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Original research article

Contraceptive care at the time of medical abortion: experiences of women and health professionals in a hospital or community sexual and reproductive health context

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Abstract

Objective: To examine experiences of contraceptive care from the perspective of health professionals and women seeking abortion, in the contexts of hospital gynaecology departments and a specialist sexual and reproductive health centre (SRHC).
Materials and methods: We conducted in-depth semistructured interviews with 46 women who had received contraceptive care at the time of medical abortion (gestation≤9 weeks) from one SRHC and two hospital gynaecology-department-based abortion clinics in Scotland. We also interviewed 25 health professionals (nurses and doctors) involved in abortion and contraceptive care at the same research sites. We analysed interview data thematically using an approach informed by the Framework method, and comparison was made between the two clinical contexts.
Results: Most women and health professionals felt that contraceptive counselling at abortion was acceptable and appropriate, if provided in a sensitive, nonjudgemental way. Participants framed contraceptive provision at abortion as significant primarily as a means of preventing subsequent unintended conceptions. Accounts of contraceptive decision making also presented tensions between the priorities of women and health professionals, around 'manoeuvring' women towards contraceptive uptake. Comparison between clinical contexts suggests that women's experiences may have been more positive in the SRHC setting.
Conclusions: Whilst abortion may be a theoretically and practically convenient time to address contraception, it is by no means an easy time to do so and requires considerable effort and expertise to be managed effectively. Training for those providing contraceptive care at abortion should explicitly address potential conflicts between the priorities of health professionals and women seeking abortion.
Implications: This paper offers unique insight into the detail of women and health professionals' experiences of addressing contraception at the time of medical abortion. The comparison between hospital and community SRHC contexts highlights best practise and areas for improvement relevant to a range of settings.

Keywords: Medical abortion; Postabortion contraception; Long-acting reversible contraception (LARC); Qualitative research

1. Introduction

Around one third of women who have abortions in United Kingdom and half in the United States will go on to have a subsequent abortion [1,2]. Evidence varies regarding the impact of specialist contraceptive counselling at abortion on contraceptive uptake and rates of subsequent abortion [3–5], although evidence that long-acting reversible contraception (LARC) in particular can contribute to reducing subsequent unintended conceptions continues to grow [6–9].

It is thought 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 [10,11]. Research addressing the degree to which women want contraceptive care at abortion or feel this is appropriate timing nevertheless reports mixed findings [12,13]. Women's receptivity to contraceptive counselling at that time may be reduced by difficulties reported in managing the volume of information provided at abortion

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[14] and by the misinformation and significant knowledge gaps around (particularly intrauterine) contraception that persist amongst women seeking abortion [15]. Women also report valuing the opportunity to address contraception at abortion and not feeling 'coerced' by doing so [16].

A limited amount of research has addressed women's experiences of contraceptive care at abortion. With respect to contraceptive decision making in general, United States research has found that, whilst women and health professionals' priorities may be largely 'concordant', mismatches occur around the priorities of each, which underscores the importance of shared decision making in this context [17]. Women's preferences have been found to include the desire for an 'intimate, friend-like relationship with their providers' and for 'comprehensive information about options, particularly about side effects' [18].

The location of abortion provision has implications for the contraceptive care offered. In the United States, for example, the politicisation and stigmatisation of abortion has factored in the development of nonhospital-based abortion services [19]. United States providers have been working towards the integration of contraceptive counselling into abortion services but face significant barriers [12,20,21]. In Scotland, abortion is almost exclusively provided through the National Health Service (NHS) and has traditionally been provided in hospital gynaecology departments. However, effective contraceptive counselling is known to be time consuming, making it challenging to address effectively in overburdened hospital settings [14]. In recent years, the appropriateness of community (as distinct from hospital) settings for medical abortion provision in the United Kingdom has been assessed and found suitable [22]. Community-based sexual and reproductive health centres (SRHCs), which integrate genitourinary medicine and family planning services, may offer specialist postabortion contraceptive counselling and provision, which may in turn contribute to increasing uptake and reducing subsequent unintended conceptions [23]. From the perspective of service provision, constraints on addressing contraception at abortion have been found to include added pressure on already busy and complex clinic schedules (particularly where staff are less familiar with methods) and an absence of appropriate training in LARC insertion [24].

Little research to date has looked in depth at health professionals' experiences with providing contraceptive care at medical abortion, and even less brings together the perspectives of women and health professionals. This paper offers a holistic analysis of providing and receiving contraceptive care at medical abortion in a traditional hospital context and a more recently established SRHC setting, offering comparison of experiences in these two clinical contexts. In doing so, it foregrounds concordant and conflicting priorities of women and health professionals and highlights tensions between facilitating women's contraceptive decisions and preventing subsequent unintended conceptions.

2. Materials and methods

2.1. Design

This paper presents one aspect of the data analysis from a qualitative evaluation of NHS medical abortion provision in Scotland, which has since 2012 been offered from a specialist SRHC setting, as well as in its traditional hospital context. We adopted a qualitative research design to offer flexibility to women and health professionals in discussing their experiences in their own words and the opportunity to raise any topics that they considered relevant and that may have been unanticipated by the research team [25]. Two hospitals and one SRHC in the same area of urban Scotland were selected as study sites in order to compare and evaluate provision from the hospital and community contexts. The study was granted ethical approval by the Centre for Population Health Sciences Research Ethics Committee, University of Edinburgh.

2.2. Study participants

We provided all health professionals working in abortion services in the three sites with information on the study and invited them to participate in a confidential in-depth interview. Following an 'opt-in' procedure, willing participants indicated their interest directly to CP who then arranged the interview. Interviews were conducted with 37 health professionals in total — including nurses, doctors, clinical support workers (nursing aides) and sonographers — on experiences of medical abortion provision. Only data from the 17 (11 hospital and 6 SRHC) nurses and 8 (5 hospital and 3 SRHC) doctors in the sample are included here as only they were directly involved in contraceptive counselling and provision. Findings from other aspects of the study will be reported elsewhere.

Specialist health professionals at the same sites provided women presenting for medical abortion (gestation≤9 weeks) with study details by when they attended for assessment for abortion. Women were excluded if there were over 9 weeks pregnant, were having surgical abortion, were under 18 years of age, were unable to provide informed consent, were overly distressed at the time of attendance or spoke insufficient English to participate in an interview. Recruiting staff passed to CP the contact details of women consenting to be contacted at a later date. CP then made contact approximately 2 weeks after their initial clinic assessment. We conducted interviews with 46 women (23 from each clinical setting), up to 6 weeks after medical abortion, in a location of the woman's choosing or by telephone. CP obtained written consent from all study participants prior to the interview. Key characteristics of the sample of women interviewed are outlined in Table 1.

The participating sites use a medical abortion regimen (when gestation≤9 weeks) of oral mifepristone 200 mg, which is provided (if appropriate) at the end of an initial assessment appointment, during which women receive