

# Post-Abortion Contraception

Review of the recent literature and overview of  
Sexual and Reproductive Justice

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**NO DISCLOSURES**



# Outline

Review recent literature on post-abortion contraception (PAC) including:

- Patient factors—acceptance, concerns, counseling
- Barriers to access—provider practices/training, cost, flow
- Strategies to increase access

Introduce Sexual and Reproductive Justice

# What I hope you will take away

- Why PAC is important for increasing access and improving patient care
  - Women find it acceptable and appropriate to be offered contraception at the abortion visit
  - Not all women offered contraception will choose a method on the day of their abortion...*And that is OK*
  - No one method is right for everyone
  - Patient counseling and education is *challenging and vital* to providing high quality care
  - Change takes place incrementally over time...And needs a first step for us and for our patients
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# Background



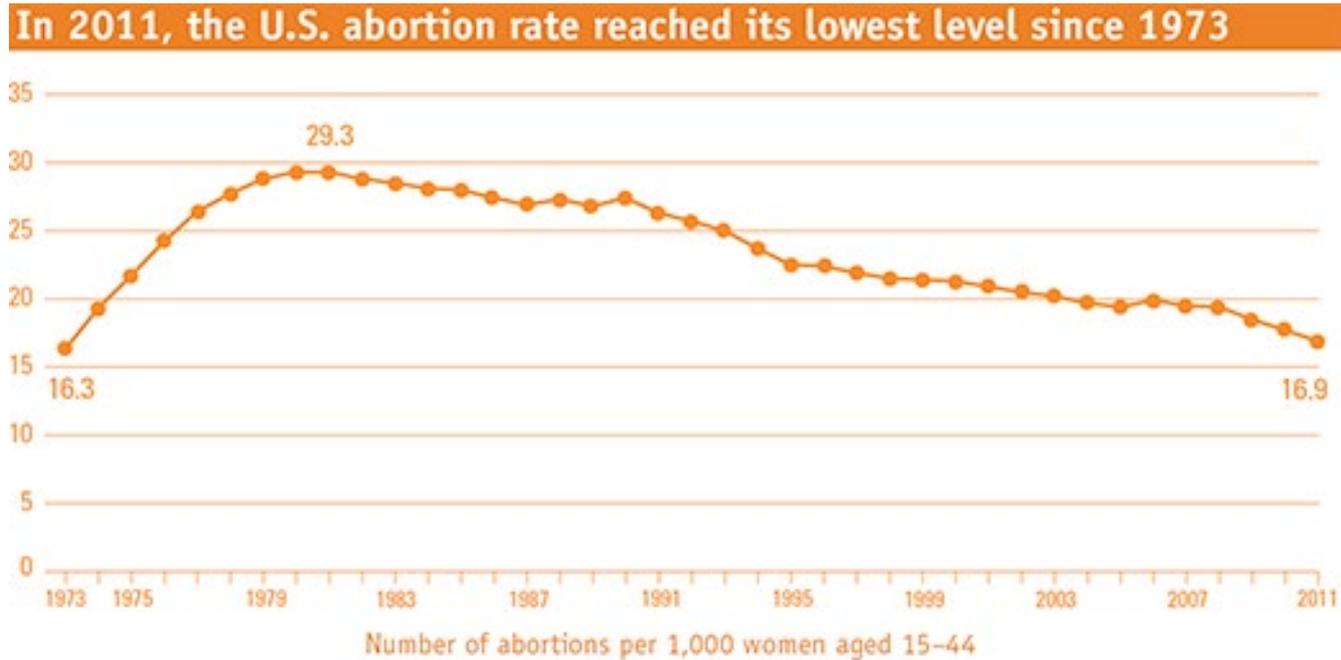
# Contraceptive access is important

- January 2015
- Right of all women

“Women must either carry an unplanned pregnancy to term and keep the baby or make a decision for adoption, or choose to undergo an abortion. Women and their families may struggle with this decision for medical, ethical, social, legal and financial reasons.”

ACOG Committee Opinion #615—Access to Contraception

# Postabortion contraception (PAC) is a vital form of contraceptive access because abortion is common



[www.guttmacher.org](http://www.guttmacher.org)



Among women stating they do not want pregnancy in one year...

Those at an abortion visit were *60% more likely to become pregnant in one year* compared to women at a contraceptive visit

# **Patient Factors**

ACCEPTANCE, CONCERNS, COUNSELING



# Acceptance—Influence of trust in Healthcare Systems on method chosen

- Cross-sectional study
- N=162 women obtaining abortion in the first trimester
- 24% wanted an IUD or implant
- IF available the same visit → 37% responded they would want it
- Validated 'trust scores' no different between those who chose an IUD or implant versus those who chose another method



# Acceptance—Immediate IUD insertion in a diverse, urban setting

- N=265 women obtaining abortion up to 23 weeks GA
- 48% chose IUD, 19% OCPs, 18% DMPA
- In multivariate model→identifying as Latina AOR 2.26 (1.04, 1.950)and gravidity AOR 3.62 (1.83, 7.14) associated with IUD use after abortion
- Highly accepted in an urban setting by women of color



# Acceptance—Immediate patch after surgical abortion

- Randomized controlled trial
- Same day as abortion patch vs Sunday after abortion patch
- Outcome→continuation at 6 months
- N=298
- 49% using patch at 6 months, no difference between groups
- 72% would choose patch again, 87% would recommend to a friend
- Most common reason would not choose patch again→side effects
- Bleeding days after abortion (median 5 days) same for both groups
- Satisfaction not different between groups



# Acceptance—OTC Contraceptive Pills

- Survey of women obtaining an abortion at 6 urban sites, 2011
- N=651
  - 45% Black, 24% White, 17% Hispanic
  - 44% completed some college
  - 75% never married and 75% income below 200% federal poverty level
  - 31% commercial insurance, 39% public insurance, 30% uninsured
- Contraceptive desired after abortion—42% Pill, 28% Other, 15% IUDs/Implants, 6% condom, 9% none
- 81% support OTC OCPs
- 61% would use OTC COCs→46% would use OTC progestin only pills
- 1/3 women not planning to use any contraception after abortion and 4/10 planning to use condoms responded they would use OTC OCPs
- ~1/2 teens responded would use OTC OCPs



# Concerns—Effect of psychological distress

- Psychological distress evaluated in women having abortion using 4 validated scales
- Tested association between level of distress and contraceptive method chosen on the day of abortion
- 253 women analyzed
  - 16% severe depressive symptoms and high level of global distress
  - More distressed more likely to choose a more effective method (AOR =1.46, CI 1.09-1.95)
  - Supports distress as real but women decision-making capacity not negatively affected



# Counseling—Shared experience and postabortion IUD use

- Cross sectional study
- Surveyed before and after abortion up to 23 weeks
- N=299 completed both
- 50% chose IUD
  - 83% heard of IUDs before, 60% knew someone with an IUD, 33% knew someone with a positive IUD experience
- Staff shared personal IUD experience AOR 8.1 (3.8-17.2)



# Counseling—Women’s questions after postabortion IUD insertion

- Cross sectional study
- Aim—how to increase continuation
- Surveyed ~8 weeks after abortion with immediate IUD insertion
- N=121, 95% had LNG IUD, median GA 14 weeks
- 48% had questions/concerns—mostly on bleeding/pain
- 93% satisfied with method
- 42% of those who had a follow-up visit *still* had questions/concerns
- Need for improved counseling/educational strategies
  - Materials in writing or online where she can access it after she leaves

**WHAT CAN WE DO?**



# What does this mean for my practice?

- Widely accepted by patients
- Psychological distress at time of abortion is real and patients should be offered the full range of contraceptive options
- Counseling is not easy—multiple methods of communication/accessing information may be important

# Barriers to Access



# Barriers

- Provider practices/training
- Cost/ Clinic flow
- Persistent myths



# Qualitative interviews on counseling and provision of long-acting methods

- National Abortion Federation (NAF) members sampled
- NAF accounts for half of US abortions
- Interviews with staff from 25 sites
  - 24 health educators, 20 clinicians, 44 clinic managers and billers
- Median volume 1,804 abortions/year
- Half offered IUDs and implants within the abortion visit



# Provider practices/training—Qualitative study

- Sites with clinicians specifically trained on LARC routinely counseled patients about LARC
- *Clinicians and health educators at sites that provided LARC same visit described the abortion visit as a ‘crucial opportunity for women’s contraceptive care’*
- Implant training not widespread—hindering provision



# Persistent Myths—Qualitative study

- Widespread misperceptions about LARC for nulliparous women and adolescents
- *“The only problem is the IUD is not a good choice for abortion patients. Our clientele tends to be very young here and IUDs are for a typical demographic which does not include our little 17-,18-year olds.”*



# Persistent myths—Qualitative study

- Widespread misperceptions about LARC risk after a procedure or medical abortion amongst those who do not offer this option
- Sites where LARC was not routinely offered held non-evidence-based concerns
- Sites where LARC was routinely offered more likely to express evidence-based views and express how those views had changed recently



# Cost/Flow—Qualitative study

- Costs to patients and clinics

“The disadvantages [of postabortion IUDs and implants] are number one the cost, number two, the cost; number three, the cost”

“once they [patients] learn the cost...you can see kind of a glaze go over their eyes, where it’s like, how attainable is that for me?”



# Cost/Flow—Qualitative study

- Device may be covered but not insertion procedure

“We do not get reimbursed for the doctor’s time [for] an IUD insertion at the time of abortion...so some of this is whether the physician’s willing to basically donate their time”

# Cost/Flow—Qualitative study

“There’s just some concern that we have this very finely balanced, finely tuned machine...And the insertion of an implanon or an IUD is nothing, but at what point do we counsel these people and get them consented?”

“only logistical and nothing to do with medicine”

--describing why contraceptives offered on a different day from abortion services

# Provider training—Survey of IUD practices

- Random sample of ACOG members—1150 completed surveys
- 95% viewed ACOG publications as best resource for clinical information
- 67% agreed IUDs appropriate immediately after abortion or miscarriage
  - But only 11% provide IUD insertions after abortion or miscarriage
- 19% provide abortions—more likely to provide IUDs immediately after abortion or miscarriage (27% vs 8%,  $p<.001$ ) compared to OB/GYNs who do not provide abortion services
- *Those who had recent CME on IUDs more likely to place them immediately after abortion or miscarriage (16% vs 9%,  $p<.001$ )*



**WHAT CAN WE DO?**

# Evidence-based Strategies to Increase Access



# Offer contraception within the abortion visit

- Avoids missed opportunity due to loss to follow-up/  
show rates at follow up appointments often low
- Reduces one year pregnancy and abortion rates
- Women like it/expect contraception
- Continuation not decreased with immediate  
postabortion initiation compared to routine interval  
initiation

# Evidence-based Strategies to Increase Access

- Creative solutions to patient flow
- Patient education/benefit
- Continuing education and training of ALL staff
- Offer contraception within the abortion visit
- Advocate for reimbursement policy changes



# Creative Solutions for Patient Flow

- Contraceptive education at multiple points of contact
  - When making appointment—remind patient what methods are available and how to find out more information
  - Voicemail and hold messages can include contraceptive information
  - While waiting—posters, video, brochures
  - All staff—trained on methods and wear buttons “ask me about....” to encourage questions and open communication
  - Preprinted education materials in your site’s most common languages

# Creative Solutions for Patient Flow

- Counseling scripts/checklists
- Staff training to increase efficiency of procedure set-up
  - Checklists, brief video or other visual aid
- Protocols→improve efficiency/standardize care
  - STI screening, Patient education, Ultrasound, labs, scheduling, follow-up, how to triage suspected complications
  - Tailor forms—electronic or paper—to your site's protocols and flow
  - Make documentation user-friendly and efficient—check boxes, preprinted consents

# Patient education/benefit

- Waiting room educational materials—written, video
- IUDs—less potential pain at insertion as cervix dilated and anesthesia/analgesia for surgical abortion still in effect
- Convenience—fewer visits for care

# Continuing Education and Training for All Staff

- Motivates expansion and updating of services
- Addresses myths
- Allows for sharing of ideas/resources/solutions to address common barriers
- Gives all staff information to do some patient education
- Establish a 'contracepting-friendly' environment
- Education on coding and reimbursement as well as clinical training

# Advocate for Reimbursement Policy Changes

- Medicaid family planning expansion
- Comply with Affordable Care Act
- Change to require reimbursement for provider's time/skill to place an IUD or implant postabortion—not only the device

# What I hope you now have on your mind!

- Why PAC is important for increasing access and improving patient care
  - Women find it acceptable and appropriate to be offered contraception at the abortion visit
  - Not all women offered contraception will choose a method on the day of their abortion...*And that is OK*
  - No one method is right for everyone
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**HOLD THOSE  
THOUGHTS...**



# SEXUAL AND REPRODUCTIVE JUSTICE





# WHAT IS SEXUAL & REPRODUCTIVE JUSTICE ?

Reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of women and girls...when women and girls have...the power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities.

(Strong Families Movement)



## Recently from ACOG...

**“The college supports women’s rights to decide whether to have children, to determine the number and spacing of their children, and to have the information, education, and access to health services to make those choices. Women must have access to reproductive health care, including the full range of contraceptive choices, to fulfill these rights.”**

**ACOG Committee Opinion #615—Access to Contraception**

# Background and History



# History of Reproductive Justice

- Began with **1994 International Conference on Population and Development in Cairo**
- **Shift from narrow focus on population and fertility to a broader agenda**
- **“Reproductive rights + Social justice+ Human rights”**
- **“Right to not have children, Right to have children, Right to parent our children” (SisterSong Women of Color Reproductive Justice Collective formed in 1997)**



# REPRODUCTIVE OPPRESSION

Reproductive oppression is the controlling and exploiting of women and girls through our bodies, sexuality and reproduction (both biological and social) by families, communities, institutions and society.(ACRJ)

# REPRODUCTIVE COERCION

- Behavior that attempts to influence sexual & reproductive decisions which leverage and contribute to power inequity
- Interpersonal, professional, institutional
- May be unintentional – e.g. unconscious bias

# 1910 AMERICAN BREEDER'S ASSOCIATION

UNFIT HUMAN TRAITS  
SUCH AS FEEBLEMINDEDNESS  
EPILEPSY, CRIMINALITY,  
INSANITY, ALCOHOLISM,  
PAUPERISM AND MANY OTHERS,  
RUN IN FAMILIES AND ARE  
INHERITED IN EXACTLY THE  
SAME WAY AS COLOR IN  
GUINEA-PIGS. IF **ALL**  
**MARRIAGES WERE EUGENIC**  
WE COULD **BREED OUT**  
MOST OF THIS UNFITNESS  
IN **THREE GENERATIONS.**

## THE TRIANGLE OF LIFE



**YOU** CAN IMPROVE YOUR *EDUCATION*,  
AND EVEN CHANGE YOUR ENVIRONMENT;  
BUT WHAT YOU REALLY **ARE** WAS ALL  
SETTLED WHEN YOUR PARENTS WERE  
BORN.

SELECTED PARENTS WILL HAVE  
BETTER CHILDREN **THIS**  
IS THE GREAT AIM OF **EUGENICS**



# 1956: CLINICAL TRIALS ON WOMEN IN PUERTO RICO



# 1974

Mary Alice Relf (age 14) and her sister Minnie Relf (age 12) become victims of the abusive practice of sterilizing poor, black women in the South. Their mother, who was illiterate, signed an "X" on a piece of paper, expecting her daughters, who were both mentally disabled, would be given birth control shots. Instead, the young women were surgically sterilized.





# 1990s

Norplant abuses:

welfare reform

plea bargaining in court

*“When you single out a welfare mother, wave a \$500 bill in front of her face and say the government is going to induce you not to have children, you’ve gotten into a risky area, ethically and morally.”*

Sheldon Segal,  
Inventor of Norplant

**WHAT CAN WE DO?**



# **“Guarding Against Coercion While Ensuring Access: A Delicate Balance”**





# Spread awareness

- Know our history
- Renewed concerns around coercion due to promotion of LARC methods over other methods
- Encourage insight into our own inherent biases as these are present in everyone



# Advocate

- Interact with patients and clients to support their reproductive autonomy
- All services should be voluntary, and patients should not be coerced to use or not use any particular contraceptive method
- Advocate for your patients at various levels
  - Patient-centered care in your practice
  - Hospital policies
  - Government policies—ballot box

# How does this relate to PAC?



# Resources for SRJ

<https://www.law.berkeley.edu/centers/center-on-reproductive-rights-and-justice/projects-and-initiatives/reproductive-justice-working-group/>

<http://strongfamiliesmovement.org/assets/docs/ACRJ-A-New-Vision.pdf>

<http://www.sistersong.net/>

[https://prezi.com/tmbzi0ugwsd\\_/reproductive-justice-101/](https://prezi.com/tmbzi0ugwsd_/reproductive-justice-101/)

<http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-and-Sexual-Coercion>

# Resources for SRJ

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# THANK YOU

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