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Title: Contraceptive counselling of women seeking abortion

– A qualitative interview study of health professionals' experiences

By

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ABSTRACT

OBJECTIVES

A substantial proportion of women who undergo an abortion continue afterwards without switching to more effective contraceptive use. Many subsequently have repeat unintended pregnancies. This study, therefore, aimed to identify and describe health professionals' experiences of providing contraceptive counselling to women seeking an abortion.

METHODS

We interviewed 21 health professionals (HPs), involved in contraceptive counselling of women seeking abortion at three differently sized hospitals in Sweden. The interviews were recorded and transcribed verbatim, and analysed using conventional qualitative content analysis.

RESULTS

Three clusters were identified: "Complex counselling", "Elements of counselling" and "Finding a method". HPs often experienced consultations including contraceptive counselling at the time of an abortion as complex, covering both pregnancy termination and contraceptive counselling. Women with vulnerabilities placed even greater demands on the HPs providing counselling. The HPs varied in their approaches when providing contraceptive counselling but also in their knowledge about certain contraception methods. HPs described challenges in finding out if women had found an effective method, and in the practicalities of arranging intrauterine device (IUD) insertion post-abortion when a woman asked for this method.

CONCLUSIONS

HPs found it challenging to provide contraceptive counselling at the time of an abortion and to arrange access to IUDs post-abortion. There is a need to improve their counselling, their skills, and their knowledge to prevent repeat unintended pregnancies.

INTRODUCTION

The high rates of repeat abortions in northern Europe and in the USA (40-50%) point to opportunities for improving contraceptive counselling at the time of an abortion (1, 2). While women and HPs find contraceptive counselling at the time of an abortion both appropriate and practical (3), it is unclear how best to provide contraceptive counselling in order to prevent repeat unintended pregnancies (4, 5), particularly in the context of an abortion. Women's receptivity to information about contraception may be hampered by the worry, anxiety and ambivalence which are common in the short term (6). Still, many women seem willing to change to more effective contraceptives, such as long-acting reversible contraception (LARC), following an abortion (7).

Contraceptive counselling involves interpersonal communication. The quality of the counselling is important: women who are satisfied with their contraceptive counselling are more likely to use contraception, whereas women who feel forced to try a new method are more likely to discontinue it (5).

Women seem to prefer patient-centred contraceptive counselling – which takes the woman's values and preferences regarding contraceptives into account – not least at the time of an abortion (8). It increases the woman's knowledge and her use of effective contraception for at least three months post-abortion (9). Similarly, the notion of shared decision-making casts contraceptive counselling as a process of bringing two areas of expertise together. The HPs' role includes providing information, assisting women when they consider how their preferences relate to available choices, and helping them come to an acceptable decision (5, 9). Clear and accessible information about contraceptive methods, including their effectiveness as well as potential side effects, seems to influence women's choice of contraceptive method (10). Whether this actually increases contraceptive use has, however, not been determined (4).

Many women are influenced by an HP in their choices of contraceptive methods (5, 8, 11). Consequently, HPs play an important role in contraceptive decision-making. Yet, there is limited knowledge of HPs' experiences of counselling women and of addressing their needs and preferences regarding contraception at the time of an abortion. To promote and improve counselling, it is essential to understand both HPs' and women's perspectives on it. As part of a broader investigation, this study therefore aimed to identify and describe HPs' experiences of providing contraceptive counselling to women seeking an abortion.

METHODS

In Sweden, counselling and prescription regarding contraceptives are mainly performed by midwives in the primary health care service. Women who need additional guidance are referred to a gynaecologist (12). According to the Swedish National Board of Health and Welfare, women should receive contraceptive counselling at the time of an abortion (13). This task is shared by gynaecologists and midwives at hospitals in Sweden (14). If the woman chooses to use LARC, the initiation of this method is often arranged during the follow-up 3-4 weeks after a medical abortion, whereas women who undergo surgical abortion usually have the LARC inserted immediately (15).

We conducted a qualitative interview study. To reach a range of HPs, we invited gynaecologists and midwives who were actively involved in contraceptive counselling of women seeking abortion, at departments of Obstetrics and Gynaecology at public hospitals; one large university hospital, one medium-sized county hospital, and one small district hospital, in south east Sweden. We included hospitals in communities with different rates of abortions, and HPs who probably faced a variety of socioeconomic challenges.

Information about, and an invitation to participate in the study, were given by e-mail or orally at staff meetings. We developed and, based on two pilot interviews, refined an interview

guide (Table 1). The pilot interviews were not included in the final analysis. The first author (HK) conducted the interviews between June 2014 and January 2015. Before starting the interviews, she repeated the information about the study and the respondents gave their written consent. The interviews followed the natural process of a conversation as the interview guide was used flexibly. All the questions in the guide were covered in all interviews, but not necessarily in the same order. All interviews took place in respondents' work setting, in private rooms chosen by them. The interviews lasted 25-62 minutes (median 40 minutes). They were digitally recorded and transcribed verbatim by HK. The transcripts were de-identified, coded and kept in a secure location.

We analysed the transcripts using conventional qualitative content analysis (16). This is a suitable method when the aim is to describe a phenomenon, and existing theory or research is limited. Three researchers (HK, BS and SA) initially analysed two interviews separately, then reviewed and refined the analytic strategy; the rest of the data analysis was performed by HK. The material was read through several times to get a sense of the whole. Data material was read through word by word and codes were marked to highlight exact words from the text that seemed to capture key thoughts. Then we made notes of our first impressions, thoughts and initial analysis. At this stage, we developed labels for codes which reflected key thoughts and became the coding scheme. We sorted the codes into clusters, based on how they were related (table 2). The codes and the definitions of the clusters were discussed by HK, BS and SA, and the final clusters were agreed by all the researchers.

The study was approved by the Regional Ethical Review Board in Linköping (#2013/145-31; date of approval: 24 April 2013.)

RESULTS

In all, 40 HPs were invited and 24 agreed to participate. Three of them were excluded because they were not currently providing contraceptive counselling. Ultimately, 21 HPs (15 gynaecologists and six midwives) participated in the study. Their median age was 42 years (range 30-64 years of age); 19 were females. They had worked in their profession for 1-34 years (median 10 years) (table 3).

The interview analyses yielded three broad clusters: Complex counselling, Elements of counselling and Finding a method. Below, we elaborate upon and illustrate the clusters with verbatim interview quotes.

Complex counselling

Contraceptive counselling at the time of an abortion appears more complex compared to counselling not related to abortion. The consultation covers two issues - the abortion and the decision about future contraception - that need to be addressed at a time of emotional exposure for the woman. Other aspects of complexity concerned the challenge of building a trusting relationship, particularly when meeting women with vulnerabilities and in a context in which they are emotionally exposed.

Two issues

The complexity concerned the two issues that have to be addressed in the consultation, i.e. the pregnancy termination and the contraceptive counselling. The HPs stated that women come primarily for termination of pregnancy and might be unprepared for a conversation about contraception. For the HPs, it was complicated to focus on two issues, while the women initially focused on only one.

“When you come for contraceptive counselling, you [the woman] want contraceptives, now; when you come for an abortion, you [the woman] have ended up in something you have to deal with and then you don’t have a focus on contraception.” Informant 14

Contraceptive counselling in the context of an abortion seemed to occur without giving the woman much time to contemplate her choice of future contraception. The HPs reflected that this often interfered with the counselling and the conversation about contraceptives was not given enough time.

Building trust

The HPs highlighted the importance of building trust, particularly as the women are often emotionally exposed, which is challenging because the woman and the HP typically have never met before. There was also a challenge in connecting with women and in talking about contraception at the right time, when they felt confident and safe, which HPs found often occurred after the ultrasound examination to determine gestational age.

"You have to gain some degree of trust with the person you are talking to... I [HP] probably wouldn't speak to just anybody about how I have sex and which contraceptives I use. I assume that my patients don't want to talk to someone they don't know about all of this in a brief consultation." Informant 13

Special challenges

When women expressed a feeling of guilt about having an unintended pregnancy, the HPs found that this made the counselling even more challenging. In these situations, the HPs saw the women as particularly emotionally exposed. Sometimes, the HPs worried that the conversation about contraception would increase the woman's burden of guilt. This worry was reinforced in situations where women who had undergone previous abortions reported hearing words of condemnation during previous contraceptive counselling.

"You've heard of many women who have been treated badly." Informant 10

HPs described contraceptive counselling for women with vulnerabilities as especially challenging. They felt frustrated when seeking to understand these women in order to adapt

their counselling. Vulnerabilities were described as increased needs for information and time for contraceptive decision-making. This concerned women who were not proficient in Swedish, women with mental health problems, women who had experienced repeat abortions and declined contraception. HPs felt uncertain about whether women not proficient in Swedish had actually understood the information they had received about contraception, even if the counselling was professionally interpreted, often via telephone interpreting. They saw a risk that these women would be less able to make a well-informed choice about contraception compared to Swedish-speaking women.

“It is difficult to have a discussion about contraceptives on a linguistically very basic level... I think I often become paternalistic as I say ‘this method will be good for you.’” Informant 8

Women with mental health problems, women who had experienced repeat abortion and who declined contraception in the consultation had special needs. The HPs described counselling them as demanding because the life situation of these women was often complicated. In other situations, HPs had trouble understanding the women's thoughts about sexuality and fertility, or their fear of contraceptives. When meeting young women who declined contraception or want to continue with the same (less effective) method, HPs expressed feelings of resignation.

“I have met girls who have borderline personalities, who put themselves at risk, but who think that ‘I should not continue, I should not have sex at all’, but you know it will continue, and they do not want contraception.” Informant 2

Some HPs said that some women do not care about themselves to the same extent as other women. They seem unable to understand the risks of new and unintended pregnancies. There was complexity in knowing the line between encouraging and persuading women.

“There is a limit to how much one should force a conversation the patient does not want. I can't force them to talk to me about contraception, I can't force them to accept contraception.” Informant 13

Elements of counselling

Counselling consists of different elements; providing information about contraception, guiding women in their choice of contraception, and motivating women in contraceptive use. HPs reported on how they handled these elements according to the woman's age, her previous history of unintended pregnancies and of contraception. Young women seemed to need more guidance than older women, since they had less experience of contraceptive use.

Provide information

One element was to give information about all methods, like an overview. There were HPs who made a selection and just mentioned one or a few specific methods. Several HPs stated that they framed their information about contraceptive methods according to the effects of these methods on bleeding patterns. In situations where women had already decided on a method or wanted the same as before, limited information was given about other possible alternative contraceptive methods.

“I do not give so much contraceptive advice to those who already know what they want... unless it is coitus interruptus, because then, I usually try to problematize it.” Informant 21

Guide women

Guiding women in their choice of contraceptive method was described as another central element. HPs tried to find a good option based on their impression of the woman, as their responsibility was to recommend the most sustainable method for the individual woman. Some HPs primarily recommended LARC because it was less risky and user failures were less likely.

“I [HP] try not to be really objective about this, I am trying to lead them [the women] towards the track where you don’t need to remember and can’t make mistakes by yourself.”

Informant 5

HPs focused on the methods that a woman showed interest in, as long as there were no contraindications in her medical history. HPs saw a woman’s “ownership” of the decision as important as it might increase her motivation to use contraceptives.

Motivate women

Strategies for motivating women to use contraceptives and to try new methods represented another central element. This element was referred to particularly when women had experienced a previous abortion. HPs also described using it in situations where women were sceptical of hormones or had negative experiences of contraceptive usage. HPs used motivational interviewing in the dialogue about contraception and described how they used open-ended questions in order to strengthen women's own motivation.

“I [HP] often say ‘How will you proceed now so as not to end up in this situation again?’” Informant 6

Other HP strategies for motivating women to use contraceptives included telling women anecdotes about other women’s unplanned pregnancies shortly after an abortion, or focusing on additional benefits of using contraceptives.

Finding a method

It appeared challenging to find a contraceptive method in the context of an abortion as many factors influence the counselling and the possibility to initiate a method, not only the women’s needs and preferences. Barriers included limitations in HPs’ knowledge, limited access to

effective contraception and few opportunities for HPs to follow up on their counselling and learn from feedback.

Factors influencing recommendation of method

HPs said that many factors influence women's choice and HPs' recommendations of contraceptive methods. Moreover, the contraceptive counselling was influenced by many factors such as woman's age, future pregnancy plans, economic conditions, medical history, menstrual bleeding, attitudes to different contraceptive methods and previous experiences of contraceptives. Furthermore, local traditions in different departments and colleagues' experiences of different methods might shape the counselling on contraceptive methods. Several HPs said that political decisions regarding sterilization and subsidies for different contraceptive methods also affect counselling.

"I recommend the levonorgestrel intrauterine systems [LNG-IUS] more often to young women when the LNG-IUS is subsidized and costs 10 euros compared with 100 euros when it is not." Informant 14

In the interviewed HPs' experience, mothers and friends strongly influence women's attitudes to contraception and their final choice of contraceptive method.

"If some friends are happy with it, then it creates a positive expectation" Informant 21

Preferences regarding methods

HPs described that the contraceptive pill was primarily recommended to women who had never used contraceptives and to women who planned to become pregnant in the near future. They also perceived that young women often prefer the pill because of its propensity to render a regular bleeding pattern. *"They [women] are satisfied with their combined hormonal contraceptive pills...I prescribe the pill to as many as I can."* Informant 7

Other HPs favoured LNG-IUS as they experienced that many women preferred these.

They had started to recommend IUDs to nulliparous women and perceived that the use of IUD among young women had increased. At the same time, several HPs remained sceptical concerning IUD use in nulliparous women, due to experiences of increased risk for sexually transmitted diseases and (non-evidence-supported) fear of subsequent infertility in women. Some HPs hesitated to recommend subdermal implants due to women's negative experiences of irregular bleeding pattern.

Experiences of barriers

Factors that hamper the consultation and act as barriers appeared to be knowledge, practical training and contraceptive services. Limited knowledge about certain contraceptive methods was mentioned by HPs. Therefore, they sometimes referred women to midwives in primary care for in-depth information regarding contraception.

HPs said that lack of practical training and the contraceptive services affected the access to IUDs. HPs who had undergone practical training in IUD insertion reported that IUD was recommended to a greater extent than before the training as they felt more familiar with the method and confident about inserting it correctly. They also reflected on the barrier in access to LARC. The practical arrangements for initiating IUD use post-abortion varied. In one department, HPs offered women IUD insertion routinely after a medical abortion, although the other departments told women to make appointments for insertion by themselves with the primary health care service.

HPs mentioned barriers in following up if their counselling prevented repeat unintended pregnancies, as the follow-up primarily focused on the pregnancy termination, not the subsequent contraception. This was especially the case among women who had a complicated life situation. The HPs noted that there were often no contraceptive follow-up appointments

and therefore no routine way to follow up on whether a woman had actually found and started to use an effective method that she was pleased with.

“You [HPs] are expected to try to reduce the proportion of follow-up appointments, and the women have to take the responsibility to contact us if there are any problems with the contraceptive method.” Informant 5

DISCUSSION

Findings and interpretation

The findings highlight the particular complexity of providing contraceptive counselling to women seeking abortion. The HPs viewed the women as mostly focused on the unintended pregnancy, which differs from contraceptive counselling in other situations that are not related to abortion. The interviews also indicate the complexity of providing individualized counselling particularly for: women not proficient in Swedish, women with mental health problems, women who have experienced repeat abortions, and women who decline contraception. This stresses the need to develop person-centred care, as it allows individualised solutions in complex contexts. It also highlights the necessity for shared contraceptive decision-making, as this encourages interactions between HPs and women during counselling. Furthermore this approach seems to increase women’s satisfaction and contraceptive use post-abortion (5, 8, 9).

The HPs experienced that some women needed more time, information and help in finding a method than other women, and might have special unmet needs which HPs do not always understand. There is a paradox of facilitating free choice of contraceptive use and self-care while at the same time practicing what they believe is best for the women. Some HPs in our study pointed out the challenge of free choice when counselling women who did not want to use contraceptives even if they had experienced repeat abortions. In these situations some HPs discussed that they might not have the optimal strategies for coping with demanding

dialogues. They described that they might not have the right skills and time to build sufficient trust among women in complicated life situations.

The HPs indicated wide variation regarding how to inform, guide and motivate women in their choice of contraceptives. Some women might not get evidence-based information regarding effective contraception (i.e. LARC) as several HPs said they continue to primarily recommend the contraceptive pill.

HPs described challenges in arranging IUD insertion post-abortion, but encouraged the women to book appointments by themselves when needed – a rather weak and unreliable design. Some women, especially those with vulnerabilities, who pose special challenges for HPs, are at risk of not getting contraception or not using it in an effective way. This, consequently, increases the risk of repeat unintended pregnancies.

HPs reported a lack of feedback on their own performance – most could not follow up on their counselling to learn if the women had subsequently found – and started to use – a satisfactory contraceptive method. The HPs were unable to learn from experience, since they might not be aware of undesired outcomes in terms of their patients' subsequent use (or non-use) of contraception and repeat unintended pregnancies. Therefore, HPs could continue to make less than optimal recommendations to their patients. This is a broken feedback loop which needs to be closed in order to enhance learning and improve contraceptive counselling (17-19).

Strengths and weaknesses of the study

A strength of the study is that we interviewed HPs with a range of professional experience of contraceptive counselling of women seeking abortion, in different hospital and socioeconomic contexts. This should increase the likelihood that our findings are applicable more broadly. A

weakness is that few of the respondents were midwives. This mirrors the distribution of midwives among HPs in Swedish abortion care. Furthermore, it would have been valuable to recruit more midwives, as contraceptive counselling at the time of an abortion is performed by both midwives and gynaecologists in Sweden (14), just as in other countries (3, 20). Such task-sharing will probably grow more common. The results could probably be transferred to other similar health care systems and forms of abortion provision.

We described the audit trail in the method section in this study. We seek to strengthen the study's trustworthiness by presenting quotes showing the connection between the interviews and the results.

Differences in results and conclusions

The findings point out the need for individualized counselling among women with vulnerabilities. This may reflect the correlation between repeat abortions and socioeconomic challenges such as weak social support, sick leave, unemployment (21,22) and foreign origin (21). However, these challenges may not always be addressed because most clinics have fixed appointment durations, regardless of the needs of the patient. A greater flexibility would be desirable.

In Australia, women at a socioeconomic disadvantage were less likely to leave the abortion care unit with their chosen LARC in place compared with women from higher socioeconomic groups (23). This might be due to financial barriers, misconceptions and lack of knowledge regarding LARC (24). If so, it is crucial to establish trust in the contraceptive decision-making process, especially among women at a socioeconomic disadvantage (25, 26).

Furthermore, prearranged contraceptive follow-up appointments after an abortion are rare (27). Failure to show up for scheduled appointments is common and increases the risk of a repeat abortion (28). Our study highlights the need to follow up on whether women find a

satisfactory method so HPs can evaluate the effects of their counselling in preventing repeat abortions. Multiple contacts and reminders (SMS, apps) may be needed to improve adherence and continuation but there is still limited evidence to prove this (29).

In Scotland, contraceptive counselling at the time of an abortion seemed to be feasible for both HPs and women, if provided in a considerate manner (3). Our results point out the challenge of addressing two issues in the same consultation, and there is a need to develop conditions allowing this. Women need to be better prepared for contraceptive decision-making, and some women might need additional time for contraceptive counselling related to complex life situations.

According to our study, HPs needed enhanced strategies to motivate women to switch to more effective contraceptives following their abortion. This contradicts conclusions from previous studies which suggest that women are more motivated to use contraception after an abortion (7, 30). This may be explained by the fact that this study only included the HPs' experiences, whereas the previous studies also included the experiences of women. Some HPs in our study saw it as their responsibility to find a contraceptive method for the woman; others focused only on promoting LARC. This may limit women's participation in contraceptive decision-making and may be counterproductive according to the theory of shared decision-making (5, 8, 9) as it may reduce the women's commitment to using the chosen method. This is particularly problematic for methods that require active efforts on the part of the woman, e.g. oral contraceptives or barrier methods. While women want control over the selection of the contraceptive method, most women also want their HPs to take part in the decision-making process (26). Like elsewhere (3, 20), some HPs in this study felt that they had insufficient knowledge and skills concerning some contraceptive methods, including training in IUD insertion, and felt that this hampered their contraceptive counselling.

According to our findings, HPs are influenced by many factors when recommending contraceptives, and primarily recommend the contraceptive pill post-abortion despite the effectiveness of LARC compared with oral contraceptives (31). Several HPs did not recommend LARC to nulliparous women due to a perceived increased risk of sexually transmitted infections and fear of infertility. These unfortunate misconceptions are still common among HPs (32,33) – in fact, young women would benefit the most from LARC (31). Using LARC after an abortion reduces repeat unintended pregnancies and abortions more effectively than using other methods (28,34). On the other hand, HPs said they recommended LNG-IUS to nulliparous women more often now, thanks to Swedish subsidies of hormonal contraceptives for women up to age 25 years old. Low costs for LARC increase the propensity to recommend and choose LARC after an abortion (20,24,35).

Previous studies demonstrate the importance of fast tracks and easy access to LARC for women post-abortion to prevent repeat unintended pregnancies (34,36,37). However, most HPs in our study could not orchestrate fast tracks or easy access to IUDs for their patients post-abortion. They reported challenges in arranging appointments for IUD insertion post-abortion and told women to book appointments by themselves in the general health care system (rather than schedule an appointment as part of the counselling). This is unfortunate since our and a previous study indicate that women with vulnerabilities seem to need more support to initiate LARC post-abortion (23).

Relevance of the findings: implications for clinicians and policymakers

This study highlights that there is a need to redesign conditions for providing contraceptive counselling and to develop HPs' skills in coping with demanding dialogues in the context of abortion. Furthermore, HPs have "their own" approaches for providing counselling; consequently, some women might not get accurate or sufficient information regarding contraceptives. The study also shows a need to evaluate and provide feedback on the effects of

contraceptive counselling at the time of an abortion in order to prevent repeat unintended pregnancies and abortions. An abortion register, as used in neighbouring countries, based on the Swedish personal identification number could increase HPs' ability to evaluate different interventions to prevent repeat abortions, not least among women with vulnerabilities.

Unanswered questions and future research

Future studies should focus on how to organize person-centred counselling and how to develop interventions based on both the women's needs and HPs' experiences, aiming to prevent repeat unintended pregnancies and abortions ever more effectively.

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Declaration of interest

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