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Association Between Emotional Intimate Partner Violence Around the Time of Pregnancy and Postpartum Contraceptive Use: Results from the Pregnancy Risk Assessment Monitoring System 2016–2021

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Abstract

This study assessed the relationships between emotional intimate partner violence (IPV) before, during, and after pregnancy and postpartum contraceptive use. We used 2016–2021 Pregnancy Risk Assessment Monitoring System data from seven sites ($n = 30,125$). We used multivariable logistic regression to assess indicators of emotional IPV and provider counseling associated with postpartum contraceptive use. Emotional IPV 12 months before, during, and after pregnancy were all significantly associated with reduced odds of postpartum contraceptive use. Strengthening post-partum contraceptive services by integrating IPV prevention into care is an opportunity to improve the health of postpartum people.

Keywords

intimate partner violence; postpartum family planning; maternal health; pregnancy

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Introduction

Exposure to intimate partner violence (IPV), defined as physical violence, stalking, psychological harm, or sexual violence perpetrated by a romantic or sexual partner (Breiding et al., 2015), may have adverse implications for reproductive health during the perinatal period. People exposed to physical IPV before, during, and/or after pregnancy may be less likely to use contraception in the postpartum period (Cha et al., 2015; Horne et al., 2009; Scribano et al., 2013; Stevenson et al., 2020) and more likely to experience rapid repeat pregnancy, meaning an interpregnancy interval of 18 months or fewer (Scribano et al., 2013). One in three women becomes pregnant before the recommended 18-month interpregnancy interval in the United States (Gemmill & Lindberg, 2013). Rapid repeat pregnancy is associated with adverse birth outcomes, such as preterm birth, small for gestational age, and low birth weight (Conde-Agudelo et al., 2006; Fuentes-Afflick & Hessol, 2000; Khoshnood et al., 1998; Zhu, 2005). Thus, using contraception in the postpartum period may have benefits for postpartum people who want to avoid pregnancy, and the American College of Obstetricians and Gynecologists (ACOG)'s committee opinion mentions family planning services as a strategy to increase optimally spaced births (ACOG, 2019). Past research on the effects of IPV around the time of pregnancy on reproductive health behaviors has tended to focus on physical IPV, although non-physical aggression (i.e., emotional IPV or the use of verbal and nonverbal communication with the intent to harm and/or exert control over another person; Breiding et al., 2015), compared to physical violence, occurs more frequently around the time of pregnancy (D'Angelo et al., 2022; McMahon et al., 2011). Consequently, relatively little is known about how exposure to emotional IPV around the time of pregnancy is related to contraceptive use in the postpartum period.

Contraceptive counseling during both prenatal and postpartum care is an evidence-based best practice (ACOG, 2018). ACOG's committee opinion mentions that healthcare providers should screen women of reproductive age for IPV, including during obstetric care (ACOG, 2012). Exposure to IPV around the time of pregnancy, however, may mitigate the potentially positive effects of counseling on postpartum contraceptive use. For example, a study of U.S. women with a recent live birth found an inverse relationship between physical IPV around the time of pregnancy and postpartum contraceptive use, regardless of receipt of prenatal birth control counseling (Cha et al., 2015). To our knowledge, no studies have investigated if receipt of counseling about either contraception or IPV (during prenatal or postnatal care) may mitigate the potentially negative effect of emotional IPV on use of postpartum contraception.

Reasons for nonuse of contraception in the postpartum period vary. A study using 2012–2015 data from the Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7 found that not having sex, not wanting to use birth control, and being worried about side effects from birth control were primary reasons (Stevenson et al., 2020). In addition, some of these reasons varied by reported exposure to physical IPV around the time of pregnancy (Stevenson et al., 2020). Additionally, a content analysis of open-text responses on reasons for contraceptive nonuse from PRAMS 2012–2015 data found that the two most prominent reasons were personal preference to not use birth control and concerns with birth control

side effects (Richards et al., 2022). It is unknown if reasons for nonuse of postpartum contraception vary by exposure to emotional IPV around the time of pregnancy.

The primary objective of this analysis was to assess the relationships between exposure to emotional IPV 12 months before, during, and after a live birth and postpartum contraceptive use. We also examined reasons for not using contraception by exposure to emotional IPV around the time of pregnancy to understand if reasons for nonuse vary by IPV exposure. Lastly, we sought to evaluate differences in postpartum contraceptive use among individuals who experienced emotional IPV by receipt of contraceptive counseling and IPV counseling prenatally and postnatally.

Methods

We used 2016–2021 data from the PRAMS. PRAMS is an ongoing population-based surveillance system, conducted in partnership with CDC and state and local health departments, of individuals who recently had a live birth. To implement PRAMS, individuals with a live birth who are residents of and delivered their infant in a participating site are identified via vital record birth certificate files and contacted 2–6 months after the live birth (Shulman et al., 2018). Potential participants are selected using a stratified systematic sampling scheme. Sites may stratify two of six variables for oversampling of subpopulations: birth weight, maternal race and ethnicity, education, and age, geographic area, and Medicaid status. PRAMS uses systematic sampling so that all potential participants have the same probability of being selected within each stratum (Shulman et al., 2018). PRAMS has approval from the CDC Institutional Review Boards and participating jurisdictions.

The PRAMS survey includes a core set of questions asked by all participating sites and standard questions that sites may choose to include in their questionnaires. Additionally, PRAMS requires a minimum overall response rate threshold for the release of data for each year (2015–2017: 55%; 2018–2020: 50%). Seven sites (Alaska [2016–2020], Iowa [2016–2020], Illinois [2016–2021], Indiana [2018], Maryland [2016–2020], Virginia [2016–2021], Wyoming [2016–2021]) that used a standard question about emotional IPV and met the minimum overall response rate threshold for one or more of the study years were included in this study.

Measures

Our primary outcome of interest was postpartum contraceptive use. All participants were asked if they or their husbands/partners were doing anything now (at time of survey) to keep from getting pregnant. We categorized those who responded “yes” as currently using postpartum contraception; participants who responded “no” were categorized as not using postpartum contraception. Additionally, contraceptive nonusers were asked their reasons for not using contraception now; one available response option was “I had my tubes tied or blocked.” We recoded participants as contraceptive users who reported they were not using contraception now because they had tubal ligation.

We measured emotional IPV with one question that asked participants: “During any of the following time periods, did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way?” Response options included the following: “During the 12 months before I got pregnant,” “During my most recent pregnancy,” and “Since my new baby was born.” Participants were asked to check “No” if it did not happen then or “Yes” if it did, for each time period. First, we created three variables for each time period. If a participant responded “yes” to “During the 12 months before I got pregnant,” we categorized them as experiencing emotional IPV 12 months before pregnancy. If a participant responded “yes” to “During my most recent pregnancy,” we categorized them as experiencing emotional IPV during pregnancy. If a participant responded “yes” to “Since my new baby was born,” we categorized them as experiencing emotional IPV after pregnancy.

We then created two variables to represent whether any emotional IPV was experienced around the time of pregnancy and the number of time periods that emotional IPV was reported. First, we categorized a participant as experiencing any emotional IPV around the time of pregnancy if they responded “yes” to any of the aforementioned time periods. Next, we categorized the number of time periods a participant reported experiencing emotional IPV by their number of positive responses to any of the aforementioned time periods (0 time periods, 1 time period, 2+ time periods).

PRAMS asked contraceptive nonusers their reasons or their husband’s/partner’s reasons for not doing anything to keep from getting pregnant now. Participants were asked to check all reasons that applied, including “I want to get pregnant,” “I don’t want to use birth control,” “I am worried about side effects from birth control,” “I am not having sex,” “My husband or partner doesn’t want to use anything,” “I have problems paying for birth control,” and “Other.” We created separate variables for each reason for nonuse. We categorized all affirmative responses as an indication of a self-reported reason for nonuse.

All participants who reported that they received prenatal care were asked if during their prenatal care visits, a doctor, nurse, or other healthcare worker asked them if someone was hurting them emotionally or physically. Participants were also asked if during their prenatal care visits, a doctor, nurse, or other healthcare worker asked them if they planned to use birth control after their baby was born. Participants were asked to check “No” if they did not ask about it or “Yes” if they did. We created two binary variables for each item. In addition, PRAMS also asked all participants who reported that they had a postpartum checkup, if during their postpartum checkup, a doctor, nurse, or other healthcare worker asked them if someone was hurting them emotionally or physically and also if a doctor, nurse, or other healthcare worker talked to them about birth control methods they could use after giving birth. Again, we created two binary variables for each item.

Covariates selected in the multivariable models were based on significant bivariate relationships, theoretical associations with postpartum contraceptive use (Stevenson et al., 2020; Zapata et al., 2015), and model selection techniques to minimize multicollinearity. Thus, we considered age, race and ethnicity, marital status, education, state of residence, income, urban/rural, previous live birth before most recent live birth, currently breastfeeding,

wantedness of most recent live birth, and insurance at the time of the survey as covariates. Ultimately, we retained covariates that had a significant association with the outcome: age, race and ethnicity, previous live birth before most recent live birth, wantedness of most recent live birth, and state of residence in adjusted models. Data on race were collected from birth certificate files.

Analysis

In total, 31,300 individuals (unweighted) who resided in the seven sites that included the survey items of interest and met the response rate threshold for one or more years from 2016 to 2021 were included. We excluded 215 (0.7%) participants (unweighted) who reported that they were currently pregnant. Additionally, 960 (3.1%) participants (unweighted) did not provide full information about the variables in this analysis and were excluded. This includes data on IPV, meaning that participants were only included if there was full information on all variables. Thus, the analytical sample included 30,125 nonpregnant individuals with a recent live birth.

We used weighted data and corresponding sampling weights in the analysis to account for the PRAMS complex sample design (Shulman et al., 2018). Statistical significance was set at $p < .05$; we used 95% confidence intervals (CIs) to assess the statistical significance of estimated adjusted odds ratios (aORs). Data analysis was conducted using Stata SE Version 16 (StataCorp, 2019).

We first estimated the weighted prevalence of participant characteristics for the full sample. Next, we examined the weighted prevalence of exposure to the emotional IPV variables stratified by postpartum contraceptive use. We used adjusted Wald tests to compare the degree to which variables differed from each other. Then, we assessed reasons for not using postpartum contraception, stratified by any exposure to emotional IPV around the time of pregnancy, among nonusers. We again used adjusted Wald tests to compare the degree to which variables differed from each other. Next, we used multivariable logistic regression to assess the relationships between the emotional IPV variables and postpartum contraceptive use. We examined five separate models: Model 1 included emotional IPV 12 months before pregnancy; Model 2 included emotional IPV during pregnancy; Model 3 included emotional IPV after pregnancy; Model 4 included any emotional IPV around the time of pregnancy; and Model 5 included the number of time periods emotional IPV was experienced. Lastly, we used multivariable logistic regression to assess the characteristics associated with postpartum contraceptive use among individuals who reported any emotional IPV around the time of pregnancy in two separate models. The first model was restricted to individuals who reported receiving prenatal care ($n = 1,134$). The second model was restricted to individuals who reported receiving postpartum care ($n = 956$). Model 1 included two items assessing whether a healthcare worker asked about if emotional or physical IPV was experienced and plans to use birth control after delivery during prenatal care. Model 2 included two items assessing whether a healthcare worker asked about if emotional or physical IPV was experienced and plans to use birth control after delivery during postnatal care. Both models controlled for race and ethnicity, age, previous live birth before most recent live birth, state of residence, and wantedness of most recent live birth. In addition, the

weighted percent of contraceptive method users stratified by any exposure to emotional IPV among those using a contraceptive method is provided in the Appendix.

Results

The largest proportions of the sample were between the ages of 25–29 years (28.3%) and 30–34 years (31.4%) (Table 1). Fifty-seven percent of participants identified as non-Hispanic White; 17.5% identified as Hispanic of any race; 16.7% identified as non-Hispanic Black. The majority of participants had a previous live birth before most recent live birth (62.1%) and wanted their most recent live birth at that time or sooner (60.5%). Most participants were using contraception postpartum (80.3%). Across the three time periods, 2.0% of participants reported emotional IPV before pregnancy, 2.2% reported emotional IPV during pregnancy, and 1.9% reported emotional IPV after pregnancy. Three percent of the sample reported emotional IPV in any time period around the time of pregnancy. While 96.7% of participants did not report any emotional IPV, 1.5% reported emotional IPV in only one time period and 1.8% reported emotional IPV in two or more time periods.

Larger proportions of contraceptive nonusers reported emotional IPV before, during, and after pregnancy, compared to contraceptive users (2.9% vs. 1.8%, $p < .01$; 3.5% vs. 1.9%, $p < .001$; 2.6% vs. 1.7%, $p < .01$, respectively). Four percent (4.8%) of nonusers reported any emotional IPV around the time of pregnancy, compared to 2.9% of users ($p < .001$). Additionally, 2.8% of nonusers reported emotional IPV in two or more time periods, compared to 1.5% of users ($p < .001$).

Among contraceptive nonusers ($n = 5,995$), reasons for nonuse included not wanting to use birth control (39.3%), worry about the side effects from birth control (32.4%), not having sex (28.6%), other (22.9%), wanting to get pregnant (18.3%), husband or partner does not want to use birth control (9.2%), and problems paying for birth control (3.0%) (Table 2). Compared to individuals who did not report any emotional IPV around the time of pregnancy ($n = 5,662$), larger proportions of individuals who reported any emotional IPV ($n = 333$) cited not having sex (27.3% vs. 53.6%, respectively, $p < .001$) and husband or partner does not want to use birth control (8.8% vs. 17.8%, respectively, $p < .01$). A smaller proportion of individuals who reported any emotional IPV around the time of pregnancy reported wanting to get pregnant as a reason for nonuse compared to individuals who did not report any emotional IPV (10.8% vs. 18.7%, respectively, $p < .01$).

All emotional IPV indicators were significantly inversely associated with contraceptive use in the postpartum period, after adjusting for race and ethnicity, age, previous live birth before most recent live birth, state of residence, and wantedness of most recent live birth (Table 3). Individuals who reported emotional IPV 12 months before, during, and after pregnancy had 43% (95% CI: [0.43, 0.76]), 49% (95% CI: [0.39, 0.66]), and 37% (95% CI: [0.46, 0.84]) lower odds of contraceptive use in the postpartum period, respectively, compared to individuals who did not report emotional IPV in each respective time period. Individuals who reported any emotional IPV at one or more of the time periods around the time of pregnancy had 43% (95% CI: [0.46, 0.71]) lower odds of postpartum contraceptive use, compared to individuals who did not report emotional IPV in any time period. Lastly,

compared to individuals who did not report emotional IPV in any time period, individuals who reported emotional IPV in one time period and two or more time periods had 37% (95% CI: [0.45, 0.89]) and 48% (95% CI: [0.39, 0.70]) lower odds of contraceptive use in the postpartum period, respectively.

Among individuals who reported any emotional IPV around the time of pregnancy and received prenatal care ($n = 1,134$), those who were asked if someone was hurting them emotionally or physically by a healthcare worker during prenatal care had 2.22 times greater odds (95% CI: [1.33, 3.70]) of using contraception in the postpartum period, compared to individuals who were not asked (Table 4). However, being asked about plans to use birth control after delivery by a healthcare worker during prenatal care was not significantly associated with postpartum contraceptive use (aOR 1.62; 95% CI: [0.82, 3.22]). Among individuals who reported any emotional IPV around the time of pregnancy and received postpartum care ($n = 956$), those who were asked if someone was hurting them emotionally or physically by a healthcare worker during postpartum care had 2.11 times greater odds (95% CI: [1.26, 3.52]) of using contraception in the postpartum period, compared to individuals who were not asked. Yet, being asked about plans to use birth control after delivery was not significantly associated with postpartum contraceptive use (aOR: 0.67; 95% CI: [0.33, 1.40]).

Discussion

Prevention of all forms of IPV is important for optimal sexual and reproductive health (McMahon et al., 2011; Rowan, 2016). Yet, emotional IPV has received less attention relative to physical or sexual IPV in the literature (Jewkes, 2010). This analysis explored associations between emotional IPV around the time of pregnancy and post-partum contraceptive use. Participants who experienced emotional IPV in the year before pregnancy, during pregnancy, or shortly after had reduced odds of postpartum contraceptive use. Additionally, there was a stronger association for individuals who experienced emotional IPV during multiple time periods, compared to a single time period. Taken together, the results support that postpartum contraceptive use may be adversely affected by exposure to emotional IPV. These findings are similar to those from quantitative studies that found lower rates of postpartum contraceptive use among those experiencing physical IPV (Cha et al., 2015; Scribano et al., 2013; Stevenson et al., 2020; Van Horne et al., 2009). However, adequate comparison between studies is challenging, as they are heterogeneous in the measurement of IPV types and analyze different contraceptive outcomes. Our study provides evidence for the negative consequences of emotional IPV on postpartum contraceptive use for which comparable estimates are lacking.

The mechanisms linking emotional IPV with reduced contraceptive use have not been thoroughly investigated. Partner control of reproductive decisions may be one plausible and important mechanism of action to consider. We found that larger proportions of individuals who experienced any emotional IPV reported that their husband or partner did not want to use contraception, compared to individuals who did not experience any emotional IPV. This response option may be an indication of reproductive coercion, which is a form of IPV that can involve physical, sexual, or psychological tactics that interfere

with reproductive goals, such as delaying or avoiding pregnancy (Grace & Anderson, 2018). However, we note that PRAMS did not ask participants about reproductive coercion directly, and further investigation would be needed to know if this response does indicate that a participant experienced it. It may be important to understand if and how emotional IPV and reproductive coercion cooccur, and how they jointly influence contraceptive outcomes. Reproductive coercion is significantly associated with unintended pregnancy independent from physical and/or sexual IPV, and it also interacts with other forms of IPV to increase risk of unintended pregnancy (Grace & Anderson, 2018; Miller et al., 2010). Contraceptive outcomes may also be impacted by reproductive coercion. For example, women might be less likely to use any method or their ideal contraceptive method (Rosenfeld et al., 2018). Recognition that individual-level reproductive decisions are often shaped by complex interpersonal and relational contexts could help inform and improve family planning services (Lévesque et al., 2021; Malarcher & World Health Organization, 2010), like client-centered counseling and trauma-informed care.

We also found that healthcare providers asking about IPV during prenatal or post-partum care had a significant relationship with postpartum contraceptive use (controlling for providers asking about contraceptive use) among participants experiencing emotional IPV. However, asking about contraceptive use (controlling for providers asking about IPV) was not associated with postpartum contraceptive use among participants experiencing emotional IPV. IPV counseling is an important component of Quality Family Planning Services (Gavin et al., 2014). The perinatal period provides a unique and crucial opportunity for universal IPV screening with education, intervention, and ongoing support (ACOG, 2012). CDC's IPV prevention resources and the U.S. Preventative Services Task Force also highlight the importance of IPV screening coupled with referral and ongoing support (Curry et al., 2018; Niolon et al., 2017). Despite these recommendations, numerous barriers including lack of privacy, time constraints, and inadequate resources and training, curtail the IPV screening and support (Furniss et al., 2007; Sprague et al., 2012; Waalen et al., 2000). Interventions that move beyond education only and use a holistic, trauma-informed approach that considers the multilevel barriers to screening (e.g., institutional policies, providers' values, and attitudes) may improve care.

PRAMS is a cross-sectional survey. Thus, information about the timing and ordering of experiences to establish causality or temporal relationship cannot be established. The findings of this study are not generalizable to all of the United States and limited to the sites included in the analysis. Additionally, this analysis only represents experiences of those with a live birth and not other pregnancy outcomes, such as still birth or pregnancy loss. We examined postpartum contraceptive use with a single question, precluding a more nuanced investigation of types of contraceptives used, duration, frequency, or periods of discontinuation. In addition, reports of emotional IPV were also limited to one question each. Therefore, the specific acts and severity of emotional IPV cannot be ascertained. Further, the emotional IPV variable was limited to 12 months prior to pregnancy; thus, it was not possible to distinguish participants with longer IPV histories. In addition, 12 months prior to pregnancy is longer than the typical 3-month preconception period. Finally, information on the content and extent of healthcare provider discussions about IPV and contraceptive use were not available. Despite these limitations, we captured exposure in

important time periods around pregnancy, proximately capturing chronicity as exposure to emotional IPV in more than one period. Future in-depth examination of the relationships between emotional IPV and contraceptive use, including an elucidation of mechanisms that may link emotional IPV and contraceptive use, for example, self-esteem, self-efficacy, or fear of retribution, may help identify factors that support or hinder use of contraceptives.

Public Health Implications

The period around pregnancy is a time of increased vulnerability to emotional IPV. In an examination of 30,125 individuals with a recent live birth residing in seven U.S. states, our analysis highlights that any emotional IPV experienced during the perinatal period is negatively associated with postpartum contraceptive use. Postpartum contraceptive use can have important benefits for mothers and their infants, for example, by increasing the length of the interval between birth and subsequent pregnancy (Gemmill & Lindberg, 2013; Schummers et al., 2018). Thus, addressing barriers to postpartum contraceptive use is critical to improve maternal and infant health. It also further underscores the need to consider additional intervention strategies (such as healthy relationship programs, engaging men and boys as allies in violence prevention and in reproductive health, addressing harmful gender norms and unhealthy masculinities, strengthening economic support to families, and creating protective environments) to prevent emotional IPV before it begins (Niolon et al., 2017). Strengthening postpartum family planning services and integrating IPV prevention and response into care is an opportunity to improve the health of postpartum individuals in the United States.

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Appendix.

Weighted Percent of Contraceptive Method Users, Stratified by Any Exposure to Emotional Intimate Partner Violence Around the Time of Pregnancy Among Those Using a Contraceptive Method, Pregnancy Risk Assessment Monitoring System (PRAMS), 2016–2021.^a

Contraceptive method	Individuals who reported any emotional IPV around the time of pregnancy (<i>n</i> = 932 ^b)	Individuals who did not report any emotional IPV around the time of pregnancy (<i>n</i> = 24,555 ^b)
Female sterilization	9.5	8.5
Male sterilization	0.9	3.4

Contraceptive method	Individuals who reported any emotional IPV around the time of pregnancy (<i>n</i> = 932 ^b)	Individuals who did not report any emotional IPV around the time of pregnancy (<i>n</i> = 24,555 ^b)
Intrauterine device	18.0	14.9
Subdermal implant	8.8	5.1
Injectable	7.8	6.2
Pill	15.4	19.3
Patch/ring	1.8	1.5
Condom	16.6	22.6
Fertility awareness methods	1.1	3.7
Withdrawal	6.1	6.0
Abstinence	11.5	4.2
Other ^c	0.0	0.4

Note. IPV = intimate partner violence.

^aIncludes the following sites: Alaska (2016–2020), Iowa (2016–2020), Illinois (2016–2021), Indiana (2018), Maryland (2016–2020), Virginia (2016–2021), and Wyoming (2016–2021).

^bSample sizes are unweighted.

^cOther includes other unspecified methods, lactational amenorrhea method (LAM), diaphragms, spermicide/gel, and emergency contraceptive pills.

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Table 1.
Selected Characteristics of Individuals with a Recent Live Birth, Stratified by Postpartum Contraceptive Use, Pregnancy Risk Assessment Monitoring System (PRAMS), 2016–2021.^a

Characteristics	Total (n = 30,125 ^b)			Postpartum contraceptive use (n = 24,130 ^b)			Postpartum contraceptive nonuse (n = 5,995 ^b)			p ^c
	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI		
Age in years grouped										
<20	3.3	[3.0, 3.7]	3.3	3.0, 3.7	3.2	[2.6, 3.9]				.668
20–24	17.2	[16.6, 17.9]	16.9	16.2, 17.7	18.5	[16.9, 20.2]				.080
25–29	28.3	[27.5, 29.1]	28.6	27.7, 29.4	27.1	[25.5, 28.9]				.151
30–34	31.4	[30.6, 32.1]	31.7	30.8, 32.5	30.1	[28.4, 31.9]				.125
35–39	16.3	[15.7, 17.0]	16.3	15.6, 16.9	16.7	[15.4, 18.1]				.558
40+	3.5	[3.2, 3.8]	3.3	2.9, 3.6	4.3	[3.6, 5.1]				<.05
Race and ethnicity										
Non-Hispanic White	57.1	[56.3, 57.9]	58.6	57.7, 59.5	51.0	[49.2, 52.9]				<.001
Non-Hispanic Black	16.7	[16.1, 17.3]	15.8	15.1, 16.6	20.1	[18.7, 21.7]				<.001
Non-Hispanic American Indian or Alaskan Native	0.6	[0.5, 0.6]	0.6	0.5, 0.6	0.6	[0.6, 0.7]				.128
Non-Hispanic Asian	5.9	[5.6, 6.4]	5.1	4.7, 5.5	9.5	[8.5, 10.7]				<.001
Non-Hispanic multiple race	1.4	[1.2, 1.6]	1.3	1.2, 1.5	1.5	[1.2, 1.9]				.442
Non-Hispanic other ^d	0.9	[0.7, 1.1]	0.8	0.7, 1.1	1.0	[0.7, 1.5]				.457
Hispanic of any race	17.5	[16.8, 18.1]	17.8	17.1, 18.5	16.1	[14.7, 17.7]				.051
Previous live birth before most recent live birth										
No	37.9	[37.0, 38.7]	36.4	35.4, 37.3	44.0	[42.1, 45.9]				<.001
Yes	62.1	[61.3, 63.0]	63.6	62.7, 64.5	56.0	[54.7, 57.9]				<.001
State of residence										
Alaska	2.4	[2.4, 2.4]	2.4	2.3, 2.3	2.5	[2.4, 2.5]				.279
Indiana	3.9	[3.8, 4.0]	3.8	3.7, 3.9	4.0	[3.8, 4.2]				.681
Iowa	8.8	[8.7, 8.9]	9.2	9.1, 9.3	7.1	[6.9, 7.3]				<.001
Illinois	39.9	[39.8, 40.1]	39.8	39.6, 40.0	40.4	[40.0, 40.8]				.592
Maryland	15.7	[15.6, 15.9]	15.3	15.2, 15.5	17.2	[17.0, 17.5]				<.01
Virginia	27.4	[27.2, 27.6]	27.4	27.2, 27.7	27.1	[26.6, 27.6]				.796
Wyoming	1.9	[1.9, 1.9]	1.9	1.9, 1.9	1.6	[1.6, 1.7]				<.01

Characteristics	Total (n = 30,125 ^b)			Postpartum contraceptive use (n = 24,130 ^b)			Postpartum contraceptive nonuse (n = 5,995 ^b)			p ^c
	Weighted %	95% CI		Weighted %	95% CI		Weighted %	95% CI		
Wantedness of most recent live birth										
Wanted at the time or sooner	60.5	[59.6, 61.3]		59.1	58.1, 60.0		66.0	[64.2, 67.8]		<.001
Wanted later or not at all	24.8	[24.1, 25.6]		26.1	25.3, 27.0		19.6	[18.1, 21.2]		<.001
Uncertain	14.7	[14.1, 15.3]		14.8	14.1, 15.5		14.4	[13.1, 15.8]		.630
Postpartum contraceptive use										
No	19.7	[19.0, 20.4]		—	—		—	—		—
Yes	80.3	[79.6, 81.0]		—	—		—	—		—
During prenatal care visits, healthcare worker asked if someone was hurting me emotionally or physically ^e										
No	25.0	[21.0, 29.5]		21.0	16.7, 26.0		35.0	[26.9, 44.1]		<.01
Yes	75.0	[70.5, 79.0]		79.0	74.0, 83.3		65.0	[55.9, 73.1]		<.01
During prenatal care visits, healthcare worker asked if I planned to use birth control after my baby was born ^e										
No	12.8	[9.8, 16.5]		10.7	7.6, 15.0		17.8	[11.8, 26.0]		.079
Yes	87.2	[83.5, 90.2]		89.3	85.0, 92.4		82.2	[74.0, 88.2]		.079
During postpartum checkup, healthcare worker asked if someone was hurting me emotionally or physically ^e										
No	33.5	[28.7, 38.6]		30.4	25.1, 36.4		41.9	[32.3, 52.0]		.50
Yes	66.5	[61.4, 71.3]		69.6	63.6, 74.9		58.1	[48.0, 67.7]		.50
During postpartum checkup, healthcare worker asked if I planned to use birth control after my baby was born ^e										
No	9.9	[7.4, 13.1]		10.4	7.4, 14.4		8.5	[4.8, 14.7]		.532
Yes	90.1	[86.9, 92.6]		89.6	85.6, 92.6		91.5	[85.3, 95.2]		.532
Emotional IPV 12 months before pregnancy										
No	98.0	[97.7, 98.2]		98.2	97.9, 98.4		97.1	[96.4, 97.8]		<.01
Yes	2.0	[1.8, 2.3]		1.8	1.6, 2.1		2.9	[2.3, 3.6]		<.01
Emotional IPV during pregnancy										
No	97.8	[97.5, 98.0]		98.1	97.8, 98.3		96.5	[95.7, 97.1]		<.001
Yes	2.2	[2.0, 2.5]		1.9	1.7, 2.2		3.5	[2.9, 4.3]		<.001
Emotional IPV after pregnancy										

Characteristics	Total (n = 30,125) ^b			Postpartum contraceptive use (n = 24,130) ^b			Postpartum contraceptive nonuse (n = 5,995) ^b			p ^c
	Weighted %	95% CI		Weighted %	95% CI		Weighted %	95% CI		
No	98.1	[97.9, 98.4]		98.3	98.0, 98.5		97.4	[96.7, 97.9]		<.01
Yes	1.9	[1.6, 2.1]		1.7	1.5, 2.0		2.6	[2.1, 3.3]		<.01
Any emotional IPV around the time of pregnancy										
No	96.7	[96.4, 97.0]		97.1	96.7, 97.4		95.2	[94.3, 96.0]		<.001
Yes	3.3	[3.0, 3.6]		2.9	2.6, 3.3		4.8	[4.0, 5.7]		<.001
No. of time periods experienced emotional IPV										
0	96.7	[96.4, 97.0]		97.1	96.8, 97.5		95.2	[94.3, 96.0]		<.001
1	1.5	[1.3, 1.7]		1.3	1.1, 1.6		2.0	[1.5, 2.6]		<.05
2 or more	1.8	[1.6, 2.1]		1.5	1.3, 1.8		2.8	[2.2, 3.5]		<.001

Note. CI=confidence interval; IPV=intimate partner violence.

^a Includes the following sites: Alaska (2016–2020), Iowa (2016–2020), Illinois (2016–2021), Indiana (2018), Maryland (2016–2020), Virginia (2016–2021), and Wyoming (2016–2021).

^b Sample sizes are unweighted.

^c Tested using adjusted Wald test.

^d Other includes other race and Hawaiian.

^e Among participants who reported any emotional intimate partner violence.

Table 2.

Reasons for Not Using Postpartum Contraception, Stratified by Any Exposure to Emotional Intimate Partner Violence Around the Time of Pregnancy, Among Individuals with a Recent Live Birth and Not Currently Using Contraception, Pregnancy Risk Assessment Monitoring System (PRAMS), 2016–2021.^a

Reasons for nonuse	Total (n = 5,995 ^b)					Individuals who reported any emotional IPV around the time of pregnancy (n = 333 ^b)					Individuals who did not report any emotional IPV around the time of pregnancy (n = 5,662 ^b)				
	n ^c	Weighted %	95% CI	n ^c	Weighted %	95% CI	n ^c	Weighted %	95% CI	CI	n ^c	Weighted %	95% CI	CI	p ^d
Want to get pregnant	1,120	18.3	16.9	42	10.8	6.4	1,078	18.7	17.2	20.3					<.01
Do not want to use birth control	2,379	39.3	37.4	114	38.7	30.6	2,265	39.3	37.4	41.2					.783
Worried about the side effects from birth control	1,998	32.4	30.6	119	36.3	28.4	1,879	32.2	30.4	34.1					.399
Not having sex	1,748	28.6	26.9	171	53.6	44.8	1,577	27.3	25.6	29.1					<.001
Husband or partner does not want to use anything	602	9.2	8.1	48	17.8	12.0	554	8.8	7.7	10.0					<.01
Have problems paying for birth control	199	3.0	2.4	20	5.7	2.9	179	2.9	2.3	3.6					.211
Other	1,328	22.9	21.3	63	18.7	12.7	1,265	23.1	21.5	24.9					.267

Note. Reasons for nonuse may not add to 100%, because participants were asked to choose all that apply.

CI=confidence interval; IPV=intimate partner violence.

^aIncludes the following sites: Alaska (2016–2020), Iowa (2016–2020), Illinois (2016–2021), Indiana (2016–2020), Maryland (2016–2021), Virginia (2016–2021), and Wyoming (2016–2021).

^bSample sizes are unweighted.

^cUnweighted sample size.

^dTested using adjusted Wald test.

Table 3.
Indicators of Emotional Intimate Partner Violence Associated with Postpartum Contraceptive Use Compared with Contraceptive Nonuse Among Individuals with a Recent Live Birth, Pregnancy Risk Assessment Monitoring System (PRAMS), 2016–2021 ($n=30,125^a$).^b

Indicators of emotional IPV	Model 1			Model 2			Model 3			Model 4			Model 5		
	aOR	95% CI		aOR	95% CI		aOR	95% CI		aOR	95% CI		aOR	95% CI	
Emotional IPV 12 months before pregnancy															
No	Ref.			—			—			—			—		
Yes	0.57	0.43	0.76	—			—			—			—		
Emotional IPV during pregnancy															
No	—			Ref.			—			—			—		
Yes	—			0.51	0.39	0.66	—			—			—		
Emotional IPV after pregnancy															
No	—			—			Ref.			0.63	0.46	0.84	—		
Yes	—			—			0.63	0.46	0.84	—			—		
Any emotional IPV around the time of pregnancy															
No	—			—			—			Ref.			—		
Yes	—			—			—			0.57	0.46	0.71	—		
No. of time periods experienced emotional IPV															
0	—			—			—			—			Ref.		
1	—			—			—			—			0.63	0.45	0.89
2 or more	—			—			—			—			0.52	0.39	0.70

Note. Models were adjusted for race and ethnicity, age, previous live birth before most recent live birth, state of residence, and wantedness of most recent live birth.

aOR = adjusted odds ratio; CI=confidence interval; IPV=intimate partner violence.

^aSample sizes are unweighted.

^bIncludes the following sites: Alaska (2016–2020), Iowa (2016–2020), Illinois (2016–2021), Indiana (2018), Maryland (2016–2020), Virginia (2016–2021), and Wyoming (2016–2021).

Table 4.

Association of Provider Counseling for IPV and Birth Control with Postpartum Contraceptive Use Compared with Contraceptive Nonuse Among Individuals with a Recent Live Birth Who Reported Any Emotional Intimate Partner Violence Around the Time of Pregnancy, Pregnancy Risk Assessment Monitoring System (PRAMS), 2016–2021.^a

Characteristic	Model 1: Individuals who received prenatal care (<i>n</i> = 1,134 ^b)			Model 2: Individuals who received postpartum care (<i>n</i> = 956 ^b)		
	aOR	95% CI		aOR	95% CI	
During prenatal care visits, healthcare worker asked: If someone was hurting me emotionally or physically						
No	Ref.			—		
Yes	2.22	1.33	3.70	—		
If I planned to use birth control after my baby was born						
No	Ref.			—		
Yes	1.62	0.82	3.22	—		
During postpartum checkup, healthcare worker asked: If someone was hurting me emotionally or physically						
No	—			Ref.		
Yes	—			2.11	1.26	3.52
If I planned to use birth control after my baby was born						
No	—			Ref.		
Yes	—			0.67	0.33	1.40

Note. Models were adjusted for race and ethnicity, age, previous live birth before most recent live birth, state of residence, and wantedness of most recent live birth.

aOR = adjusted odds ratio; CI = confidence interval; IPV = intimate partner violence.

^aIncludes the following sites: Alaska (2016–2020), Iowa (2016–2020), Illinois (2016–2021), Indiana (2018), Maryland (2016–2020), Virginia (2016–2021), and Wyoming (2016–2021).

^bSample sizes are unweighted.