Title

CLINIC FACTORS AFFECTING IUD ACCESS AND UTILIZATION AT TIME OF SURGICAL ABORTION

Journal

CONTRACEPTION, 100(4)

ISSN

0010-7824

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Publication Date

2019

DOI

10.1016/j.contraception.2019.07.073

Peer reviewed

adolescents. This patient-centered model of immediate on-site provision is also cost saving for the medical system and should be expanded to other locations.

doi:10.1016/j.contraception.2019.07.071

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FACILITATORS AND BARRIERS TO PROVIDING EARLY ABORTION SERVICES

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Objectives: Research has shown the safety of abortion before 5 weeks' gestation, though data suggest that fewer than 50% of abortion providers offer services at this gestation.
Methods: We conducted semi-structured interviews with providers in the greater Boston area about early abortion services (EAS), defined as services provided when an intrauterine pregnancy cannot be verified by ultrasound. We utilized an implementation science framework to ask about providers' current EAS practices, along with facilitators and barriers to providing this care.
Results: Participants (n=25) were ob/gyn (60%) and family medicine (24%) physicians and women's health nurse practitioners (16%). Facilitators of providing EAS included access to formal ultrasonography, options for follow-up including external laboratories, and comprehensive staff training. Providers' comfort with EAS aligned with clarity; they were more apt to provide EAS in the presence of straightforward guidelines, clear staff roles, and a concrete plan for follow-up. Barriers to providing EAS included time burden for providers and staff, lack of infrastructure, and concerns about patient reliability for follow-up. Providers had varying perspectives about patient safety—fear of causing harm with EAS (risk of abortion failure, performing an unnecessary procedure or missing an ectopic pregnancy) versus EAS as a tool for harm reduction (promptly ending an unwanted pregnancy, expediting a diagnosis of ectopic pregnancy). All providers expressed a desire for patient-centered care, but many were conflicted about the comparative patient burdens of returning when the pregnancy location was verifiable versus the need for multiple follow-up visits.
Conclusions: We identified critical elements to address within clinical sites in order to broaden access to early abortion services.

doi:10.1016/j.contraception.2019.07.072

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CLINIC FACTORS AFFECTING IUD ACCESS AND UTILIZATION AT TIME OF SURGICAL ABORTION

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Objectives: Evaluate current availability of and barriers to post-surgical abortion intrauterine device (IUD) uptake and utilization.
Methods: Surgical abortion providers attending a national reproductive health meeting in 2018 completed surveys about abortion and contraception access. The surveys obtained information about provider and facility characteristics, payment methods, and contraceptive counseling and provision. We compared outcomes using Fisher exact testing.
Results: Overall, 84 providers from 27 different states completed surveys. The clinicians' primary practice was most often a private (n=44, 52%), Planned Parenthood (n=14, 17%) or University-based or student health clinic (n=12, 14%). Thirteen (18%) clinicians provided care at clinics that were cash only. Forty (48%) providers reported their primary facility was non-profit but 7 (8%) were not sure. Most (73, 87%) provided abortion after 14.0 weeks and 56 (67%) after 20.0 weeks. Eighty-three (99%) providers stated their facility counseled about IUDs but only 65 (77%) provide post-procedure IUDs. Most (n=70, 83%) stated their clinics provide both hormonal and copper IUDs; 10 (12%) offer just hormonal and 4 (5%) offer just copper IUDs. Of the 10 facilities that do not offer any IUDs on site, the providers stated the primary reason for 9 (90%) was acquisition cost or high price for patients. Six of these clinics accepted cash only and none were known to qualify for federal discount drug pricing.
Conclusions: Although a high proportion of facilities offer post-abortal IUD placement, high cost in this setting remains a barrier for access at those locations that do not offer this service.

doi:10.1016/j.contraception.2019.07.073

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MENSTRUAL BLEEDING AND SPOTTING WITH THE LEVONORGESTREL INTRAUTERINE SYSTEM: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Objectives: We aimed to systematically calculate the mean number of bleeding-only, spotting-only and combined bleeding and/or spotting days experienced by a general population of LNG-IUS users during the first year after insertion. By providing these measures, we hope to improve counseling on menstrual bleeding changes associated with this method.
Methods: We searched 12 biomedical and scientific literature databases for clinical studies that reported data on LNG-IUS devices releasing 20 mcg of levonorgestrel per day, collected daily menstrual bleeding data from written diaries for at least 90 consecutive days, and defined bleeding and spotting according to WHO standards. Two reviewers independently conducted all review stages and rated the quality of evidence for each article. Where possible, data were pooled using a random-effects model. We weighted bleeding and spotting measures for inter- and intra-study variance.
Results: Among 3403 potentially relevant studies, we included 9 in our meta-analysis. Combined menstrual bleeding and spotting days gradually decreased throughout the first year after insertion, from 35.6 days during the first 90-day interval to 19.1, 14.2, and 11.7 days in the second, third, and fourth intervals (I-squared values revealed reliable measures, <50%). Measures for bleeding-only and spotting-only days similarly decreased throughout the first year after insertion, with the greatest decrease between the first and second intervals.
Conclusions: Our study provides specific 90-day reference period measures that characterize menstrual patterns. Changes in menstrual bleeding pattern are of high concern to many hormonal contraceptive