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Do women want to talk about birth control at the time of a first-trimester abortion? ☆

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ABSTRACT

Objective: To investigate if women desire talking to a counselor or physician about contraception when seeking first-trimester medical or surgical abortion.**Study design:** We conducted a cross-sectional study by distributing self-administered anonymous surveys to women at three clinics in Sacramento, California; Chicago, Illinois; and Cleveland, Ohio, from October 2014 to February 2015. Participants completed surveys after registration and before any in-office counseling. We asked whether women want to discuss contraception, specific topics they want to discuss, reasons why they may not want to talk about contraception and whether they want to receive contraception services as part of their abortion care. We conducted regression analyses to assess associations between patient characteristics and the desire for counseling.**Results:** Among 3041 eligible women, 1959 (64.4%) completed surveys. Overall, 1208 (61.7%) did not want to discuss contraception prior to having an abortion, primarily citing that they already know which method they want. We found no association between the desire to discuss contraception and age, race, planned abortion method, clinic site and number of unplanned pregnancies. Among those who desired to talk about contraception, subjects preferred to discuss which contraceptive methods are easier to use and more effective as compared to previously used methods. Regardless of their desire for a discussion about contraception, 1386 (70.8%) of subjects wanted to leave the clinic with a specific method, including a long-acting reversible method [intrauterine device or implant (190, 13.7%)] or other hormonal method [pills, patch, ring or injectable (680, 49.1%)].**Conclusions:** The majority of women seeking first-trimester abortion do not come to the clinic wanting to discuss contraception, most commonly because they have a preferred method in mind.**Implications:** Providers should ask women presenting for abortion if they want to discuss contraception and not assume that they need or desire such information. Focused discussions, starting with the preferred method if known, may better satisfy women's preferences. Providers should account for such desires when allocating resources for contraception services during abortion care.

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1. Introduction

Clinical experts recommend contraception services as adjuncts to abortion care [1–3]. Such services provide a woman seeking abortion with an opportunity to discuss her contraceptive needs and to identify a method to initiate if she wants to prevent a repeat pregnancy in the

near future. Women can ovulate as soon as 10 days after a surgical abortion [4] and 20 days after a medical abortion [5], and some may resume sexual activity within 2 weeks [6,7]. These short intervals for both resumption of ovulation and sexual activity postabortion highlight the importance of immediate contraceptive initiation.

The approach to discussing contraception in the abortion setting is not a universal standard [8–11]. Despite various counseling models, the effectiveness of contraception counseling to prevent subsequent unintended pregnancy has not been consistently proven [11–20].

A pilot survey-based study of 202 women seeking first-trimester surgical abortion in northern California showed that 65% of respondents did not want to discuss contraception at the time of abortion [21]. Of these women, 52% indicated that they already knew which

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contraceptive method they wanted. Among respondents who expressed an interest in discussing contraception, the majority wanted information about methods that are easier to use and more effective than the method they used prior to the current pregnancy. While limited in size and generalizability, this pilot study indicates that women seeking abortion have specific interests regarding discussions about contraception at the time of their abortion. To assess generalizability and the validity of these findings, we conducted this multicenter cross-sectional survey of women seeking first-trimester medical or surgical abortion at three centers across the United States to understand their desire for discussing contraception as part of abortion care.

2. Materials and methods

We recruited women seeking first-trimester medical or surgical abortion services from October 2014 to February 2015 at three study sites: Women's Health Specialists in Sacramento, California; Family Planning Associates in Chicago, Illinois; and Preterm Abortion Clinic in Cleveland, Ohio. Contraception counseling was incorporated into abortion service provision differently at each site. The Sacramento site offered contraception counseling only to specific women who voluntarily requested contraceptive services. The other two sites routinely provided contraception counseling to all women seeking abortion services.

We included women 18 years and older seeking first-trimester (through 14 weeks 0 day of gestation) medical or surgical abortion. Because we used an anonymous survey administered before women had an ultrasound examination, we based the gestational age for study entry on what the woman believed her gestational age to be at the time of initial presentation to the clinic. We excluded women who could not read English or Spanish or did not understand the survey. The University of California, Davis, Institutional Review Board approved the study for all sites.

An envelope containing the study survey was distributed by clinic staff to each potential subject before any preprocedure counseling was provided. A cover letter attached to the envelope explained the study and its goal to investigate "contraception counseling among women who plan a first-trimester abortion." The letter also stated eligibility characteristics for study participation, the voluntary nature of study participation and that completion of the survey was considered consent for participation. The letter emphasized that clinic staff would not know whether or not the potential subject was interested in contraception counseling. The envelope contained the survey, a business envelope for the subject to insert and seal the completed survey, and a \$5 gift card as compensation for study participation. The subject completed the survey in the waiting room, sealed the completed survey in the business envelope and deposited it into a locked collection bin. Study participation ended upon return of the survey. Because the surveys were anonymous, we did not link the surveys to the final abortion outcome or contraceptive choice.

The survey asked the subject to provide nonidentifying sociodemographic information, obstetric and contraceptive history, and current contraceptive use leading to the index pregnancy. On the last page, the survey asked women about their interest in speaking with a clinician or counselor about contraception on the day of their abortion procedure (Appendix). The survey specifically asked if women "want[ed] to talk to a counselor or doctor about birth control." Those who reported interest in talking about contraception were asked to select from a list of options regarding which specific topics they would like to discuss. Among women who indicated that they did not want to talk about contraception at the time of their abortion visit, the survey asked about their reasons for disinterest. The survey also allowed women to provide additional information if they had other reasons for interest or disinterest beyond the list of options provided.

We defined our primary outcome as the proportion of respondents who indicate interest in discussing contraception. We also sought to

characterize the women who are interested or not interested in talking about contraception, and assess the different reasons for interest or disinterest in such a discussion. We estimated the sample size as a convenience sample based on the projected number of women seen in each study site seeking first-trimester abortion services. We attempted to enroll a convenience sample of 2000 women which, for a presumed 35% rate of interest in contraception counseling [21], would provide a 95% confidence interval of 32.9%–37.1%. Accounting for an estimated 30% rate of nonparticipation and incomplete surveys, we would need to include 2857 subjects. Based on known clinic volumes, the three centers together served approximately 180 eligible subjects per week, implying a 4-month recruitment period would provide an estimated 2880 eligible subjects. We explored the difference in confidence interval if we doubled the sample size and found a minimal narrowing to 33.5%–36.5%, confirming that our planned study cohort of 2000 subjects would provide an accurate estimate of the desired outcome.

We included only completed surveys in the analysis, which we defined as completion of at least 50% of the survey questions. We stratified contraceptive methods using the World Health Organization (WHO) tiered effectiveness classification as Tier 1: the intrauterine device, implant and sterilization; Tier 2: oral contraception, patch, ring and injectable; Tier 3: barrier and fertility-awareness-based methods; and Tier 4: withdrawal and spermicide [22]. We performed univariate analyses using Fisher's Exact Tests, χ^2 analyses and Student's *t* tests as appropriate. For multivariable linear and logistic regression analyses, we included any variable with a *p* value of .1 or less on univariate analyses and variables considered to be strong clinical confounders in the multivariable analyses (age, race, study site, planned abortion method, number of previous unplanned pregnancies and contraceptive use at the time of conception). We performed statistical testing using Stata 12 (StataCorp, College Station, TX, USA) and considered a *p* value <.05 as statistically significant.

3. Results

The study sites encountered 3041 potentially eligible women during the study period including 2140 (70.3%) from Chicago, 424 (13.9%) from Cleveland and 477 (15.7%) from Sacramento. In total, 2066 eligible women received and returned surveys (1335 from Chicago, 415 from Cleveland and 316 from Sacramento). We included 1959 complete surveys in the analysis; the proportion of completed surveys by study site matched the proportion based on relative clinic volume. Participant characteristics for the entire population and for those women who wanted to talk about contraception are presented in Table 1. Overall, participants had a mean age of 27.2 ± 5.9 years.

Less than a third of subjects (604 subjects, 30.8%) reported that they wanted to talk to a counselor or doctor about contraception as part of their abortion care. The majority of subjects who responded favorably preferred to discuss contraceptive methods described as easier to use and methods that are more effective than those that they had previously used (Fig. 1). In multivariable analysis, only Hispanic ethnicity, income >\$100,000, history of 3 or more abortions, and use of a WHO Tier 1 or Tier 4 contraceptive method at the time of conception predicted a desire to discuss contraception (Table 2). Because of the 31% missing data rate for contraceptive method prior to current pregnancy, we performed a second multivariable analysis without contraceptive method, and the aforementioned predictors from the original analysis still remained significant (data not shown).

Of the 1208 (61.7%) women who did not want to talk about contraception, 643 (53.2%) reported that they already knew which postabortion contraceptive method they wanted. Fig. 2 depicts the proportion of subjects citing specific reasons for their disinterest. Subjects who reported disinterest in talking about contraception because they were content with the method they were using at the time of conception were more likely to have been using either a short-acting hormonal method (*p*=.01) or no contraception (*p*<.001). Subjects who reported

Table 1

Demographics of women seeking first-trimester medical or surgical abortion and desire for discussion about contraception at the abortion visit.

Characteristic	Total N=1959	Desired discussion about contraception n=604	Did not desire discussion about contraception n=1355	p value ^a
Study site				.75
Chicago, Illinois	1283 (65.5)	384 (63.6)	899 (66.3)	
Cleveland, Ohio	400 (20.4)	132 (21.8)	268 (19.8)	
Sacramento, California	276 (14.1)	88 (14.6)	188 (13.9)	
Age (years)				.88
18–20	228 (11.8)	74 (12.2)	154 (11.4)	
21–25	657 (33.9)	213 (35.3)	444 (32.8)	
26–30	517 (26.7)	159 (26.3)	358 (26.4)	
31–35	321 (16.6)	101 (16.7)	220 (26.2)	
≥36	214 (11.1)	57 (9.4)	157 (11.6)	
Unanswered	22 (1.1)			
Race				.59
White	600 (30.6)	192 (33.4)	408 (30.1)	
Black	868 (44.3)	253 (44.0)	615 (45.4)	
Asian	69 (3.5)	16 (2.8)	53 (3.9)	
More than one race	152 (7.8)	54 (9.4)	98 (7.2)	
Other	187 (9.6)	60 (10.4)	127 (9.3)	
Unanswered	83 (4.2)			
Ethnicity				<.001
Non-Hispanic/Latina	1362 (69.6)	395 (72.9)	967 (71.4)	
Hispanic	394 (20.1)	147 (27.1)	247 (18.2)	
Unanswered	203 (10.4)			
Number of previous unplanned pregnancies				.25
1	215 (11.0)	59 (10.0)	156 (11.5)	
2	525 (26.8)	152 (25.8)	373 (27.5)	
3	529 (27.0)	174 (29.5)	355 (26.2)	
4	308 (15.7)	94 (15.9)	214 (15.8)	
5 or more	317 (16.2)	111 (18.8)	206 (15.2)	
Unanswered	65 (3.3)			
Number of previous abortions				<.01
None	824 (42.1)	236 (39.9)	588 (43.4)	
1	550 (28.1)	173 (29.2)	377 (27.8)	
2	275 (14.0)	87 (14.7)	188 (13.9)	
3 or more	264 (13.5)	96 (16.2)	168 (12.4)	
Unanswered	46 (2.4)			
Highest level of education				.09
Less than high school	73 (3.7)	21 (3.5)	52 (3.8)	
High school/GED	528 (27.0)	161 (26.8)	367 (27.1)	
Some college	826 (42.2)	270 (44.9)	556 (41.0)	
College degree	387 (19.8)	119 (19.8)	268 (19.8)	
Graduate school or above	130 (6.6)	30 (5.0)	100 (7.4)	
Unanswered	15 (0.8)			
Annual household income				.03
<\$25,000	814 (43.4)	264 (45.3)	550 (40.6)	
\$25,000–\$50,000	353 (18.8)	107 (18.4)	246 (18.2)	
\$50,001–\$100,000	194 (10.3)	53 (9.1)	141 (10.4)	
>\$100,000	94 (5.0)	20 (3.4)	74 (5.5)	
Unknown	422 (22.5)	139 (23.8)	283 (20.9)	
Unanswered	82 (4.2)			
Planned abortion method				.49
Surgical	1050 (31.3)	191 (32.3%)	859 (63.4)	
Medical	613 (53.6)	324 (54.8%)	289 (21.3)	
Don't know	247 (12.6)	76 (12.9)	171 (12.6)	
Unanswered	49 (2.5)			
Contraceptive method prior to current pregnancy ^b				.04
None	267 (13.6)	75 (12.8)	192 (14.2)	
Tier 1 (IUD, implant, sterilization)	35 (1.8)	10 (1.7)	25 (1.8)	
Tier 2 (CHC, POP, injectable)	268 (13.7)	61 (10.4)	207 (15.3)	
Tier 3 (barrier, FAB methods)	451 (23.0)	277 (47.3)	174 (12.8)	
Tier 4 (withdrawal, spermicide)	331 (16.9)	163 (27.8)	168 (12.4)	
Unanswered	607 (31.0)			

GED = General Education Development, IUD = intrauterine device, CHC = combined hormonal contraception, POP = progestin-only pill, FAB = fertility-awareness-based. Data are presented as n (%).

^a p value for univariate comparison of variable for women who desired as compared to women who did not desire discussion about contraception.

^b Tiers based on WHO tiered effectiveness classification (WHO 2011); when participants provided more than one response, the data reflect the most effective method.

that they did not plan to use immediate postabortion contraception or plan to become pregnant soon were more likely to report that they were not using any contraception leading to the current pregnancy ($p<.001$ for both).

Despite the fact that a large proportion of subjects reported that they did not want to talk about contraception, most subjects ($n=1386$, 70.8%) wanted to leave the clinic with a contraceptive method (Table 3). The desire for immediate postabortion contraception

* Responses are not necessarily mutually exclusive

Fig. 1. Preferred topics for discussion among women seeking first-trimester surgical or medical abortion and desiring discussion about contraception ($n=604$)*.

was significantly associated with a history of not using contraception leading to the current pregnancy ($p<.001$); most of these women preferred to leave the clinic with a WHO contraceptive Tier 1 or 2 method.

Table 2
Multivariable correlates to desire for discussion about contraception in women seeking first-trimester abortion^a

Characteristic	aOR (95% CI)
Ethnicity	
Not Hispanic/Latino	Reference
Hispanic	1.47 (1.02–2.11)
Income	
<\$25,000	Reference
\$25,000–\$50,000	0.82 (0.60–1.12)
\$50,001–\$100,000	0.87 (0.59–1.29)
>\$100,000	0.56 (0.32–0.99)
Unknown	0.94 (0.70–1.26)
Number of previous abortions	
None	reference
1	1.09 (0.80–1.48)
2	1.27 (0.85–1.88)
3 or more	1.64 (1.06–2.54)
Contraceptive method prior to current pregnancy ^b	
None	Reference
Tier 1 (IUD, implant, sterilization)	3.10 (1.11–8.62)
Tier 2 (CHC, POP, injectable)	1.38 (0.88–2.15)
Tier 3 (barrier, FAB methods)	1.37 (0.97–1.92)
Tier 4 (withdrawal, spermicide)	1.83 (1.26–2.64)

aOR = adjusted odds ratio; planned adjustment included any variable with a p value of .1 or less on univariate analyses (Table 1) plus inclusion of age, race, study site, planned abortion method, number of previous unplanned pregnancies and contraceptive use at the time of conception regardless of p value.

^a Variables evaluated in the multivariable analysis that were not statistically significant are study site, age, race, education, planned abortion method and number of previous unplanned pregnancies.

^b Tiers based on WHO tiered effectiveness classification (WHO 2011); when participants provided more than one response, we counted the most effective method.

4. Discussion

Our study validates previous findings on women's desires for discussing contraception as part of abortion care [21]. Although we did not use a validated instrument, we did use the same survey used in the original smaller study [21] with only minor modifications to improve comprehension. We found similar results in this much larger population which included three study sites in geographically different areas across the United States representing a diverse population in varying practice settings. Even though we encountered a greater number of potentially eligible subjects than we anticipated for the sample size calculation (3041 vs. 2800 women), we only included 1959 subjects in the final analysis as opposed to the planned sample size of 2000 subjects; however, the difference in sample size only increases the upper limit of the 95% confidence interval by 0.1%. While the majority of survey respondents were recruited from the Chicago site, we did not find any statistical difference in outcomes based on study site (Table 1).

Similar to the pilot study, we again noted that the majority of women seeking first-trimester abortion do not want to talk about contraception in this setting because they already know which post-abortion contraceptive method they prefer. Our findings suggest a framework to tailor discussions about contraception as part of abortion care to better meet women's desires. Contraceptive services, including counseling and method initiation, are important to some but not all women who are seeking first-trimester abortion.

To ensure reading comprehension, we asked women whether they wanted to discuss contraception rather than directly asking them if they want counseling. Our study assumes that the subject would interpret "talk[ing]" about contraception as interchangeable to counseling, especially since the cover letter introducing the study to the potential subject specifically stated that the study objective was to investigate contraception counseling. We also assume that there is a distinction between discussions about contraception counseling and providing women with prescribing information. Counseling involves an active dialog about a specific contraceptive method or several methods, commonly occurring when women are undecided about their method of

* Responses are not necessarily mutually exclusive

Fig. 2. Reasons for disinterest in discussion about contraception among women seeking first-trimester surgical or medical abortion ($n=1208$)*.

choice. In contrast, the provision of prescribing information is a limited discussion that confirms the chosen method, including refusal of other methods, and reviews relevant factors including contraceptive efficacy, administration, side effects and potential need for backup contraception. This distinction highlights the variation in the extent of contraception counseling. One approach entails efficacy-based comprehensive counseling about all contraceptive options. This model is thorough but may be construed as coercive and time-consuming by women who are disinterested in contraception counseling when seeking abortion services. In a randomized trial, Langston and colleagues [23] found no difference in the rate of contraceptive initiation or method choice comparing structured contraception counseling and usual care, with the content and duration of counseling at the discretion of the abortion provider, to usual care alone. Alternatively, contraception counseling can be reserved for women who voluntarily report that they are requesting

contraceptive services, an approach that emphasizes reproductive empowerment and autonomy. This approach is consistent with Dehlendorf et al. [24] who observed that women desire more autonomy in their contraceptive decision-making process compared to decisions about their general health. Future research should focus on the effects of different models of contraception counseling as a part of abortion care, and their effects on contraceptive initiation and rates of repeat unintended pregnancy. Such investigations must also take into consideration that many women already know which contraceptive method they want and that the benefit of discussing contraception may be limited to affirming women's preferences rather than educating them about all options. Kavanaugh et al. [25] noted that 69% of 542 women consider the abortion setting to be an appropriate time to receive information, with 54% indicating that less than 5 min is an appropriate duration for such a discussion. If abortion providers require extensive discussions about contraception for all women seeking abortion, such counseling may be perceived as coercive. For example, Kalmuss et al. [26] reported that perceived pressure from health care providers contributed to early discontinuation of the contraceptive implant.

Our findings suggest that family planning providers should consider redirecting resources toward reformatting tailored discussions about contraception at the time of abortion and strengthening contraception programs in other clinical settings. These efforts may include improving knowledge and practice surrounding contraception such as timing of initiation, appropriate use of a backup contraceptive method and emergency contraception, and limiting logistical barriers to contraceptive initiation and continuation that may lead to disinterest in contraception, such as financial cost and health screening requirements. For women who indicate that they are interested in more effective contraceptive methods, abortion providers could focus their efforts on eliminating

Table 3

Postabortion contraceptive method desired by women obtaining a first-trimester abortion when asked upon clinic registration ($n=1386$)

Contraceptive method	n (%)
Tier 1 (IUD, implant, sterilization)	198 (14.3)
Tier 2 (CHC, POP, injectable)	680 (49.1)
Tier 3 (barrier, FAB methods)	271 (19.6)
Other	1 (0.1)
Don't know	193 (13.9)
Not answered	33 (2.4)

Tiers based on WHO tiered effectiveness classification (WHO 2011); when participants provided more than one response, the data reflect the most effective method.

logistical barriers for immediate initiation of methods that require a clinician for administration (i.e., injectables and LARC methods).

Since we surveyed women upon clinic registration, before they received any counseling at the clinic, we did not evaluate how women feel about receiving contraception counseling despite any initial disinterest. Our findings also may not represent women's desires for discussing contraception once they have had their abortion procedure. Since this was an anonymous survey, we could not evaluate the effect of counseling on rates of contraceptive initiation or repeat unintended pregnancy.

Based on the characteristics of our population, generalizability of our findings to younger women or those seeking second trimester abortion is limited. In addition, our anonymous survey-based methodology did not allow confirmation of true study eligibility based on confirmed gestational age. The self-administration format of the surveys also allowed for incomplete survey responses. We encountered 7.5% missing responses with regard to the outcome of interest. We also had missing responses to <6% of sociodemographic data except for ethnicity which represented 10.4% of missing responses. In addition, 31% of respondents also did not provide information on the contraceptive method used leading to the index pregnancy; a possible limitation is a lack of a sensitivity analysis for this variable as a predictor for the primary outcome.

Our study offers insight into US women's preferences with regard to discussing contraception when seeking first-trimester abortion. In our mission to support women and their families, we as abortion providers must continue to bear in mind the distinctive elements of contraception care both within and outside of the abortion setting. Advocating for women's choices in reproductive health may also mean providing only the counseling that women desire.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.contraception.2018.08.005>.

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