The findings of this study will provide a clear understanding of how women intend to participate during the reproductive process and what health professionals could do to promote such participation. We expect to generate discussion with the audience about shared decision making during this process, with particular interest in how this could be achieved with vulnerable population.

Shared Decision Making In Contraceptive Care: Deficiencies And Solutions

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Background and Aims
\Despite significant advances in contraceptive technology and access, nearly 40% of contraceptive users in the United States are not satisfied with their method, increasing their risk of imperfect contraceptive use and unintended pregnancy. We sought to better understand current processes of decision-making about contraceptive methods in the United States, women's and health care providers' information priorities for contraceptive decision-making, and women's and providers' preferences for the design and delivery of a tool to facilitate shared contraceptive decision-making.

Methods
Online surveys were administered to convenience samples of 417 women and 188 contraceptive care providers residing in the United States. Levels of shared decision-making about contraceptive methods were measured using the three-item, patient-reported CollaboRATE measure. Women's and providers' information priorities for contraceptive decision-making were assessed via their ratings and rankings of the importance of 34 different questions about the features of contraceptive options. Women's and providers' preferences for the design and delivery of a shared contraceptive decision-making tool were assessed via purpose-developed items.

Results
Less than one-quarter of women (23.9%) reported optimal levels of shared decision-making when a contraceptive method was most recently chosen in their health care visit. Women's and providers' ratings of the importance of the various questions for contraceptive decision-making were similar for 18 questions, but dissimilar for the remaining 16 questions. For women, the question rated most important was "*How does it work to prevent pregnancy?*", closely followed by "*Is it safe?*". Alternatively, for providers, the questions rated as most important were "*How often does a patient need to remember to use it?*" and "*How is it used?*". Women's qualitative comments spoke to a need for a more comprehensive and more patient-centered approach to information provision and counseling about contraceptive methods. With respect to the design of a tool to respond to this need and facilitate shared contraceptive decision-making, providers tended to prefer a paper tool to an electronic document or application.

Conclusion
Currently, women in the United States report suboptimal levels of shared decision-making about contraceptive methods. This finding, together with our observation of discordance between women's and provider's information priorities for contraceptive decision-making, may explain the significant prevalence of women dissatisfied with their current contraceptive method in the United States. Efforts to improve shared contraceptive decision-making are critical, and the insights provided by this study should inform their design and delivery.

Evidence-based decision aids in women's health improve the decision making process

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Background and Aims
Women face many complex and value-laden health decisions. We have developed evidence-based decision aids to help women make informed healthcare decisions in three areas: planning for safety in an abusive intimate relationship (safety decision aid); making a decision about a future childbirth delivery for women with a prior cesarean (childbirth decision aid); and deciding when to begin regular screening mammograms for women in their forties (mammography screening aid).

Methods
All three computerized decision aids were developed based on evidence from systematic reviews and used the International Patient Decision Aids Standards to guide development. The decision aids included educational components and interactive activities to help the women set priorities for the respective health and healthcare decisions. Eligible women (abused women; women with a prior cesarean; or 40 year-old women at average risk for breast cancer) were recruited to use the appropriate decision aid and participate in an evaluation study. No women participated in more than one evaluation study. The safety decision aid and childbirth decision aid were evaluated in randomized controlled trials and the breast cancer decision aid was evaluated in a before-after study. In all three studies, the women reported their levels of decisional conflict (a measure of the decision process) around the respective decision before and after using the decision aid. In the mammography screening study, the women also reported levels of decision self-efficacy. Both randomized controlled trials were analyzed with an intent-to-treat approach1,2. These studies included repeated measure analyses to determine if the change in decisional conflict from baseline was the same for both groups. For the mammography screening before-after study, Wilcoxon ranked-sum tests were performed to evaluate change.