Postpartum Contraception Use is one of twenty Maternal and Child Health (MCH) **National Performance Measures (NPMs)** for the Title V MCH Services Block Grant to States Program. This NPM is focused on increasing the percent of women* who use a most or moderately effective method of contraception following a recent live birth.

For Postpartum Contraception Use, there are 9 evidence-based strategies from MCHbest (see page 3)

The **What Works Evidence Accelerators** provide background information and a summary of effective strategies to advance each of the NPM topic areas. The strategies support increased accessibility of postpartum contraception as well as policy changes and educational efforts that promote use of a patient-centered approach to postpartum contraceptive counseling and care. See also: Postpartum Visit | Postpartum Mental Health Screening Accelerators.

Overview.

Postpartum contraception is a highly effective clinical intervention that can help women achieve their personal goals and improve population health outcomes.[1] The health benefits include preventing short-interval pregnancies,[2] which may lead to increased risk of preterm birth, low birth weight, and infant mortality.[3,4,5,6] Clinical, public health, and policy efforts have focused on increased access to postpartum contraception, particularly long-acting reversible contraception (LARC).[6,7,8,9,10,11] It is imperative to ensure access to the full range of contraceptive methods to support reproductive autonomy and fully enable women to choose the method that best meets their needs.[6,12,13,14,15,16,17]

A 2022 American College of Obstetricians and Gynecologists (ACOG) Committee Statement on Patient-Centered Contraceptive Counseling focused on recommendations for clinicians to apply a patient-centered, reproductive justice framework to contraceptive counseling by:

- Acknowledging historical and ongoing reproductive mistreatment of people of color and individuals who have been marginalized.
- Recognizing that counselor bias can affect care and work to minimize the effect of bias on counseling and care provision.
- Prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method.
- Adhering to the recommended ethical approach of shared decision-making where the patients' expertise in their own lives and bodies is on equal footing with the clinician's expertise.[18]

Effectiveness. ACOG recommends that women consider timing, breastfeeding, and effectiveness of birth control methods in making their choice about which method will work best for them.[19] LARC, such as contraceptive implants and intrauterine devices, and irreversible surgical contraception (including female and male sterilization), are considered the *most effective* birth control methods.[20,21] Short-acting reversible contraception (SARC), including oral pills, injectable contraception, diaphragms, patches, and rings are considered *moderately effective* birth control methods.[20,21] Less effective methods include condoms, sponges, cervical caps, spermicide, natural family planning, and withdrawal.[6,20,21] These contraceptives are categorized based on their ability to reliably prevent pregnancy when used correctly. Prevalence of postpartum contraceptive use is highest when women receive both prenatal and postpartum contraceptive counseling.[22,23] Providers should share medically accurate and unbiased information and give women the time and space to make their decision.[24]

Data.

This NPM is measured through data from the Pregnancy Risk Assessment Monitoring System (PRAMS). In 2018, 12.5% of women who recently gave birth to a live infant were using permanent methods; 18.9% were using LARC, 26.3% were using SARC, 26.7% were using less effective methods, and 15.7% were using no contraception.[6] Those without insurance had lower odds of using permanent methods, LARC, and SARC than those with private insurance.[6] Rural respondents had greater odds than urban respondents of using all method categories: permanent, LARC, SARC, and less effective methods.[6] From 2015 to 2018, LARC use increased overall from 17.8% to 18.7%. However, use of no method also increased from 13.7% to 15.8%. Use of SARC decreased from 28.8% to 26.3%.[6]

Social Determinants of Health (SDOH).

Social and structural determinants of health can shape women's contraceptive preferences, access, and utilization after childbirth.[1] Structural factors, such as distance to clinic, fees for transportation and parking, clinic hours, childcare access, ability to miss work, and out-of-pocket costs, may affect postpartum contraception use.[1] The lived experiences of racism, discrimination, stigma, intimate partner control or violence, difficulty accessing health care, and provider bias and behaviors can create barriers to the achievement of women's reproductive health goals.[18]

It is possible to reduce barriers through high-quality contraceptive counseling that is disentangled from clinician priorities and equips women with the knowledge and guidance needed to fulfill their reproductive desires and ensures access to the full range of contraceptive methods to meet their family planning goals.[18,25,26] Reducing loss to follow-up for postpartum care is also likely to improve use of contraception.[26] Strategies such as patient navigation, the inclusion of contraceptive counseling with infant well-visits, and telehealth could improve access to postpartum counseling.[26]

Health Equity.

The historical context of paternalistic medical practices, eugenics, and contraceptive coercion targeting women of color and women with low incomes contributes to ongoing disparities in contraceptive access, uptake, and autonomy.[25] Black and Hispanic women are less likely to use a contraceptive method compared to White women.[25,27] In addition, Black and Hispanic women more commonly use less effective contraception methods.[25,28] Provider bias also perpetuates health inequities.[18,25] Black and Hispanic women with low incomes are more likely to be recommended LARC methods compared to White women with low incomes, indicating that racial disparities persist even within socioeconomic categories.[25,29]

Many contraceptive access initiatives have shifted from LARC-first or LARC-centered approaches to focus on expanding access to the full range of contraceptive methods to support individuals' preferences and reproductive autonomy.[17,30] This "next generation" of contraceptive access efforts are expanding to address a broader range of barriers faced by women in and out of the health care system.[17] A person-centered framework for high quality, equitable contraceptive care was developed that recognizes the influence of social and structural contexts.[17] The continuum of care to meet women's contraceptive needs includes outreach and trust building, access, quality, and follow-up support.[17] The framework provides a template that programs can use to guide planning and implementation to meet the contraceptive needs of all women and advance health equity.[16,17]

Key Resources.

Research found that interventions combining multiple points of health system contact, such as using direct in-person contraceptive counseling, written education materials/videos, or appointment reminders combined with other care during prenatal or postpartum visits increased the use of postpartum contraception.[24,30,31,32,33]

Search the Established Evidence database for peer-reviewed research articles related to strategies for increasing postpartum contraception use.

Find field-based resources focused on increasing postpartum contraception use relevant to Title V programs in the MCH Digital Library.

Partnership and the Role of Title V.

Title V can support postpartum contraception use through:

Equitable, Patient-Centered Contraceptive Care.[18] Title V agencies can support increased access to contraceptive counseling and education by:

- Developing multimedia-based education tools, such as videos and infographics, in multiple languages to support contraceptive counseling.[33]
- Engaging with health systems to offer provider trainings on shared decision-making through patient-centered contraceptive counseling during prenatal and postpartum visits.[25,26]

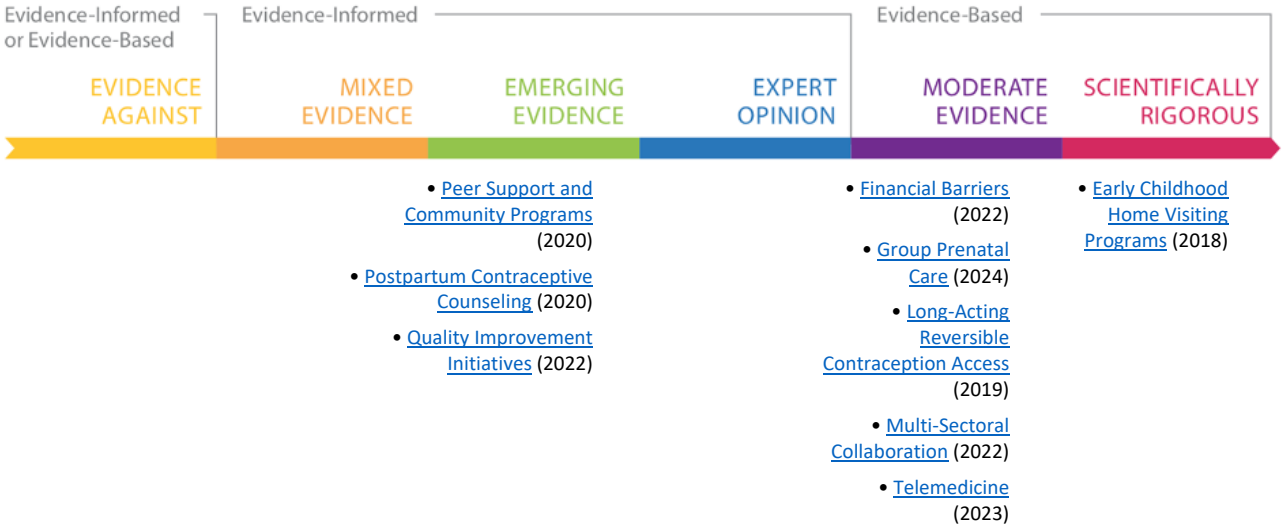
Financial Support for Postpartum Contraception. Title V agencies can promote greater accessibility to postpartum contraception by:

- Working with policymakers to expand the window of Medicaid pregnancy coverage to improve contraceptive access.[26]
- Supporting separate reimbursement for postpartum LARC provision.[34]

NPM 3: Postpartum Contraception Use.

This page summarizes the latest strategies, practices, and resources that have emerged as potential approaches for increasing the percent of women who reported they are using a most effective (long-acting reversible contraceptive such as contraceptive implants and intrauterine devices or systems as well as irreversible surgical contraception) or moderately effective (injectables, oral pills, patches, rings, or diaphragms) method of contraception following a recent live birth. It provides a framework to identify, understand, and implement "what works" in creating new or strengthening current Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

Evidence-Based/Informed Strategies. 9 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.



Field-Based Resources and Programs. Resources from state-/community-based programs have been identified for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs.

- Medicaid Reimbursement for Postpartum LARC [by State/Jurisdiction] describes the pathways that states and jurisdictions can take to obtain reimbursement for funding immediate postpartum long-acting reversible contraception (IPP LARC) outside of the global obstetric payment.
- Delaware Contraceptive Access Now (DelCAN) initiative is a statewide program and set of policy changes focusing on reducing unintended pregnancies and improving access to and delivery of family planning services and contraceptives, including LARCs.
- Kansas Long-Acting Reversible Contraception (LARC) Clinical Components provides information on medical eligibility, different types of LARC products available, how to document insertions, managing side effects and complications, etc. Mostly clinical guidance, no external data or metrics
- Maryland Immediate Postpartum Long-Acting Reversible Contraception (IPP LARC) toolkit addresses considerations for integration of IPP LARC into existing workflows and protocols. The toolkit aims to provide hospitals with technical assistance as they integrate IPP LARC into routine practice.
- Virginia Postpartum LARC Toolkit provides guidance and resources for Virginia hospitals who want to begin offering immediate postpartum LARCs.
- Immediate Postpartum Contraception Coverage in Washington summary describes how Washington State law requires commercial insurance plans to cover the cost of immediate postpartum contraception provided in hospital and birth center settings as a separate payment from the standard labor and delivery payment.

Key Findings. The following are key findings emerging from the literature:

1. Medicaid expansion to include reimbursement for LARC methods and the inclusion of postpartum care benefits in Emergency Medicaid can be effective in increasing use of all forms of effective contraception and increase attendance at postpartum visits.[35,36,37]
2. Counseling was found to be most effective in promoting the use of most and moderately effective contraceptive methods when delivered throughout the perinatal period, in group care settings, and when delivered at the 3-month postpartum appointment.[38,39]
3. The provision of free postpartum contraception counseling combined with open access to most and moderately effective contraceptive methods throughout the perinatal period can increase postpartum contraception use.[40,41]
4. Postpartum contraception education delivered via videos and other multimedia formats, provided with traditional/routine postpartum contraception counseling can be effective in increasing uptake of postpartum contraception.[42]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify effectiveness in increasing postpartum contraceptive use, but initial studies have shown promise of these strategies in MCH settings:

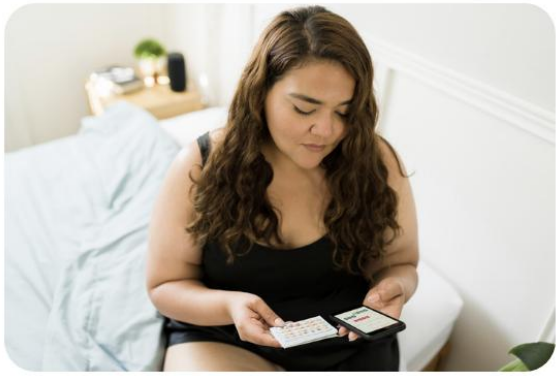
- Implementing quality improvement initiatives within healthcare facilities to address access barriers and enhance the overall quality of contraceptive services.[43]
- Involving partners in contraception counseling and decision-making to engage couples in discussions about family planning and shared responsibility for contraception.[44]
- Training peer educators who can provide information, counseling, and support related to postpartum contraception.[45]
- Expanding pharmacist authority to include prescribing, ordering, and administering contraception to help overcome geographic barriers to accessing a health care professional who can prescribe birth control.[46]

Practice. The following tools can be used to translate evidence to action to advance this NPM:

- Postpartum Contraception Guide (Partners in Contraceptive Choice and Knowledge). This decision aid helps provide patient-centered postpartum contraception counseling.
- Immediate Postpartum Family Planning (Family Planning High Impact Practices). This issue brief provides practice information and implementation guidance for facility-based postpartum contraceptive counseling.

Partnership. The following organizations focus on advancing postpartum contraception access:

- Postpartum Contraception Access Initiative. ACOG training program for health care providers to deliver a full range of immediate postpartum contraceptive methods.
- Society of Family Planning. Provides clinical guidance and resources on all types of family planning, including postpartum contraception.



Frameworks and Tools for "What Works."

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help? Contact us for training and technical assistance customized to your needs.

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* Note. Throughout this document, we use terms such as woman, women, and mother to describe people who have the biological capacity to become pregnant. We acknowledge that some pregnant and/or birthing people do not identify with these terms. However, we use these terms as a reflection of language used in the peer-reviewed research that predominantly refers to study participants as "women." Our findings are not meant to be exclusive of individuals who do not identify as female. Read more in NCEMCH's Gender Identity Statement.

References

[1] Moniz, M. H., Peahl, A. F., Zinsser, D., Kolenic, G. E., Stout, M. J., & Morgan, D. M. (2022). Social vulnerability and use of postpartum long-acting reversible contraception and sterilization. *American Journal of Obstetrics & Gynecology*, *227*(1), 111-113.
[2] de Bocanegra H, Chang R, Howell M, & Darney P (2014). Interpregnancy intervals: impact of postpartum contraceptive effectiveness and coverage. *American Journal of Obstetrics and Gynecology*, 210, 311.el–311.e8.
[3] Ahrens KA, Nelson H, Stidd RL, Moskosky S, & Hutcheon JA (2019). Short interpregnancy intervals and adverse perinatal outcomes in high-resource settings: An updated systematic review. *Pediatric and Perinatal Epidemiology*, 33, 025–047.
[4] Conde-Agudelo A, Rosas-Bermüdez A, & Kafury-Goeta AC (2006). Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. *JAMA*, 295, 1809–1823.
[5] McKinney D, House M, Chen A, Muglia L, & Defranco E (2017). The influence of interpregnancy interval on infant mortality. *American Journal of Obstetrics and Gynecology*, 216, 316.el–316.e9. [
[6] Bruce, K., Stefanescu, A., Romero, L., Okoroh, E., Cox, S., Kieltyka, L., & Kroelinger, C. (2023). Trends in Postpartum Contraceptive Use in 20 U.S. States and Jurisdictions: The Pregnancy Risk Assessment Monitoring System, 2015-2018. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *33*(2), 133–141.
[7] Centers for Medicare & Medicaid Services, (n.d.). Contraception in Medicaid: Improving Maternal and Infant Health.
[8] National Institute for Children's Health Quality. (2016). Strategies to increase access to long-acting reversible contraception (LARC) in Medicaid.
[9] Wachino V (2016a). *Re: Medicaid family planning services and supplies*. Baltimore: U.S. Centers for Medicare and Medicaid.
[10] American College of Obstetricians and Gynecologists. (2023). The LARC Program. About Us.
[11] The Association of State and Territorial Health Officials. (2021). *Increasing access to contraception*. Immediate Postpartum Long-Acting Reversible Contraception (LARC).
[12] Gomez AM, Fuentes L, Allina A (2014). Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspectives in Sexual and Reproductive Health*, 46,171–175.
[13] Gubrium AC, Mann ES, Borrero S, Dehlendorf C, Fields J, Geronimus AT, ... Sisson G (2016). Realizing reproductive health equity needs more than long-acting reversible contraception (LARC). *American Journal of Public Health*, 106,18.
[14] Higgins JA, Kramer RD, & Ryder KM (2016). Provider bias in long-acting reversible contraception (LARC) promotion and removal: Perceptions of young adult women. *American Journal of Public Health*, 106,1932–1937.
[15] Kroelinger CD, Morgan IA, DeSisto CL, Estrich C, Waddell LF, Mackie C, ... Rankin KM (2019). State-identified implementation strategies to increase uptake of immediate postpartum long-acting reversible contraception policies. *Journal of Women's Health*, 28, 346–356.
[16] Dehlendorf, C., & Perritt, J. (2022). Statewide contraceptive access initiatives: a critical perspective. *American Journal of Public Health*, *112*(S5), S490-S493.
[17] Holt, K., Reed, R., Crear-Perry, J., Scott, C., Wulf, S., & Dehlendorf, C. (2020). Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *American journal of obstetrics and gynecology*, *222*(4), S878-e1.
[18] American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women, Contraceptive Equity Expert Work Group, and Committee on Ethics (2022). Patient-Centered Contraceptive Counseling: ACOG Committee Statement Number 1. *Obstetrics and gynecology*, *139*(2), 350–353.
[19] American College of Obstetricians and Gynecologists. (2023 April). Postpartum Birth Control. Frequently Asked Questions.
[20] American College of Obstetricians and Gynecologists. (2023 April). Effectiveness of Birth Control Methods | ACOG.
[21] U.S. Department of Health and Human Services. Office of Population Affairs. (n.d.). Contraceptive Options and Effectiveness - Most or Moderately Effective Contraception | HHS Office of Population Affairs.
[22] Zapata LB, Murtaza S, Whiteman MK, Jamieson DJ, Robbins CL, Marchbanks PA, … Curtis KM. Contraceptive counseling and postpartum contraceptive use. *American Journal of Obstetrics and Gynecology.* 2015;212(2):171.e1–171.e8.
[23] Coleman-Minahan, K., Aiken, A. R. A., & Potter, J. E. (2017). Prevalence and Predictors of Prenatal and Postpartum Contraceptive Counseling in Two Texas Cities. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *27*(6), 707–714.

[24] Thompson, I., Bryant, A. G., & Stuebe, A. M. (2022). Centering the Patient in Postpartum Contraceptive Counseling. Clinical obstetrics and gynecology, 65(3), 588–593.
[25] Bullington, B. W., Sata, A., & Arora, K. S. (2023). Shared decision-making: the way forward for postpartum contraceptive counseling. *Open Access Journal of Contraception*, 121-129.
[26] McAllister, A., Christensen, T., Dixit, E., Chesnokova, A., & Sonalkar, S. (2023). Achieving equity in postpartum contraception access. *Clinical Obstetrics and Gynecology*, *66*(1), 63-72.
[27] Dehlendorf, C., Park, S. Y., Emeremni, C. A., Comer, D., Vincett, K., & Borrero, S. (2014). Racial/ethnic disparities in contraceptive use: variation by age and women's reproductive experiences. *American journal of obstetrics and gynecology*, *210*(6), 526-e1.
[28] White, K., & Potter, J. E. (2014). Reconsidering racial/ethnic differences in sterilization in the United States. *Contraception*, *89*(6), 550-556.
[29] Dehlendorf, C., Ruskin, R., Grumbach, K., Vittinghoff, E., Bibbins-Domingo, K., Schillinger, D., & Steinauer, J. (2010). Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *American journal of obstetrics and gynecology*, *203*(4), 319-e1.
[30] Malcolm, N. M., Patterson, K. V., Pliska, E. S., Akbarali, S., Moskosky, S. B., & Hart, J. (2022). Scaling up evidence-based practices in contraceptive access initiatives. *American Journal of Public Health*, *112*(S5), S473-S477.
[31] Thompson, E. L., Vamos, C. A., Logan, R. G., Bronson, E. A., Detman, L. A., Piepenbrink, R., Daley, E. M., & Sappenfield, W. M. (2020). Patients and providers' knowledge, attitudes, and beliefs regarding immediate postpartum long-acting reversible contraception: a systematic review. Women & health, 60(2), 179–196. https://doi.org/10.1080/03630242.2019.1616042
[32] Lopez, L. M., Grey, T. W., Chen, M., & Hiller, J. E. (2014). Strategies for improving postpartum contraceptive use: evidence from non-randomized studies. The Cochrane database of systematic reviews, (11), CD011298.
[33] Sze, Y. Y., Berendes, S., Russel, S., Bellam, L., Smith, C., Cameron, S., & Free, C. J. (2023). A systematic review of randomised controlled trials of the effects of digital health interventions on postpartum contraception use. BMJ sexual & reproductive health, 49(1), 50–59.
[34] American College of Obstetricians and Gynecologists. (2023 November). Medicaid Reimbursement for Postpartum LARC | ACOG
[35] Smith, M., McCool-Myers, M., & Kottke, M. J. (2021). Analysis of Postpartum Uptake of Long-Acting Reversible Contraceptives Before and After Implementation of Medicaid Reimbursement Policy. Maternal and child health journal, 25(9), 1361–1368.
[36] Rodriguez, M. I., Skye, M., Lindner, S., Caughey, A. B., Lopez-DeFede, A., Darney, B. G., & McConnell, K. J. (2021). Analysis of Contraceptive Use Among Immigrant Women Following Expansion of Medicaid Coverage for Postpartum Care. JAMA network open, 4(12), e2138983.
[37] Liberty, A., Yee, K., Darney, B. G., Lopez-Defede, A., & Rodriguez, M. I. (2020). Coverage of immediate postpartum long-acting reversible contraception has improved birth intervals for at-risk populations. American journal of obstetrics and gynecology, 222(4S).
[38] Reyes-Lacalle, A., Montero-Pons, L., et al. (2020). Perinatal contraceptive counselling: Effectiveness of a reinforcement intervention on top of standard clinical practice. Midwifery, 83, 102631.
[39] Torres, L. N., Turok, D. K., et al. (2018). Increasing IUD and Implant Use Among Those at Risk of a Subsequent Preterm Birth: A Randomized Controlled Trial of Postpartum Contraceptive Counseling. Women's health issues, 28(5), 393–400.
[40] Kawatu, J., Clark, M., Saul, K., Quimby, K. D., Whitten, A., Nelson, S., Potter, K., & Kaplan, D. L. (2022). Increasing access to single-visit contraception in urban health care settings: Findings from a multi-site learning collaborative. Contraception, 108, 25–31.
[41] Huang, Y., Merkatz, R., Zhu, H., Roberts, K., Sitruk-Ware, R., Cheng, L., & Perinatal/Postpartum Contraceptive Services Project for Migrant Women Study Group (2014). The free perinatal/postpartum contraceptive services project for migrant women in Shanghai: effects on the incidence of unintended pregnancy. Contraception, 89(6), 521–527.
[42] Qureshey, E. J., Chauhan, S. P., Wagner, S. M., Batiste, O., Chen, H. Y., Ashimi, S., Ross, P. J., Blackwell, S. C., & Sibai, B. M. (2022). Educational Multimedia Tool Compared With Routine Care for the Uptake of Postpartum Long-Acting Reversible Contraception in Individuals With High-Risk Pregnancies: A Randomized Controlled Trial. Obstetrics and Gynecology, 139(4), 571–578.
[43] Kilander, H., Weinryb, M., Vikström, M., Petersson, K., & Larsson, E. C. (2022). Developing contraceptive services for immigrant women postpartum - a case study of a quality improvement collaborative in Sweden. BMC health services research, 22(1), 556.
[44] Sack, D. E., Peetluk, L. S., & Audet, C. M. (2022). Couples-based interventions and postpartum contraceptive uptake: A systematic review. Contraception, 112, 23–36.
[45] Yee, L. M., Martinez, N. G., Nguyen, A. T., Hajjar, N., Chen, M. J., & Simon, M. A. (2017). Using a Patient Navigator to Improve Postpartum Care in an Urban Women's Health Clinic. Obstetrics and gynecology, 129(5), 925–933.
[46] National Conference of State Lesislatures. (2023 October). Strengthening Access to Affordable, High-Quality Contraception - National Conference of State Legislatures (ncsl.org)

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