Title

POSTER ABSTRACTS P70 SEXUAL ACTIVITY AMONG BREASTMILK FEEDING WOMEN NOT USING HORMONAL CONTRACEPTION

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pital between December 2019 – November 2020. Questions, based on the Behavioral Model of Health Services (BMHS), focused on women's beliefs about planning for pregnancy, experiences with prenatal and immediate postpartum contraception counseling, and perceived need for postpartum contraception. For analysis, we used a priori codes based on BMHS and allowed additional themes to emerge from the data.
Results: Fifteen women (7 Black and 8 White) completed interviews 14-60 days postpartum. All women reported receiving prenatal and immediate postpartum contraception counseling, with 14 women reporting using or planning to use contraception. Five women said prenatal counseling helped with their contraception decision-making. Three Black women described unsupportive, coercive prenatal counseling. Most women reported immediate postpartum counseling had no bearing on their contraception decision. Black women who received unsupportive, coercive prenatal counseling reported unsupportive, coercive immediate postpartum counseling. All women said their previous contraception use or future pregnancy intentions mainly informed their postpartum contraception decision. Additional factors included contraception information from other sources and access to Medicaid.
Conclusions: Contraception counseling can aid some women with their postpartum contraception decision, but other experiences and preferences are salient. Counseling inconsistent with reproductive justice, not soliciting patient needs and values, is harmful particularly to Black women who are more likely to be pressured to select certain contraceptives.

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P70
SEXUAL ACTIVITY AMONG BREASTMILK FEEDING WOMEN NOT USING HORMONAL CONTRACEPTION
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Objectives: To assess resumption and continuation of sexual activity among breastmilk feeding women (at breast, expressing milk, or combination) within six months postpartum.
Methods: In this 6-month prospective observational study, we enrolled women ages 15-45 years who planned to exclusively breastmilk feed and not use hormonal contraception for the duration of the study. We conducted monthly surveys assessing when participants resumed vaginal intercourse. After participants had resumed intercourse, we queried them monthly and defined continuation of sexual activity as having vaginal intercourse at least once in the previous month.
Results: Of 394 enrolled participants, we included 350 (89%) with follow-up data on sexual activity. Of these, 274 (78%) resumed intercourse prior to study completion or early discontinuation. Median time to resumption of intercourse was 7 weeks postpartum (range 2-25 weeks); 104 (38%) reported having intercourse at 6 weeks or less, 125 (46%) between 6 and 12 weeks, and 45 (16%) after 12 weeks. Among 134 participants with data on subsequent sexual activity and who resumed intercourse at 7 weeks postpartum or earlier, 117 (87%) continued sexual activity for the remainder of their study participation. Of 263 who completed the entire 6 months of follow-up, 35 (13%) had not resumed intercourse.
Conclusions: Among breastmilk feeding women, half resume intercourse before two months postpartum with >80% experiencing sexual activity by three months postpartum. Most continue sexual activity thereafter. Postpartum contraception counseling should be tailored based on sexual activity and infant feeding practices.

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P71
ENGAGING CLINICIANS IN A PRE-IMPLEMENTATION ASSESSMENT OF THE WOMEN & PERSON-EMPOWERED COMMUNITY ACCESS FOR REPRODUCTIVE EQUITY (WE CARE) INTERVENTION
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Objectives: To assess clinicians' perspectives on WE CARE (an emergency department (ED) family planning counseling and referral intervention that uses an online health tool and community health workers) to inform intervention design for implementation.
Methods: We conducted one-on-one, semi-structured interviews with Emergency Medicine, Family Medicine, and Obstetrics & Gynecology clinicians until thematic saturation. The Consolidated Framework for Implementation Research (CFIR) informed the interview guide and was used to code all transcripts. A CFIR expert conducted an external coding audit.
Results: We interviewed 30 clinicians (female (77%), ED staff (47%), white (63%), and attending physicians (43%)). WE CARE was highly acceptable. Dominant CFIR domains include: (1) Clinicians suggested *Design Quality and Packaging* modifications, particularly the referral processes, to promote successful implementation; (2) transportation and insurance were essential *Patient Needs and Resources*; (3) WE CARE was *Compatible with the Value* of "no missed opportunity" to help patients; (4) *Compatibility with Work Processes* – WE CARE posed scheduling and reimbursement challenges to clinics; (5) Clinicians expressed concerns about an ED *Culture* of reproductive health frustrations, resistance to change, and competing priorities. Others identified the ED "safety net" culture and long wait times as assets to the intervention; (6) WE CARE had a significant *Relative Advantage* over the status quo. A few clinicians identified more advantageous alternatives (e.g., WE CARE in the clinic, home, or community settings); (7) *Engaging Key Stakeholders* throughout the hospital was a critical implementation element.
Conclusions: Clinicians contextualized several implementation constructs relevant to designing and implementing an ED family planning intervention.

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P72
ENGAGING BLACK WOMEN IN DEVELOPING CONTRACEPTIVE MESSAGING: A USER-CENTERED DESIGN RESEARCH APPROACH
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Objectives: To understand Black women's perspectives on family planning experiences to inform messaging strategies for a county-wide contraceptive access program
Methods: Partnering with a human-centered design research team and our community advisory board, we recruited 15 self-identified Black women who resided in Marion County to participate in a survey to enlist participant perspectives and experiences. We asked women to write a 'Break-Up Letter' and/or 'Love Letter' to a healthcare provider regarding a negative contraception/family planning experience.
Results: Study participants' experiences with and feelings about pregnancy planning and contraception were largely positive–though qualitative descriptions of birth control ranged from "wonderful" to "not natural." Break-Up letters talked about feeling "invalidated" and wanting to be heard:
"I felt like when I told you I wanted more kids, you made this face that showed you didn't think that was a good idea and tried to talk me out of it."
"*I will be replacing you with some one that is more informed on the things I want and more available."*
"I just wish you would truly listen to me and what I am sharing about my body."
Conversely, Love letters stated:
"The way you take your time and make sure all my questions are answered . . . . means a lot to me."
"Thank you for listening to me and giving me your thoughts without pushing your beliefs on me."
Conclusions: User-centered design offers innovative engagement strategies to design public health messaging for contraceptive care that is responsive to the needs of marginalized and minoritized communities.

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P73
DISPERSION OF CONTRACEPTIVE ACCESS POLICIES ACROSS THE US FROM 2007 TO 2017
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Objectives: Person-centered access to contraceptive methods benefits reproductive autonomy, sexual wellbeing, menstrual regulation, and other preventive health. However, contraceptive access varies by social and geographic position, with policies potentially perpetuating or alleviating health inequities. We describe geographic and time-trend variation in state-level contraceptive access policies over a recent decade in the US.
Methods: We collected data on 23 policies across 50 states and Washington, DC from 2007 to 2017 from sources including the Guttmacher Institute, National Conference of State Legislatures, National Health Law Project, and NexisUni. We examined expansive and restrictive policies related to: contraceptive education, insurance coverage, minor confidentiality and consent, prescribing and dispensing authority, family planning funding bans, and provider refusal.
Results: The most commonly enacted policies during the study period expanded contraceptive access: 1) prescribing authority for nurse practitioners, midwives (n=50, 98% of jurisdictions), and clinical nurse specialists (n=37, 73%); and 2) Med-