reported completing IPP IUD placement training than residents in nonexpansion states \( (P < 0.001) \). Residents within university programs in expansion states reported more IPP IUD training than those in nonexpansion states \( (P < 0.001) \). In states with a reimbursement policy for IPP IUD placement, more residents in expansion states reported completing IPP IUD training than those in nonexpansion states \( (P < 0.001) \).

**CONCLUSION:** The findings from this study expand on a previous analysis noting lower rates of LARC training in community-based vs academic programs.\(^5\) State policies may contribute to the variation in the amount of LARC training that residents receive. IPP LARC training occurred more frequently in states with insurance expansions regardless of published policies for reimbursement. A strength of this study was the 85% response rate among all residency program locations, sizes, and types. A limitation was our focus on number of IUD placements as a marker for proficiency in addition to the limited number of demographic questions and survey questions allowed in the survey. Although many factors contribute to differences in LARC training across the United States, state and federal policy may affect physician education and training.

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**REFERENCES**


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FIGURE
Themes derived from Reddit user posts

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example posts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional experiences</strong></td>
<td></td>
</tr>
<tr>
<td>Comfort in setting where abortion takes place: desire for privacy vs preference for clinical setting</td>
<td>I am reading about medical vs surgical abortions and it seems like a majority of women choose to have a medical abortion due to the privacy nature of it. Is it weird that I feel like I would rather have the surgical one? Because I don’t want to tell my friends/family, I almost would enjoy having the company of a doctor/nurse with me. I’ve been reading all night and have made the decision to just do the surgical rather than the medical because I don’t wanna be home with my family and miscarry here with them all here.</td>
</tr>
<tr>
<td>Anticipated emotional impact of the abortion modality and/or setting</td>
<td>I am so incredibly nervous about the pain and the psychological trauma of laying on that table. I don’t want to see or feel the pill-induced miscarriage happening. I don’t want to let the baby go. It’s going to kill me.</td>
</tr>
<tr>
<td><strong>Pregnancy profiles</strong></td>
<td></td>
</tr>
<tr>
<td>Gestational age as an influence over method choice</td>
<td>I’m approximately 6–7 weeks pregnant. Is this a good time for medical abortion or should I wait it out? The earlier the better right? I’m scared now, because if it’s too late to have the medical abortion, I’m not sure I can go through with surgical.</td>
</tr>
<tr>
<td>Underlying medical conditions as a factor in method choice</td>
<td>I was diagnosed with multiple sclerosis about 2/3 weeks ago and I was wondering if anyone has had any problems getting the pills before because of a health problem?</td>
</tr>
<tr>
<td><strong>Process-specific concerns</strong></td>
<td></td>
</tr>
<tr>
<td>Concerns about pain</td>
<td>I heard about getting a needle in your cervix. Does that hurt? And what does it actually feel like when you’re getting the procedure done? I know it’ll only last a few minutes, but I’m genuinely so scared. If you’ve gone through this procedure before, would you recommend opting for the valium and/or sedation? Do you think it was necessary or helped a lot? I am so incredibly nervous about the pain.</td>
</tr>
<tr>
<td>Thoughts about method duration</td>
<td>Also, the surgical procedure itself is only 5–10 minutes vs hours long for medical. How long does the appointment take, from when you arrive to when you can go? I read it can take from 2-6 hours.</td>
</tr>
<tr>
<td>Considerations regarding method effectiveness and complications</td>
<td>I’m more or less concerned with what’s going to happen if it doesn’t work, which would mean having the invasive abortion surgery, and that would be horrifying For hours on end, I was reading horror stories about the medical abortion—and then to read it could fail?? Okay. Not taking the risk.</td>
</tr>
<tr>
<td><strong>Structural barriers</strong></td>
<td></td>
</tr>
<tr>
<td>Access to transportation</td>
<td>I’m only 18 and I still live with my mom. She is going to kill me. Has anybody gone through Aid Access [non-profit organization that provides medication abortion by mail]? What kind of packaging does it come in? I can’t go to Planned Parenthood because it’s over 3 hours away. And I don’t drive . . . Would I need a ride home from the procedure? This is silly, but would they allow me to Uber home? If I cannot take the sedation or pain relief due to not having a ride, this would definitely push me to the medical route.</td>
</tr>
<tr>
<td>Considerations about cost</td>
<td>I had enough in savings to go to Planned Parenthood, but it would’ve depleted my bank account and we probably wouldn’t be able to make appointments. So I took the cheaper &amp; easier way, and I ordered mifepristone and misoprostol online from overseas. I am very nervous about having the procedure this late, but the surgical option was not financially viable for me. I can hardly afford the medical termination.</td>
</tr>
</tbody>
</table>

Themes regarding abortion method choice, with examples of posts relating to each theme.

input from those who never make it through the clinic doors.\textsuperscript{1–3} We aimed to better document the decision making process regarding abortion methods through analyzing posts on Reddit, a website used by nearly a quarter of US-based young adults that contain user-aggregated content dispersed over 2 million user-created and -monitored message boards.\textsuperscript{3}

**STUDY DESIGN:** In February 2020, we used Python\textsuperscript{5} to web-scraper the 250 most recent posts that mentioned abortion, removing all identifying information and usernames and assigning each post a unique number. We focused on posts related to modality choice before undergoing abortions; we established codes, then themes, using a combined deductive and inductive analytical approach. We excluded posts clearly posted from outside the United States. A total of 3 qualitatively trained evaluators coded the posts in NVivo 12 (QSR International, Burlington, MA), reaching saturation after analyzing 148 posts. The University of Wisconsin-Madison Health Sciences Institutional Review Board approved this study.

**RESULTS:** We identified the following 4 themes related to the decision making process about abortion methods: emotional experiences, pregnancy profiles, process-specific concerns, and structural barriers (Figure). The posters who discussed emotional experiences considered the perceived emotional impact of the abortion modality. Some favored medication-induced abortion because they felt that the clinical setting necessary for surgical abortion would be psychologically challenging, whereas others preferred the in-clinic emotional experience of surgical abortions. Some users incorporated their pregnancy profiles, including gestational age or underlying medical conditions, into decisions about modality. Posters earlier in gestation leaned toward medication abortion, whereas others with underlying medical conditions wondered if medication abortion was the right option for them. Process-specific concerns pertained to method duration, effectiveness, and the associated pain. Pain-related posts documented anticipated pain during surgical procedures only. Finally, structural barriers encompassed external circumstances, primarily transportation and cost. Many posters referenced preferring medication over surgical abortion, which requires procedural sedation, because they could not secure a ride home or to the clinic at all. The 2 most common themes were emotional experiences and process-specific concerns.

**CONCLUSION:** Social media research regarding abortion likely captures individuals who either never undergo or self-manage abortions. In this exploratory study, similar to in-clinic research with abortion patients, Reddit users deciding on the abortion modality considered method impact on the psychological or physical pain and access to external resources such as finances and transportation.\textsuperscript{1–3} Because of individual variation in preference, access to all medically appropriate abortion methods is essential. Evidence-based information about abortion should be widely available online. Study strengths include the novel use of social media to obtain information from populations perhaps unreached by traditional research methods. A weakness is that because we did not scrape usernames, separate posts may have come from the same individual or from outside the United States. Future research on abortion could benefit from engagement with online data.

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Impact of the COVID-19 pandemic on preterm birth and stillbirth: a nationwide, population-based retrospective cohort study

OBJECTIVE: This study aimed to establish whether there was a decrease in the rate of prematurity in France after the beginning of lockdown (March 17, 2020) and whether there was an increase in the rate of stillbirths compared with 2017 to 2019.

STUDY DESIGN: We included all births from January to September of each year from 2017 to 2020 from the national Programme de Médicalisation des Systèmes d’Information database: 496,171 newborns from women with singleton pregnancies and 15,441 newborns from women with multiple pregnancies were included for 2020. Concerning the 2017 to 2019 period, we included a mean of 518,798 newborns from women with singleton pregnancies and 16,441 newborns from women with multiple pregnancies per year. Prematurity was defined according to the World Health Organization classification as a birth that occurred before 37 weeks’ gestation (WG).1 We also studied extremely preterm births (before 28 WG), moderate preterm births (between 28 and 31 WG), and late preterm births (between 32 and 36 WG). Prematurity rates were compared by month between the 2 periods (January to September months of 2017, 2018, and 2019 vs January to September 2020) using chi-squared test, and the variations (relative risk difference) were calculated. We also identified hospital stays for COVID-19 in 2020 in relation to the date of admission during pregnancy by International Classification of Diseases, Tenth Revision, codes U0710, U0711, U0712, U0714, or U0715. This algorithm has been used in previous studies.2,3 This study was approved by institutional review boards.

RESULTS: Between April to May 2017 to 2019 and April to May 2020, there was a decrease of −7.53% in the rate of prematurity (from 5.31% to 4.91%; P<0.01) for singleton pregnancies (Figure). Between these 2 periods, the rate of change was −12.90% between 22 and 27 WG (P=0.03), +1.96% between 28 and 31 WG (P=0.69), and −8.24% between 32 and 36 WG (P<0.01). The decrease in the rate of prematurity was still observed after the end of lockdown (from June to September 2020). For multiple births, there was no decrease in prematurity between January to September 2017 to 2019 and January to September 2020: 50.14% vs 50.36% (P=0.63), respectively, for twins and 95.51% vs 94.9% (P=0.62), respectively, for high-order multiple pregnancies. In January to September, there were 363 stillbirths among singleton pregnancies in 2017 to 2019 and 114 in 2020 (0.00% change rate). Among the 1752 women with a diagnosis of SARS-CoV-2 infection with singleton pregnancies, the rate of prematurity was higher in 2020 than in 2017 to 2019 (9.93% vs 5.32%; P<0.05 for all). On the contrary, the rate of prematurity was lower

FIGURE
Rate of prematurity among singleton births

By month for 2017 to 2019 and 2020.