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O19**Contraceptive counseling at the time of first-trimester abortion: what do women want?**

Cansino C

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Objectives: We investigated if women desire contraceptive counseling when seeking a first-trimester abortion.

Methods: We conducted a cross-sectional study by distributing self-administered anonymous surveys to women seeking first-trimester medical or surgical abortion at three clinics in Sacramento, Chicago and Cleveland. Surveys were completed after registration and before in-office counseling. We asked women about whether they wanted to discuss contraception, specific topics they wanted to discuss, reasons why they may not want contraceptive counseling and whether they wanted to receive contraceptive services as part of their abortion care.

Results: Of the 1959 respondents, 61.7% did not want to discuss contraception prior to the abortion, primarily because they already knew which method they wanted. Desire for counseling was not associated with age, race, planned abortion method, clinic site, number of unplanned pregnancies or contraceptive method used prior to the current pregnancy. Among those who wanted counseling, women preferred to discuss which methods would be easier to use and more effective than methods they used previously. Regardless of their desire for counseling, 70.8% of respondents wanted to leave the clinic with a specific method, such as a long-acting reversible method (IUD or implant, 18.5%) or other hormonal method (pills, patch, ring or injectable, 66.5%).

Outcomes: Most women seeking a first-trimester abortion do not want to discuss contraception, most often because they have a preferred method in mind. Abortion providers should account for such desires when allocating resources for abortion care provision.

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O20**Improving contraceptive services in primary care: a quality improvement collaborative pilot**

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Objectives: Federally qualified health centers (FQHCs) provide comprehensive primary care services, including family planning, to underserved populations. However, FQHCs without Title X family planning program funding offer a limited scope of contraceptive services. Little is known about the use of quality improvement collaboratives in improving contraceptive care at FQHCs. We initiated a quality improvement collaborative pilot in February 2014 to assess the feasibility of this approach to create sustained improvements in contraceptive service provision at non-Title X-funded FQHCs.

Methods: We recruited four non-Title X-funded FQHC sites in New York City to participate in the 20-month quality improvement collaborative pilot. We developed a set of change ideas and quality measures to drive the adaptation and implementation of best practices for contraceptive care, with targeted efforts for pregnancy intention screening and contraceptive counseling. Sites formed quality improvement teams and received training and technical assistance relevant to contraceptive service provision. Teams carry out site-specific improvement activities, report monthly on quality measures and attend quarterly learning sessions.

Results: Since monthly reporting began in May 2014, the average annual pregnancy intention screening rate increased from 3% to 68%. Among patients seeking to prevent pregnancy, the average proportion of those leaving with an effective method increased from 2% to 46%.

Outcomes: FQHCs face significant challenges in providing quality contraceptive care. Interim results of our quality improvement collaborative pilot support the use of this approach to achieve dramatic improvements in contraceptive service provision at these facilities and other primary care practices.

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O21**Side-effects and contraceptive uptake in urban Burkina Faso**

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Objectives: According to standard models of the demographic transition, decreases in the total fertility rate and increases in the contraceptive prevalence rate are lagging in Burkina Faso, compared with other development indicators. Several theories have been proffered to explain why Burkinabé women use contraceptives so infrequently, but few studies have explicitly focused on fear of side-effects from hormonal methods. This qualitative study examines why fear of side-effects — infertility in particular — resonates so strongly in this context and explores the impact on contraceptive uptake.

Methods: Sixty semistructured interviews were conducted with heads of poor households, and structured observations were conducted in six health facilities that offer family planning services in Ouagadougou's periurban areas. Inductive content analysis was used to elucidate and describe emergent themes.

Results: Fear of permanent infertility, though not supported by biomedical evidence, was nonetheless cited by many respondents as a primary reason for nonuse of hormonal contraceptives. Respondents blamed subsequent miscarriages or inability to conceive on prior hormonal method use, or cited desire for future children as reasons for never-use of hormonal methods. Health center observations show that quality of counseling is often poor and nurses often conceal the true side-effect profiles of hormonal methods, which contributes to distrust and promotes credence in myths and rumors.

Outcomes: Researchers have often overlooked fear of side-effects because it does not align with the accepted understanding of hormonal contraception, yet addressing these firmly held beliefs is critical to increasing uptake of effective contraceptive methods.

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Poster Abstracts**P1****A randomized controlled trial comparing different doses of intravaginal misoprostol for early pregnancy failure**

Hombalegowda RB

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Objectives: We compare the efficacy and adverse effects of different doses of intravaginal misoprostol (400 mcg vs. 800 mcg) in inducing complete abortion in patients with early pregnancy failure.

Methods: A total of 50 women with ultrasonographic diagnosis of early pregnancy failure (less than 12 weeks) were prospectively included in this randomized controlled trial. Subjects were randomly assigned to receive either 400 mcg or 800 mcg of intravaginal misoprostol (25 in each group). A second dose of the same strength was administered if there was no expulsion after 24 h. Dilatation and curettage was performed in cases of incomplete expulsion, no expulsion after 48 h or excessive vaginal bleeding.

Results: The groups did not differ significantly in mean age, period of gestation and parity. Mean induction abortion time was significantly shorter in the 800 mcg group (17.67±5.39 h) than in the 400 mcg group (28.56±6.96 h), $p=0.001$. The complete abortion rates were significantly different at 24 h (71.4% in 800 mcg vs. 31.6% in 400 mcg, $p=0.02$), but not at 48 h (84% in