

Addressing contraception at the time of abortion: experiences of women and health professionals



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Abortion is considered to be an appropriate time to offer contraceptive advice to women although it is recognised that there are challenges in doing so. This research offers an insight into the perspectives of women receiving and professionals providing contraceptive care at the time of abortion.

References

- ¹Information Services Division Scotland (2015) Abortion Statistics: Year Ending 31 December 2014, available at <http://www.isdscotland.org/Health-Topics/Sexual-Health/Abortions/> (last accessed 11/06/2015).
- ²Heikinheimo, O., Gissler, M. and Suhonen, S. (2008) 'Age, parity, history of abortion and contraceptive choices affect the risk of repeat abortion.' *Contraception* 78(2): 149-154.
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Authors and acknowledgements

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Key points

- In order to reduce the number of unintended pregnancies, sexual health and reproductive health services provide contraceptive advice alongside abortion.
- This study set out to identify similarities and differences between the experiences of women who received abortion care and of health professionals who gave that care in both specialist community-based sexual and reproductive health centres and hospital settings
- When women seek abortion it may be a good time to address contraception, but it is not necessarily an easy time to do so, and requires skill and expertise.
- Health professionals consider Long-Acting Reversible Contraception (LARC) to be the best option for most women and the contraceptive advice given to women at the time of abortion reflects this.
- Many women value knowledge about contraception from friends and family as much as, if not more than, clinical information.
- A third of women in this study left abortion services without uptake of LARC or user-dependent (oral or patch) contraception; the research identifies a range of reasons for non-uptake relating to both personal and service issues.
- Provision of effective contraceptive care requires adequate clinic time and adequate training, which is challenging in a time-pressured service.

Background

Around 11,500 women have an abortion in Scotland each year, and around one third of these women will go on to have a subsequent abortion at some point in their lifetime.¹ While abortion treatment in Scotland has historically been provided from a hospital setting, recent developments in abortion medication mean it can now be provided on an outpatient basis from hospitals as well as from specialist community-based sexual and reproductive health centres (SRHCs).

A key aim, in enabling Scottish SRHCs to provide abortions, is to improve contraceptive uptake by women following abortion, particularly the use of long-acting reversible contraception (LARC), such as a contraceptive implant or injection or an intrauterine device or system. This may contribute to reducing numbers of subsequent abortion² and is one means by which women can have increased reproductive control. While it has been argued that women having an abortion may be highly motivated to secure contraception, particularly LARC, and that this may also be a convenient time for them to do so,³ little is known about women's experiences of contraceptive care at abortion or of health professionals' experiences of

providing this care. No research to date has brought together the perspectives of health professionals and women who have experienced abortion care.

The study

This study set out to identify similarities and differences between the experiences of women who received abortion care and of health professionals who gave that care in both SRHC and hospital settings. In relation to contraception specifically, we aimed to establish whether, and in what ways, receiving care in the two types of settings influences and informs decisions about future contraceptive use. Findings from this study can further understanding, and inform policy development around how contraceptive advice and methods are provided at the time of abortion.

25 health professionals (nurses and doctors) and 46 women who had received an abortion from one SRHC and two hospitals in the same Scottish NHS Health Board area took part in in-depth interviews.

The table overleaf shows the breakdown of contraceptive uptake by the women that participated in the study.

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Participants' contraceptive uptake at abortion

	LARC (IUD/S,implant, injection)	User-dependent (oral/patch contraception)	User-dependent (oral/patch contraception)	Total
Hospitals	9	3	11	23
SRHC	12	6	5	23

Findings

Timing: addressing contraception at abortion

Most women said they had wanted to address contraception at abortion, suggesting it was an "obvious" time to do so, and that they were "glad" to talk about it. Some had already explored options (via internet searches or information supplied by their GP at referral) and therefore did not feel they needed further counselling, but were amenable to having their chosen method provided as part of their abortion care.

In line with their wider experiences of abortion care, women emphasised the importance of not feeling judged by health professionals. Some women reported an element of "force" in relation to making a decision about contraceptive uptake but noted that the way in which contraception was presented meant they did not feel "pressured" or "told off".

That's definitely the time to talk about it. And I think it's really good that they almost force you to make some sort of decision. (Darcey, 38)

Nevertheless others, particularly at the hospitals, described more explicitly negative experiences, saying they felt "blamed" for not using an effective method, pressured to accept a method, and that contraception was a disproportionate focus of their abortion consultation.

I felt like I had to have it to please [doctor] because he was putting so much pressure on me. I was just, like, "give me a break. If it's my choice not to have it then it should be my choice." (Jodie, 25)

Health professionals predominantly believed abortion to be an appropriate time to address contraception, because most women are likely to be "receptive" at that time due to the experience of dealing with an unintended pregnancy. Nevertheless, most were aware of the sensitivities of doing so and, like the women who had experienced care, stressed the need to be non-judgemental:

Possibly that's the best time... even though it might be construed as being... you don't want it to come over as being judgemental saying "this wouldn't have happened if you'd used proper contraception". It's more "this is a very stressful time for you and I'm sure you never want to be in this position again. Have you thought about what contraception you would like to use?" (SRHC nurse)

Preventing subsequent abortions

Many women understood the need to address contraception at the time of abortion in terms of not wanting to have to

make the decision to end another unintended pregnancy or to experience the medical abortion process again (which for many was unpleasant and painful).

I got the Depo[provera] the day that I got the pessary [misoprostol] in hospital. As soon as they said it I was like "I'm taking it. I don't want to go through that again." (Fearn, 22)

Similarly health professionals framed contraceptive care at abortion as a measure "to make sure this doesn't happen again". While hospital staff tended to focus on prevention of pregnancy, SRHC staff also emphasised the broader context of women's wellbeing, with contraception playing a key part in enabling them to "move on" following abortion.

Health professionals' accounts illustrated tensions between wanting to support women's reproductive choices and a belief that abortion should not be used as contraception. This was most evident when discussing women who have attended repeatedly for abortion. Such cases were reported by most health professionals as being less acceptable than a first abortion; unnecessary given the contraceptive options being offered; and as a source of professional frustration.

Some people just won't listen and you kind of think "well, we will see you back here, I'm sure"...It's just frustrating because you've tried your best to make them realise that – of course they can have a termination – but you want to try and work with them to... kind of take responsibility for their own contraception. (SRHC nurse)

'Choosing' LARC

While the method of contraception was presented by health professionals as being the women's choice, the policy emphasis on encouraging LARC uptake was reflected in health professionals' accounts. LARC was considered by the majority of health professionals to be the most appropriate contraceptive method for women following an abortion, and thus as something which should be promoted. Some described attempting to gently manoeuvre women towards LARC.

I try not to push people into [LARC] but I'll try and manoeuvre them gently and try and make them feel as if it's their idea [...] as if it's a kind of joint decision because then I think they're more likely to stick with it. (SRHC doctor)

Encouraging LARC uptake was presented as challenging, however, and this was reflected in women's accounts of the factors they considered when deciding whether or not to use these methods. Women commonly valued and prioritised the experiences of friends and relatives over clinical information, particularly regarding implantable LARC, when making decisions. Women cited previous problems with and perceived side-effects of hormonal methods, and their longer-acting and invasive nature, as deterrents to LARC uptake. The relative lack of user control was also a concern for some, including requirement for a health professional to remove them if they wanted to discontinue use.

Some (particularly SRHC) health professionals described working with this knowledge, taking women's "preconceived ideas" as a starting point for a more in-depth conversation about her needs and preferences. Many others reported finding the significance women give to information from family and friends perplexing and frustrating.

These findings may reflect that women's contraceptive decision-making at abortion is not straightforward. Several who made negative comments had nevertheless taken post-abortion LARC, as they also perceived advantages – including their own reliability and "forgetability". For most it was a matter of weighing advantages of convenience and efficacy against disadvantages of perceived side-effects and qualms about their implanted nature.

Reasons women leave without contraception

The research identified a range of issues relating to non-uptake of contraception following abortion, from both women and health professionals' perspectives, which related to women's circumstances and choices, and to service issues.

While health professionals tended to frame non-uptake in terms of women's indecision and reluctance to take control of their fertility, women presented a more complex picture. For some women, the level of bodily intrusion in the course of abortion assessment and treatment (including blood tests, sexually transmitted infection swabs, vaginal tablets, passing the pregnancy and the experience of being pregnant) was described as being as much as they could cope with, and meant they decided not to agree to a method of contraception at that time.

I didn't want any more needles inside me or anything so I rejected the contraception. I'm actually going back tomorrow to get the implant done... dreading it! (Lara, 27)

Key service-related issues were also identified as inhibiting contraceptive provision. Time pressures were keenly felt

by health professionals. Several described the means by which women are processed through the different stages of the abortion clinic as being like a "conveyor belt". Service developments which enable women to return home to pass the pregnancy have significantly increased the amount of information that has to be imparted to women to ensure that they are able to cope with passing the pregnancy at home. This allows less time for discussion of contraception and staff often referred to having to "fit it in" at the end of the consultation. Moreover, an insufficient number of hospital health professionals were trained in fitting contraceptive implants, which inhibited their ability to provide this service, as noted by health professionals and women receiving care.

She [nurse] explained that I couldn't actually get the implant on the day 'cause whoever normally does it wasn't available [...] She gave me some contraceptive leaflets and advised me to speak to my doctor about getting the implant. (Lisa, 30)

There were also differences amongst health professionals in relation to their perceived role in contraceptive counselling and provision at abortion. For nurses in particular, effective contraceptive provision was a marker of success and a source of professional satisfaction. However junior medical doctors (who work in hospitals only) were perceived by colleagues and themselves as being less skilled in contraceptive counselling. This resulted in nurses 'double-checking' with women about their contraceptive needs, which added to the time pressures within the service.

Implications for policy and practice

- The focus should remain on facilitating women's choice of contraception even in instances where this is not to make a contraceptive decision at abortion. This is challenging for health professionals in the context of organisational and policy pressures to reduce rates of repeat abortion and to encourage uptake of LARC over other forms of contraception.
- Health professionals should be appropriately trained and supported to offer contraceptive care at abortion. This includes ensuring that a sufficient number of nursing staff are trained in contraceptive implant provision and that junior doctors are given additional training to support them in providing contraceptive counselling at abortion.
- The time required for empathetic and effective contraceptive care at the time of abortion needs to be recognised and incorporated in the resourcing and organisation of abortion clinics.
- Health professionals should recognise the significance of the non-clinical information from friends and family that women draw upon when making contraceptive decisions, and aim to work with rather than dismiss such knowledge.
- It is important to women that they do not feel judged by health professionals when addressing contraception at time of abortion.

* Pseudonyms are used throughout.