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Patients' experiences with South Carolina's immediate postpartum Long-acting reversible contraception Medicaid policy

Emily S. Mann [a,*], Ashley L. White [a], Peyton L. Rogers [a], Anu Manchikanti Gomez [b]

[a] Department of Health Promotion, Education, and Behavior, Arnold School of Public Health, University of South Carolina, 915 Greene Street, Columbia, SC 29208
[b] Sexual Health and Reproductive Equity Program, School of Social Welfare, University of California, Berkeley, 120 Haviland Hall MC 7400, Berkeley, CA 94720-7300

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ABSTRACT

Objectives: We sought to examine women's experiences with immediate postpartum LARC counseling and use in the context of South Carolina's Medicaid policy.
Study design: In 2016–18, we conducted semi-structured individual interviews with 25 women, ages 18–35, who gave birth within 2 years of the interview in South Carolina while insured by Medicaid and received contraceptive counseling about immediate postpartum LARC during their pregnancies. We analyzed the interviews using a combination of deductive and inductive coding approaches.
Results: Participants were counseled on immediate postpartum LARC during prenatal care (n=23) and/or while in the hospital for childbirth (n=16). Some expressed dissatisfaction with providers' approaches to contraceptive counseling because they either did not receive enough information to make a fully informed decision or felt they were being pressured to use LARC. Among those who received in-hospital contraceptive counseling, some objected to the timing because they were in labor and/or already had a non-LARC postpartum contraceptive plan. Three out of the 10 participants who elected to receive immediate postpartum LARC later desired removal but encountered barriers.
Conclusions: Our findings suggest providers' timing, style, and content of contraceptive counseling about immediate postpartum LARC may not be sufficiently patient-centered. Additionally, lack of access to unfettered LARC removal limits patients' reproductive autonomy.
Implications: If providers use a patient-centered approach to immediate postpartum LARC counseling, consistently engage in comprehensive contraceptive counseling during prenatal care, avoid pressuring patients to choose LARC, and collaborate with hospital staff to increase care coordination, they can improve Medicaid recipients' contraceptive care experiences and facilitate informed contraceptive decision-making.

1. Introduction

Women living below or near the poverty line have higher rates of unintended pregnancy than women in higher income groups [1]. Racial and ethnic disparities also exist; Black women experience the highest rates of unintended pregnancy across all income groups [1]. Low-income women are more likely than the general population of reproductive-aged women to experience a short interval pregnancy, defined as a pregnancy occurring within 1 year of delivery [2]. Given their purported association with adverse health outcomes, public health experts emphasize the importance of preventing unintended and short interval pregnancies [3].

For the past decade, professional health associations and agencies have promoted long-acting reversible contraception (LARC), which include intrauterine devices (IUDs) and the etonogestrel implant, as the "first-line" option for pregnancy prevention because of high rates of effectiveness, lack of "user failure," cost-efficiency, and reversibility [4–7]. Previous studies note that when access barriers are removed, including cost, lack of knowledge, and lack of same-day placement, women are more likely to choose LARC [8–10]. As a result of these findings, many experts now perceive low rates of LARC use among women regarded as at-risk for unintended and short interval pregnancies primarily as a matter of access [11–13].

In 2012, South Carolina became the first U.S. state to implement an immediate postpartum LARC Medicaid policy to improve access to and increase use of LARC among low-income women who wish to prevent pregnancy. Historically, hospitals could not receive full reimbursement for placing LARC during an in-patient hospital stay for childbirth outside the global fee for labor and delivery [14]. Since Medicaid recipients have higher rates of unintended and short interval pregnancies than women who are privately insured, and 55% do not return for their six-week

* Corresponding author.
E-mail address: emann@mailbox.sc.edu (E.S. Mann).

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postpartum visit, public health experts regard facilitating access to immediate postpartum LARC as an efficient and cost-effective intervention for this population [13–18].

The South Carolina Birth Outcomes Initiative (BOI), in collaboration with Advocates for Youth and Choose Well SC, developed a toolkit outlining best practices for contraceptive counseling and care delivery to Medicaid recipients in the context of the policy [18]. The toolkit emphasizes that providers should engage in multiple conversations about postpartum contraceptive options during prenatal care visits in order to facilitate patients' informed decision making about immediate postpartum LARC prior to the onset of labor [18]. Additionally, upon hospital admission for childbirth, the admitting physician should review the patient's chart and confirm whether or not she wants an immediate postpartum LARC placed. Although the toolkit focuses on in-hospital counseling about the implant, clinical guidelines recommend IUD insertion within 10 min of placental delivery to reduce the likelihood of expulsion [19]. Therefore, health care providers may regard confirming patient preference for an IUD as time-sensitive, whereas they can insert an implant at any time postpartum prior to hospital discharge [19]. Patients can also choose to receive a non-LARC method postpartum. As of April 2019, 40 states and the District of Columbia have adopted similar policies [15].

While scholarship assessing the implementation of immediate postpartum LARC Medicaid policies has examined questions of hospital administration, billing, health care providers' attitudes, and utilization rates [16,17,20–23], to our knowledge no research has explored the contraceptive counseling experiences of women who are the focus of these policies. In this analysis, we present findings from a qualitative study of South Carolina Medicaid recipients who recently gave birth in a hospital system implementing the state's immediate postpartum LARC Medicaid policy.

2. Materials and methods

2.1. Data collection

The data presented here are drawn from a larger qualitative study with 30 publicly insured women conducted between November 2016 and March 2018 that explored their experiences with South Carolina's immediate postpartum LARC Medicaid policy and related themes using individual interviews. Eligibility criteria included a) identifying as female; b) being 18–35 years old; c) having at least one live birth in a hospital within one of the South Carolina health systems implementing the policy within 2 years prior to the interview; and d) being insured by Medicaid at the time of the most recent live birth. We recruited participants through clinics, social service agencies, and community-based organizations.

Interviews lasted an average of 41 min and explored: (a) participants' perceptions of the contraceptive counseling they received in the context of prenatal care and their most recent live birth; (b) access to immediate postpartum LARC; (c) if they had the option, whether they accepted or declined immediate postpartum LARC, and why; and (d) user experience with immediate postpartum LARC, if applicable. During the interviews, we showed each participant the widely used Bedsider information sheet about contraceptive methods (see Figure 1) in order to facilitate a discussion of their experiences with contraceptive counseling and use. Participants had the option to keep the information sheet at the end of the interview. We conducted interviews in a setting chosen by the participant (e.g., fast food restaurants, coffee shops, their homes).

2.2. Data analysis

Professional transcriptionists provided verbatim transcription of interviews. E.S.M, A.L.W., and P.L.R. coded the transcripts using Atlas.ti. We derived deductive codes from the interview guide and developed inductive codes through an iterative process of constant comparison across emerging categories of analysis [24]. The coding process focused on capturing participants' narratives about how they perceived health care providers' approaches to counseling about immediate postpartum LARC and other contraceptive methods during their most recent pregnancy and their contraceptive decision-making following their most recent birth. Here, we highlight deductive codes focused on participants' perceptions of the contraceptive counseling they received during prenatal care and while in the hospital for labor and delivery as well as postpartum LARC use, when applicable. Additionally, two inductive codes emerged as salient themes. These include participants' negative perceptions of the timing of contraceptive counseling in the context of labor and delivery and barriers to LARC removal following negative user experiences. As only 25 out of the 30 participants reported any experience with contraceptive counseling during prenatal care and/or during their hospital stay for childbirth, the results presented in this article focus on this subset of interviews.

2.3. Ethical considerations

E.S.M, a White woman in her early 40s, P.L.R., a Black woman in her early 20s, and two additional research assistants conducted the interviews. While we aimed to achieve race concordance between interviewers and participants, in a few cases, E.S.M. interviewed Black participants; P.L.R. and another Black research assistant interviewed White participants. Participants chose their own pseudonyms in order to protect their privacy and confidentiality, and received an incentive of $30. The University of South Carolina's Institutional Review Board approved the study protocol.

3. Results

3.1. Participant characteristics

Among the 25 participants included in the analysis presented here, 18 identified as Black/African-American, five as White/Caucasian, and two as multiracial (see Table 1). The mean participant age was 25.1 years (SD 3.1). The majority of participants (n=16) attended some college, and two had earned a four-year college degree. Sixteen participants had two or more children. Over half the participants (n=15) were married, cohabiting, or in a serious relationship. Most participants (n=20) had given birth within the 12 months before the interview, and two were currently pregnant. Ten participants elected to receive an immediate postpartum LARC (eight IUDs, two implants); however, two had to wait until their six-week postpartum visit for IUD placement due to provider inattention. Nine were using a LARC method at the time of the interview; one had discontinued IUD use; and two participants planned to have an IUD inserted postpartum (one immediately, as she was 8 months pregnant at the time of the interview; and the second at the six-week postpartum visit, as she had recently given birth). Additionally, three participants had discontinued implant use, but none were placed postpartum.

As noted above, participants received counseling about immediate postpartum LARC during their prenatal care visits and/or during their hospital stay for childbirth. Only two exclusively received in-hospital immediate postpartum LARC counseling, while 23 reported receipt of counseling about immediate postpartum LARC during prenatal care, with most reporting multiple conversations about postpartum contraception. Most of these participants (14 of 23) also received counseling about immediate postpartum LARC during their hospital stay for childbirth. Out of the nine who reported not receiving in-hospital contraceptive counseling, five indicated they already had a postpartum contraceptive plan in place.

3.2. "It's like they're getting a commission": Dissatisfaction with approaches to contraceptive counseling

When asked about their perceptions of the contraceptive counseling they received during either individual or group-based prenatal care

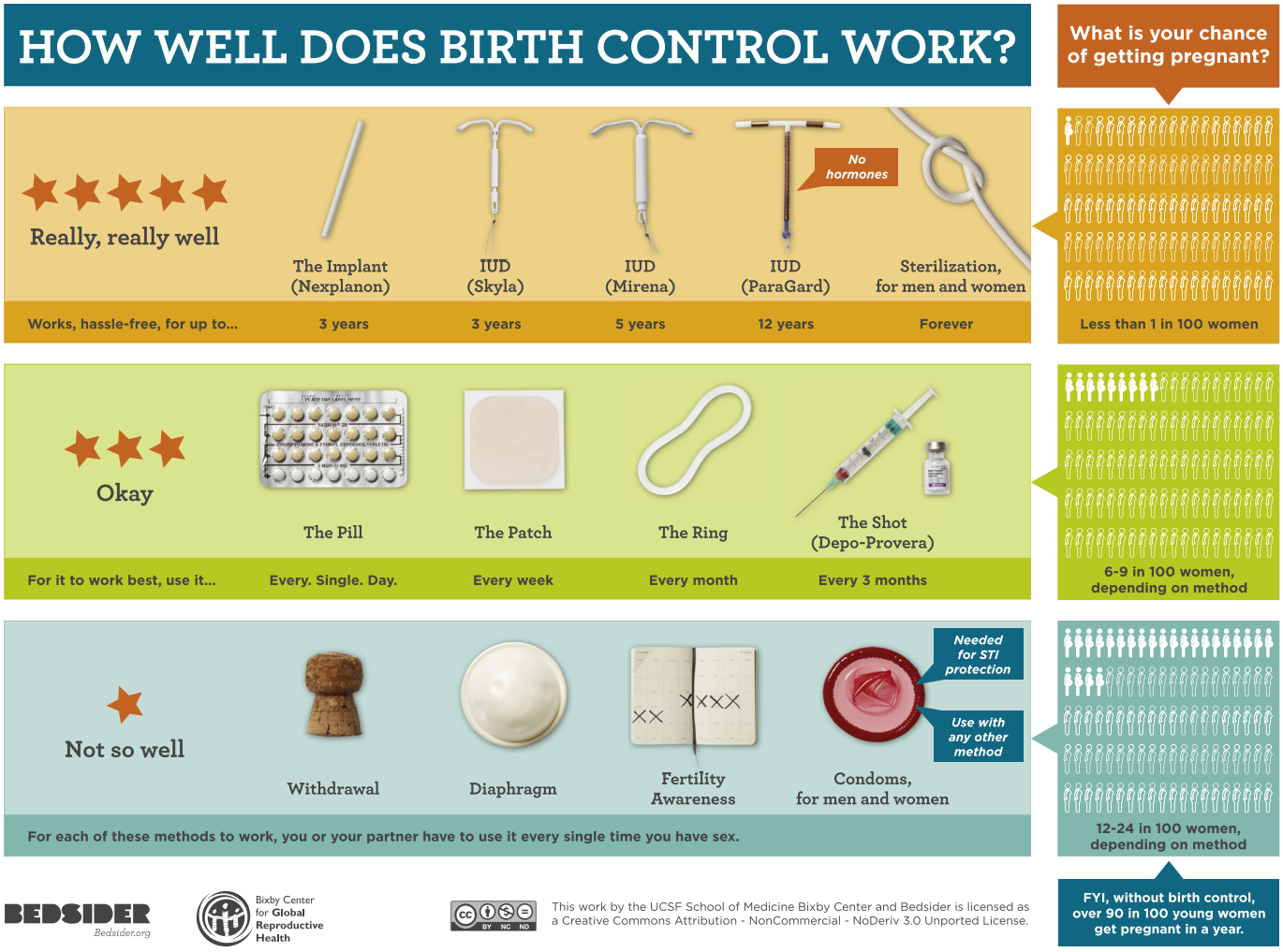

Figure 1. Bedsider contraception information sheet.

and/or during their inpatient hospital stay, some disclosed they found their providers' approaches to counseling about immediate postpartum LARC problematic. These participants noted that they thought providers were overly enthusiastic about encouraging them to get an IUD or implant. Vermel, a 27-year-old Black mother of two children, raised questions about providers' motivations:

> They just keep promoting these long-term methods. It's like they're getting a commission or something. I always wondered that. They were really, really trying to push this product. They asked me what was I going to do [for contraception]. It was like they were selling me. They were really making me feel like they were selling me. Like, "You should try it." "No. I don't want to."

Among those who received individual prenatal care, some did not think they received adequate information about their contraceptive options. Marie, a 22-year-old White mother of one child, received counseling about her postpartum contraceptive options during a third-trimester prenatal visit but felt dissatisfied with the conversation:

> They didn't really give me much information on them, they were just like, "Here, here, here, these are your choices. This is what this does, this does." That's about it. No after-effects or instructions on how to go about them.

Despite not feeling fully informed, Marie planned to have an implant inserted postpartum. However, none of the providers discussed the option to have a LARC placed after giving birth, so she did not receive an implant. She expressed her frustration when she said, "That probably should be in your discharge papers or when they're talking to you about being discharged or something on your way out to go home."

Queen, a 26-year-old Black mother of three children, recounted feeling pressured to get a postpartum IUD, despite the fact that she had requested sterilization multiple times in the past and signed the Medicaid consent form to have the procedure conducted after the birth of her third child:

> They offered me the Mirena, but the whole time she was trying to offer me Mirena…I just wanted my tubes tied, but the first time I asked them about it, they said I wasn't old enough. The second time, after I had [my second child] I asked, and they said no surgeon would do it because of how young I was. After I had [my third child] 4 years later, they said they forgot to do it. It was just crazy. They always offered me this thing right here <*points to a picture of an IUD on the Bedsider information sheet*>, and I just don't do good with side effects. You can't force me to take stuff if I don't want to take it...You can give me information on it, but you can't just say you need to stop having babies, but I don't want you to stop all the way having babies, so no tubal ligation, but here's some Mirena. No. No.

By contrast, some of the participants were either satisfied with or neutral about the contraceptive counseling they received in the context of prenatal care; among those who described receiving contraceptive counseling during their pregnancies about the full range of postpartum options, they were more likely to be enrolled in a group-based prenatal

Table 1
Medicaid recipients' demographic characteristics, receipt of contraceptive counseling, and current contraceptive use (n=25).

Characteristic	N
Mean age (SD), years	*25.1 (3.1)*
Race/ethnicity	
White	5
Black	18
Multiracial	2
Relationship status	
Cohabiting or married	10
In a serious relationship	5
Single	10
Educational attainment	
Some high school	1
High school	8
Some college or associate degree	14
Bachelor's degree	2
Health insurance status at time of interview	
Uninsured	2
Publicly insured	21
Privately insured	2
Number of children	
1	9
2	9
3	7
Current contraceptive use[1]	
Condoms	1
Oral contraceptive pill	2
Intrauterine device (IUD)	7
Implant	2
Shot	4
Other (e.g., abstinence, withdrawal)	3
Tubal ligation	1
No method	2
Currently pregnant	1
Months since most recent birth	
0–2	7
3–6	5
7–12	8
13–24	5
Received prenatal contraceptive counseling	
Yes	22
No	3
Received in-hospital LARC counseling	
Yes	16
No (5 had a postpartum contraceptive plan)	9

[1] No participants reported currently using multiple methods.

care program. When asked to detail what was discussed in this context, Brittany, a 28-year-old Black mother of one child, explained:

> They actually showed us this [Bedsider] chart, and went through these [methods] with us, and definitely spent a lot of time on the top one [IUDs, the implant], about what's maybe best. For the first group [of methods], they basically said those would be the most effective, especially for moms who really, really don't want to be pregnant. Basically explaining, especially for the top group, what kind of things that you can expect as far as how long you can keep them, or whether you're going to be cramping, whether you're going to experience mood swings and things like that. As far as the middle group [pill, patch, ring, shot], they did spend time on that one, but did let us know that those are not as effective. Then for the last one [e.g., withdrawal, fertility awareness], it wasn't a joke, of course, but we briefly went over that one, because that one doesn't work very well, obviously (see Figure 1).

Brittany's experience reflects a tiered efficacy approach to contraceptive counseling, which is now considered a best practice among providers (30). This counseling experience informed her decision to have an IUD placed immediately postpartum, as we detail below. However, for those who were dissatisfied with the counseling they received, all but one declined immediate postpartum LARC.

3.3. "I don't know, but I'm having contractions": Timing of immediate postpartum contraceptive counseling

Participants had varied responses when reflecting on when they received counseling about the option of immediate postpartum LARC. Twenty-three participants described postpartum contraceptive counseling during at least one of their prenatal care visits and some noted that their providers discussed contraception many times over the course their pregnancies. Among the 16 participants who received counseling about immediate postpartum LARC while in the hospital for labor and delivery, some objected to the timing because they were in active labor and experiencing pain. Others objected to receiving counseling in this context because they had already decided on a non-LARC method earlier in their pregnancy or they were not planning to use a contraceptive method postpartum. Ultimately, 10 participants received immediate postpartum LARC, with four choosing their method (three IUDs, one implant) while in the hospital for labor and delivery.

Kaylynn, a 24-year-old White mother of three children, had not discussed contraception with her provider during her prenatal visits, which appeared to be related to moving to South Carolina from out of state and initiating prenatal care late in her pregnancy. She was in labor and had just been admitted to the hospital when a health care provider told her about the option to get immediate postpartum LARC. She explained:

> When they admitted me, they came in and they said, "Hey did you talk to anybody about what birth control you're wanting to get?" I'm like, "Not really definite for anything." They said, "Well, here's the options that we can give you"... Me and my boyfriend talked about it and [the IUD is] what we decided to do. We signed the paper and then they just did it right after I had [my son].

While she ultimately chose to have an IUD placed immediately postpartum, Kaylynn felt that "it was kind of weird" that a provider was asking her these questions while she was six centimeters dilated. When she was initially asked about postpartum contraception, she responded, "I don't know, but I'm having contractions." Overall, she thought, "It was kind of bad timing."

Some participants had decided on a method during prenatal care. Renee, a 24-year old multiracial mother of one child, said that her provider discussed contraception at each prenatal visit; as she understood it, her provider "just wanted to make sure that I had chosen or at least thought through one of the methods." Because of past use and satisfaction, Renee decided to use the shot post-pregnancy. Despite making this decision prior to the onset of labor, Renee recalled a doctor insisting she discuss the option of getting an immediate postpartum LARC when she was being admitted to the hospital:

> The doctor before I was checked in asked me [about contraception] right before they took me back, if anything, because she was trying to talk me into getting an IUD. I was like, "I don't know, we'll talk about it later. I'm in pain right now, I don't want to talk"... I just told her that I was really set on getting the shot, and she was like, "Are you sure?" and I was just like, "Yeah, if you don't mind."

During what she described as a "five-minute conversation," Renee felt that the provider was pushing the IUD, with the interaction ending when the doctor agreed to administer the shot prior to hospital discharge. Despite Renee's overall positive impression of her care during childbirth, she found it troubling that the doctor insistently asked about immediate postpartum LARC while she was in labor, especially since she had already planned to use a non-LARC method postpartum.

3.4. "Can you take it out for me?": Barriers to LARC removal

Among the 10 participants who chose immediate postpartum LARC, seven were pleased with the method and had not experienced any

objectionable side effects; however, three conveyed dissatisfaction and suffering. For these participants, barriers to removal emerged as a problem.

When the interviewer asked Brittany how her experience with using a postpartum IUD had been, she replied, "So far, I despise it with everything in my spirit." When the interviewer asked her if her doctor would remove her IUD, Brittany replied:

> I don't think so. I think that ... Knowing that she knows me and how I felt about not really wanting to be pregnant at the time…she'll probably ask me, "Well, why do you want to do it?" And I don't think she'll try to convince me not to do it, but make me give her a good enough reason for her to want to do it. Of course, if I ask her to do it, she'll do it. But I think she'll ask me why.

While Brittany contextualized why her doctor might not remove her IUD on demand in a way that suggests she would find her doctor's reluctance understandable, she also acknowledged she would have to make a convincing case for her doctor to agree to remove it. This appeared to deter her from pursuing removal.

Keisha, a 28-year-old Black mother of three children, was one of two participants who had an implant placed immediately postpartum. Her experience with trying to access implant removal painted a distressing picture:

> I've got to get rid of this thing. I don't want this. Take it out. Can you take it out for me? Take it out. I don't like it at all…The health department, they're going to take it out. I was going to get my primary care doctor to remove it, but she was like it's going to be $300 to just get it removed. I'm like, "No ma'am. I deny. No." I can go somewhere else and get it done for free and get something else because I can't. I can't with this thing no more. I'm tired.

Since Keisha no longer had Medicaid coverage due to a change in her eligibility, financial and other logistical barriers prevented her from having it removed on demand.

Jayla, a 29-year old Black mother of two children, had an IUD inserted immediately postpartum; however, she had it removed because it was misplaced. Unfortunately, it took approximately a month before that occurred. She elaborated:

> They did an ultrasound and they found that it was leaning to the side instead of sitting straight up. And they couldn't find the strings. And 2 days later, she said, "Come back in, they're gonna have another person look to see if they could remove it." So, they scheduled an appointment for another ultrasound…I waited a few weeks and I went back to the doctor and she removed it.

Medicaid recipients' accounts of barriers to LARC removal, including a lengthy wait time in the case of IUD misplacement, indicate that for some, accessing immediate postpartum LARC insertion is easier than receiving timely, at-will removal without out-of-pocket costs.

4. Discussion

This study examined publicly insured women's experiences with South Carolina's efforts to increase access to immediate postpartum LARC and reduced unintended and short interval pregnancy rates through its 2012 Medicaid policy. The results reveal that some Medicaid recipients are dissatisfied with providers' timing of and approaches to postpartum contraceptive counseling, even when they choose immediate postpartum LARC. Participants' negative experiences with contraceptive counseling while at the hospital to give birth indicate that some providers are not handling the timing of the conversation with sufficient sensitivity. These interactions resulted in some participants feeling pressured to choose immediate postpartum LARC, regardless of whether or not they had already made a decision about which, if any, method they planned to use postpartum. Additionally, three of the postpartum LARC users encountered barriers to accessing timely and free removal of immediate postpartum LARC. These experiences indicate a pressing need to ensure that unfettered access to removal is on par with efforts to facilitate access to immediate postpartum LARC among this population, especially for individuals who lose Medicaid coverage later due to changes in their eligibility.

Participants' accounts of their experiences with immediate postpartum LARC counseling suggest that in some cases, providers' enthusiasm for LARC's efficacy supersedes what may be best for an individual patient; this is consistent with previous research focused on contraceptive care, including in post-abortion settings [25–29]. Additionally, practices of reproductive oppression, including forced and coercive sterilization campaigns, have a long history of targeting economically vulnerable women and women of color, which may help explain why some of the participants expressed skepticism about providers' motivations for encouraging them to use immediate postpartum LARC [32,33]. Emerging research suggests that providers who adopt a patient-centered, shared decision-making approach to contraceptive counseling can foster patient trust, dispel misconceptions about contraception, and help optimize women's use of contraception in ways that foster meaningful reproductive health equity [30,31]. Women who are economically and racially marginalized would likely benefit from providers' use of such an approach so as to eliminate coercion and avoid the "one-size-fits-all" mentality that appears to inform some providers' approaches to contraceptive counseling about LARC [20,36]. While Medicaid covers the cost of the full range of postpartum contraceptive options, the emphasis on the time-sensitivity of immediate postpartum IUD insertion may inadvertently encourage some providers to emphasize IUDs when counseling about postpartum contraception in the context of a hospital birth. Similarly, it is important that providers avoid pressuring patients to leave a LARC in place in cases where they desire removal [26,34].

While prior research indicates that publicly insured women prefer contraceptive counseling during prenatal care appointments throughout pregnancy [35], and most participants did receive such counseling, seven out of the 30 participants in the larger study from which this analysis is drawn did not. We did not make receipt of contraceptive counseling during pregnancy an eligibility criterion because all participants gave birth in hospital systems known to implementing the policy; however, as an unexpected finding, this indicates unevenness in policy implementation that is worthy of future investigation. Best practices for contraceptive counseling call for a discussion of the full range of options, positive and negative side effects, method effectiveness, and potential barriers to effective use [36]. In the context of South Carolina's immediate postpartum LARC Medicaid policy, the South Carolina BOI has emphasized the importance of providers engaging in multiple conversations about postpartum contraceptive options during prenatal care visits. Participants who received contraceptive counseling in the context of group-based prenatal care tended to be more likely to report being counseled on the full range of postpartum contraceptive options and more satisfied with the information they received. This indicates that a group setting for postpartum contraceptive counseling may be optimal for patients relative to other modes of counseling during prenatal care visits in part because there is more time for discussion with the provider as well as with other pregnant women in the group. While we recognize that our findings are not generalizable to all providers across the state, they do suggest that providers do not engage in contraceptive counseling consistently. We recommend that providers routinely engage in conversations about immediate postpartum LARC with pregnant Medicaid recipients prior to their arrival at the hospital for delivery, whenever possible [14,34].

Among participants who had decided on a non-LARC postpartum contraceptive method during prenatal care and were asked again about immediate postpartum LARC at the hospital during labor, some found this off-putting. A few conveyed they felt they were being pressured into choosing LARC. Such experiences suggest two important considerations. First, there appears to be a gap in care coordination

within some hospitals, whereby the patient's chart from prenatal care is not available to labor and delivery staff and therefore a patient's previously stated preference about postpartum contraception is unknown. Second, patients would likely benefit from their provider acting as a partner in creating a postpartum contraceptive plan that meets each patient's individual needs rather than a provider-directed approach that emphasizes LARC methods as the best options because they are highly effective [34,37]. Ensuring quality of care during all aspects of pregnancy-related care is critical for economically and racially marginalized women, some of whom are at elevated risk of adverse health outcomes, given that this is a time when they may have their most consistent interactions with the health care system. Previous research suggests that negative encounters with family planning care may affect engagement with contraception, providers, and the health care system throughout the life course [28], further highlighting the need for patient-centered care.

This study is not without limitations. Participants self-selected into this study. Thus, it is possible that those with strong feelings, whether negative or positive, about their postpartum contraceptive experiences in the context of the Medicaid policy were more likely to participate in an interview. Second, the study was restricted to those ages 18–35. Women outside of this age range may have had different experiences. Third, the study participants all resided in South Carolina; since the state's historical and political landscape is distinct from other states that have similar policies, participants' experiences with providers may be different than for Medicaid recipients in other regions. Future research efforts are needed to examine how immediate postpartum LARC Medicaid policies and related contraceptive access initiatives are unfolding for economically and racially marginalized women throughout the United States. Despite these limitations, this study centers the perspectives of women who are the intended beneficiaries of the South Carolina immediate postpartum LARC Medicaid policy in a way that other studies have yet to do [16,17,20–23] and allows for an examination of how the policy is being implemented from their vantage points. Even though the policy was initiated in 2012, participants' experiences provide powerful evidence that the quality of immediate postpartum LARC care delivery varies significantly.

5. Conclusions

This qualitative study sheds light on an under-examined dimension of immediate postpartum LARC Medicaid policies by focusing on Medicaid recipients' experiences with contraceptive care delivery in the context of their most recent live birth. While participants did generally receive contraceptive counseling that covered multiple options, some voiced dissatisfaction with providers while simultaneously questioning how and when counseling took place and what methods were emphasized. We call for increased attention to prenatal care visits as an opportunity for multiple contraceptive counseling sessions that center patient needs and concerns over time, which may also improve patient-provider relationships. Ideally, these sessions will allow patients the opportunity to develop a postpartum contraceptive plan that meets their needs, including the option of immediate postpartum LARC.

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