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Women's questions after postabortion insertion of intrauterine contraception

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Abstract

Background: Postabortion insertion of intrauterine contraception has the potential to decrease unintended pregnancy and repeat abortions, but little is known about how to ensure that women receive appropriate counseling about this method in this setting. The goal of this investigation was to document women's questions and to assess retention of information provided during contraceptive counseling after immediate postabortion intrauterine contraceptive placement.

Study Design: Women who received postabortion intrauterine contraceptives (IUCs) at an urban, hospital-based abortion clinic were surveyed 2–3 months postabortion to evaluate for expulsion, assess their concerns about IUC and evaluate retention of information provided during contraceptive counseling.

Results: Of 141 women contacted, 121 participated. Almost half of participants (46%) had responses to the question "Do you have any questions or concerns about your intrauterine device?" that fell into the following categories: spotting/bleeding (16%), cramping/pain (15%), string management (10%), expulsion concern (5%). Seventy percent reported less bleeding during menses than prior to IUC placement, and 37% had less cramping. Sixty-three percent were able to accurately report statistics regarding IUC efficacy, 56% recalled common side effects, and 42% remembered what to do if expulsion occurred.

Conclusion: Although IUCs are highly effective and their placement in the abortion setting is safe, women frequently have questions and do not recall critical counseling information about IUCs. In order to improve IUC continuation, techniques to improve both patient knowledge retention and anticipatory guidance should be studied further.

Keywords: Intrauterine contraception; Counseling; Contraceptive; Abortion

1. Introduction

Unintended pregnancy is a significant public health issue in the United States, with over half of pregnancies being unintended [1]. While nonuse of contraception among women who are at risk for unintended pregnancy is one factor contributing to these statistics, an additional concern is that among women using contraception, there is low utilization of the most highly effective methods of contraception, such as intrauterine contraception (IUC). Specifically, of women experiencing unintended pregnancies in the United States, 48% were using a contraceptive during the month of conception [2], with oral contraceptives and condoms being the most common reversible methods used [1]. As both these methods require frequent administration and have failure rates over 10 times that of IUC [3], only 5.5% of women at risk of pregnancy use IUCs [1]. Increased use of more effective methods could have an important impact on unintended pregnancy in the United States, especially when typical use is equivalent to perfect use.

Addressing the contraceptive needs of women undergoing abortion is of particular importance, as almost half of women undergoing abortion in the United States have had a

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prior abortion [4] and women who have had an abortion have an increased risk of unintended pregnancy [5]. Because IUCs are known to be safe and to have high continuation rates when placed immediately after abortion, they are an important option to offer women undergoing termination of pregnancy [6–8]. While immediate placement of IUCs after an abortion has a slightly higher risk of expulsion compared with interval insertion [9,10], planned interval insertion significantly increases the risk that a woman will not return for placement or that she may become pregnant before her next office visit [9,11,12]. Postabortion placement of an IUC is therefore estimated to increase 1-year continuation rates significantly, as compared with delayed or interval insertion (75% versus 52%, respectively), avoiding 52 unintended pregnancies per 1000 women per year [12]. Therefore, postabortion insertion of IUCs has promise in decreasing the high rates of unintended pregnancy and repeat abortion in the United States.

One consideration when advising postabortion IUC insertion is whether women who choose this method are likely to continue it for a substantial period of time. While the available data suggest that continuation rates are reasonably high in postabortion settings, with one study finding 81% continuation at 6 months [7], there is a clear incentive to determine whether there are barriers to IUC continuation that could be addressed by counseling [13]. In the general population of women using IUCs, the most common reasons for discontinuation include changes in bleeding from both types of IUC available in the United States [copper T (CuT) and levonorgestrel intrauterine contraceptive (LNG-IUC)] and dysmenorrhea from the Cu T [14]. While counseling may be one means to address women's concerns about methods and make them aware of potential side effects, the extent to which this counseling is of benefit in general is unclear. Meta-analyses of contraceptive counseling in a variety of settings showed little effect of counseling in changing knowledge, attitudes and behaviors [15,16], and even less is known in the setting of pregnancy termination. The goal of this study is to identify potential areas of improvement of counseling of women having postabortion insertion of IUCs by asking women to detail the questions they have about their method 2 to 3 months after having it placed, as well as to quantify what people remember from their counseling sessions regarding method characteristics.

2. Methods

2.1. Setting

This study was conducted at the Women's Options Center of San Francisco General Hospital, which is university affiliated and serves a diverse, predominantly low-income community.

The clinic performs approximately 2200 surgical abortions each year. Each woman meets with a counselor individually before her abortion to discuss contraception in detail. Counselors are health educators trained in options and contraceptive counseling. This counseling is individualized for each patient, and those who choose IUCs are given extensive counseling about side effects and method characteristics. Forty-one percent of patients leave the clinic having chosen immediate IUC insertion after the abortion [17].

2.2. Study design

Women who undergo postabortion IUC placement are called approximately 6 weeks later to assess patient satisfaction, expulsion rate and side effects. The IUCs are placed immediately postabortion, and strings generally are cut to a length of 2–3 cm. Patients are encouraged to feel for the IUC strings 3–4 weeks after placement, and every 4–6 weeks thereafter. If they cannot feel the strings, counselors recommend that they make an appointment with a clinician to verify placement as soon as possible and that they use backup contraception until then. They also are encouraged to schedule a follow-up appointment 1 month after their abortion. For this study, we added a protocol to record responses to the question "Do you have any questions or concerns about your intrauterine device?" as well as ask questions about knowledge of topics commonly included in counseling and written materials in the clinic. Responses were transcribed verbatim and were not limited to a single response per patient. We obtained verbal consent for these questions. Three attempts were made to reach the patient by her given contact number. Approximately half were able to be contacted using these methods. This study was approved by the University of California, San Francisco's Committee on Human Research.

2.3. Study population

Inclusion criteria were insertion of an IUC immediately after pregnancy termination, fluency in English or Spanish and being 15 to 44 years of age. Exclusion criteria were incarceration or inability to consent. All patients who met these criteria were asked to participate during this routine follow-up phone call between January and July 2009.

2.4. Measures

After obtaining informed consent, patients were asked the following open-ended question: "Do you have any questions or concerns about your intrauterine device?" Their answers were transcribed verbatim. Their questions or concerns were first addressed by the research assistant and referred to a clinician (M.D. or R.N.) when necessary. Participants were then asked questions adapted from a 21-question survey originally described by Drey et al. [18]. Covered topics included bleeding, pain and satisfaction. The interviewer also asked whether the patient had been to a health care provider to check for the strings and/or had felt for them herself. The participants were asked open-ended questions to measure retention of information provided during the