Postpartum Family Planning in Pediatrics: A Survey of Parental Contraceptive Needs and Health Services Preferences

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Abstract

OBJECTIVE: Infant well-child visits are increasingly being explored as opportunities to address parental postpartum health needs, including those related to reproductive health. To inform

potential pediatric clinic-based interventions, this study assessed postpartum contraceptive needs and health services preferences.

METHODS: We surveyed postpartum individuals attending 2 to 6-month well-child visits at three Northern California pediatric clinics (2019–20). We examined unmet contraceptive needs; the acceptability of contraceptive education, counseling, and provision at well-child visits; and sociodemographic and clinical correlates. We conducted univariate and multivariable regression modeling to assess associations between sociodemographic and clinical variables, the status of contraceptive needs, and acceptability measures.

RESULTS: Study participants (n = 263) were diverse in terms of race and ethnicity (13% Asian, 9% Black, 37% Latinx, 12% Multi-racial or Other, 29% White), and socioeconomic status. Overall, 25% had unmet contraceptive needs. Unmet need was more common among participants who had delivered more recently, were multiparous, or reported   1 barrier to obtaining contraception; postpartum visit attendance, education, race, and ethnicity were not associated with unmet need. Most participants deemed the following acceptable in the pediatric clinic: receiving contraceptive information (85%), discussing contraception (86%), and obtaining a contraceptive method (81%). Acceptability of these services was greater among participants with unmet contraceptive needs, better self-rated health, and private insurance (all $P < .05$).

CONCLUSIONS: A quarter of participants had unmet contraceptive needs beyond the early postpartum period. Most considered the pediatric clinic an acceptable place to address contraception, suggesting the pediatric clinic may be a suitable setting for interventions aiming to prevent undesired pregnancies and their sequelae.

Keywords

contraception; family planning; health services research; pediatrics; postpartum

There is a growing recognition of the need for innovation in the delivery of peripartum health services. In the United States, as many as 40% of postpartum individuals do not attend a postpartum obstetric visit, representing important missed opportunities for contraceptive counseling and provision.[1] Consequently, mistimed and unwanted pregnancies are common among postpartum individuals,[2] leading to closely spaced pregnancies that carry a higher risk of morbidity and mortality[3] and adverse perinatal outcomes.[4,5] The COVID-19 pandemic and the overturning of *Roe v. Wade* have resulted in even greater barriers to obtaining reproductive health services and have exacerbated existing reproductive health inequities,[6–8] underscoring the growing need to ease access to reproductive care.

While postpartum individuals inconsistently attend obstetric visits,[1,9] they are more likely to attend well-child visits during the postpartum period.[10] This healthcare interface in the pediatric clinic presents an opportunity to identify and address unmet contraceptive needs. Some studies have investigated rates of unmet contraceptive needs among parents at pediatric visits,[11–13] though rates of contraceptive need specifically during the first 6 postpartum months are unknown. This time period is significant, given this is when most birth parents resume contraceptive use, and when there is the greatest risk of an undesired short interpregnancy interval and its sequelae.[3–5] Aside from understanding the rates of contraceptive need, the preferences of postpartum parents must be explored, as they are also

critical inputs to the development and implementation of potential interventions to address contraceptive needs during pediatric visits. The current literature on parental perspectives is limited to a few small, qualitative studies.[14–16]

To address these gaps in the literature and inform future interventional studies, we conducted a multi-site survey study to assess 1) rates of unmet contraceptive needs among postpartum individuals (ie, 6 months after delivery) attending infant well-child visits, and 2) parental preferences for addressing postpartum contraception in the context of a well-child visit. Based on our prior qualitative research,[14] we hypothesized that the majority of postpartum individuals would deem pediatric clinic-based contraceptive services acceptable and that the acceptability would be higher among people with unmet contraceptive needs. We expected that acceptability might vary as a result of differential access to contraceptive care resulting from reproductive health inequities[17] and the quality of past reproductive health care experiences,[18] and thus, examined differences by sociodemographic characteristics.

Methods

Community Advisory Engagement

During the design and conduct of this research, we engaged two established reproductive health equity-focused community advisory groups at the University of California San Francisco: the California Preterm Birth Initiative's Community Advisory Board (https://pretermbirthca.ucsf.edu/community-advisory-board) and the Person-Centered Reproductive Health Program's Patient Stakeholder Group (https://pcrhp.ucsf.edu/patient-stakeholder-group). Both groups reviewed our initial research plan and survey instrument, considering the community relevance, cultural appropriateness, and equity implications. One community advisory board member (co-author Z.C.) remained on the study team throughout the project to review and provide input into recruitment and data collection procedures, interpretation of findings, and dissemination.

Participants

We conducted a cross-sectional survey study with 263 English or Spanish-speaking postpartum individuals presenting for their infant's 2 to 6-month well-child visit. We surveyed people who were 2 months or more postpartum to permit assessment of the rate of contraceptive needs not met over the course of routine postpartum obstetric care, which generally occurs before 2 months.[1] Recruitment and data collection occurred at three pediatric primary care clinics in the San Francisco Bay Area, California, which were purposefully selected to sample from distinct clinical settings with socioeconomically, racially, and ethnically diverse patient populations. Two clinics were free-standing community clinics, and one clinic was an academic-affiliated clinic co-located with adult primary care and specialty services. None of the study sites routinely assessed parental contraceptive needs before or during the study period.

Data collection took place from July 2019 through October 2020. From July 2019 through March 2020, we approached potentially eligible individuals in-person during their child's visit to gauge interest, complete informed consent, and conduct a one-time tablet-based

Research Electronic Data Capture survey.[19] We paused recruitment in March 2020 due to COVID-19-related research restrictions. In May 2020, we resumed recruitment by telephone, contacting potentially eligible individuals up to three times within 1 week of their infants' scheduled 2 to 6 month well-child visit. Due to the timing of clinic engagement and ability to host study staff, most of the pre-pandemic surveys were conducted at one clinic site, while the surveys conducted after May 2020 were mostly at the two other clinic sites. All participants received $25 gift cards.

We obtained informed consent from all participants. The initial study protocol and the modified phone procedures were approved by the Institutional Review Board at the University of California, San Francisco.

SURVEY ITEMS

Survey items assessed preferences for addressing contraceptive needs during a pediatric encounter. Informed by the Person-Centered Contraceptive Care Framework[20] and prior research,[14,17,21] we assessed factors likely related to reproductive health services preferences. Survey items eliciting contraceptive needs and preferences and barriers to obtaining contraception were developed based upon community advisor and expert input[20,22] and preliminary qualitative research.[14] The full survey underwent cognitive testing with 10 individuals from the target sample. We developed a Spanish version of the survey through professional translation, back-translation, and cognitive testing.

PARTICIPANT CHARACTERISTICS—Demographic variables included self-reported age, race, ethnicity, and education. Health care access questions included type of insurance, postpartum visit attendance, presence of an established primary care provider, and an 18-item checklist of barriers to obtaining postpartum contraception (Appendix 1). Social support questions, drawn from the Centers for Disease Control and Prevention Pregnancy Risk Assessment Monitoring System,[23] assessed the degree to which participants felt supported (eg, emotionally, with infant care, financially) by partners and others in their social networks. Specifically, we included five questions on general social support and eight questions on partner support (if applicable). We elicited symptoms of postpartum depression using the Patient Health Questionnaire-9 (PHQ-9).[24,25]

CONTRACEPTIVE NEED—Items to assess contraceptive needs included a desire to use contraception, current contraceptive use, and satisfaction with the current method. We defined unmet contraceptive needs as 1) desire to use contraception, and 2) not using any current method or feeling very or somewhat unsatisfied with the current method. This definition is intentionally broad to be inclusive of individuals who currently have an unmet need for whatever reason. Items utilized yes/no, multiple choice, or 5-point Likert scale response choices. For women with unmet contraceptive needs, we asked which methods they were considering.

HEALTH SERVICES PREFERENCES/ACCEPTABILITY—We queried participants' health services preferences for addressing contraception in the pediatric clinic using the following: "The next questions are about addressing future pregnancy plans and birth control at a pediatric

visit like the one your child had today. How would you feel about the following during a pediatric visit?" The question stems were 1) Receiving information about pregnancy planning and birth control, 2) Discussing future pregnancy plans and birth control, and 3) Getting a birth control method. Response choices were on a 5-point Likert scale that included labels 1 = unacceptable, 3 = neutral, and 5 = acceptable. We also asked participants to rate the utility of receiving educational materials via different modes (ie, face-to-face, paper handout, tablet in the waiting room, text message, and email), with possible responses ranging from 1 = not at all useful to 5 = very useful.

DATA ANALYSIS

We powered our study to estimate the proportion of individuals with unmet postpartum contraceptive needs with reasonable precision. Using an estimated 20% prevalence of unmet postpartum contraceptive needs in San Francisco and Alameda counties,[26] a sample size of 256 has a 95% confidence interval (CI) of half-width +/− 5% (eg, 20% [15%, 25%]).

We computed descriptive statistics for demographics, healthcare access, social support, postpartum depression, and contraception questions. For the PHQ-9 scale to assess postpartum depression symptoms, we created a sum score and categorized it as follows: 0 to 4 = None, 5 to 9 = Mild, 10 to 14 = Moderate, 15 to 19 = Moderately Severe, and 20 to 27 = Severe.[24] As in previous research that utilized the social support and partner support questions,[27] we created sum scores, then categorized them as low, medium, or high support (social support: 0–1 = Low, 2–3 = Medium, 4–5 = High; partner support: 0–3 = Low, 4–5 = Medium, 6–8 = High).

We compared characteristics between participants with and without contraceptive needs, using the Chi-square test for dichotomous variables and two sample t-tests for continuous variables. We computed descriptive statistics for health service preferences for the full sample. We assessed differences in mean acceptability ratings by age, time since delivery, race and ethnicity, education, insurance type, postpartum depression screen score, and status of contraceptive need using one-way Analysis of Variance (ANOVA).

We examined the association between participant characteristics and health service preferences, using multivariable linear regression, including prespecified variables of race and ethnicity and status of contraceptive need. We also included statistically significant variables from bivariate analyses of acceptability. For analyses that included race and ethnicity, White was specified as the reference group to explore possible differences in the acceptability of a new approach to contraceptive care among groups that have historically been affected by reproductive oppression.[20]

SENSITIVITY ANALYSIS—We assessed differences between participants surveyed before versus during the pandemic using the Chi-square test for dichotomous variables and two sample t-tests for continuous variables. We also repeated bivariate and multivariable analyses including only participants who completed surveys pre-pandemic (n = 197), to compare the overall pattern of findings to the results from the full sample (n = 263).

We used the University of California San Francisco Clinical and Translational Science Institute Sample Size Calculators for power calculations (https://www.sample-size.net) and IBM SPSS Statistics Version 28 for all other analyses.

Results

Participant Characteristics

A total of 263 of 305 (86%) individuals contacted about the study completed a survey (90% of individuals approached in person, and 75% of individuals reached by phone). We surveyed individuals presenting for their infant's 2-month (38%), 4-month (31%), or 6-month (31%) well-child visits. The sample was diverse in terms of race, ethnicity, and socioeconomic status (Table 1). A total of 29 of 263 (11%) participants completed the survey in Spanish.

Contraceptive Need

A quarter of participants reported unmet contraceptive needs. Participants were more likely to report unmet contraceptive needs if they were multiparous, had delivered more recently, or experienced at least one barrier to obtaining postpartum contraception (Table 1). The most commonly cited barriers were: *I was more focused on my child(ren)* (11%) and *I didn't have time* (11%; Appendix 1).

Of the 66 participants with unmet contraceptive needs, 45 (68%) were considering a method that would require a provider prescription or procedure. Specifically, 20 (44%) were considering a short-acting prescription method, 26 (58%) were considering long-acting reversible methods, and 6 (13%) were considering permanent methods (participants could select more than one method).

Health Services Preferences/Acceptability

Most participants rated the following as acceptable in the pediatric clinic (ie, 3 on a 5-point Likert scale): receiving contraceptive information (85%), discussing contraception (86%), and getting a contraceptive method (81%). Mean acceptability ratings were similar for receiving contraceptive information (M = 3.8, SD = 1.4), counseling and discussion (M = 3.8, SD = 1.3), and obtaining a contraceptive method in the pediatric clinic (M = 3.6, SD = 1.4; Table 2). In unadjusted analyses, acceptability ratings were slightly higher for participants with higher age, private insurance, worse postpartum depression symptoms, better self-rated health (Table 2), and unmet contraceptive need (Figure). In the adjusted analysis, the associations with insurance, self-rated health, and status of contraceptive needs remained (Table 3).

Regarding the mode of communication for receiving postpartum contraception patient education, participant ratings on a 5-point scale were highest for face-to-face (M = 3.8, SD = 1.4) and were nearly as high for other paper and digital modes (range = 3.5–3.7).

SENSITIVITY ANALYSIS

Sensitivity analyses showed that while there were demographic and other clinical differences between participants surveyed before and during the pandemic (reflecting the distinct demographics of the participating clinics' patient populations), there were no differences in unmet needs (Appendix 2). Overall patterns of acceptability in the subsample of participants surveyed pre-pandemic (n = 197) closely aligned with the results for the full sample (Appendices 3 and 4).

DISCUSSION

The findings from this survey demonstrated that one in four postpartum individuals attending 2 to 6 month infant visits had unmet contraceptive needs. Most participants, especially those with unmet contraceptive needs, would be open to a range of potential pediatric clinic-based services to identify and meet their needs, including receipt of patient education, discussion and counseling with clinic providers, and obtaining contraception.

The high rate of unmet contraceptive needs in our study aligns with another pediatric clinic-based study of parents with < 36-month age children[11] and with related indicators in California's Maternal and Infant Health Assessment.[26] Previous studies did not focus on parents during the first 6 postpartum months, when a closely spaced pregnancy is associated with more serious health impacts.[5] Of note, our definition of unmet need was carefully defined to align with patients' needs, values, and preferences by both not considering those who did not wish to be using contraception as having unmet needs, and including those who were dissatisfied with their method. Taken together, these findings confirm a clinically significant rate of postpartum patients in need of contraceptive care beyond the typical 8-week window for a postpartum visit. The most commonly cited barriers among participants were prioritization of newborn care and lack of time, supporting a need for improved flexibility and convenience in the delivery of postpartum health services, such as bundling services with routine infant care.

In addition, our study demonstrates broader generalizability of the findings from previous smaller studies on the acceptability of addressing parental contraception during a well-baby visit[14–16,28] and adds some specific, actionable targets for future interventional research. We found some statistically significant variation in the overall acceptability of pediatric clinic-based contraceptive services across parent characteristics, including the type of insurance, postpartum depression, and status of contraceptive need. While these differences were generally small and may not be clinically meaningful, potential subgroup variation in preferences should be considered in subsequent initiatives. For example, we found that participants with higher self-rated health deemed pediatrics-based contraceptive services as slightly more acceptable compared to those with lower self-rated health. While all should have access to comprehensive and high-quality health care, this suggests that individuals with more complex healthcare needs may prefer or already have access to such care outside the pediatric setting. We found similar rates of acceptability of various methods for engaging postpartum parents (eg, face-to-face, digital), raising the possibility of a variety of health services innovations. The role of community members with lived experience would be

valuable in the development and testing of innovative community-oriented and clinic-based initiatives.

The small number of participants in our study who had greater than mild postpartum depression symptoms appeared to have considerably higher rates of unmet contraceptive needs and endorsed the highest acceptability of pediatric clinic-based services compared to those with mild or no postpartum depression in bivariate analyses. Postpartum depression has been shown to predict postpartum visit nonattendance, and that nonattendance was mitigated by navigation support services.[29] While the present study was not adequately powered to make similar conclusions, the reproductive needs and preferences of individuals with postpartum depression are an important area of future investigation.

We observed small absolute differences in the acceptability of pediatric clinic-based services between racial and ethnic subgroups that did not reach statistical significance. Of note, this study may not have been adequately powered to meaningfully assess such variation. The reproductive health needs and health services preferences of Black, Indigenous, and People of Color individuals is an important area of future inquiry, given the historical context of medical racism in reproductive health care.[18,20] If identified in future studies, any such variation should not be used as a rationale to target interventions toward any subgroup of individuals, which could inadvertently undermine reproductive autonomy and exacerbate reproductive health inequities.

Interventions conducted thus far have had limited impact due to poor uptake or feasibility limitations, suggesting an implementation science approach will be a critical next step toward the development of an intervention that is both acceptable and feasible to diverse patient stakeholders.[30] A randomized controlled trial of same-day, long-acting reversible contraceptive services co-located with pediatric care showed high likability of the intervention for a racially and ethnically diverse sample. However, the intervention had only 17% uptake,[31] potentially due to the time needed to both receive infant care and long-acting reversible contraceptive placement in one visit. This factor may be particularly salient for multiparous women who potentially require additional childcare support while they access their own care. Another study in a pediatric resident clinic demonstrated the feasibility of screening postpartum parents for unmet contraceptive needs, with a similarly low uptake rate of offered services.[32] A study of obstetrician-gynecologists embedded in a pediatric clinic showed high acceptability of co-located reproductive health services and earlier provision of postpartum contraceptives compared to patients receiving usual postpartum care;[33] while promising, the scalability and sustainability of such a model is uncertain. Finally, the Interventions to Minimize Preterm and Low birthweight Infants through Continuous Improvement Techniques (IMPLICIT) model of inter-conception screening at child-focused family medicine visits has been widely studied as a means to identify contraceptives and other health needs, yet its effectiveness at connecting parents with needed services has not been established.[12,13]

Considering our findings in context with the literature on interventions, the pediatric clinic is a promising setting for improving postnatal care for patients who are not already receiving care within an integrated practice, such as a family medicine clinic. However, interventional

approaches will need to account for the complex and multi-level factors at play to effectively and flexibly meet the needs of both patient and clinical stakeholders.[20,34] Primary care-based intervention designs will need to take into consideration the competing demands in a primary clinic for other preventive care and screening services,[35] and perhaps broaden their scope to engage interdisciplinary health care team members and collaborate with adult reproductive health services providers. Such collaboration could also facilitate conversation about new or ongoing contraceptive needs that may not have been addressed during routine postpartum obstetric care, for example, our study participants who attended postpartum visits though still reported unmet contraceptive needs at 2 to 6 months.

Our findings should be interpreted in light of study limitations. First, responses may have been influenced by social desirability bias, which could have been exacerbated by the verbal administration of phone surveys during the COVID-19 pandemic. In addition, while we had nearly universal participation during in-person recruitment, participation rates dropped when we shifted to phone recruitment, which may have increased recruitment bias. Reassuringly, we did not see significant differences in sensitivity analyses to assess the pandemic-related change in recruitment and data collection approaches. Finally, the findings may have limited generalizability to other patient populations or geographic areas due to differences in the barriers and facilitators to accessing health care. For example, our sample included a relatively high rate of partnered individuals who reported generally high levels of social support, which could affect their healthcare preferences. The study sample also had a high rate of insurance coverage, which likely reflects California's expanded Medicaid and other health insurance programs that facilitate postpartum contraceptive access for low-in-come individuals, suggesting that rates of unmet contraceptive needs may be higher in states without such services. Despite the limitations, this study contributes to the field's growing acknowledgment of the need for a new set of approaches that respond to the myriad demands faced by postpartum parents, when their families' needs and time pressures can take precedence over parents' own needs.

In conclusion, the current study provides useful insight into the reproductive health needs and health services preferences among a diverse sample of postpartum individuals, demonstrating the pediatric clinic is an acceptable and promising site for intervention. The variation in reproductive needs and preferences demonstrates the importance of flexibility and choice in the delivery of such health services. Given that a lack of postpartum contraception can lead to unintended, closely spaced pregnancies and subsequent worse infant and parent outcomes, innovations in pediatric health care services to improve postpartum contraception have the potential to substantially improve health.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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WHAT'S NEW

One in four postpartum individuals had unmet contraceptive needs, and > 80% considered contraceptive education, counseling, and provision within the pediatric clinic to be acceptable. Findings suggest the pediatric clinic is a promising venue for easing access to postpartum contraceptive care.
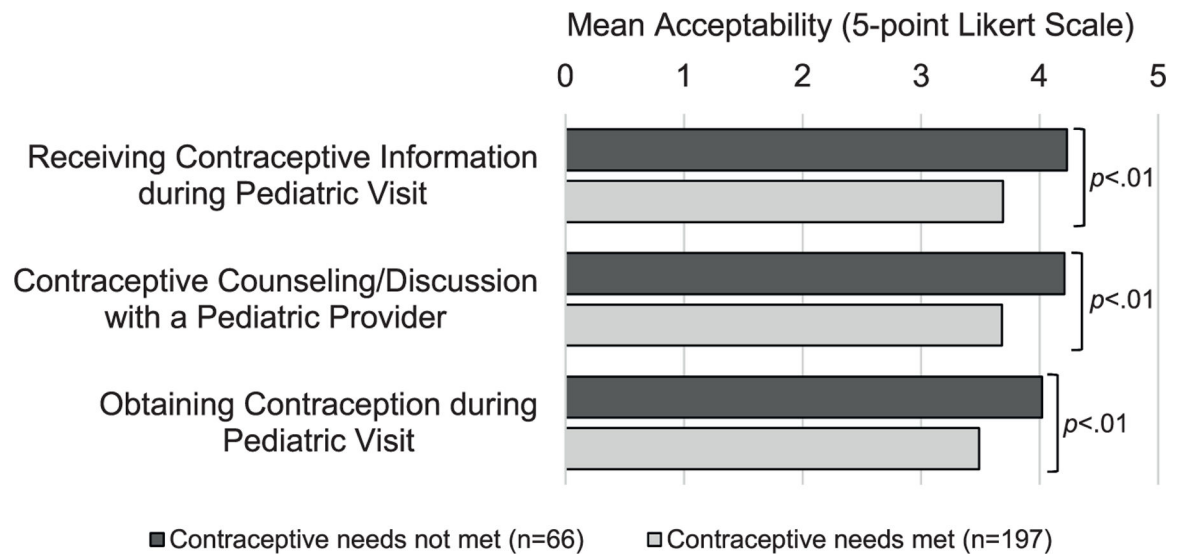
Figure.
Acceptability of addressing postpartum contraception during a pediatric encounter, by the status of contraceptive need (n = 263).

Table 1.

Participant Characteristics by Status of Contraceptive Need[*] (N = 263), Bivariate Analysis

	Full Sample (n = 263)	Participants With Unmet Contraceptive Need (n = 66)	
	Range, Mean [SD] or n (Column %)	Range, Mean [SD] or n (Column %)	P[†]
Parental age (y)	16–51, 31.9 [6.1]	18–41, 31.7 [5.3]	.78
Time since delivery			.01
2 mo	99 (38%)	33 (50%)	
4 mo	82 (31%)	22 (33%)	
6 mo	82 (31%)	11 (17%)	
Race and ethnicity			.56
Asian	35 (13%)	12 (19%)	
Black	24 (9%)	7 (11%)	
Latinx	94 (37%)	24 (38%)	
Multiracial/Other	30 (12%)	6 (9%)	
White	73 (29%)	15 (23%)	
Preferred language			.45
English	234 (89%)	58 (88%)	
Spanish	29 (11%)	8 (12%)	
Highest education			.74
High school or less	75 (29%)	21 (32%)	
Some college	62 (24%)	16 (25%)	
College graduate	121 (47%)	28 (43%)	
Health insurance			.88
Private	155 (60%)	40 (61%)	
Public/Medicaid	99 (38%)	25 (38%)	
None	6 (2%)	1 (2%)	
Established primary care	215 (83%)	51 (77%)	.12
Attended postpartum visit	211 (81%)	51 (77%)	.22
Primiparity	118 (46%)	23 (35%)	.04
Preterm delivery[‡]	28 (11%)	9 (14%)	.24
Breastfeeding exclusively	114 (43%)	30 (46%)	.40
Postpartum depression[§]			.08
None (0–4)	227 (86%)	53 (80%)	
Mild (5–9)	22 (8%)	6 (9%)	
Moderate (10–14)	14 (5%)	7 (11%)	
Self-rated health			.31
Excellent	93 (36%)	21 (32%)	
Very good	91 (35%)	23 (35%)	
Good	67 (26%)	17 (26%)	
Fair	10 (4%)	5 (8%)	

	Full Sample (n = 263)	Participants With Unmet Contraceptive Need (n = 66)	
	Range, Mean [SD] or n (Column %)	Range, Mean [SD] or n (Column %)	P [†]
Married/partnered	245 (93%)	64 (98%)	.22
Social support [**]			.66
High (4)	212 (82%)	54 (82%)	
Medium (2–3)	18 (7%)	6 (9%)	
Low (1)	28 (11%)	6 (9%)	
Partner support [**]			.50
High (6)	229 (87%)	57 (86%)	
Medium (4–5)	4 (2%)	2 (3%)	
Low (3)	30 (11%)	7 (11%)	
1 Barrier(s) to getting postpartum contraception [††]	68 (26%)	29 (44%)	.00
Practice type			.40
Academic	129 (49%)	31 (47%)	
Community	134 (51%)	35 (53%)	

[*]Contraceptive need is defined as the desire to use contraception and either not using any current method or feeling very or somewhat unsatisfied with the current method.

[†]P-value for comparison of participants with contraceptive needs not met (n = 66) and contraceptive needs met (n = 197; not shown).

[‡]Defined as < 37 wk of gestation.

[§]Patient Health Questionnaire-9.[24,25]

[**]Social and partner support items from the Centers for Disease Control and Prevention Pregnancy Risk Assessment Monitoring System.[23]

[††]Assessed using an 18-item questionnaire developed for this study (see Methods).

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Table 2.

Participant Characteristics and Acceptability of Pediatric Clinic-Based Contraceptive Health Services, Among Postpartum Individuals with 2–6 mo Infants (n = 263), Bivariate Analysis

	n	Acceptability of *Receiving Contraceptive Information* During Pediatric Visit*		Acceptability of *Contraceptive Counseling/Discussion With a Pediatric Provider* *		Acceptability of *Obtaining Contraception During Pediatric Visit* *	
		Mean [SD]	P	Mean [SD]	P	Mean [SD]	P
Full sample	263	3.8 [1.4]		3.8 [1.3]		3.6 [1.4]	
Age			.09		.06		.04
< 29 y	86	3.7 [1.3]		3.7 [1.3]		3.5 [1.3]	
30–39 y	151	3.8 [1.4]		3.8 [1.3]		3.6 [1.5]	
> 40 y	20	4.5 [0.9]		4.5 [0.9]		4.4 [1.0]	
Time since delivery			.30		.17		.42
2 mo	99	4.0 [1.3]		4.0 [1.4]		3.7 [1.4]	
4 mo	82	3.8 [1.3]		3.9 [1.2]		3.7 [1.3]	
6 mo	82	3.7 [1.5]		3.6 [1.4]		3.5 [1.5]	
Race and ethnicity			.63		.60		.19
Asian	35	3.7 [1.3]		3.6 [1.2]		3.3 [1.4]	
Black	24	3.6 [1.6]		3.8 [1.5]		3.3 [1.6]	
Latinx	94	3.8 [1.4]		3.8 [1.5]		3.7 [1.5]	
Multiracial/other	30	3.8 [1.3]		4.0 [1.3]		3.6 [1.4]	
White	73	4.0 [1.2]		4.0 [1.1]		3.9 [1.3]	
Highest education			.16		.11		.65
High school or less	75	3.6 [1.5]		3.6 [1.5]		3.5 [1.6]	
Some college	62	3.8 [1.3]		3.8 [1.4]		3.6 [1.4]	
College graduate	121	4.0 [1.3]		4.0 [1.2]		3.7 [1.4]	
Health insurance			.02		.00		.04
Private	155	4.0 [1.2]		4.0 [1.1]		3.8 [1.3]	
Public/Medicaid	99	3.6 [1.5]		3.5 [1.6]		3.4 [1.4]	
Postpartum depression†			.05		.17		.56
None (0–4)	227	3.8 [1.4]		3.8 [1.4]		3.6 [1.4]	
Mild (5–9)	22	3.6 [1.3]		3.6 [1.3]		3.5 [1.3]	

	n	Acceptability of *Receiving Contraceptive Information* During Pediatric Visit*		Acceptability of *Contraceptive Counseling/Discussion* With a Pediatric Provider*		Acceptability of *Obtaining Contraception* During Pediatric Visit*	
		Mean [SD]	P	Mean [SD]	P	Mean [SD]	P
Moderate (10–14)	14	4.6 [0.9]		4.4 [1.0]		4.0 [1.4]	
Self-rated health			.11		.03		.33
Excellent	93	4.1 [1.3]		4.1 [1.2]		3.8 [1.4]	
Very good	91	3.8 [1.3]		3.8 [1.3]		3.6 [1.4]	
Good	67	3.6 [1.5]		3.5 [1.5]		3.5 [1.5]	
Fair	10	3.5 [1.7]		3.4 [1.8]		3.1 [1.6]	
Practice type			.61		.71		.77
Academic	129	3.9 [1.3]		3.8 [1.3]		3.6 [1.4]	
Community	134	3.8 [1.4]		3.8 [1.4]		3.7 [1.5]	

*
Participants responded on a 5-point Likert scale with anchors of 1 = unacceptable and 5 = acceptable.

†
Patient Health Questionnaire-9,24,25

Table 3.

Participant Characteristics and Acceptability of Pediatric Clinic-Based Contraceptive Health Services, Among Postpartum Individuals with 2–6 mo Infants (n = 263), Multivariable Analysis*,†

	Acceptability of *Receiving Contraceptive Information* During Pediatric Visit			Acceptability of *Contraceptive Counseling/Discussion* With a Pediatric Provider			Acceptability of *Obtaining Contraception* During Pediatric Visit		
	B	(95% CI)	P	B	(95% CI)	P	B	(95% CI)	P
Age	.01	(−0.02, 0.04)	.45	.01	(−0.02, 0.03)	.71	.02	(−0.02, 0.05)	.31
Public health insurance	−.43	(−0.83, −0.03)	.04	−.74	(−1.12, −0.35)	.00	−.44	(−0.86, −0.03)	.04
Postpartum depression‡	.27	(−0.06, 0.59)	.11	.20	(−0.12, 0.51)	.23	.15	(−0.20, 0.49)	.41
Race and ethnicity§									
Asian	−.32	(−0.86, 0.22)	.25	−.35	(−0.87, 0.18)	.20	−.63	(−1.20, −0.06)	.03
Black	−.11	(−0.76, 0.54)	.74	.35	(−0.28, 0.98)	.28	−.32	(−1.00, 0.36)	.36
Latinx	.22	(−0.25, 0.68)	.36	.42	(−0.03, 0.87)	.07	.25	(−0.23, 0.74)	.31
Multiple/Other	.06	(−0.53, 0.64)	.85	.45	(−0.12, 1.00)	.12	.06	(−0.56, 0.68)	.85
Self-rated health **	.27	(0.08, 0.47)	.01	.33	(0.14, 0.52)	.00	.22	(0.02, 0.42)	.04
Unmet contraceptive need	.56	(0.18, 0.94)	.00	.58	(0.20, 0.95)	.00	.58	(0.18, 0.99)	.01

*
Model includes prespecified variables (*race, status of contraceptive need*) and variables with a significant difference in acceptability in bivariate analyses (*age, health insurance, postpartum depression, self-rated health*; Table 2).

†
Unstandardized coefficients from multivariable linear regression.

‡
Patient Health Questionnaire-9[24,25] scores categorized (see Methods), with the highest category indicating more postpartum depression symptoms.

§
White as the reference group (see Methods).

**
Ordinal 5-point scale with a higher score indicating better self-rated health.