SURE Rapid Response

What is the effect of counseling in unwanted pregnancy?

March 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key messages

- One-third of all Ugandan women of reproductive age want to stop or delay further childbearing but annually about 775,000 women have unintended pregnancies. This leads to some 297,000 induced abortions translates to an annual abortion rate of 54 per 1,000 women aged 15–49

- There is a paucity of research in the area of counselling in unwanted pregnancy in low income and much of the research done is of low quality often failing to consider social and cultural norms when developing hypotheses

- However evidence found shows that counselling at the point of crisis aside from relieving the anxiety and disappointment also makes it more likely that those affected will return more readily for other help and services they may need

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Supporting the Use of Research Evidence

REACH
Regional East African Community Health Policy Initiative

EVIPNet
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Who requested this rapid response?

This document was prepared in response to a specific question from a policy maker in Uganda.

! This rapid response includes:

- Key findings from research
- Considerations about the relevance of this research for health system decisions in Uganda

X Not included:

- Policy or practice related recommendations
- Detailed descriptions

What is SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.
www.evipnet.org/sure

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

Background

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

Unintended pregnancies are by definition unwanted pregnancies as well as those that are mistimed (J. Joseph Speidel et al., 2008). Worldwide, 38% of pregnancies are unintended, that is about 80 million unintended pregnancies each year, and these result in about 42 million induced abortions per year, and 34 million unintended births (J. Joseph Speidel et al., 2008). Some studies have shown up to 80% of women expecting their first child expressing some form of anxiety and disappointment about it (Caplan G, 1957) and these include those in both stable and unstable relationships. However the extent to which these feelings are changed into a welcome experience depends on how the anxieties are handled. In another study, of several women studied one fifth had had a pregnancy they did not want, and a quarter had had one that came too early (Ann Cartwright, 1988).

In Uganda, annually about 775,000 women have unintended pregnancies (Susheela Singh et al., 2006). The proportion of births in Uganda that were unplanned rose from 29% in 1995 to 38% in 2000–2001, indicating high levels of unintended pregnancy. Furthermore, the gap between ideal and actual family size more than doubled in Uganda between 1988 and 2000, reflecting a growing desire for smaller families that has not been matched by an increase in the use of modern contraceptives. One-third of all Ugandan women of reproductive age want to stop or delay further childbearing and an estimated 297,000 induced abortions are performed each year in Uganda, which translates to an annual abortion rate of 54 per 1,000 women aged 15–49. These statistics are important because concealed in them is the fact that unwanted pregnancy and unsafe abortion occur disproportionately among the most disadvantaged members of society, who are also the least likely to have access to high-quality post-abortion services (United Nations Population Fund, 22–25 June 1998).

Facing an unwanted pregnancy is a challenging situation for a woman and often results in conflicting and chaotic feelings; she may go through a time of shock which is followed by feelings of despair, anger, helplessness and guilt. Women in these circumstances must deal with these circumstances and take decisions on how to handle the situation; in this decision-making process, the pros and cons of different choices have to be carefully weighed.

Among other things, improving knowledge about, access to and use of effective contraceptives would lead to lower rates of unwanted pregnancy and induced abortion (Susheela Singh et al., 2006); this can be achieved through among other methods, counselling. Counselling in relation to unwanted pregnancy involves the mother (with or without her partner, family or support system) with opportunities to discuss their problems from their perspective or in their context with someone they can trust (Juliet Cheetham, 1977). This is intended to identify and explore the background to the problems and consider the possible alternative solutions available bearing in mind the inevitable possible conflict of

interests and helping the affected mother couple and family choose the one possible strategy they are most comfortable with. It in addition involves helping them organize the resources available to them so as to efficiently maximize these under the alternative course of action chosen.
This paper presents data from the literature on the effect of counselling in unwanted pregnancy.

Summary of findings

Although it might be impossible to show the true figures of unwanted pregnancy in our society, literature shows that many mothers and fathers face this crisis to different degrees every year and many children are born into situations in which they are vulnerable, if measures are not taken to resolve the real or perceived crisis.
Counselling is based on the assumption that there is value in the free expression of both painful and pleasurable feelings and in the honest examination of conflicts; and that there is a relationship between these processes and future behaviour less damaging to those involved and others concerned (Juliet Cheetham, 1977).

There is a paucity of research in the area of counselling in unwanted pregnancy in low income, or Sub-Saharan African countries; much of that done is heterogeneous in design and of low quality often failing to measure direct outcomes, using short follow up periods, using convenience sampling and failing to randomize, and failing to consider social and cultural norms when developing hypotheses (Moos MK et al., 2003). In particular, few studies have looked at the effectiveness of counselling in the clinical setting or have provided evidence-based suggestions of how counselling might be improved to increase its effectiveness.

A systematic review to examine the evidence about the effectiveness, benefits and harms of counselling in a clinical setting to prevent unintended pregnancy in adults and adolescents and to use the evidence to propose a research agenda, highlighted the evidence paucity and emphasized that numerous issues in this area warranted more thorough investigation (Moos MK et al., 2003). Of the studies identified and included in this review, it was noted that none reported on harms of counselling or on the costs or cost-effectiveness of different approaches to counselling about unintended pregnancies in the primary care setting. In addition, nearly no experimental or observational literature reliably answered questions about the effectiveness of counselling in the clinical setting to reduce rates of unintended (unwanted, mistimed) pregnancies.

However in a study whose aim was to examine the decision making process in unwanted pregnancy with a focus on aspects of the decision-making process among women having abortions (first or repeat), in comparison with women continuing their pregnancies with or without having experienced abortions, it was noted that counselling seemed to be important among a considerable number of women finding it hard to make a decision about the way forward including the option of an abortion (Marie Tornbom et al., 1999). Furthermore, the timing of this counselling seemed to be important too. In this study, the number of women who were ambivalent about what to do concerning the pregnancy when they visited the health facility to ask for abortion services seemed to differ probably depending on the point at which they encountered the facility services, that is at what stage of the decision-process they were. If the contact occurs early in this process, more women might express ambivalent feelings than later on, with probably better consequences because of early access to information and medical help. In this study inquiry was also made about how difficult it was to decide about the pregnancy and it was found that more than half of the women answered difficult or very difficult, and this is where counselling seemed to be of help. The study also noted that counselling women or/and couples faced with an unwanted pregnancy and therefore considering abortion seems to be very important both to women finding it hard to make the decision and to women who are at risk for post-abortion problems. It was also noted that special attention is required for women feeling influenced by someone else and/or having marked social problems.

Another systematic review of literature done to assess the effects of primary prevention interventions on unintended pregnancies among adolescents, found that a combination of educational and contraceptive interventions appears to reduce unintended pregnancy among adolescents (Oringanje C et al.). The educational interventions referred to here include counselling, health education and more. Intervening, even if brief, during crisis periods can have maximum effect when compared to other approaches. This may be because people in crisis are at a turning point (Parad H and et al., 1990). They face problems that cannot be overcome by using their current or existing coping mechanisms. The anxiety and helplessness they face can interrupt the tasks of daily life, and people can feel helpless to the point of not being able to function effectively. However a crisis, if positively resolved can also provide an opportunity for growth and development for the victim.

It has also been shown that counselling at the point of crisis aside from relieving the anxiety also makes it more likely that those affected will return more readily for other help they may need (Juliet Cheetham, 1977). This comes from the evidence of women who return for post-abortal care and reveal they can do so easily because of the sympathetic treatment they got at the time of crisis. They say they understand the operation better including its complications.

A research to examine the causal impact of attributions and coping self-efficacy on adjustment to abortion (following unwanted pregnancy) was done examining 283 women (Mueller Pallas and Major Brenda, 1989). Prior research had identified several factors that predispose women to experience relatively more adjustment problems following an abortion, and these included young age, lack of or weak social support by partner or parents, a difficult or conflicted abortion decision, and a general lack of psychosocial stability before the abortion (Adler N, 1982, Elizabeth M. Belsey et al., 1977). This study pointed to several additional psychological factors that may place women at somewhat higher risk for experiencing problems after an abortion; they included low perceived self-efficacy for coping with the abortion, blaming the pregnancy on another person, and blaming the pregnancy on their character. In conclusion, it showed that women may benefit greatly from pre-abortion counselling designed to identify such predispositions. It further suggested that even brief interventions designed to raise coping expectations and/or to minimize character-based self-blame may be effective in facilitating post-abortion adjustment, at least immediately and that more forceful, personalized, and lengthy interventions might be expected to have longer lasting effects.

There has been research done mostly on the female partner during this crisis and not much on the male partner, the family and others indirectly affected. Involving the male partner is thought to lead to better outcomes for both the present and future (similar) situations. A study on college students' attitudes toward shared responsibility in decisions about abortion (following unwanted pregnancy) and implications for counselling, found among other things, that there was a need for more research on the male's experience with an unplanned pregnancy, more systematic explanation of their perceptions relative to seeking and obtaining pregnancy counselling, and level of satisfaction with such counselling (Ryan IJ and Dunn PC, 1983). However it should be noted that students interviewed felt less strongly about the complete involvement of the male in abortion decision making and other situations of unplanned pregnancy; 33% indicated that the male should be completely involved in the decision of a repeat abortion but only 25% felt that the male should share responsibility for an abortion when the couple is in a stable relationship and 20% said that the male should share in the decision when a couple is no longer in a relationship.

Conclusion

Although there is generally a lack of research evidence in the area, and that found being of a fairly low quality, that available confirms that counselling is an effective strategy in dealing with mothers with an unintended pregnancy. It not only relieves the anxiety at the time of

crisis, it helps identify options for courses of action and may be instrumental in their return to the facility for other services like post abortal care and contraception counselling. The male partner's experience with counselling, during this period, among other aspects needs more rigorous exploration.

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Conflicts of interest
None known.

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The Regional East African Community Health-Policy Initiative (REACH) links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States.
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