

Low-Income Texas Women's Experiences Accessing Their Desired Contraceptive Method at the First Postpartum Visit

CONTEXT: Early access to contraception may increase postpartum contraceptive use. However, little is known about women's experiences receiving their desired method at the first postpartum visit or how access is associated with use.

METHODS: In a 2014–2016 prospective cohort study of low-income Texas women, data were collected from 685 individuals who desired a reversible contraceptive and discussed contraception with a provider at their first postpartum visit, usually within six weeks of birth. Women's experiences were captured using open- and closed-ended survey questions. Thematic and multivariate logistic regression analyses were employed to examine contraceptive access and barriers, and method use at three months postpartum.

RESULTS: Twenty-three percent of women received their desired method at the first postpartum visit; 11% a prescription for their desired pill, patch or ring; 8% a method (or prescription) other than that desired; and 58% no method. Among women who did not receive their desired method, 44% reported clinic-level barriers (e.g., method unavailability or no same-day provision), 26% provider-level barriers (e.g., inaccurate contraceptive counseling) and 23% cost barriers. Women who used private practices were more likely than those who used public clinics to report availability and cost barriers (odds ratios, 6.4 and 2.7, respectively). Forty-one percent of women who did not receive their desired method, compared with 86% of those who did, were using that method at three months postpartum.

CONCLUSION: Eliminating the various barriers that postpartum women face may improve their access to contraceptives. Further research is needed to improve the understanding of clinic- and provider-level barriers.

Perspectives on Sexual and Reproductive Health, 2018, 50(4):189–198, doi:10.1363/psrh.12083

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The American College of Obstetricians and Gynecologists recommends that contraception be available immediately following delivery and at the first postpartum visit.^{1,2} Starting a highly effective method of contraception right after delivery is associated with a reduction in unintended pregnancies and short interpregnancy intervals.^{3–6} When immediate postpartum contraception is not available or when women do not wish to start a method immediately after delivery, same-day access to contraception at the first postpartum visit becomes crucial. Women who are not breast-feeding may be at risk of pregnancy within four weeks of delivery, and some low-income women lose public health insurance 60 days after delivery.^{7,8} Little is known about women's experiences accessing their desired method of contraception at the first postpartum visit, but available evidence suggests that access is low.^{9,10} A California study found that only 13% of women using Medi-Cal or Family PACT services received contraception at their first visit.⁹ A study of postpartum women in North Carolina found that 45% who were interested in getting an IUD or implant did not receive one at six weeks postpartum because they were unable to return for a required insertion visit.¹⁰

A number of system-, clinic- and provider-level barriers may prevent women from receiving their desired method in the months following delivery. Inadequacies in insurance coverage or provider reimbursement, as well as out-

of-pocket costs, present critical health system barriers.^{5,11–16} A Texas study found that two-thirds of postpartum women were unable to access their desired method within the first six months after delivery because of various financial and health system obstacles.¹⁷ In this state, coverage for mothers using Pregnancy Medicaid (i.e., Medicaid that covers prenatal care, delivery and postpartum care, including contraception for the woman) expires 60 days after they give birth, which limits their ability to see a provider following delivery. Mothers using CHIP Perinatal (part of Emergency Medicaid offered to low-income women who do not qualify for Pregnancy Medicaid, such as undocumented immigrants) receive no coverage for contraception except through Title X-supported clinics or the small number of clinics that receive family planning grants from the state. Out-of-pocket costs for these women can significantly reduce their likelihood of obtaining contraceptives, especially more expensive methods, such as the IUD and the implant.^{18,19}

Even when women are insured, they may not receive their desired contraceptive at the first postpartum visit because clinics may not provide the full range of methods. Long-acting methods are particularly difficult for smaller private clinics to provide because of high up-front costs, poor reimbursement rates and costs of training staff in insertion.²⁰ Among clinics that do provide the full range

of methods, many do not offer same-day insertion of IUDs and implants.^{13,21,22} Requiring women to attend a follow-up visit to obtain their desired method is a known barrier to postpartum contraceptive use.⁵ Challenges with patient scheduling and clinic visit flow, as well as medically unnecessary delays (such as when providers require a visit to test for STDs prior to an IUD placement visit), are reasons clinic staff give for not providing same-day insertion.^{13,21,22}

Another barrier to women's receiving postpartum contraception is that during prenatal or postpartum visits, clinicians may not routinely provide contraceptive counseling. Or they may provide insufficient counseling (i.e., may not give enough information or may discourage use of methods without offering a rationale) or inaccurate counseling (i.e., may present health information that is not consistent with current evidence-based guidelines). This is problematic because prenatal and postpartum contraceptive counseling, both independently and in combination, are associated with increased postpartum contraceptive use.^{23,24} Yet, a study in Texas found that only half of women received prenatal contraceptive counseling, and 30% received prenatal or postpartum counseling that covered the IUD and the implant.²⁵ Other studies have suggested that providers often discourage postpartum use of implants and IUDs because they have inaccurate perceptions of medical contraindications, such as misperceptions regarding delivery type, age or breast-feeding status.^{25,26} However, it remains unknown if insufficient or inaccurate contraceptive counseling is associated with same-day access to contraception at the first postpartum visit.

In this study, we use data collected from low-income women in interviewer-administered surveys conducted three months after delivery to assess whether they had been able to get same-day access to moderately and highly effective reversible methods at their first postpartum visit. We also identify barriers women faced in obtaining their desired method at that visit and examine how barriers varied for women of different social and demographic characteristics. Finally, we investigate whether these barriers were associated with method use at three months postpartum.

METHODS

Study Design and Sample

Data were collected as part of the Texas Postpartum Contraception Study, which examined a prospective cohort of 1,700 women who had given birth and had Medicaid coverage or no insurance. To produce a representative sample of such women in large cities, we approached hospitals from all major metropolitan areas in the state. The hospitals were selected on the basis of agreement to participate in the study. Women were screened and recruited in the postpartum units of eight hospitals in six cities between October 2014 and April 2016; each facility was assigned its own recruiter. Eligible individuals were aged 18–44; lived within the hospital's catchment area (50–200 miles, depending on population density); spoke English or Spanish; had delivered a healthy, singleton baby; and wanted to delay

childbearing for at least two years. In addition, either their delivery was covered by public insurance or they had no insurance. Among the six hospitals for which we have response data at baseline, the average participation rate among eligible women was 67%. Interviewer-administered baseline surveys were completed in person at the time of recruitment, and participants were interviewed over the phone at three, six, 12, 18 and 24 months.

For the current study, we used data from the three-month follow-up survey, when women were asked whether they had attended a postpartum medical visit and whether they had received contraceptive counseling from a medical provider in the preceding three months. Of the 1,469 women who had completed this follow-up survey, we excluded 312 who had not been in need of contraception at the first postpartum visit because prior to being discharged after delivery, they had undergone a sterilization procedure (234) or had received an IUD (20), an implant (45), or an injectable or a prescription for a combined hormonal contraceptive (13). We also excluded women who had not discussed contraception in-person with a provider at any time after discharge (278, of whom 211 had not had any postpartum medical visit). Finally, we excluded 60 women who had desired female sterilization—because this involves additional barriers not associated with reversible methods and is not feasibly obtained at the first postpartum visit—and 134 women who had desired a method that did not require the involvement of a medical provider (such as condoms or withdrawal). Our final analytic sample included 685 women in need of a reversible contraceptive at their first postpartum visit. The institutional review boards of the University of Texas at Austin and participating hospitals approved the study.

Qualitative Data

•**Measures.** To capture women's experiences obtaining contraception at their first postpartum visit, we asked those who had talked to a provider about contraception whether they had received a method at their first medical visit (i.e., postpartum checkup or other visit at which they received contraceptive counseling) following hospital discharge. Women were then asked a series of questions about their experiences obtaining contraception; questions varied depending on answers to previous questions. Women who had received a method were asked what method was provided, and then were asked "At your postpartum checkup, was there a birth control method that you wanted to get, but were unable to get?" Those who said yes were asked which method they had wanted. Possible barriers to receiving the desired method were determined by asking "Why weren't you able to get this method?"

For women who had not received a method at their first postpartum visit, we asked what method they had planned to obtain after the visit and how or when they had planned to get it. Next, we asked whether there was a method they had wanted to get at their first visit, but had been unable to. For those who answered no, we explored possible barriers

in their plan to get the method as described earlier. Women who answered yes were asked what method they had wanted and why they had not been able to get it.

•**Analysis.** The study's first five authors—all proficient or fluent in English and Spanish—read, discussed and coded the open-ended responses in the original language. To identify barriers women experienced at their first postpartum visit, we coded emerging themes in the following manner: Using Atlas-ti, two researchers coded each response, addressed any discrepancies, discussed new potential codes and recoded until a final coding scheme was established. Although we had not specifically asked women what happened after their first postpartum visit, many had explained how they eventually received or did not receive their desired method. We used these data to provide context for whether women had eventually received their desired method and what they had had to do to obtain it. Reported health barriers were classified as inaccurate provider counseling or legitimate health barriers according to the Centers for Disease Control and Prevention's medical eligibility criteria.²⁷ The first author, a nurse practitioner, verified these classifications.

Quantitative Data

•**Measures.** The baseline survey collected information on women's age (18–24, 25–29, or 30 or older), language of interview (English or Spanish), parity (one, two, or three or more) and educational level (less than high school, high school completion, greater than high school). A combined race, ethnicity and nativity measure was used (foreign-born Hispanic, U.S.-born Hispanic, black, or white or other) because 97% of foreign-born participants were Hispanic and we wanted to avoid conflating race or ethnicity with nativity. Insurance status (insured or uninsured) and childbearing intention (wants more children, does not want more children, does not know) were assessed at baseline and in all follow-up surveys. The three-month survey also asked about women's current contraceptive method, whether they had attended a postpartum medical visit, the timing of the first postpartum visit (1–3 weeks, 4–6 weeks, or 7 or more weeks) and whether they had received contraceptive counseling by a medical provider after hospital discharge. We classified the location of contraceptive counseling as private practice or publicly funded clinic. Thirteen women had received contraceptive counseling at a clinic in Mexico; because we wanted to capture the wide range of experiences of women living in Texas, we included them in our analyses, categorizing them as having gone to a publicly funded clinic.*

From the qualitative analysis, we used women's responses regarding their first postpartum visit and desired contraceptive method to create a four-category variable. Women who had received their desired method at their postpartum visit were categorized as having received their desired

method the same day. Participants who had received a prescription for their desired method were categorized as having received a prescription for the pill, patch or ring. Women who had received a method (or a prescription for a method) other than their desired one were classified as having received another method the same day. Finally, individuals who had received no method or only a prescription for their desired injectable, IUD or implant were classified as having received no method (or such a prescription) the same day. (The standard of care is to receive such methods in the clinic.)

We also created a dichotomous variable that distinguished women who had experienced no barriers (received their desired method the same day or reported personal reasons for not having gotten a method) from everyone else. The desired method at first postpartum visit and method used at the three-month survey were categorized as implant; IUD; injectable; or pill, patch or ring. Finally, because some women had experienced more than one barrier, we created a dichotomous variable for each of the main barriers that emerged from the qualitative analyses.

•**Analysis.** First, we examined the social, demographic and reproductive characteristics of our sample. Second, we calculated the prevalence of receipt of a contraceptive at the first postpartum visit for the full sample and by desired method type. Third, we calculated the frequency with which each barrier was identified overall and by desired method, using chi-square tests to assess differences. Next, using multivariate logistic regression analysis that accounted for the clustering of women within hospitals, we examined associations between reported barriers and selected characteristics; no same-day insertion and "other" clinic barriers were combined because of small sample sizes. These models adjusted for all of the women's characteristics except language of interview, parity, educational level, childbearing intention and timing of postpartum visit, which did not improve model fit. We also conducted a sensitivity analysis that examined participant responses regarding inaccurate contraceptive counseling by race and ethnicity. Finally, among women who had not received their desired method at the first postpartum visit, we examined method use at three months postpartum using chi-square tests. Stata 13 was used for all quantitative analyses.

RESULTS

Sample Characteristics and Method Access

Women in our sample were predominantly young (56% were 18–24 years old), English-speaking (68%) and Hispanic (81%), and most had at least a high school education (69%—Table 1). At three months postpartum, a majority of women were uninsured (73%), had received postpartum contraceptive counseling at a public clinic or in Mexico (55%) and wanted more children (59%); six in 10 had had their first postpartum visit at 4–6 weeks.

Twenty-three percent of women received their desired method at the first postpartum visit; another 11% received a prescription for their desired pill, patch or ring; and 8%

*Results from sensitivity analyses that excluded these 13 women were not substantially different from results of models that included them.

TABLE 1. Percentage distribution of low-income women who were in need of reversible contraception after giving birth and had discussed contraception with a provider at their first postpartum medical visit, by selected characteristics, Texas Postpartum Contraception Study, 2014–2016

Characteristic	% (N=685)
Age	
18–24	55.5
25–29	26.1
≥30	18.4
Language of interview	
English	67.9
Spanish	32.1
Race/ethnicity/nativity	
U.S.-born Hispanic	42.3
Foreign-born Hispanic	39.0
Black	13.7
White/other	5.0
Educational level	
<high school	31.5
High school	40.6
>high school	27.9
Hospital	
1	22.9
2	10.1
3	6.9
4	20.3
5	4.8
6	20.2
7	11.5
8	3.4
Parity	
1	33.4
2	35.3
≥3	31.2
Insurance status three months postpartum	
Uninsured	73.2
Insured	26.8
Postpartum counseling location	
Public clinic/Mexico/other	54.9
Private practice	45.1
Childbearing intention three months postpartum	
Wants more	58.6
Does not want more	30.6
Does not know	10.8
Timing of postpartum visit	
1–3 weeks	24.6
4–6 weeks	59.7
≥7 weeks	15.7
Total	100.0

Note: Percentages may not total 100.0 because of rounding.

received a method (or a prescription for a method) other than the desired one (Figure 1). However, 58% of women received no method or got only a prescription for their desired injectable, IUD or implant. Notably, access varied considerably by desired method. Only 10% of women who wanted an implant and 8% of those who wanted an IUD received it at the first postpartum visit, whereas 52% of women who wanted the injectable received it, and 74% of those who wanted the pill, patch or ring got either the method itself or the corresponding prescription.

Barriers at First Postpartum Visit

Among women who did not receive their desired method at the first visit, we identified eight types of barriers. Three were clinic-level barriers (method unavailable, no same-day provision and other), and two were provider-level ones (inaccurate counseling and insufficient counseling). The remaining barriers involved cost, health or medical contraindications, and prescription issues. Clinic-level barriers were the most common ones (reported by 44% of women), followed by provider-level barriers (26%) and cost barriers (23%). Personal reasons, such as wanting to discuss contraceptive options with a partner, were not considered a barrier because in such instances the woman chose not to receive a method that day.

•**Clinic-level barriers.** Twenty-one percent of women were told to return on a different day to obtain their desired method, with no reason given, suggesting that the clinic did not offer same-day provision. Another 16% were unable to obtain their desired method because it was unavailable; some clinics did not stock the method, and women were asked to return after the method was ordered or after they had obtained it by prescription from a pharmacy. Other clinics referred women elsewhere or told them they did not provide the method; some simply did not give a referral. A 29-year-old mother of two described her experience:

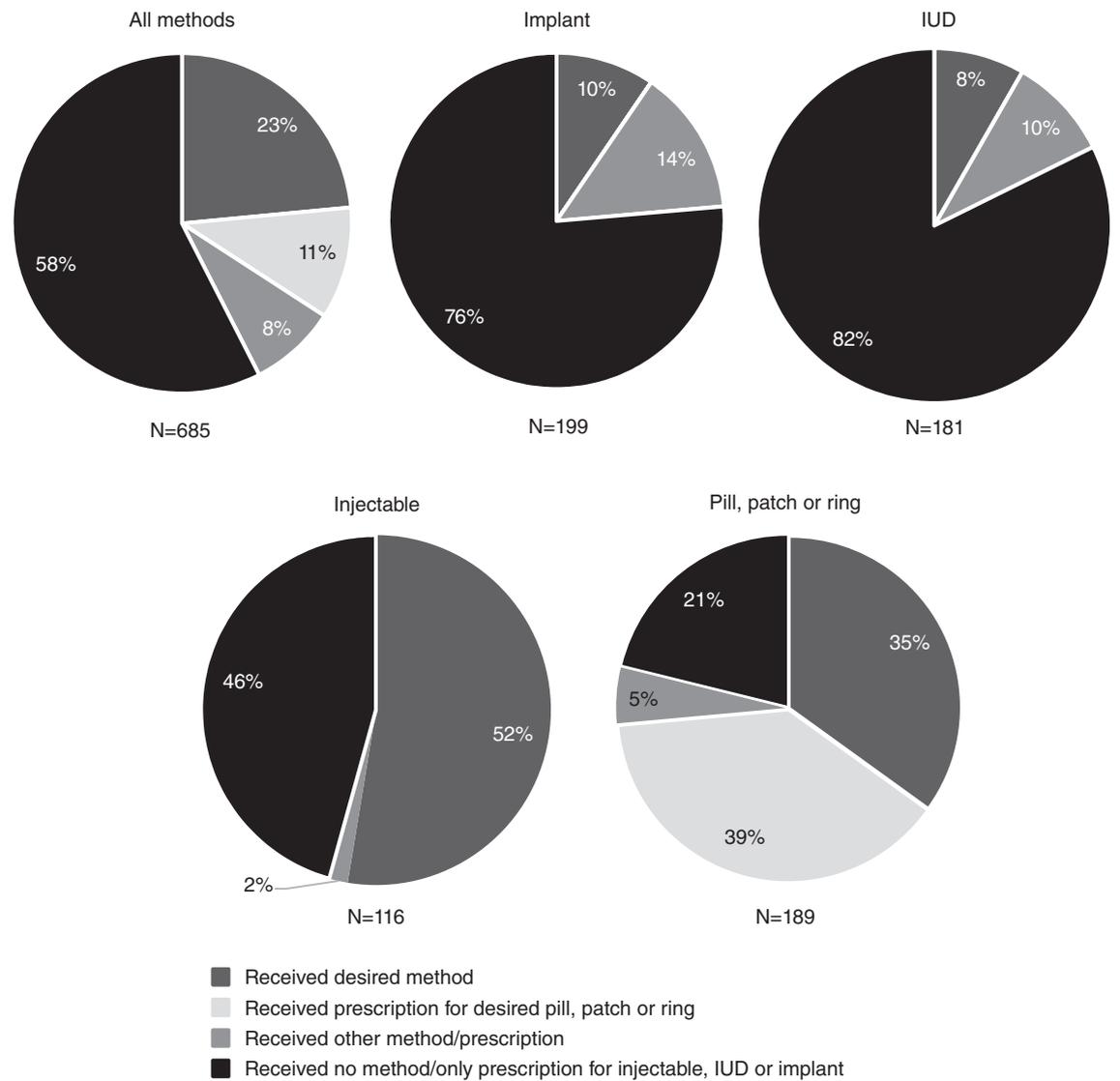
“Well, I asked him about the IUD, and he suggested the pill. But I ... wanted something that lasts longer. He said that I had to look somewhere else to get birth control because he doesn’t do it there at his office. But he didn’t recommend anywhere to go; he said I’d have to look around. He doesn’t do anything there, like the pill or that thing you put in the arm, or the IUD, nothing.”

Finally, 7% of women experienced other clinic barriers, such as the provider’s being “too busy” to provide a method or telling them to schedule another appointment to further discuss and receive a method.

•**Provider-level barriers.** Twenty-three percent of women said their provider discouraged them from using a given method for a health reason or refused to provide it for this reason; fewer than a third of these instances were consistent with current evidence-based practice guidelines.²⁷ Legitimate health barriers included medical contraindications, such as being unable to start combined oral contraceptives while hypertensive or being unable to receive an IUD at two weeks postpartum. Among reasons that providers inaccurately gave for refusing to provide a method, 33% related to menstruation—for example, providers told women that they could not use a method if they had not begun menstruating after delivery or were not currently menstruating. A 31-year-old, Spanish-speaking mother of three described why she did not get and still had not obtained her desired IUD:

“Because I hadn’t gotten my period and they told me to use the injection. [Another clinic] also told me no. [I didn’t make] the appointment for the IUD [because] the doctor from the first visit told me I have to use the injection three times and then I can use [the IUD].”

FIGURE 1. Percentage distribution of women who made a postpartum medical visit, by contraceptive access experience at the first visit, according to method



Another 31% of women's reports of inaccurate provider counseling were related to other health barriers (e.g., providers discouraged use of a method because of a woman's young age), and 22% were related to recovery from childbirth (e.g., providers refused to prescribe any method until six weeks after delivery). Finally, 13% of inaccurate counseling reports concerned breast-feeding, including refusal to provide even progesterone-only methods (e.g., the IUD and the implant) to breast-feeding women.

Although all women discussed some contraceptive method with their provider, 9% reported insufficient counseling as the reason they did not receive their desired method. Some providers did not explain how to obtain a method or share enough information for women to make an informed decision. Others discouraged women from using methods but gave no health reasons. A 25-year-old mother of two recalled that the provider "brushed me off

when I wanted the implant, and said I needed to take the pill." Similarly, another woman said she wanted the injectable but her doctor "convinced her" to use the pill instead.

•Cost barriers. Women reported multiple types of cost barriers. Some individuals without insurance simply could not afford their desired method because of high up-front costs. Other women were eligible for income-based discounts, but use of this benefit did not guarantee timely access. According to a 19-year-old, Spanish-speaking mother of one:

"I only wanted the IUD. They told me that I had to make another appointment to apply for discounts in order to get it for free, [and] that I would only pay for the copay. I made the second appointment for the discount, [but] I didn't have some of the required documents, [and] they told me I couldn't apply without them."

Some women reported that even with insurance coverage, their providers would not supply their desired method

because of the administrative and cost strain on the clinic. A 30-year-old mother of four described her situation: “My doctor’s office could do [the IUD], but my Medicaid wouldn’t pay for it up front—Medicaid would pay them after instead of before—so they wouldn’t do it.” Finally, some women said their provider incorrectly told them that Medicaid covered certain methods, such as the pill, but not others, such as the implant.

•**Other barriers.** Eleven percent of women received a prescription for their desired method and reported none of the foregoing barriers. However, picking up a prescription at a pharmacy can be a barrier in itself, given the time, transportation cost and risk that a prescription may not make it to the pharmacy. Multiple women said they still had not been able to pick up their prescription at the time of interview, and a 24-year-old mother of two reported that

the prescription for her patch “never got sent over [to the pharmacy], so I never got it.”

Variations in Barriers

Reported barriers varied by women’s desired contraceptive method. Women who wanted an IUD or implant more frequently than others reported method unavailability, no same-day provision, inaccurate provider counseling and cost barriers (Table 2). Those who desired the injectable were more likely than those desiring the pill, patch or ring to experience method unavailability, no same-day provision and inaccurate counseling. And consistent with the number of medical contraindications for estrogen-containing contraceptive methods,²⁷ women desiring the pill, patch or ring were the most likely to experience a legitimate health barrier.

Multivariate regression analysis showed that reported barriers differed by women’s social and demographic backgrounds (Table 3). Those aged 25–29 were more likely than 18–24-year-olds to report inaccurate provider counseling (odds ratio, 2.3). U.S.-born Hispanic women and black women were less likely than foreign-born Hispanics to report a cost barrier (0.5 and 0.6, respectively); black women had an elevated likelihood of reporting inaccurate provider counseling when compared with either foreign-born Hispanics (2.6) or U.S.-born Hispanics (not shown). Sensitivity analyses showed that the inaccurate counseling that black women received was most commonly related to an IUD or implant, and often pertained to menstrual cycle timing. Insured women were less likely than their uninsured counterparts to experience a cost barrier (0.5), inaccurate counseling (0.7) or other clinic barriers (0.6). Finally, women who received contraceptive counseling from a private practice were more likely than those receiving it at a public clinic or in Mexico to report a cost barrier (2.7) or method unavailability (6.4), but less likely to report other clinic barriers (0.3).

TABLE 2. Percentage of women experiencing various types of barriers to receiving a method at the first postpartum visit, by desired method

Type of barrier	All	Implant	IUD	Injectable	Pill/patch/ring
Clinic-level					
Method unavailable	12.3	18.6	19.3	7.8	1.6
No same-day provision	16.2	24.6	24.3	9.5	3.7
Other clinic barrier	5.4	9.0	5.0	5.2	2.1
Provider-level					
Inaccurate counseling	13.0	15.1	18.8	14.7	4.2
Insufficient counseling	7.0	8.0	6.1	6.9	6.9
Cost					
	17.8	22.6	26.0	11.2	9.0
Other					
Health/medical contraindication	5.0	1.0	7.7	0.9	9.0
Prescription	10.7	0.0	0.0	0.0	38.6
None	26.4	12.1	9.4	56.9	39.2

Notes: Women could report more than one barrier. Except for insufficient counseling, the percentages differ across method types at p<.05.

TABLE 3. Odds ratios (and 95% confidence intervals) from multivariate logistic regression analyses assessing associations between reported barriers to obtaining desired contraceptive methods at first postpartum visit and selected characteristics

Characteristic	Cost	Inaccurate counseling	Insufficient counseling	Method unavailable	All other clinic barriers
Age					
18–24 (ref)	1.00	1.00	1.00	1.00	1.00
25–29	0.72 (0.46–1.13)	2.26 (1.17–4.38)*	1.15 (0.55–2.37)	0.96 (0.51–1.83)	0.76 (0.52–1.12)
≥30	1.03 (0.60–1.78)	0.87 (0.39–1.92)	0.90 (0.38–2.13)	0.92 (0.38–2.26)	0.44 (0.17–1.17)
Race/ethnicity/nativity					
Foreign-born Hispanic (ref)	1.00	1.00	1.00	1.00	1.00
U.S.-born Hispanic	0.54 (0.31–0.93)*	0.70 (0.33–1.46)	0.71 (0.29–1.75)	1.05 (0.48–2.28)	0.85 (0.43–1.69)
Black	0.58 (0.42–0.81)**	2.56 (1.36–4.80)**	0.49 (0.18–1.32)	0.86 (0.34–2.17)	1.18 (0.60–2.33)
White/other	0.41 (0.16–1.08)	1.31 (0.61–2.82)	2.59 (0.90–7.48)	0.73 (0.31–1.72)	0.30 (0.06–1.40)
Insurance status three months postpartum					
Uninsured (ref)	1.00	1.00	1.00	1.00	1.00
Insured	0.50 (0.35–0.71)***	0.66 (0.48–0.91)*	1.49 (0.62–3.58)	1.34 (0.82–2.19)	0.55 (0.40–0.76)***
Postpartum counseling location					
Public clinic/Mexico/other (ref)	1.00	1.00	1.00	1.00	1.00
Private practice	2.73 (1.45–5.11)**	0.84 (0.54–1.32)	1.14 (0.40–3.29)	6.36 (1.86–21.80)**	0.28 (0.11–0.75)*

*p<.05. **p<.01. ***p<.001. Notes: Models account for clustering of participants among hospitals and control for desired method. Language of interview, parity, educational level, childbearing intention and timing of postpartum visit were omitted from the analyses because they did not improve model fit. ref=reference group.

Method Use

Although some women received their desired method at a subsequent postpartum visit, many described how barriers at the first visit started a cascade of additional barriers, including issues with appointment availability and transportation, some of which prevented them from ever obtaining their method. Indeed, 36 women recalled that their insurance expired while they tried to overcome other barriers. An 18-year-old, Spanish-speaking mother of two explained, “I needed to make another appointment, but now the insurance doesn’t cover me anymore.” A 31-year-old mother of two described her situation: “I was given a prescription for the NuvaRing, but [told] not to start that day. My doctor told me I had to wait six weeks before I could use birth control, and since I wasn’t up for my six weeks, I didn’t get it right away. So by the time I was able to fill it, my insurance had already expired.”

Another reason women may have needed more than two visits to receive their method was that the clinic did not explain financial discount eligibility until the first postpartum visit. Women then had to complete multiple visits, including one to apply for the discount, which presented challenges related to time, child care and transportation. Waiting for the clinic to obtain Medicaid approval to order the method also raised additional barriers. A 31-year-old mother of two explained that she was not able to get an IUD: “I had to get it approved by Medicaid before the prescription could be sent to the pharmacy, but now I can’t because I am out of coverage.... I am waiting for the referral to [a public clinic] so I can get a discount, because I can’t afford it.” Women whose postpartum provider did not offer the desired method were often required to complete another series of visits with a provider who did. Thus, some women needed three or more visits to obtain their desired method, in addition to spending time and energy looking for a clinic that provides the method when they did not receive a referral.

Forty-one percent of women who did not receive their desired method at the first postpartum visit eventually obtained it and were using it at three months postpartum, compared with 86% of women who received their desired method at the first visit. Fewer than half of women who desired each method type were using that method at three

months, and those not using their desired method were most often using a less effective one—withdrawal, male condoms or natural family planning (Table 4). For example, 42% of women who desired the implant were using it at three months postpartum, while 25% were using the injectable, pill, patch or ring, and 28% were using withdrawal, male condoms or natural family planning. Women who wanted the injectable were the least likely to be using their desired method at three months postpartum (36%), and women who wanted the IUD were the most likely to be doing so (45%).

DISCUSSION

Our data point to substantial deficiencies in access to contraception at the first postpartum visit among low-income women in Texas. Fewer than one-quarter of women who had discussed contraception with a provider received their desired method at this visit. Women who had desired an IUD or implant were the least likely to obtain their desired method. However, they were more likely to be using their preferred method at three months postpartum than were women who had desired short-acting methods. While cost was an important barrier to contraceptive access, a number of provider- and clinic-level barriers were also reported, and these often cascaded to create insurmountable obstacles. Overall, fewer than half of women who did not receive their desired method at the first visit were using it by three months postpartum. Moreover, the majority of women who were not using their desired method were using less effective ones. Finally, women commonly reported having incorrectly been told they were ineligible for a method for which they had no medical contraindication. This barrier was particularly salient for black women, 25–29-year-olds and uninsured individuals.

In our study, the level of contraceptive access at the first postpartum visit was slightly higher than the 13% found among California women using Medi-Cal or Family PACT services.⁹ However, if we include the 278 women who had not attended a postpartum visit or discussed contraception with a provider, the proportion of our sample who received their desired method at the first visit was only about 16%.

The finding that women who had wanted to get an IUD or an implant at their postpartum visit were more likely to be using their preferred method at three months postpartum than were women who had desired short-acting methods may reflect barriers to continuation for the latter: Short-acting contraceptives may require travel to a clinic or pharmacy to obtain the method every month, and may include a copay with each prescription or out-of-pocket costs if women are uninsured. Requiring insurance companies to reimburse pharmacies for up to a 12-month supply of the pill or the patch, as Colorado did in 2017, could help overcome these barriers and improve contraceptive continuation.²⁸ On the other hand, the differences in continuation rates may reflect that women who wanted a long-acting method had greater motivation to avoid another pregnancy than those wishing to use short-acting methods.

TABLE 4. Percentage distribution of women who had not received their desired method at the first postpartum visit, by the method used three months postpartum

Method used at three months	Method desired at first visit			
	Implant (N=180)	IUD (N=165)	Injectable (N=55)	Pill/patch/ring (N=123)
Implant	42.2	4.2	1.8	1.6
IUD	4.4	44.8	1.8	0.0
Injectable	12.8	6.7	36.4	8.1
Pill/patch/ring	12.2	6.1	9.1	38.2
Less effective method	28.3	37.0	49.1	51.2
None	0.0	1.2	1.8	0.8
Total	100.0	100.0	100.0	100.0

Notes: All distributions are significantly different at $p < .001$. Less effective methods are withdrawal, male condoms and natural family planning. Percentages may not total 100.0 because of rounding.

Our data also shed new light on cost barriers, suggesting that even attempts to offer income-based discounts may generate additional obstacles. Requiring women to return to the clinic for financial screening on a different day often led to other barriers. Foreign-born Hispanic women were more likely than U.S.-born Hispanic women to experience a cost barrier, and previous research found that foreign-born individuals were less likely than U.S.-born ones to be relying on their desired IUD, implant or sterilization at six months postpartum.²⁹ Thus, expanding public insurance coverage to immigrants, regardless of documentation status, as well as providing same-day appointments for financial screening, could improve access to postpartum contraception.

Despite evidence-based guidelines recommending that providers offer same-day access to the full range of contraceptive methods, it appears that public clinics and, in particular, private practices are still not doing so. This finding is consistent with results from a California study showing that public clinics receiving Title X funding were more likely than private practices and clinics not receiving such support to provide IUDs and implants.³⁰ The difference may be related to method reimbursement or provider training. Moreover, not all clinics and practices provide the methods they do offer on the same day. While some women are able to return for a follow-up visit to obtain their desired method, others are not, because of a host of barriers, such as work, child care and transportation issues, and possible loss of insurance coverage between visits. Perhaps the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality or the Texas Health and Human Services Commission could develop quality indicators that include stocking the full range of contraceptive methods and offering same-day provision. In the meantime, clinics and providers can help remove barriers by offering more flexible and timely appointments, assisting with scheduling follow-up appointments or connecting patients to resources such as Medicaid's free transportation to medical visits.³¹

Finally, women's frequent reports of inaccurate counseling are concerning, and improvements in the quality of contraceptive counseling appear to be needed. However, we cannot be sure if inaccurate counseling is related to a lack of provider knowledge, as reported in other studies;³²⁻³⁵ provider constraints, such as pressure to see more patients in a reduced time; a lack of priority for providing contraceptives and same-day access;^{13,21} or the use of medical eligibility as a pretext for not providing methods that are costly to the clinic. Indeed, we found that insured women were less likely than uninsured women to receive inaccurate counseling, suggesting that provider or clinic reimbursement may play a role in this issue. Perhaps some providers give non-evidence-based counseling as a way to generate payments for extra visits, or offer IUDs only to older women in an effort to reduce the number placed and hence reduce associated clinic costs. We fear that some providers make decisions that may negatively impact quality of care but allow them to stay afloat financially. Biggs

and colleagues¹³ finding that some providers required two visits for IUD or implant insertion to reduce the risk that women would discontinue an expensive method supports this hypothesis.

Inaccurate provider counseling was reported more often by black women than by foreign-born or U.S.-born Hispanic women. This could reflect implicit or explicit provider bias, or individuals' placing provider advice within the historical context of reproduction coercion in the United States.³⁶ Additionally, Hispanic women of Mexican origin may have a different perspective on IUDs, since these devices are widely used postpartum in Mexico.³⁷ This racial and ethnic difference in reports of inaccurate provider counseling deserves further consideration.

The reason for 25-29-year-olds' elevated likelihood of reporting inaccurate provider counseling is less clear. This finding could reflect differences in women's interpretations of provider counseling by their motivations to avoid pregnancy and desire for additional children, or it could derive from provider assumptions about pregnancy intervals and family size for women of varying ages.

Because our study did not allow us to determine why inaccurate counseling is occurring, and because some women may misunderstand or misinterpret contraceptive counseling, clearly barriers regarding counseling warrant further investigation. Future research on the quality of contraceptive counseling, particularly studies that audio-record patient visits, could examine differences in the accuracy of counseling women receive depending on their insurance status, race or ethnicity, age, and other social, demographic and reproductive characteristics. Evaluation of providers' contraceptive knowledge, attitudes and practices,¹³ as well as training in contraceptive counseling using pretests and posttests,³⁵ may illuminate specific areas that are ripe for intervention.

Limitations

Several limitations should be noted. Recall bias may exist even though we asked about these experiences only 1-2 months after the first postpartum visit. Furthermore, women could have changed their method preference between that visit and the follow-up interview. Another limitation is that our sample is not representative of Texas women with Medicaid-covered deliveries. Finally, we could not determine an accurate response rate for baseline participation because the study used different recruiters at each hospital, some of whom did not record individuals who declined to participate. Women who had negative delivery experiences may have been less likely than others to participate, but our impression was that the main motivation for declining the baseline interview was having visitors or juggling competing activities in the hospital.

Conclusion

Many low-income women in Texas do not receive their desired contraceptive method at the first postpartum visit, and this experience is associated with the use of less effective

tive methods at three months postpartum. The barriers that women in our study described suggest that expansions in public insurance, particularly for undocumented immigrants, and complete method reimbursement may improve contraceptive access at these visits. The identified clinic- and provider-level barriers merit further examination from researchers, as well as from clinical and programmatic perspectives, including the need to better understand the reasons for and ways to address inaccurate provider counseling.

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Acknowledgments

This project was supported by a grant from the Susan Thompson Buffett Foundation to the Texas Policy Evaluation Project and by grant 5-R24-HD042849 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) to the Population Research Center at the University of Texas at Austin. The lead author received support from NICHD grant R24-HD066613 to the University of Colorado Population Center.

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