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Contraception xx (2017) xxx – xxx

Contraception

Original research article

An exploration of perceived contraceptive coercion at the time of abortion

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Received 28 June 2017; revised 5 December 2017; accepted 8 December 2017

Abstract

Objective: To explore patient experiences of contraceptive coercion by healthcare providers at time of abortion.
Study Design: We conducted a qualitative study of English-speaking women seeking abortion services at a hospital-based clinic. We used the Integrated Behavioral Model and the Reproductive Autonomy Scale to inform our semi-structured interview guide; the Scale provides a framework of reproductive coercion as a lack of autonomy or power to decide about and control decisions relating to reproduction. We enrolled participants until thematic saturation was achieved. Two coders used modified grounded theory to analyze transcribed interviews with Nvivo 11.0 (K=0.81).
Results: The 31 women we interviewed from June 2016 to March 2017 were all in the first trimester, and predominantly young (mean age 27±5 years), non-Hispanic Black (52%) and Medicaid-insured (68%). Some participants (42%) reported feeling "pressured" into choosing some form of contraception. A subset of participants (26%) voiced that providers seemed to prefer LARC methods or were "pushing" a specific method. Several participants perceived pressure to choose any method due to providers' preference to prevent repeat abortions. Conversely, participants who were offered a range of methods through the use of decision aids and who were given time to deliberate demonstrated more reproductive autonomy.
Conclusions: Almost half of participants perceived a form of coercion around their contraceptive counseling. Coercion manifested in perceived provider preference for specific methods or immediate initiation of a method. Participant narratives involving decision aids to offer a range of methods and time for deliberation demonstrated greater reproductive autonomy and less coercion. Abortion stigma may mediate potentially coercive interactions between patients and providers.
Implications: This qualitative study explored contraceptive coercion at the time of abortion. Findings highlighted provider pressure to initiate contraception, LARC preference, and abortion stigma. Offering many methods and opportunity for deliberation supported autonomy and satisfaction. Findings inform ongoing efforts to improve contraceptive counseling and promote reproductive autonomy, while addressing unintended pregnancies.
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Keywords: Coercion; Contraception; Abortion; Qualitative; Counseling; Shared-decision making

1. Introduction

Reproductive autonomy is defined as one's ability to make strategic decisions about whether or not to become pregnant [1]. Current literature on reproductive autonomy provides a framework for understanding contributing factors such as self-efficacy, decision-making power, communication, and an individual's management of coercion [1]. Contraceptive coercion is one form of reproductive coercion, and refers to any behavior that interferes with contraception use in an attempt to either promote or discourage pregnancy [1,2]. Contraceptive coercion is associated with unintended pregnancy, sexually transmitted infections and intimate partner violence [2,3]. Unintended pregnancies resulting from contraceptive coercion are associated with depression and low birth weight [4].

Professional guidance for reproductive health providers iterates the importance of identifying methods concordant with patient preferences [5–7] while also emphasizing high efficacy of specific LARC methods [6–8]. Novel frameworks for contraceptive counseling emphasize patient-centered care, shared decision making, and informed consent to improve women's autonomy and minimize coercion while still addressing unintended pregnancy [9].

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https://doi.org/10.1016/j.contraception.2017.12.009
0010-7824/Published by Elsevier Inc.

In surveys of women seeking abortion services, only half desire to receive contraceptive services at that time and some women report pressure from providers to choose a birth control method during their abortion [10,11]. Limited research exists regarding how providers may contribute to contraceptive coercion in health care interactions. We conducted a qualitative study to explore women's perceptions of contraceptive coercion by providers at the time of abortion.

2. Material and methods

2.1. Research design and recruitment

We approached all women undergoing abortion at an academic medical center from June 2016 – March 2017. Eligible women were age 18 years and older, spoke English, and were undergoing medical or surgical abortion. We excluded women with early pregnancy failure or fetal demise and those receiving care from the primary investigator (KB). In our setting, abortion is covered by Medicaid and the gestational age limit for abortion is 23 weeks and 6 days of gestation. Patients are typically seen for two visits: preoperative and operative for surgical abortion, and medication initiation and follow up for medical abortion, and may interact with obstetricians/gynecologists, family medicine providers, nurse practitioners, nurses, students and residents during these visits. These providers initiate postabortion contraception counseling during the pre-abortion visit, and continue counseling or confirm choices as needed on the day of the procedure or at the time of follow up after medication abortion follow. While there is no standardized, universal counseling tool used in our setting, most providers use a tiered effectiveness framework for contraceptive counseling [12].

A trained research assistant approached eligible women to discuss the study after the women had signed clinical consents for surgical abortion or after Mifepristone administration for medication abortion patients. The research staff scheduled interested patients for a study visit for consent and the interview on a separate date after completing abortion care. Participants provided informed consent verbally using a standardized script prior to the one-hour study interview. All participants received compensation for time and travel. This Boston Medical Center Institutional Review Board approved the study.

2.2. Structured interview guide and data collection

We conducted semi-structured interviews with participants in a private, non-clinical setting. We used the Integrated Behavioral Model and the Reproductive Autonomy Scale to develop our interview guide [1,13]. The Reproductive Autonomy Scale is a validated scale used previously to measure factors and correlation with reproductive autonomy [1]. The Integrated Behavioral Model seeks to describe elements to why a person chooses to perform a given behavior [13].

We piloted the interview guide with four participants and adjusted the guide using an iterative process throughout data collection. We anticipated that we would need approximately 30–50 interviews to achieve thematic saturation. We used purposive sampling to sample as diverse a participant sample as feasible and based on ongoing coding during study enrollment, achieved thematic saturation after 31 interviews were conducted and analyzed [14].

All interviews were conducted by one female clinical researcher (KB) trained in qualitative research methodology, digitally recorded, and transcribed by a professional transcription service unaware of research goals. We collected field notes during the interview process. Participants were not contacted after the research interview to protect privacy. We imported de-identified transcripts into qualitative data analysis software for analysis (QSR International's NVivo 11.0) [15]. We recorded demographic information into the Research Electronic Data Capture (REDcap) system [16].

2.3. Data analysis

We performed qualitative analysis of transcripts using modified grounded theory. An initial code dictionary was developed, informed our theoretical models. Two researchers (KB, PM) coded half of the interviews and discrepancies in coding were arbitrated with a high level of inter-reader reliability (K=0.81). The remaining interviews were coded by a single researcher (KB). We identified recurrent themes and representative participant quotations for each theme. Given that the purpose of qualitative inquiry is to generate hypotheses rather than make claims about the prevalence of specific findings, attention was paid to the identification of distinct themes rather than the numeric prevalence of these themes.

3. Results

We screened 664 patients during the study period: 348 were ineligible, mostly for lack of English fluency (n=220). Of the remaining 316 eligible women, 109 declined participation and 176 did not return for the scheduled study interview. A total of 31 women were enrolled and completed interviews. Participants generally completed their scheduled interview about 2 weeks after their medical or surgical abortion, ranging from a day prior to two months after. Gestational age at the time of abortion ranged from 5 weeks 1 day to 12 weeks 3 days. Participant baseline characteristics are summarized in Table 1.

An experience of coercion was coded as such if the participant expressed negative interactions with their provider around their contraceptive choice, if the language used around the experience with the provider was a synonym for the word "coercion" (ex: pressured, forced, encouraged), or if the participant experienced conflict with the provider around their contraceptive goals.

Most participants (n=18, 58%) did not specifically endorse experience of pressure or coercion. Themes most relevant to experiences of coercion and autonomy are presented below and summarized with representative quotes in Table 2.

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