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Meeting the Needs of Postpartum Women: Provider Perspectives on Maternal Contraceptive Care in Pediatric Settings

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Abstract

OBJECTIVE: Closely spaced, mistimed, and unwanted pregnancies are common among postpartum women and can lead to adverse maternal and perinatal outcomes. Women inconsistently attend postpartum obstetric visits, though they reliably interface with pediatric providers during the postpartum months, presenting novel opportunities to identify and address unmet family planning needs.

METHODS: We conducted a qualitative study to explore pediatric provider perspectives on addressing maternal family planning in three settings: a neonatal intensive care unit, a primary care clinic, and a high-risk infant follow-up clinic.

RESULTS: Pediatric providers were generally open to incorporating postpartum family planning screening and counseling into a pediatric encounter, if given appropriate training and implementation support. Providers largely agreed that contraceptive provision to women was not feasible in their practices, and they shared ideas for utilizing the pediatric encounter to connect women with comprehensive contraceptive care.

CONCLUSION: Pediatric providers perceived postpartum family planning screening and counseling, and not contraceptive provision, as potentially acceptable and feasible in their practice settings. These exploratory findings justify further investigation to assess their generalizability and to develop postpartum family planning interventions for pediatrics.

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Keywords

contraception; family planning; health services research; postpartum; preterm birth

Amid a fragmented landscape of postpartum care for women, there is a dearth of evidence-based strategies to identify and meet women's postpartum contraceptive needs. Mistimed and unwanted pregnancies are common among postpartum women,[1] leading to pregnancies that are closely spaced and thus at increased risk of maternal morbidity and mortality[2] and adverse perinatal outcomes.[3] Unmet contraceptive needs are also common among women who deliver preterm,[4,5] who are less likely to receive antenatal contraceptive counseling,[6] less often attend postpartum visits,[7] and experience unique barriers to obtaining postpartum contraceptive care.[8,9] The COVID-19 pandemic[10,11] and the overturning of Roe v. Wade have exacerbated barriers to obtaining reproductive health services and underscored the need for improved flexibility and innovation in the delivery of reproductive care. To address important gaps in postpartum services, the American College of Obstetricians and Gynecologists updated their postpartum guidelines in 2018 to recommend care defragmentation and improvement in the frequency and consistency of visits, stressing that about 40% of women do not attend a postpartum visit.[12] Other approaches to improve access have been to increase pre/interconception health services across a range of healthcare settings, including pediatrics,[13] though further implementation work is needed.

While addressing postpartum contraception during pediatric visits should not substitute comprehensive postpartum or interconception care, pediatric encounters could serve as an anchor for identifying unmet postpartum health needs,[14–16] similar to the pediatric approach to postpartum depression.[17] Women frequently[18] and reliably[19] interface with pediatric providers in the postpartum period, as compared to inconsistently attended postpartum obstetric visits.[7,20] In addition, pediatric providers often develop long-term, relationships with families and serve as trusted resources for decisions about current and future children. Our prior qualitative research suggested that postpartum women in pediatric primary care, NICU, and high-risk infant follow-up (HRIF) would consider family planning interventions in these settings acceptable.[8] Other studies have similarly demonstrated women's acceptance of discussing or obtaining postpartum contraception during pediatric encounters, including during general pediatric visits,[21,22] child-focused family medicine visits,[23] pediatric visits with embedded obstetric services,[24] and in the neonatal intensive care unit (NICU).[4]

Pediatric providers are another key stakeholder group to engage in initiatives that incorporate maternal health into pediatric practice. A few studies have suggested that primary care pediatricians[21] and general pediatric residents in primary care clinics[25] may be amenable to screening women for contraceptive needs and referring for reproductive care. However, little is known about the perspectives of other pediatric provider types or perspectives on the range of possible pediatrics-based postpartum family planning interventions (eg, screening, counseling and education, contraceptive provision).

Aside from pediatric primary care, research on women who delivered preterm,[9] including our own previous study,[8] suggests high rates of unmet contraceptive needs and unique barriers to obtaining postpartum services. We found that for women who delivered preterm,

the NICU was frequently their only interface with healthcare during the early postpartum period.[8] We therefore conducted a qualitative study to explore pediatric providers' perceived facilitators and barriers to addressing postpartum family planning in practice settings with frequent interface with postpartum women: NICU, pediatric primary care, and HRIF.

METHODS

SETTING

The study was conducted in 2017−2018 in the San Francisco Bay Area, California at three sites where pediatric providers commonly encounter postpartum women through their care of term and preterm infants: a level II NICU, a pediatric primary care clinic, and an HRIF clinic staffed by developmental and behavioral pediatric providers. The level II NICU predominantly cares for late preterm and stable early preterm infants who may be inpatient for an extended period to work on feeding and growth. The primary care clinic is part of a county health system whose patient population is 95% publicly insured and predominantly Latinx. The NICU and HRIF sites are affiliated with an academic children's hospital that serves a racially, ethnically, and socioeconomically diverse patient population, with about half of patients being publicly insured.

PARTICIPANTS AND RECRUITMENT

We conducted purposive stratified sampling of pediatric providers who interface with postpartum women in distinct practice settings (ie, NICU, primary care, HRIF), aiming for maximum variation sampling.[26] Eligible participants were pediatricians, pediatric nurse practitioners, or neonatal nurse practitioners who worked at any of the 3 sites during the data collection period. We first contacted all potentially eligible participants by email, and we additionally engaged providers in person at all sites.

The Stanford University and San Mateo County Medical Center Institutional Review Boards reviewed and approved the protocol and materials. We conducted the study in accord with prevailing ethical principles, including written, informed consent with all participants prior to any study procedures. All participants received $25 compensation.

SURVEY ITEMS AND INTERVIEWS

We developed closed-ended and open-ended questions to describe the sample and address the study objectives. We pilot tested questions with three providers from the target sample, then modified for clarity. Trained interviewers (co-authors LT and JC) conducted the interviews in English at the clinical study sites.

OPEN-ENDED QUESTIONS—Survey questions explored current screening and referral practices and perspectives on potential postpartum family planning interventions in their practice settings. Specifically, we inquired about comfort with family planning screening, counseling, and provision; current practices for referring parents to adult health services; and facilitators and barriers to incorporating maternal family planning services into practice.

CLOSED-ENDED QUESTIONS—Descriptive questions queried participants' training background, practice setting, and experience with family planning counseling and contraceptive provision. To understand providers' acceptance of such interventions conceptually, apart from logistical feasibility, we adapted two closed-ended questions from a study of long-acting, reversible contraceptive placement in a pediatric setting: *If there were no hassles for you at all [meaning it wouldn't add time, stress, or cost to your work flow], would you discuss future reproductive plans with mothers during a pediatric encounter?,* and *If there were no hassles for you at all [meaning it wouldn't add time, stress, or cost to your work-flow], would you provide contraception to mothers during a pediatric encounter?* [27] Possible response choices on a 5-point Likert scale were: definitely not, probably not, neutral, probably yes, and definitely yes.

DATA ANALYSIS

We analyzed descriptive data using IBM SPSS Statistics Version 24.[28] We used Dedoose software Version 8.0.35 to conduct thematic analysis of qualitative data.[29] After completing each interview, 2 investigators (LT, JC) transcribed audio-recordings and independently reviewed and coded transcripts line-by-line. We developed codes inductively, then reconciled and refined codes and the emerging thematic framework using an iterative team-based process at regular team meetings, ensuring 100% agreement.[30] We re-reviewed and re-coded all transcripts using the final codebook.[31] We triangulated qualitative data with results from the closed-ended questions.[32] Results were reported according to COREQ criteria.

RESULTS

Twenty-one providers were interviewed overall: seven (29%) in the NICU, nine (90%) in primary care), and five (100%) in HRIF (Table 1). Fourteen providers were physicians, 8 were pediatric nurse practitioners, and three were neonatal nurse practitioners. Participants had been in practice an average of 15.3 years (range 1−30 years). Primary care providers prescribed contraception an average of 3.3 times a month; NICU and HRIF providers did not prescribe contraception in their practices. Detailed participant characteristics are in Table 1.

In response to the closed-ended questions, 17 (81%) providers probably or definitely would *discuss* future reproductive plans with women during a pediatric encounter, if there were no hassles (meaning it wouldn't add time, stress, or cost to their workflow). When asked the same question about *providing* contraception to women, 10 (48%) providers probably or definitely would provide contraception to women in their practice, while 8 (38%) probably or definitely would not *provide* contraception.

Four themes emerged from the qualitative analysis (Table 2). Below we describe each theme, and representative quotes are in Table 2.

THEME 1: PROVIDERS WERE GENERALLY OPEN TO INCORPORATING SOME ELEMENT OF FAMILY PLANNING INTO PRACTICE

Providers expressed a willingness to use the pediatric visit to conduct family planning screening and counseling. They recognized the relevance of the topic to their pediatric

patients and the family unit. Some identified the unique opportunity of doing so during a pediatric encounter, recognizing that women had limited interface with adult providers in the early postpartum period. Other providers cited the psychosocial stress experienced by their previous patients' mothers due to unplanned, closely spaced pregnancies.

Providers in each setting felt they already had some family planning expertise, and some were already discussing the topic with postpartum women. Primary care providers described being trained in contraceptive counseling due to their experience caring for adolescents, and discussing family planning with postpartum women felt like a natural extension of this work. NICU and HRIF subspecialists felt uniquely suited to talk about birth spacing in the context of preterm birth and recurrence risk. HRIF providers also shared experiences in which they already discussed family planning, in the context of genetic disease risk recurrence.

THEME 2: BARRIERS TO SCREENING AND COUNSELING ABOUT FAMILY PLANNING IN PEDIATRIC SETTINGS

Despite a general openness to discussing the topic, providers raised several barriers to conducting screening and counseling. The most commonly cited barrier was the providers' own discomfort broaching the topic. Several providers were decades out of training and were uncomfortable with their inadequate or outdated knowledge on contraceptive methods and counseling best practices. Others felt uncomfortable due to the sensitive and personal nature of the topic. They feared being perceived by women as judgmental about reproductive decisions, especially if there were not a standardized and universal approach to counseling. A subset of providers worried that women might consider the topic inappropriate for a pediatric encounter, where the focus is typically the child. This concern was especially prominent among NICU providers, who felt that talking about future pregnancies could seem insensitive. Shifting the focus away from the current infant's intensive care needs could be seen as inappropriate or even as "giving up" on the hospitalized infant.

Participants also described logistical and systems barriers to screening and counseling. Most notably, providers in all three settings were concerned about the time they would need for potentially lengthy family planning conversations. They described the myriad of topics they already needed to address under strict time constraints. Providers also cited the lack of a clear process for referring to an adult provider if they were to identify unmet contraceptive needs. Many primary care providers acknowledged that they did not know how to refer to the affiliated obstetrics and gynecology clinic, despite being co-located and within the same health system. A few NICU providers identified the potential for referring women to the obstetrics and gynecology service "just across the hall," but felt that there was no clear process for doing so.

THEME 3: FACILITATORS TO SCREENING AND COUNSELING ABOUT FAMILY PLANNING IN PEDIATRIC SETTINGS

Participants volunteered several potential solutions to overcome the barriers to screening and counseling. When considering the time burden of a family planning intervention, providers proposed utilizing existing support staff, such as community health workers or social workers, to facilitate family planning discussions and referrals to adult providers.

This suggestion was raised frequently by providers at the primary care site, where a community health worker already coordinated all early newborn visits and met with most new parents. Some primary care providers envisioned that a support staff member could incorporate family planning needs assessments into these early newborn visits that were part of the existing workflow. Other primary care providers proposed having the community health worker additionally meet with families at later visits. Alternatively, some primary care providers envisioned conducting a needs-assessment themselves and referring to the community health worker as needed to coordinate referrals. HRIF and NICU providers suggested that social workers at their sites could screen women and coordinate referrals. One NICU provider felt that the mental health therapist who met with all mothers of NICU patients would be best suited for family planning discussions in the NICU setting. In addition to utilizing support staff, a few primary care providers suggested prepared materials and signage in exam rooms to expedite family planning conversations. Others suggested adding screening questions to the existing pre-visit questionnaire, thereby reserving discussions for only women with unmet needs.

Another commonly mentioned solution was multidisciplinary collaboration with adult health providers. Providers felt that enhanced collaboration could reduce the potential time burden and prevent the need for pediatric providers to provide contraception to adult patients. Primary care providers imagined collaborative meetings with the co-located obstetrics and gynecology providers, where they could develop consistent family planning messaging from prenatal to postpartum and a simple referral process for reproductive care. NICU providers envisioned a process in which women could be referred to the nearby labor and delivery unit to receive care by the obstetricians there. An HRIF provider suggested coordinating with the co-located adolescent medicine clinic to facilitate same-day contraceptive provision.

To overcome knowledge gaps in contraceptive methods and counseling approaches, providers in all settings proposed training sessions with family planning experts. To mitigate the risk of bias in decisions about whom or how to counsel, providers stressed the importance of utilizing standardized screening tools and having conversations with *all* women, and not just a targeted few. One provider suggested leading with a normalizing comment such as “I ask everyone this question,” to ensure women know that the topic is universally addressed. Others suggested again that written materials could help to normalize the topic and standardize the approach. Standardized screening questions, brochures, and visual displays would relay to women that there is nothing about their specific circumstance that prompted the conversation.

THEME 4: FEW PROVIDERS WERE WILLING TO PROVIDE CONTRACEPTION TO MOTHERS OF PEDIATRIC PATIENTS

Though most providers were open to screening and counseling, few were willing to provide contraception. Some providers described discomfort about safety and adverse effects, follow-up, and monitoring. Providers’ safety concerns most often related to contraindications to estrogen-containing methods, including related logistical barriers, such as obtaining a woman’s blood pressure during a pediatric-focused visit. Fragmented electronic medical record systems affecting access to women’s medical histories were

another cited safety barrier. Outpatient providers also raised concerns about follow-up and monitoring. If they were to prescribe oral contraceptives or administer an injectable method at the pediatric clinic, would they be responsible for prescribing refills or repeat injections? Who would follow-up if there were adverse effects or complications? An additional common follow-up concern centered around the loss of health insurance by women who were covered by the state's Emergency Medicaid during pregnancy and would therefore lose coverage at 60 days postpartum. Providers felt uncomfortable with starting contraceptives, knowing that refills or repeat injections would likely be inaccessible.

Provider discomfort about provision also related to concerns about their scope of practice. Several stated specific age cut-offs for their practice. The stated age cutoff differed by provider type (ie, physician, pediatric or neonatal nurse practitioner) and also by setting (ie, NICU, primary care, HRIF), though there was variation within practice settings. Neonatal nurse practitioners explained that they were only licensed to see patients up to age 2, which they perceived as a clear barrier to contraceptive provision to women. Some providers raised legal concerns about prescribing to women outside of their typical pediatric age range.

A few primary care pediatricians brainstormed ways to overcome these barriers so that they could prescribe women the same range of methods they prescribed to adolescents. These pediatricians suggested that if the systems barriers around safety, follow-up and monitoring could be addressed (ie, they had access to a woman's medical records and a clear follow-up plan), they would be comfortable prescribing these methods to postpartum women. However, none of the participants were comfortable providing long-acting reversible methods, such as intrauterine devices or implants, either to their adolescent patients or to this expanded group of patients. Both general pediatric and subspecialty providers suggested that their lack of training and the time required to administer these methods were insurmountable barriers.

DISCUSSION

In this qualitative study of pediatric providers in a NICU, pediatric primary care clinic, and HRIF clinic, we found that providers were open to the idea of screening and counseling women about postpartum family planning, if given the appropriate training and support for implementation. Compared to primary care and HRIF providers, NICU providers expressed greater hesitation about broaching the topic, as their primary focus was on the acute needs of the hospitalized infant, though they were open to engaging support staff and obstetric colleagues to address what they recognized as an important gap in postpartum healthcare. Most providers in all three settings agreed that the *provision* of contraceptive methods to women was unacceptable or infeasible in their practices.

Of note, participants' responses to the closed-ended and open-ended questions did not fully align. While nearly half of participants indicated in response to the closed-ended question that they would be open to providing contraception to women, few suggested a willingness to do so during subsequent responses to open-ended questions. This gap is likely owing to the closed-ended question wording that specified, "if there were no hassles," which

suggests that many providers may have found the idea of providing contraception to women acceptable, though the logistical barriers felt insurmountable.

Our participants' willingness to discuss but not provide contraception aligns with a national survey finding that the majority of pediatric providers deemed maternal family planning relevant to child health, though far fewer providers felt a responsibility to address it during a pediatric encounter.[33] Our study contributes in-depth provider perspectives about perceived barriers to providing contraception to the mothers of pediatric patients, including concerns and uncertainty about monitoring and follow-up, as well as inadequate or outdated training on contraceptive care. Similar to our findings, a study on the perspectives of pediatric residents,[25] and another of postpartum pediatric and obstetric providers,[21] revealed logistical concerns related to time burden and care integration barriers. Our study adds provider ideas for utilizing their opportune interface with postpartum women that account for provider concerns about time and resources, safety, and scope of practice, such as the utilization of support staff or novel tools that may facilitate screening and referral. They also suggested training on evidence-based contraceptive counseling that specifically acknowledged the unique aspects of providing such care in a pediatric clinic. Overall, when considered in conjunction with our prior research exploring women's perspectives in these same settings,[8] our results suggest that each of these distinct pediatric settings may be acceptable and feasible venues for identifying women with unmet family planning needs and connecting them with comprehensive care.

A future direction of this work is the exploration of potential models of care that align with patient and provider stakeholder perspectives. One model is a closed-loop system of pediatric clinic or NICU-based screening, referral for contraceptive services, and subsequent follow-up to assess for ongoing unmet needs and barriers to care, analogous to the pediatric approach to postpartum depression.[17] Screening for family planning needs in pediatric settings would require that providers and support staff be trained in evidence-based, patient-centered communication methods that acknowledge the sensitive nature of the topic.[34] A streamlined screen and refer model could ensure postpartum women are able to connect with comprehensive postpartum or interconception care for any health needs that arise during this period, beyond contraceptive needs. The design of such a model must address the potential for losing to patients to follow-up at each step.

Another model that may have less potential for loss to follow-up is an integrated clinic with co-located pediatric and women 's health services. The feasibility of an integrated model would depend on existing health system infrastructure, alignment of the needs of each discipline, and the engagement of leadership, providers, and staff in integration efforts. A combined women's and infant clinic would extend an integrated approach to care, offered by some novel mother-infant clinics[35] and family medicine models,[23] to families who elect a pediatrician or who require specialized pediatric care.

The barriers and facilitators discussed by the participants in this study and our prior study with postpartum women highlight the need for future research that is grounded in implementation science. Deep stakeholder engagement around local context (e.g., health

system infrastructure and financing) in the development, implementation, and evaluation of interventions, will be critical to maximizing the potential for successful uptake.[36]

Our study must be interpreted in light of its limitations. First, this small, exploratory study conducted in one geographic area should be considered hypothesis-generating and not generalizable to the broader population of pediatric providers across other regions and clinical settings. Second, these interview data may have been affected by social desirability bias, though the pattern of our findings is consistent with the findings from an anonymous, quantitative survey,[33] providing some assurance that provider responses were not overly influenced by social desirability. In addition, this study took place before the American College of Obstetricians and Gynecologists updated their postpartum guidelines to recommend earlier and more frequent visits, though the impact on access to postpartum care is not yet clear.

In conclusion, this exploratory research suggests that NICUs, pediatric primary care clinics, and HRIF clinics may be acceptable and feasible settings for postpartum family planning screening and counseling, with the potential to ease access to postpartum contraceptive care and prevent unintended, closely-space pregnancies and their sequelae.

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REFERENCES

1. Ahrens KA, Thoma ME, Copen CE, et al. Unintended pregnancy and interpregnancy interval by maternal age, National Survey of Family Growth. Contraception. 2018;98:52–55. 10.1016/j.contraception.2018.02.013. [PubMed: 29501647]
2. Hutcheon JA, Nelson HD, Stidd R, et al. Short interpregnancy intervals and adverse maternal outcomes in high-resource settings: an updated systematic review. Paediatr Perinat Epidemiol. 2019;33: O48–O59. 10.1111/ppe.12518. [PubMed: 30311955]
3. Ahrens KA, Nelson H, Stidd RL, et al. Short interpregnancy intervals and adverse perinatal outcomes in high-resource settings: an updated systematic review. Paediatr Perinat Epidemiol. 2019;33: O25–O47. 10.1111/ppe.12503. [PubMed: 30353935]
4. Verbiest S, McClain E, Stuebe A, et al. Postpartum health services requested by mothers with newborns receiving intensive care. Matern Child Health J. 2016;20:125–131. 10.1007/s10995-016-2045-6. [PubMed: 27357697]
5. Zerden ML, Falkovich A, McClain EK, et al. Addressing unmet maternal health needs at a pediatric specialty infant care clinic. Womens Health Issues. 2017;27:559–564. 10.1016/j.whi.2017.03.005. [PubMed: 28431902]
6. Toscano M, Li D, Dye T, et al. Antepartum contraceptive counseling in women with preterm birth. Am J Perinatol. 2019;36:1310–1316. 10.1055/s-0038-1676831. [PubMed: 30609431]
7. DiBari JN, Yu SM, Chao SM, et al. Use of postpartum care: predictors and barriers. J Pregnancy. 2014 530769. 10.1155/2014/530769. 2014.

8. Congdon JL, Trope LA, Bruce JS, et al. Meeting the needs of postpartum women with and without a recent preterm birth: perceptions of maternal family planning in pediatrics. Matern Child Health J. 2020;24:378–388. 10.1007/s10995-019-02829-x. [PubMed: 31875305]
9. Thiel de Bocanegra HT, Kenny J, Sayler K, et al. Experiences with prenatal and postpartum contraceptive services among women with a preterm birth. Womens Health Issues. 2020;30:184–190. [PubMed: 31859188]
10. Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences. Guttmacher Institute; 2020. Published June 18 Accessed October 8, 2020; https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.
11. Diamond-Smith N, Logan R, Marshall C, et al. COVID-19's impact on contraception experiences: exacerbation of structural inequities in women's health. Contraception. 2021;104:600–605. 10.1016/j.contraception.2021.08.011. [PubMed: 34461136]
12. The American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstet Gynecol. 2018;131:e140–e150. 10.1097/AOG.0000000000002633. [PubMed: 29683911]
13. Upadhya KK, Psoter KJ, Connor KA, et al. Cluster randomized trial of a pre/interconception health intervention for mothers in pediatric visits. Acad Pediatr. 2020;20:660–669. 10.1016/j.acap.2019.10.003. [PubMed: 31629944]
14. Cheng TL, Kotelchuck M, Guyer B. Preconception women's health and pediatrics: an opportunity to address infant mortality and family health. Acad Pediatr. 2012;12:357–359. 10.1016/j.acap.2012.04.006. [PubMed: 22658953]
15. Zuckerman B, Nathan S, Mate K. Preventing unintended pregnancy: a pediatric opportunity. Pediatrics. 2014;133:181–183. 10.1542/peds.2013-1147. [PubMed: 24470643]
16. Trope LA, Congdon JL, Brown L, et al. Family planning in pediatrics: an appeal for enhanced training. J Pediatr. 2018;200:4–5. 10.1016/j.jpeds.2018.06.012. [PubMed: 30144929]
17. Earls MF, Yogman MW, Mattson G, et al. Incorporating recognition and management of perinatal depression into pediatric practice. Pediatrics. 2019;143. 10.1542/peds.2018-3259.
18. Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, Ill: American Academy of Pediatrics; 2008.
19. Abdus S, Selden TM. Adherence with recommended well-child visits has grown, but large gaps persist among various socioeconomic groups. Health Aff (Millwood). 2013;32:508–515. 10.1377/hlthaff.2012.0691. [PubMed: 23459729]
20. American College of Obstetricians and Gynecologists. Committee Opinion No. 666: Optimizing postpartum care. Obstet Gynecol. 2016;127: e187–e192. 10.1097/AOG.0000000000001487. [PubMed: 27214194]
21. Henderson V, Stumbras K, Caskey R, et al. Understanding factors associated with postpartum visit attendance and contraception choices: listening to low-income postpartum women and healthcare providers. Matern Child Health J. 2016;20:132–143. 10.1007/s10995-016-2044-7. [PubMed: 27342600]
22. Harris K, Sivamurthy S, Mohiuddin H, et al. Contraceptive counseling in the postpartum period: could pediatricians have a role? Matern Child Health J. 2020;24:923–931. 10.1007/s10995-020-02947-x. [PubMed: 32372242]
23. Rosener SE, Barr WB, Frayne DJ, et al. Interconception care for mothers during well-child visits with family physicians: an IMPLICIT network study. Ann Fam Med. 2016;14:350–355. 10.1370/afm.1933. [PubMed: 27401423]
24. Kumaraswami T, Rankin KM, Lunde B, et al. Acceptability of postpartum contraception counseling at the well baby visit. Matern Child Health J. 2018;22:1624–1631. 10.1007/s10995-018-2558-2. [PubMed: 29931493]
25. Caskey R, Stumbras K, Rankin K, et al. A novel approach to postpartum contraception: a pilot project of Pediatricians' role during the well-baby visit. Contracept Reprod Med. 2016;1:7. 10.1186/s40834-016-0018-1. [PubMed: 29201396]

26. Patton Michael Quinn. Qualitative Research & Evaluation Methods. 4th ed. Saint Paul, MN: SAGE Publications, Inc.; 2014.. Accessed November 1, 2021; http://us.sagepub.com/en-us/nam/qualitative-research-evaluation-methods/book232962.
27. Miller MK, Randell KA, Barral R, et al. Factors associated with interest in same-day contraception initiation among females in the pediatric emergency department. J Adolesc Health. 2016;58:154–159. 10.1016/j.jadohealth.2015.10.016. [PubMed: 26802990]
28. IBM. SPSS Statistics for Macintosh. IBM Corporation; 2017. https://www.ibm.com/products/spss-statistics.
29. Dedoose. SocioCultural Research Consultants, LLC; 2018. www.dedoose.com.
30. Crabtree BF, Miller WL. Doing Qualitative Research. Thousand Oaks, California: SAGE Publications; 1999.
31. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15:1277–1288. 10.1177/1049732305276687. [PubMed: 16204405]
32. Patton MQ. Enhancing the quality and credibility of qualitative analysis. Health Serv Res. 1999;34(5 Pt 2):1189–1208. [PubMed: 10591279]
33. Venkataramani M, Cheng TL, Solomon BS, et al. Addressing parental health in pediatrics: physician perceptions of relevance and responsibility. Clin Pediatr (Phila). 2017;56:953–958. 10.1177/0009922817705189. [PubMed: 28429619]
34. Dehlendorf C, Fox E, Sobel L, et al. Patient-centered contraceptive counseling: evidence to inform practice. Curr Obstet Gynecol Rep. 2016;5:55–63. 10.1007/s13669-016-0139-1.
35. Smith H, Sheeder J, Ehmer A, et al. Implementing interconception care in a dyadic adolescent mother−child clinic. Matern Child Health J. 2021;25:1670–1676. 10.1007/s10995-021-03212-5. [PubMed: 34398406]
36. Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4:50. 10.1186/1748-5908-4-50. [PubMed: 19664226]

WHAT'S NEW

Many women experience barriers to meeting their postpartum contraceptive needs, and pediatric encounters are opportunities to ease access to care. This study contributes the perspectives of pediatric providers on addressing family planning in three distinct practice settings.

Table 1.

Sample Characteristics Overall and by Study Site (N = 21)

	Full Sample (N = 21)	NICU (N = 7)	Primary Care Clinic (N = 9)	HRIF Clinic (N = 5)
Gender				
Female	18	4	9	5
Male	3	3	0	0
Race or ethnicity				
Asian	7	1	6	0
Black	1	1	0	0
Latinx	3	1	2	0
White	13	6	1	5
Provider type				
Physician	14	4	6	4
Pediatric nurse practitioner	4	0	3	1
Neonatal nurse practitioner	3	3	0	0
Years in practice (range, mean)	1–30, 15.3	2–28, 11.5	5–20, 16.2	1–30, 18.2
Monthly frequency of prescribing contraception	3.3	0	3.3	0

NICU indicates neonatal intensive care unit; and HRIF, high-risk infant follow-up.

Table 2.

Qualitative Themes With Representative Quotes From Providers in the NICU, Pediatric Primary Care, and High-Risk Infant Follow-Up Clinic (N = 21)

Themes and Subthemes	Representative Quotes
Theme 1: Providers were generally open to incorporating some element of family planning into practice	
Recognize relevance to patient and family	*In a pediatric center, the whole family is the patient...it's in the best interest of the child. Not even birth spacing and prematurity, but just about resources in families* [HRIF provider] *I feel nothing happens for the first 6 weeks of life, nobody is talking about the mom. Everybody is so focused on the baby.* [Primary Care Provider] *I've seen multiple women take their babies home from the NICU and already be pregnant. It's not that they don't need contraception. They need it.* [NICU Provider] *I think it's a very reasonable conversation, particularly in our population, where you hear about parents who don't want to become pregnant again because of a previous high risk pregnancy.* [NICU Provider]
Some providers are already discussing family planning with women	*I usually ask [women] even at the six week visit...you know it's very difficult to handle two kids within a year or close range. I usually say, 'are you using anything for birth control?', and they'll tell me yes or they have an appointment, or they haven't, and if they're not using anything, I always offer them condoms here.* [Primary Care Provider] *I've talked with families, mothers about family planning, and usually those conversations are related to genetics, genetic findings in the patient. I've talked with mothers about whether they're following up with theirOB/Gyn.* [HRIF Provider] *Once I get to know families or if families had a preterm infant, I just make it a point to check in with them regarding the risk of prematurity and in the face of having a preterm infant sitting there in the NICU...just reminding mothers that interpregnancy interval is one of the factors that affects prematurity rates...just kind of put something in their minds about contraception and the need to maybe reach out to their providers.* [NICU Provider]
Theme 2: Barriers to Screening and Counseling about Family Planning in Pediatric Settings	
Inadequate or outdated family planning knowledge and skills	*I think opening the door, starting the conversation suggests that I know something current about recommendations, and so that would make me hesitate...feeling that my knowledge was not current, not up to snuff.* [HRIF Provider] *I would be generally comfortable with [family planning] topics, particularly interval between births, and perhaps any discomfort in doing so would be just lack of familiarity with the with prescriptions, profiles of agents...* [NICU provider]
Discomfort due to concern about the topic being perceived as inappropriate or judgmental	*Sometimes it's a little uncomfortable to bring up [family planning] because it kind of says that maybe we think that they should, you know, wait a while for the next kid or stop where they are or something like that. And you are trying not to come across judgmentally.* [Primary Care Provider] *I think there might be parental surprise or reluctance to engage in that conversation. ' Why are we talking about this topic here?'* [HRIF provider] *In NICU, it would feel insensitive to me at a time that they would be fighting for the outcome of the most recent pregnancy. I would feel like I was losing focus on the battle at hand. I could see that as off-putting for families.* [NICU Provider]
Logistical and Systems Barriers	*Time. We're busy with our specific patient population. And while it's a family unit, and the care of the parent is important, that might be difficult.* [NICU Provider] *There's always the time issue, it can lead to other conversations.* [Primary Care Provider] *It would be nice to have an easy referral to the OB providers, if there were an easy, in house route to send them to.* [NICU Provider] *I know that there was a while where they didn't have enough providers [in OB] so it's about getting appointments. I don't know what the set-up is downstairs, I don't know if they have a walk in situation, I don't know if they have a specific day where they do birth control.* [Primary Care Provider]
Theme 3: Facilitators to Screening and Counseling about Family Planning in Pediatric Settings	
Use of Support Staff	*Maybe we can have a dedicated visit with a community health worker...[they] could be the catalyst to say, ok, I'm going to talk to [the obstetric]provider.* [Primary Care Provider] *If the social worker has had a relationship with the family...or now we have therapists who come to see the family– if these people are the first to broach the subject, and then they bring the pediatrician in as the medical provider, that could be a way for all of that to connect.* [NICU Provider]
Multidisciplinary Collaboration	*It could be a lot easier for the whole transition if [obstetrics and pediatrics] just figured out some really standardized ways of communicating...'this is the day we think [a woman] is going to deliver, and this is what she has consented to for her birth control...and if she happens to deliver [elsewhere] by accident and she misses that great moment, now she is transitioning to the postpartum team'... There's no reason, other than inertia to not make that articulation smoother for moms.* [Primary Care Provider] *It would be nice to have an easy referral to the OB providers, if there were an easy in house route.* [NICU Provider] *If we could schedule [same-day contraceptive appointments] and share nurses with the adolescent clinic or something...Then we wouldn't do the procedure, because they're better at it anyway, but they are right next door. We share a workroom already, and we could just schedule it that way... or at least good communication with their primary care person to say you know, we did the counseling piece, you just gotta schedule it.* [HRIF Provider]

Themes and Subthemes	Representative Quotes
Training on contraceptive counseling and methods	*I think it's a really good topic. I would like to be more comfortable. I would like more advice on how to broach the subject with parents, because I think it's really important.* [HRIF Provider]
Normalizing the topic and standardizing communication	*I would approach it similarly to other discussions that have tried to destigmatize certain things like depression screening...but then if you do it in a really standardized fashion, it at least diminishes the concern* [NICU Provider] *If it could be part of the screening questions when they come in, then it might be something neutral enough that we can review with them... and we could ask it neutrally when we are just reviewing the form.* [Primary Care Provider] *There's been a lot done in medical education on normalizing comments, like 'I ask all my patients this question' and just starting it that way makes it less uncomfortable.* [HRIF Provider]
Theme 4: Few Providers Were Willing to Provide Contraception to Mothers of Pediatric Patients	
Safety, follow-up, and monitoring concerns	*Parents sometimes lose their health insurance...how is it going to be covered?* [Primary Care Provider] *In terms of dispensing birth control, I would feel a little bit uncomfortable, because the mom is not my patient, and that would involve going into her medical record and looking at her own primary care physician's notes and seeing if she has a history of migraines with aura and all these other contraindications...Sometimes I am the mom and baby's pediatrician, and in that case, definitely they're under 18, she's my patient as well. I don't have qualms about doing that.* [Primary Care Provider]
Clinical infrastructure barriers	*[Concern about] logistics of getting the mom registered as a patient somehow to prescribe.* [Primary Care Provider]
Scope of practice, including legal concerns	*I'm a pediatrician, and my license is good for pediatric patients...I don't write prescriptions for adults.* [Primary Care Provider] I think that [provision is] stepping outside of my scope of practice. Not only am in pediatrics, but I'm in developmental and behavioral pediatrics...my focus is young children, so the oldest child I take care of is typically 10 or 11 or 12. [HRIF provider] *I don't feel bad about discussing it. I don't know if I would want to be the one providing it because the mothers are not our patients. I would not want to be the one who inserts an IUD - it's afar stretch fora neonatologist.* [NICU Provider]
Long-acting reversible contraception-specific challenges	*If they want the IUD or the implant– I have not had the training for that– so they would either have to be set up with a colleague here or I refer them to the teen center.* [Primary Care Provider]

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