. Based on a national study of primiparous women, it was conservatively estimated that IPV affects approximately 8% and 5% of women before and during pregnancy, respectively, with rates of victimization increasing to 12% after delivery [4].

All forms of abuse may have serious consequences such as physical injuries, mental health problems, repeat abortions, sexually transmitted infections and death [2,5,6]. Poor birth spacing is also prevalent among IPV-exposed women [7] and could lead to poor perinatal outcomes including preterm births, small-for-gestational-age or low-birth-weight infants, and neonatal death [8–11]. Disparities in perinatal problems evident in high-risk populations may be partially attributed to IPV, which disproportionately impacts women who are young, poor, less educated and racial/ethnic minorities [5,12,13].

* Corresponding author. Tel.: +1 804 828 9785.
E-mail address: chas@vcu.edu (S. Cha).

http://dx.doi.org/10.1016/j.contraception.2015.04.009
0010-7824/

IPV has been well studied and emerges as a prominent risk factor for engaging in adverse behaviors [14,15]. Women who experience IPV are more likely to abuse substances and engage in risky sexual behaviors including multiple sex partners, early sexual debut and unprotected sex [15,16]. Victims are also more likely to report inconsistent or lack of contraceptive use [13,17,18]. Recent studies have also explored racial/ethnic disparities in contraceptive use, efficacy and choice of method [19,20]. Foreign-born Asian and black women are less likely to use highly effective contraceptive methods (i.e., intrauterine device and hormonal methods) compared to white women [20]. Data from the 2006–2010 National Survey of Family Growth also indicated that more Hispanic (15.0%) and non-Hispanic black (21.3%) women experienced contraceptive failures within the first 12 months of typical use than non-Hispanic white women (10.1%) [19]. While this may be partially attributed to method preferences, IPV and partner interference were not considered. This is critical since minority women are more likely to experience partner violence [1].

Prior studies highlight women's compromised ability to enforce decisions about contraceptive use and pregnancy particularly in abusive relationships [7,21–24]. Reproductive coercion, that is, coercive behaviors by male partners that promote or encourage the termination of pregnancy, has been previously reported [7,25]. In one nationally representative sample of adult women, 8% of respondents reported that their current partner interfered with their birth control use [26]. Women who indicated partner interference with birth control use were twice as likely to report high partner involvement in contraceptive services compared to women whose partners did not interfere. Nevertheless, variable IPV definitions (e.g., physical vs. sexual abuse), differences in assessment of IPV occurrence (e.g., before, during or after pregnancy; lifetime vs. past year), failure to account for important confounders, study design and sample size issues have contributed to inconsistent and biased results [13,17,18,27]. These limitations warrant further investigation of the association between IPV victimization and postpartum contraceptive use.

The framework for this study is based on the ecosocial model for IPV and Coker's model of IPV and sexual health [16,28]. Collectively, they illustrate the contextual factors and mechanisms through which IPV affects women's sexual health and behaviors. The study objective is to examine the extent to which IPV around the time of pregnancy is associated with postpartum contraceptive use among women in the United States. Furthermore, this paper evaluates differences by race/ethnicity and receipt of prenatal birth control counseling.

2. Methods

2.1. Study population

This study analyzed data from the national 2004–2008 Pregnancy Risk Assessment Monitoring System (PRAMS). The Centers for Disease Control and Prevention established this population-based surveillance system to collect national data on maternal behaviors around the time of pregnancy. Detailed methodology for collecting PRAMS data is published elsewhere [29]. The sample for this analysis included women who delivered a live birth and received some form of prenatal care (N=193,310).

2.2. Measurements

A survey item asking, "Are you or your husband or partner doing anything now to keep from getting pregnant? Some things people do to keep from getting pregnant include not having sex at certain times [rhythm] or withdrawal, and using birth control methods such as the pill, condoms, cervical ring, IUD, having their tubes tied, or their partner having a vasectomy" assessed postpartum contraceptive use. Responses were categorized as contraceptive use or nonuse.

IPV was determined by survey items that asked about physical abuse by a current or former partner/spouse in the 12 months before or during pregnancy. Responses were recoded into four dichotomous variables based on the timing of IPV: (a) preconception IPV (abuse in the 12 months prior to pregnancy only), (b) prenatal IPV (abuse during pregnancy only), (c) both preconception and prenatal IPV and (d) preconception and/or prenatal IPV [30]. Women who failed to answer all questions about timing of abuse by an intimate partner were not included in the mutually exclusive categories (i.e., "preconception IPV," "prenatal IPV," "preconception and prenatal IPV") to avoid misclassification (n=3579).

Sociodemographic, psychosocial and behavioral factors were considered as potential covariates. Maternal sociodemographic variables included race/ethnicity, age, education, household income, marital status at delivery, insurance during pregnancy, adequacy of prenatal care utilization and participation in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Receipt of prenatal birth control counseling was based on a question that asked, "During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about … birth control methods to use after my pregnancy?" Health behavioral factors (i.e., prenatal cigarette smoking, pre-pregnancy birth control use and pre-pregnancy multivitamin use), parity, pregnancy intention for the last pregnancy and stressful life events in the 12 months before delivery were also considered.

2.3. Statistical analysis

Analyses were conducted in SAS 9.4 to account for the complex survey design. Descriptive statistics such as unweighted frequencies and weighted percentages were generated to assess the distribution of characteristics among participants by postpartum contraceptive use. Separate logistic regression models provided odds ratios (ORs) and 95% confidence intervals (CIs) to determine factors