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REPRODUCTIVE, FEMALE AND CHILD HEALTH

ORIGINAL ARTICLE

Missed opportunities in postpartum contraception: Bridging the gaps for patients who deliver at Catholic hospitals in Illinois

Angel Boulware[1] | Jocelyn Wascher[2] | Zarina Wong[3] | Lee Hasselbacher[2] | Jessica Chen[4] | Lori Freedman[5] | Debra Stulberg[1]

[1]Department of Family Medicine, University of Chicago, Chicago, Illinois, USA

[2]Department of Obstetrics and Gynecology, University of Chicago, Chicago, Illinois, USA

[3]Department of Ob/Gyn, Division of Family Planning, John A. Burns School of Medicine, Honolulu, Hawaii, USA

[4]Department of Obstetrics and Gynecology, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania, USA

[5]Department of Obstetrics, Gynecology & Reproductive Sciences, ANSIRH and the Bixby Center for Global Reproductive Health, University of California, San Francisco, California, USA

Correspondence

Angel Boulware, Department of Family Medicine, University of Chicago, 5841 South Maryland Ave, MC7110, Room M156, Chicago, IL 60637, USA.
Email: Aboulware@uchicago.edu

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Abstract

Introduction: Catholic hospitals' religious restrictions limit postpartum contraceptive care and reproductive counselling. This qualitative study explores opportunities for patients and providers to ensure access to desired postpartum contraception care.

Methods: We interviewed people who had obstetric experiences in Illinois Catholic hospitals: 21 patients and 23 providers, including clinicians, doulas, nurses, and maternal health home visitors. We transcribed interviews and coded transcripts then used a thematic content approach for analysis. To guide future interventions, we sought interviewees' perspectives on opportunities to improve postpartum contraceptive care for patients affected by these restrictions.

Results: Patients delivered in Catholic hospitals for varied reasons unrelated to religious affiliation and were generally unaware of limits on access to contraception. Some providers offered referrals or workarounds for some contraceptive methods. The majority of providers described the importance of initiating contraceptive counselling during the prenatal period, but few patients reported receiving comprehensive contraceptive counselling during this time. Patients who received contraceptive counselling often had these experiences with doulas and maternal health home visitors who were not affiliated with religious health centres.

Conclusion: Contraceptive counselling in the prenatal period can be a particularly helpful tool for patients delivering in hospitals that limit access to postpartum contraception, particularly in Catholic hospitals. Prenatal counselling can support advance planning if a patient needs to transfer or seek care outside their preferred health system. Where counselling and referrals are prohibited by religious restrictions, doulas and other maternal health home visitors can bridge gaps and support patient decision-making and navigation to receive postpartum contraceptive care.

KEYWORDS

contraception, gynecology, obstetrics, postpartum health, prenatal care, women's health

INTRODUCTION

The US healthcare system includes an increasing number of Catholic hospitals, which are required by the US Council of Catholic Bishops to follow the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs).[1–3] The ERDs are a set of rules about permissible healthcare that include restrictions on the provision of contraception as well as other reproductive services. Despite these limitations, Catholic hospitals account for a large portion of reproductive healthcare. In 2020, 15.2% of deliveries across the US occurred in a Catholic hospital, accounting for more than 500 000 births.[4]

Prior research has demonstrated that fewer contraceptive services are offered in Catholic birthing hospitals.[5] Restrictions imposed by the ERDs can extend to limitations on contraceptive counselling and training physicians in contraceptive knowledge, which could further limit patients' access.[6] Patients seeking care at these hospitals are often unaware of the religious affiliation or restrictions, and they are unlikely to choose a hospital based on its religious affiliation[7,8] As a result, they may not anticipate how religious restrictions will affect their access to contraception, especially in the inpatient setting during a postpartum admission.[6,9–13]

A range of contraceptive methods are appropriate in the immediate and early postpartum period, but these are often restricted in Catholic hospitals. For instance, long-acting reversible contraception methods and sterilisation could be provided onsite immediately following delivery but are rarely permitted in Catholic settings.[14] In some settings where even counselling about contraception is prohibited, patients may not be aware that they could seek out these options at a later time.[14] In addition, contraceptive care is more difficult to access as the patient becomes more remote from delivery.[15,16] In most states, a woman's Medicaid eligibility based on pregnancy ends in the weeks following delivery.[17]

Access to postpartum contraception is critical in supporting maternal health and autonomy. Short interpregnancy interval (IPI) is common among women using no postpartum contraception,[6,16] and contraception use is highest when contraceptive counselling is provided during prenatal and postpartum periods.[18] Although there is debate about the causal link, shorter IPI is associated with an increased risk of adverse birth outcomes,[19,20] preterm birth and low birth weight for some people.[21–23] Given the lack of access to contraception in Catholic hospitals, it is unsurprising that research has shown associations between delivery in a Catholic hospital and a greater incidence of short IPI.[24,25]

Previous research has highlighted the lack of patient awareness of religious restrictions on care and, therefore, the need for greater hospital transparency.[9,10,12,26] However, even with increased awareness of restrictions, pregnant people will continue to receive care at Catholic hospitals because insurance, quality of care and distance are more important determinants of obstetric hospital choice.[8,27] Given the restrictions on contraceptive care that these patients encounter, finding ways to mitigate this lack of access is important for their reproductive health and autonomy.[8] This study aimed to explore when and how people delivering in Catholic hospitals are counselled and receive contraception, and to identify novel opportunities to improve care and access when hospital policy restricts contraceptive provision or counselling. We interviewed patients and providers with a focus on postpartum contraception in hospitals affected by the ERDs.

METHODS

We conducted phone interviews with patients and providers who had received or provided obstetric care from Illinois Catholic hospitals. The study's methods have been described in detail in a previous study.[14]

Recruitment

We identified Illinois all Catholic hospitals using the Catholic Health Association of the United States directory. To recruit individual respondents we used purposive sampling to enrol participants from diverse geographies within Illinois and to gain perspectives from as many Illinois Catholic birthing hospitals as possible. Also known as selective sampling, this purposive sampling approach allows researchers to recruit study subjects to aligned with the specific aims of a study.

Eligibility criteria for patient participants were that they had experienced a pregnancy in the last 10 years and delivered or received obstetric care at an Illinois Catholic Hospital. Of the 153 individuals who filled out the screening form, 42 proved eligible. We contacted 29 participants that provided the greatest diversity in hospital representation and 21 completed interviews. Of the eight we contacted who did not complete interviews, six did not respond despite three attempts (and provided no information), one declined to participate because they initially thought the study was about postpartum health complications and one participant was ineligible for the study. We ended outreach when we had reached thematic saturation.

Eligible provider participants included nurses, doulas (a trained professional who supports people during pregnancy), physicians, midwives or maternal health home visitors who currently or previously cared for patients who delivered in one of 22 Catholic hospitals in this sample. We used professional networks, organisational contacts and snowball sampling to identify eligible providers, then reached out via email. We invited 50 providers to participate. Twenty-three providers completed interviews, with two participants in a joint interview (Table 1). Of the 27 we contacted who did not complete interviews, 17 did not respond despite three attempts, six declined and four were ineligible because they did not work with pregnant patients or in a Catholic hospital.[14] The influence of respondents' individual backgrounds was beyond the scope of the study, so we collected little information on religious practices or upbringing. Personal religious affiliations are provided solely to describe the sample characteristics.

Data collection

Interviews with patients were conducted by two researchers (A. C., L. H.) in 2019–2020. In this study, recruiting patients

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TABLE 1 Participant and hospital characteristics.

Participants ($N = 44$)	
Role	
Patient	21
Doula or home visiting programme worker	7
Ob/Gyn	11
Certified nurse midwife	3
Family physician providing maternity care	2
Personal religious affiliation	
Catholic	7
Christian	4
Muslim	2
Other	2
None provided	29
Hospitals ($N = 22$)	
Religious affiliation	
Current Catholic affiliation	21
Prior Catholic affiliation	1
Non-Catholic	0
Location	
Chicago (city)	4
Suburbs of Chicago	10
Illinois outside Chicago area	8

Abbreviation: Ob/Gyn, obstetrics and gynecology.

comfortable discussing experiences at a Catholic hospital involved multiple approaches, impacting the study duration. Questions explored participants' counselling experiences with postpartum contraception options during prenatal, delivery and postpartum periods. Interviewers also asked participants about their healthcare experiences at Catholic hospitals, their understanding of hospital religious affiliation and religious policies. We did not ask about the influence of their own religion or other personal background.

Two researchers (J. C., L. H.) conducted interviews with providers in 2019–2020. Interview questions asked providers how they explained religious hospital policies to patients and how policies impacted reproductive counselling and contraception. Providers were also asked to discuss the consequences of religious policies and their attitudes toward religious policies.

All researchers were pretrained and conducted all interviews following a semistructured interview guide. All participants provided verbal consent and were compensated with a $50 gift card for their time. The [university] institutional review board approved this study.

Data analysis

We used a thematic content approach to conduct data analysis. We transcribed interviews using an automated transcription service, which were then manually verified and thematically coded using a qualitative data application (Dedoose version 8.0). As described previously,[14] the research team created individual but coinciding codebooks for provider and patient transcripts based on emergent themes and interview guides. When coding patient and provider transcripts, study team members coded two transcripts and met to review coding for concordance and discuss areas of disagreement. We repeated this process until the team established a sufficient level of coding concordance. Coders then divided and independently coded the remaining transcripts. The research team developed narrative memos describing key themes to facilitate in-depth analysis and synthesis. We grouped all provider transcripts together for analysis; however, where a provider's specific role (e.g., doula, doctor, midwife) contributed a unique perspective, we highlight that professional perspective in the results. In a prior analysis, we described the consequences of Catholic hospital policies for postpartum patients, with a focus on how restrictions impeded access to contraceptive counselling and care.[14] Here, we report on themes that describe missed opportunities to ensure patients receive desired care and suggestions for novel approaches to prevent harmful consequences of denied care. In reporting our findings, we followed the Standards for Reporting Qualitative Research.

RESULTS

Participants included 21 patients and 23 providers who collectively had experience with 22 Catholic birthing hospitals. The Catholic birthing hospitals included 10 hospitals in the Chicago suburbs, eight elsewhere in the state, and four in the city of Chicago. Provider participants included Obstetrics and gynecologies, maternal health workers (e.g., doulas, home visiting nurses or home visiting programme staff), midwives and family medicine physicians (Table 1). These 23 providers collectively had experiences at 16 Catholic hospitals across the state. Many also had experience working in non-Catholic settings; some individuals worked in community health centres and delivered at Catholic hospitals while others had privileges at multiple hospitals. Catholic hospitals fully employed some providers, while others held delivering privileges but worked at separate, unaffiliated clinics. For patients, themes included a wide range of reasons for choosing their birthing hospital, desire for more counselling on contraceptive options and the benefit of doulas and maternal health workers in filling this need. For providers, themes included encountering restrictions on contraceptive care and counselling, the value of discussing contraception in the prenatal period and the importance of doulas and maternal health workers.

Patients: Factors influencing delivery hospital

Patients in our study reported a range of reasons for choosing their delivery hospital, including factors such as accessibility, insurance restrictions and quality of care, while religion was not commonly reported as a reason.

Location was a commonly cited reason for choosing a hospital, along with insurance coverage. For example, one patient explained: 'It was convenient to my home … and, with the insurance plan that I had, that's where I was allowed to go'. A second participant echoed this sentiment saying, 'It was the one closest to my house, and I had heard really good things about it and the doctors who I worked with'. A second common theme of provider reputation or relationship as an influence on hospital choice is highlighted by this statement. Another participant explained, 'I think if my OB (Obstetrician) hadn't been delivering there, I wouldn't have chosen a Catholic hospital'. In this case, this participant chose the hospital in spite of religious affiliation because other factors outweighed its importance to her. Another participant reinforced the idea that the individual providers were more important in her decision than the institution: 'I think it's more for us [patient and her husband] at least, a preference of like what kind of care we want from the person we're getting it from more than the organisation we're getting it from'. The influence that the patient–provider relationship has on hospital choice led some of our patient participants to seek care at Catholic hospitals, suggesting that providers could play a role in anticipating these restrictions.

A few patients expressed a specific desire to receive care in a Catholic hospital. One participant stated, 'I like it a little bit better than any other just because they, in a way I believe they care more. They will do the prayer request and they will come in and help you more emotionally'.

Providers: Bridging contraceptive gaps through workarounds and referrals

Most providers reported that family planning and contraceptive services were restricted in the Catholic hospitals where their patients delivered. Several providers indicated that the Catholic hospital's restrictions even limited the counselling they could provide.

Despite the restrictions, providers noted that many patients continued seeking reproductive care at Catholic hospitals. A physician and doula both reported that even when patients encountered contraceptive barriers from religious restrictions, few patients left their hospital for another one that could provide their desired care. Because of this, providers tried to support patients' contraceptive needs by finding ways to work around religious restrictions, either through workarounds or referrals. For example, providers often mentioned finding medical conditions they could diagnose the patient with to justify providing contraception. When asked how contraception could be offered, one provider said, 'Yes, so if there's any abnormal uterine bleeding, dysmenorrhoea, those are medical indications that we can prescribe any kind of contraception for'.

Several providers also discussed referring their patients to non-Catholic hospitals or independent clinics to receive the postpartum contraception care they otherwise would not be able to receive. For example, many providers reported that when a patient desired a tubal ligation, the provider would either schedule them for delivery at a secular hospital, if possible, or arrange a later surgery at a secular hospital. Most providers agreed that receiving a second surgery or switching hospitals did not offer optimal solutions for patients or the most cost-effective or accessible options, but in some cases, it was the only option. As one physician explained about separating the Caesarean delivery (c-section) and tubal ligation, 'something important to remember is that that would potentially be two surgeries. Let's say they had their c-section at [the Catholic hospital], then they would be exposed to the additional risk that's posed by an additional surgery'. At the same time, the physician also discussed the practical limitations of scheduling a patient for a c-section and tubal ligation at another hospital, 'let's say their insurance didn't cover them at the other hospital, that we would just not do it'. Other providers described barriers that could arise when making referrals, including challenges with transportation, childcare or scheduling. When asked about barriers to attending postpartum visits, one provider said:

> Yeah, I mean we do have clients that lack transportation. Either they don't have a car at all, or maybe they have one car, and their significant other is using that to go to work. Or it could be that, when we have clients that are under the age of 16 that can't even drive themselves to an appointment, then they're having to rely on someone else to get them there. […] I honestly would have to say that transportation is a lot of the issue of getting to aftercare, or even prenatal care.

This provider acknowledges the practical difficulties postpartum patients have with accessing contraception even when referrals can be placed.

Providers: Prenatal conversations about contraception

Providers recognised value of prenatal conversations about contraception.

Even though some settings restricted even counselling about contraception, many of the providers sought out ways to incorporate it wherever possible. For example, in the following three excerpts, physicians explained the importance of having postpartum contraceptive conversations in the prenatal period. One physician working in a Catholic hospital stated: 'It actually starts at the initial prenatal visit. We kind of have a list of things that need to be discussed with the patient. One of the

things that needs to be documented is a discussion on options for family planning'. Another physician providing obstetric care in a Catholic hospital also expressed the importance of the timing of these conversations and suggested that ideal care would involve starting early:

> Having a decision settled by probably 32 weeks… Ideally, being able to counsel patients on we can do X, Y, and Z in the hospital, we can do these other options at whatever time after you have your baby, and then already having a firm game plan on if they're planning to breast feed or not and then what's compatible with that and what's not. I think a lot of it if we just do it in the pre-natal period, I feel like people are going to feel a lot more comfortable with everything later because they're just so overwhelmed with the baby afterwards.

A physician working in both a Catholic and secular hospital, expressed similar statements:

> So, it's something that we sometimes start talking to patients about earlier than the third trimester, but it's definitely on the sheet, that it needs to be addressed in some form written in, in the third trimester. […]. We give patients options, counselling of what the different options are and what we recommend…

One physician stated they speak to their patients about postpartum contraception in both the prenatal and postpartum periods,

> I talk about it in the prenatal time, generally in the third trimester when we get to the point of talking about the delivery and the experience and what they're planning afterwards. We have it as a checklist as one of our educational points for our third-trimester education. I also will talk to them about it in the, obviously, postpartum time, too, before they go home from the hospital.

Citing concerns about short birth intervals, pressure from partners to resume sexual activity, and a lack of awareness that fertility may return early, providers supported conversations about contraception before and after the birth, even if they could not always provide that counselling themselves.

Patients: More prenatal conversations about contraception wanted

Many patients agreed that beginning contraceptive conversations immediately after the delivery or during the 4- to 6-week appointment is difficult. Patients described those time periods as being very hectic so they would prefer to have contraceptive conversations in the prenatal period to allow them time to think and plan out their options. However, despite physicians' support of postpartum contraception conversations during the prenatal period, most patient participants reported they did not actually have a conversation about future contraception at their prenatal appointments. Several patients said they would have wanted the opportunity to get more information about various contraceptive methods. One patient reported they would have appreciated having a conversation about potential options:

> I've had issues with different contraceptives. Honestly, now, I would personally like to be on one. But I haven't really found a person that's willing to have an in-depth conversation with me about it just because I've had issues with different birth controls, which I have been on birth control since I was probably seventh or eighth grade just because I always had issues with periods. That's when I was first put on them, and then I've had issues with that since then.

Some of the patients who reported having prenatal contraceptive conversations with physicians noted they were helpful and informative. However, other patients who had prenatal conversations mentioned the discussions were often short, sometimes little more than being handed reading material: 'In prenatal care, they had pamphlets sitting out in the ladies waiting room, and it's up to you to get it if you want to read it, but no, because it's like a Catholic hospital, so they're not going to be too much into that'.

Patients and providers: Doulas and maternal health workers in prenatal counselling

All the patients who reported receiving prenatal care from a doula or maternal health home visitor had conversations about postpartum contraception during the prenatal period. These patients described the conversations to be in-depth and informative. One patient said her doula was 'helpful' and provided information she did not have.

We interviewed 10 doulas and maternal home health visitors in this study (Table 1). Most of them provided care and support through their employment in secular community health settings and organisations unaffiliated with the Catholic hospitals where their patients delivered. Many of them described how contraceptive counselling was integrated into organisation-wide standards of care. For example, one doula with a community health programme described, 'We absolutely start talking about it prenatally… [there's a] whole section in our prenatal group about STIs

and birth control. The home visitors are also tasked with that same conversation. You have to show that you've done it prenatally as well as postnatally'. One provider described offering weekly prenatal classes as part of a doula programme and including discussions about postpartum contraception as part of the curriculum. Several doulas began to see patients when they are 4–5 months pregnant and developed relationships that allow for discussions about contraception. As one doula explained,

> So, we talk about [contraception] when we're discussing their goals and their plans for the immediate future, their plans for a year from now. So, we start that conversation at the beginning. That way, if I need to gather more information, I have time to do that. We can discuss it more. So, when the time comes, they can have a more informed, made a more informed decision and they feel more prepared.

Another doula stressed the importance of encouraging patients to speak with their doctor about postpartum contraception during prenatal visits: 'part of my job is to help them feel confident as a young woman to be able to say, "I need to have this conversation"'. Several doulas reported that they also include conversations about contraception in their postpartum visits with patients. Because these maternal home health visitors are seeing patients in their homes or in other settings outside of the Catholic hospitals where they ultimately deliver, they were free to discuss contraception and make referrals for care.

DISCUSSION

Despite religious restrictions preventing them from receiving desired services, patients within this study largely continued to receive care at Catholic hospitals. Patients were motivated to choose their delivery hospital by geography, provider relationships, insurance and other reasons unrelated to religious affiliation. Many of the providers we interviewed also reported transportation, childcare and scheduling as limitations to referring patients to a different facility, indicating that avoiding restrictions by delivering elsewhere may not be an option for some patients. Providers discussed how in these situations, patients could be forced to undergo additional surgeries unnecessarily to attain their desired contraceptive. In other cases, hospital providers felt compelled to find medical diagnoses that would allow for the implementation of a contraceptive method.

This aligns with previous research that demonstrated how providers working in Catholic hospitals often experience conflicts with their institution over these religiously based policies.[28,29]

Of the themes identified, the importance of comprehensive contraceptive counselling emerged in both patient and provider interviews. Despite this agreement, most patients reported they did not receive such counselling, particularly in the prenatal period. While some of the providers reported offering to counsel, few patients recalled counselling conversations. Our interviews did not match patients to their providers, and it is possible the provider sample we interviewed was biased towards those more motivated to counsel patients on contraceptive compared to the wider provider population. It is also possible providers restricted by the Catholic ERDs did not have these discussions because they could not provide contraceptives.

Prior research has shown that postpartum contraceptive use was highest when contraceptive counselling was provided during both prenatal and postpartum periods.[18] Our findings reinforce this correlation, with both provider and patient themes highlighting that prenatal care is a critical period to begin discussing postpartum contraception. Furthermore, our findings align with prior research that suggests these conversations are the most effective when they occur over time, rather than having the conversation once or giving patients pamphlets to read and inform themselves about their options.[18] Prenatal counselling may be especially important in instances when counselling at the time of delivery or postpartum is limited by restrictions on care; advance planning for patients when it is known they will encounter religious restrictions may aid in accessing contraception. It may also enable patients to ultimately receive their preferred contraceptive method, which is the best indicator of contraceptive autonomy.[30,31]

Another path to ensuring patient contraceptive access in the face of known restrictions is leveraging the prenatal and postpartum care provided by doulas and maternal health home visitors. Doulas support women throughout labour and delivery and can also counsel women on contraceptive options; they are often unaffiliated with the delivery hospital and, therefore, unconstrained by religious restrictions.[32,33] In addition to workarounds mentioned by hospital/delivering providers, such as referrals and medical diagnoses to allow for contraception, supportive providers like doulas found workarounds by learning about other hospitals and clinics where patients could receive contraception and disseminating that information during their prenatal period so the patient had an awareness of their options. Patients satisfied with their prenatal contraceptive counselling experience all stated that doulas or other maternal health workers counselled them. Some physicians also saw the value of enlisting the help of doulas in connecting patients to contraceptive counselling and care. These collaborations could help ensure that the patient gets contraceptive education and support in navigating the care they need regardless of the hospital's limitations. Educating providers working in Catholic hospitals on the benefits of doula support and ensuring access to doulas for these patients could help mitigate religious restrictions.

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We recognise our findings for both providers and patients may not be generalisable. Those providers who were willing to speak with us may have different perspectives on their hospital's religious restrictions than their colleagues; however, with this analysis, we were interested in identifying opportunities to enhance access so bias should have less influence in this domain. In addition, some of the themes highlight more provider experiences because they are more aware of regulations regarding Catholic ERDs. To decrease bias in patient interviews, we recruited participants to tell us about their prenatal and postpartum experiences with contraception but did not mention religious restrictions in materials; instead, we screened eligible participants by the delivery hospital and only interviewed those who delivered at Catholic hospitals. We recognise there are multiple barriers to timely, patient-centred postpartum contraceptive care. This study sought to explore potential mitigations to the specific barriers posed by religious institutional restrictions and did not explore other barriers as deeply, although some arose during our interviews. While this study was not designed to compare postpartum contraception in Catholic versus non-Catholic facilities, many interviewees contextualised their experiences in Catholic facilities with other experiences they had in non-Catholic facilities, allowing for comparison in some instances. Similarly, we did not design our study to make comparisons across provider types or over time. We recognise that doulas, midwives and physicians of different specialties each make distinct contributions to patient care, and it is a limitation that we did not analyse their interviews to detect group differences. We also enroled patients who had experienced a birth at a Catholic hospital in the past 10 years, which may have included changes in how hospitals applied or enforced the ERDs. We did not specifically assess for time trends, but many patients shared multiple birth experiences and we did not detect chronological patterns in their experiences.

Our findings revealed several ways that providers can help mitigate harms introduced by religious restrictions on access to postpartum contraception: by informing patients upfront about restrictions, supporting transfer of care or referrals, leveraging workarounds and by providing prenatal contraceptive counselling, when possible, to support access. Prenatal counselling about postpartum contraception limitations and options can also help mitigate the harm caused by religious barriers to contraceptive access. Table 2 includes a summary of our recommendations for providers whose patients deliver in a Catholic hospital. While these recommendations may not be feasible in all Catholic hospitals, delivering providers may be able to apply these by building and leveraging relationships with surrounding clinics, doulas and maternal health home visitors to bridge gaps in care when Catholic health systems impose restrictions.

Policymakers can also ensure that insurance is not a barrier for patients seeking care outside of religious health centres by supporting extended postpartum coverage and expanded coverage for doulas and maternal health home

TABLE 2 Recommendations to providers to ensure patient access to postpartum contraception.

If your patients deliver in a hospital that offers immediate postpartum contraception.

1. Offer patients counselling on postpartum contraceptive options during prenatal care visits.
2. Early on, advise patients on limitations that may restrict contraception at the delivery hospital, particularly restrictions on tubal ligation. Establish protocols to facilitate the transfer of care for patients who would like to seek care elsewhere and inform the patient of what to expect.
3. If patient's desired contraception is available at the delivery hospital, ensure patients have the choice to receive it before discharge or provide contraceptive counselling and a wide range of methods at later postpartum visits.

If your patients deliver in a hospital that limits contraception, but allows counselling and referrals or you can offer outpatient postpartum contraception.

1. Offer patients counselling on postpartum contraceptive options during prenatal care visits.
2. Early on, advise patients on limitations that may restrict contraception at the delivery hospital, particularly restrictions on tubal ligation. Establish protocols to facilitate the transfer of care for patients who would like to seek care elsewhere and inform the patient of what to expect.
3. Plan ahead! Some hospitals with religious restrictions will allow contraception if there is an appropriate medical reason. Some hospitals with logistical barriers to having contraception on site will allow a patient or provider to bring the method (e.g., intrauterine device or implant) to the hospital for insertion.
4. If contraception cannot be offered at the hospital after delivery, provide contraceptive counselling and a wide range of methods at postpartum visits.
5. If contraception and counselling cannot be offered at the hospital or as a part of regular postpartum visits, provide referrals to a trusted local provider. Ideally, the provider would make these referrals during the prenatal and postpartum period and would help the patient make the appointment.

If your patients deliver in a hospital that restricts contraception, restricts counselling and referrals and your practice also limits outpatient postpartum contraception provision.

1. Early on, advise patients on limitations that may restrict contraception at the delivery hospital, particularly restrictions on tubal ligation. Establish protocols to facilitate the transfer of care for patients who would like to seek care elsewhere and inform the patient of what to expect.
2. If contraceptive counselling cannot take place during the prenatal or postpartum period, direct patients to printed materials or other resources that would inform them about postpartum contraceptive options.
   - If counselling and resource-sharing cannot take place, refer patients to nearby clinics that could provide counselling around postpartum contraceptive options. Consider also referring patients to doula and home visiting services where they could receive postpartum support and contraceptive counselling.
   - If referrals cannot be made, maintain a list of places where a patient can receive comprehensive information about contraception (e.g., Besider.org, reproductiveaccess.org).
3. Plan ahead! Some hospitals with religious restrictions will allow contraception if there is an appropriate medical reason.

(Continues)

TABLE 2 (Continued)

If your patients deliver in a hospital that offers immediate postpartum contraception.
4. If contraception and counselling cannot be offered at the hospital or as a part of regular postpartum visits, provide referrals to a trusted local provider. Ideally, the provider would make these referrals during the prenatal and postpartum period and would help the patient make the appointment. Consider also referring patients to doula and home visiting services where they could receive postpartum support and contraceptive counselling. ○ If referrals cannot be made, maintain a list of places where a patient may reasonably expect to receive information about contraception in the community. ○ Alternatively, the delivering hospital could establish a relationship with a nearby clinic that can offer early postpartum contraception visits and establish protocols to refer patients.

visitors,[34] who can counsel about contraception. The American Recovery Plan Act (March 2021) created a temporary option for states to extend postpartum Medicaid coverage to a full year,[35] and 27 states have been implemented this coverage thus far.[36] This would allow patients more time to seek contraceptive care in the postpartum period, which could be especially helpful for Catholic hospital patients who need to find new providers.[17] Several states, including Illinois, have also passed legislation to develop pathways for doulas to seek reimbursement through Medicaid; such policies should be implemented with input from doulas and other programmes can also be established to support community doula services.[37] Private insurance plans could improve access to reproductive care by ensuring that an adequate number of their in-network facilities do not have religious restrictions on care. Policy-makers could also pursue legislation like that recently passed in Illinois, which would require private insurance plans to provide for covered services to be reimbursed if a patient has to go outside their network to find care due to religious restrictions.[38] If religiously-affiliated health centres cannot be compelled to provide standard reproductive health services, referrals or even transparency about their limitations, lawmakers should support policies that help mitigate the challenges presented for patients.

Contraceptive counselling in the prenatal period can be a particularly helpful tool for patients delivering in hospitals that limit access to postpartum contraception, including Catholic hospitals. Prenatal counselling can support advance planning if a patient needs to transfer or seek care outside their preferred health system. Where counselling and referrals are prohibited by religious restrictions, doulas and other maternal health home visitors can bridge gaps and support patient decision-making and navigation to receive postpartum contraceptive care.

AUTHOR CONTRIBUTIONS

Each author participated actively in conducting analyses, drafting sections of the manuscript, editing, and approving the final, submitted version. **Angel Boulware**: Formal analysis (equal); writing—original draft (lead). **Jocelyn Wascher**: formal analysis (equal); writing—original draft (supporting). **Zarina Wong**: Formal analysis (equal); writing—original draft (supporting). **Lee Hasselbacher**: Formal analysis (equal); conceptualisation (equal); methodology (equal); project administration (lead); writing—original draft preparation (supporting). **Jessica Chen**: Investigation (equal) analysis; data curation (supporting). **Lori Freedman**: Conceptualisation (supporting); formal analysis (equal); methodology (equal); writing—review and editing (equal). **Debra Stulberg**: Formal analysis (equal); conceptualisation (lead); methodology (equal); supervision (lead); writing—review and editing (equal); funding acquisition (lead).

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

This study constituted human subjects research and was conducted with ethical approval by the University of Chicago Institutional Review Board, protocol # IRB19-1229. The study did not involve nonhuman animal research.

ORCID

Angel Boulware http://orcid.org/0000-0001-9053-744X
Zarina Wong http://orcid.org/0000-0002-6069-0838
Debra Stulberg https://orcid.org/0000-0001-9942-0862

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