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Authors

Matulich, Melissa
Cansino, Catherine
Culwell, Kelly R
et al.

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Understanding women's desires for contraceptive counseling at the time of first-trimester surgical abortion☆

Melissa Matulich, Catherine Cansino, Kelly R. Culwell, Mitchell D. Creinin*

Department of Obstetrics and Gynecology, University of California, Davis, Sacramento, CA 95817

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Abstract

Objective: The objective was to investigate whether or not women presenting for a first-trimester surgical abortion want to discuss contraception on the day of their procedure.

Study Design: Between October 2012 and January 2013, an anonymous self-administered survey was distributed to women receiving first-trimester surgical abortions at four northern California family planning clinics. The survey obtained demographic information about each woman and inquired about her desire for contraceptive counseling during her appointment. Results were analyzed using both univariate and multivariable regression analyses to assess trends in responses related to desire for contraceptive counseling based on demographic and other variables.

Results: Of the 199 respondents, 64% reported that they did not want to talk to a counselor or doctor about contraception on the day of their abortion. About half of the women (52%) who did not want to discuss contraception indicated they already knew what they wanted for pregnancy prevention. Of the 25% who reported that they did want to discuss contraception, the most important topic desired from the counseling was identification of methods that were easier to use than what they used previously.

Conclusion: The majority of women seeking first-trimester surgical abortion may not desire additional information about contraception on the day of the procedure.

Implications Statement: This study demonstrates that a significant proportion of women may not want contraceptive counseling on the day of a planned surgical abortion.

Keywords: Contraception; Abortion; Counseling; Survey

1. Introduction

In the United States, nearly half (49%) of the 6.4 million pregnancies each year are unintended [1]. The consequences of unintended pregnancies are broad, involving medical, emotional, social and financial costs on women, their families and their communities [2]. The United States Preventive Services Task Force recommends contraception counseling to prevent unintended pregnancy [3]. Theoretically, contraceptive counseling at the time of abortion should reduce the rate of unintended pregnancies and repeat abortions, but effectiveness is difficult to evaluate. Clinical trials and literature reviews from both the United States and Europe over the past decade have failed to show any benefit of highly specialized counseling as compared to routine counseling in the uptake of highly effective contraceptive methods [4] and in the reduction of unintended pregnancy rates or repeat abortions [5,6]. Most notable is a randomized trial from the United Kingdom which found that specialists' contraceptive advice and enhanced provision increased contraceptive uptake, in particular the use of long-acting methods, but did not reduce repeat abortion rates over the following 2 years [6]. A recent trial from the CHOICE project in the United States showed a reduction in population-based repeat abortion rates with directed counseling, provision of free product and immediate access to contraceptive methods amongst a cohort of women who opted to enroll in the trial [7]. However, the study does not

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* Corresponding author. Tel.: +1 916 784 6670.
E-mail address: mitchell.creinin@ucdmc.ucdavis.edu (M.D. Creinin).

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directly compare the outcomes of the 16% of the cohort enrolled after an abortion to those women who had an abortion and did not enroll in the trial. Without this comparison, along with the fact that the CHOICE project was more than just a counseling intervention, this report still does not provide the necessary evidence that specialized counseling alone has an impact on repeat abortion rates.

One prior study has evaluated whether or not women at an abortion clinic were interested in contraceptive counseling and method provision from their abortion provider [8]. This report included 542 respondents from five high-volume abortion clinics. In this study, approximately half of the women stated they preferred to receive contraceptive services (including information and methods) during their abortion care as compared to other health care settings. Oddly, a greater percentage (67%) wanted to leave the clinic with a contraceptive method. The population in this study included medical and surgical abortion patients, and the survey was not uniformly administered before the abortion; in fact, it is highly probable based on how the methods are described that many of the respondents answered the survey after their abortion or contraceptive counseling. Thus, the influence of the counseling itself would potentially have an impact on the study results.

We performed this study to learn more about what women presenting for a first-trimester surgical abortion want to discuss about contraception. Our primary goal was to understand if women wanted contraceptive counseling on the day of the abortion as well as the reasons why they did or did not want to have such a discussion.

2. Materials and methods

We conducted this anonymous survey to document what women want with regards to contraception counseling at the time of their first-trimester surgical abortion. We enrolled participants at four family planning clinics in northern California: Women's Health Specialists in the city of Sacramento, the suburb of Santa Rosa, the rural city of Redding and the college town of Chico. The practice at these facilities is to tell women when they are scheduling the appointment that contraceptive counseling will be available during the visit; however, the specific details of available methods are not discussed. Postabortal contraceptive methods offered at these clinics at the time of the study included oral, injectable, transdermal and vaginal hormonal options; female and male condoms; and emergency contraception pills. Women were also given the option to return at a later date for intrauterine device (IUD) insertion or to be referred to another provider for the contraceptive implant. The study was approved as an exempt application by the University of California, Davis, Institutional Review Board. The study was registered with Clinicaltrials.gov, identifier number NCT01807715.

Clinic staff offered participation in the study to women 18 years and older who were seeking a first-trimester (less than or equal to 12 weeks) surgical abortion on that day. Gestational age for study entry was based on what the woman believed her gestational age was at the time of presentation to the clinic. Women who could not read the survey were excluded from this study.

Clinic staff distributed surveys between October 2012 and January 2013 to women in the waiting room before any preprocedure or contraceptive counseling. Each potential subject received a manila envelope that included the 4-page 25-question survey; a business envelope to insert and seal the completed survey; and a cover letter which introduced the research goals, stated the voluntary nature and stressed the complete anonymity of the study. If the survey applied to the woman, she would fill it out while in the waiting room, seal the completed survey in the business envelope and deposit it into a sealed collection bin. Questions assessed sociodemographic information, current contraceptive use leading to the index pregnancy and whether she desired to speak to a doctor or counselor about contraception on the day of their procedure. Women were then asked to select which topics they would like to discuss about contraception from a list of options or were asked to select the reasons why they would not like to discuss contraception from a list of options. The survey contained no identifying questions.

One site (Santa Rosa) had staffing issues which resulted in only three surveys being completed. Given the limited number of subjects from this one location, the results from the Santa Rosa participants are excluded from the analysis.

We estimated the intended sample size based solely on the number of women who would complete the survey in the 4-month study period. We estimated this convenience sample would include approximately 200 women based on the estimated number of women seen in the clinic during the planned study duration.

The questionnaires were unsealed only after the entire study was completed. Responses were numerically coded into an Excel database. Descriptive analyses were performed to characterize the study cohort. Univariate analyses were completed to assess trends in responses related to desire for contraceptive counseling. Multivariable models were built using variables which had a univariate p value of .20 or less. Study site was intended to be forced into the model regardless of p-value. Data were analyzed using Stata Statistical software version 9.0 (Stata Corp., College Station, TX, USA).

3. Results

Of the 208 completed surveys, 6 were excluded based on the eligibility criteria and an additional 3 were excluded from the Santa Rosa location, leaving 199 surveys for analysis. Baseline information about participants is presented in Table 1. More than half of the women (59.8%) reported a

Table 1
Demographic information of study participants (N=199)

	Frequency (n)	Percentage (%)
Age (years)		
18–20	26	12.9
21–25	72	36.2
26–30	53	26.6
>31[a]	48	24.1
Race		
Caucasian	125	62.8
African American	25	12.6
Asian	10	5.0
Native American	7	3.5
Other	22	11.1
Unanswered	10	5.0
Ethnicity		
Not Hispanic	150	75.4
Hispanic	31	15.6
Unanswered	18	9.0
Relationship status		
Single	127	63.8
Married	35	17.6
Separated	17	8.5
Divorced or widowed	19	9.5
Unanswered	1	0.5
Gravidity		
One	40	20.1
Two	37	18.6
Three	45	22.6
Four	29	14.6
Five or more	48	24.1
Parity		
Zero	71	35.7
One	55	27.6
Two	48	24.1
Three or more	25	12.6
Number of previous elective abortions		
Zero	89	44.7
One	39	19.6
Two	30	15.1
Three	22	11.1
Four or more	18	9.0
Unanswered	1	0.5
Number of unplanned pregnancies[b]		
One	79	39.7
Two	51	25.6
Three	32	16.1
Four	22	11.1
Five or more	14	7.0
Unanswered	1	0.5
Highest level of education		
Less than high school	12	6.0
High school/GED	47	23.6
Some college	98	49.2
College degree	41	20.6
Unanswered	1	0.5
Work status		
Unemployed	48	24.1
Employed, part- or full-time	90	45.2
Student[c]	35	17.6
Homemaker	23	11.6
Unanswered	3	1.5
Annual household income		
<$25,000	117	58.8
$25,000–$50,000	23	11.6
$50,001–$250,000	11	5.5
>$250,000	7	3.5
Unknown	36	18.1
Unanswered	5	2.5
Number of persons living in household		
Lives alone	27	13.6
Two	57	28.6
Three	52	26.1
Four	33	16.6
Five or more	29	14.6
Unanswered	1	0.5
Religion		
Christian	87	43.7
Other	23	11.6
Not religious	77	38.7
Unanswered	12	6.0
Contraception[d]		
Category 1	88	44.2
Category 2	29	14.6
Category 3	3	1.5
None	63	31.7
Unanswered	16	8.0
Clinic location		
Sacramento	72	36.4
Chico	63	31.8
Redding	63	31.8
Unanswered	1	0.5
Travel time to clinic (by car)		
<30 min	127	63.8
30–59 min	33	16.6
1 h–1 h 59 min	27	13.6
2 h or more	10	5.0
Unanswered	2	1.0

[a] Oldest subject was 43 years.
[b] Including current pregnancy.
[c] If participant marked student and employment, student was counted as primary employment status.
[d] Method being used at time of current pregnancy; categorization was based on the WHO contraception effectiveness categorizations 2007 [9]: category 1=emergency contraception, natural family planning methods, withdrawal, male or female condoms, or diaphragm; category 2=hormonal patch, vaginal ring, oral contraceptives or injection; category 3=implant, IUD, tubal ligation or vasectomy.

history of multiple unintended pregnancies. Most women who were using any contraception during the month of conception were using barrier methods, natural family planning methods, withdrawal or emergency contraception.

Approximately two thirds (64%) of the women reported that they did not want to talk to a counselor or doctor about contraception on the day of their first-trimester surgical abortion, 29% reported that they did want to discuss contraception, and 7% did not respond. In univariate analyses, race and clinic location influenced the response to this question. Both African–American and Asian women were more likely to desire contraceptive counseling compared to Caucasian women [odds ratio (OR)=3.02, 95% confidence interval (CI): 1.20–7.62 and OR=4.94, 95% CI: 1.30–18.82, respectively]. However, in multivariable

analyses, only clinic location remained significant. Women at the rural Redding clinic were less likely to want to engage in a conversation about contraception (OR=0.29, 95% CI: 0.09–0.95) compared to the reference group of women at the Sacramento clinic.

Of the 49 women who indicated a desire to discuss contraception and answered the follow-up questions, the most frequently cited information desired were easier to use methods (31%), more effective methods (29%) and where contraception can be obtained (22%) (Fig. 1). Of the women who expressed interest in talking about contraception options on the day of their procedure, nearly all (92%) wanted to leave the clinic with a form of contraception.

Of the 128 women who did not want to talk about contraception, more than half (52%) reported that they "already knew what they wanted" (Fig. 2). There were no significant trends with regards to claiming to practice abstinence or reporting that they knew what contraception they wanted.

4. Discussion

This study of women planning first-trimester surgical abortions at four northern California clinics explores women's interest in contraceptive counseling on the day of their abortion procedure. Unlike studies that evaluate different methods of postabortion contraceptive counseling (e.g., standard counseling vs. a new intervention), we simply wanted to find out firstly if women even want any counseling on the same day as their abortion. We focused on that single issue, keeping the study anonymous and not linking the information to whether or not they left the clinic with a contraceptive. Women completed the questionnaire in the waiting room before seeing any staff to potentially discuss contraception. As such, what methods were or were not available at the clinic on the day of the abortion would therefore have no relevance as to whether or not the women intended or desired to discuss the methods.

Approximately two-thirds of women in our sample reported that they did not want to engage in contraceptive counseling on the day of their procedure. This rate is substantially higher than was reported by Kavanaugh and colleagues from a large survey that included 542 respondents from five high-volume abortion clinics [8]. The difference between the study's findings and our current trial is likely related to differences in methodology. It is also possible that women in our region who strongly desired long-acting highly effective contraceptive methods on the day of the surgical abortion may have asked at the time the appointment was scheduled and chose to go elsewhere, impacting the makeup of the population in our survey. Regardless, both our current study and the results published by Kavanaugh and colleagues [8] similarly show that women do not uniformly desire contraceptive counseling at the time of their abortion.

The unanswered question is why do a majority of women not want contraceptive counseling on the day of the abortion visit. Kavanaugh and colleagues [8] found that poor women (described as women on Medicaid) were more likely to want contraception at the time of the abortion. Our population was similar demographically to the cohort enrolled by Kavanaugh and colleagues [8]; however, with our primarily low-income group of participants (based on income level), we did not find such a correlation. Whereas providers may view an

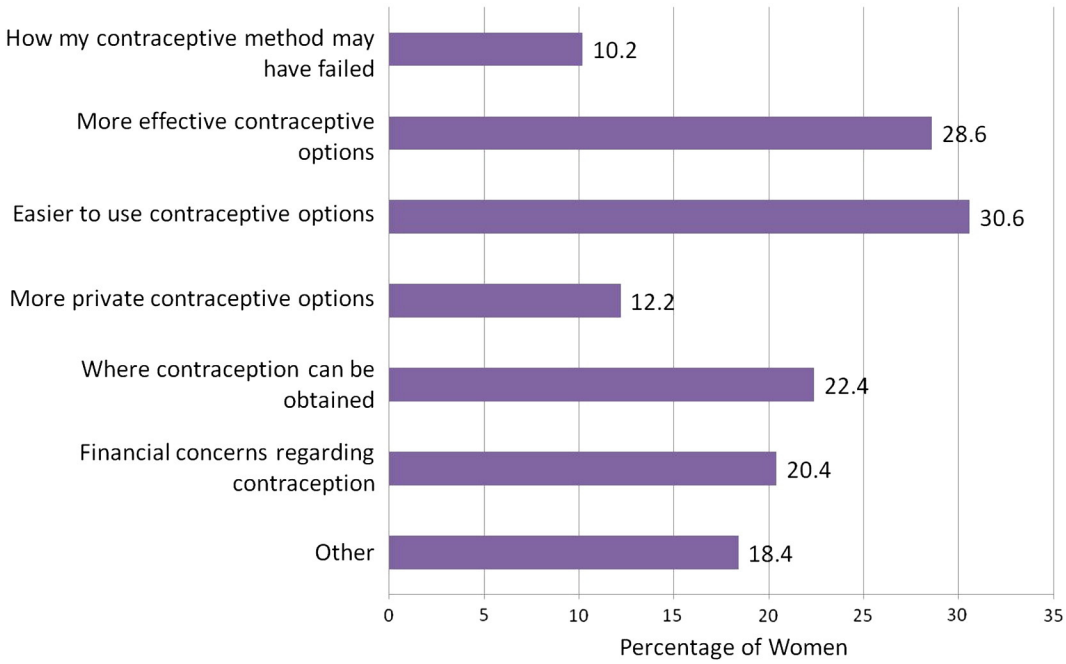

Fig. 1. Aspects of contraception that women would like to address if contraceptive counseling is desired the day of a first-trimester surgical abortion.

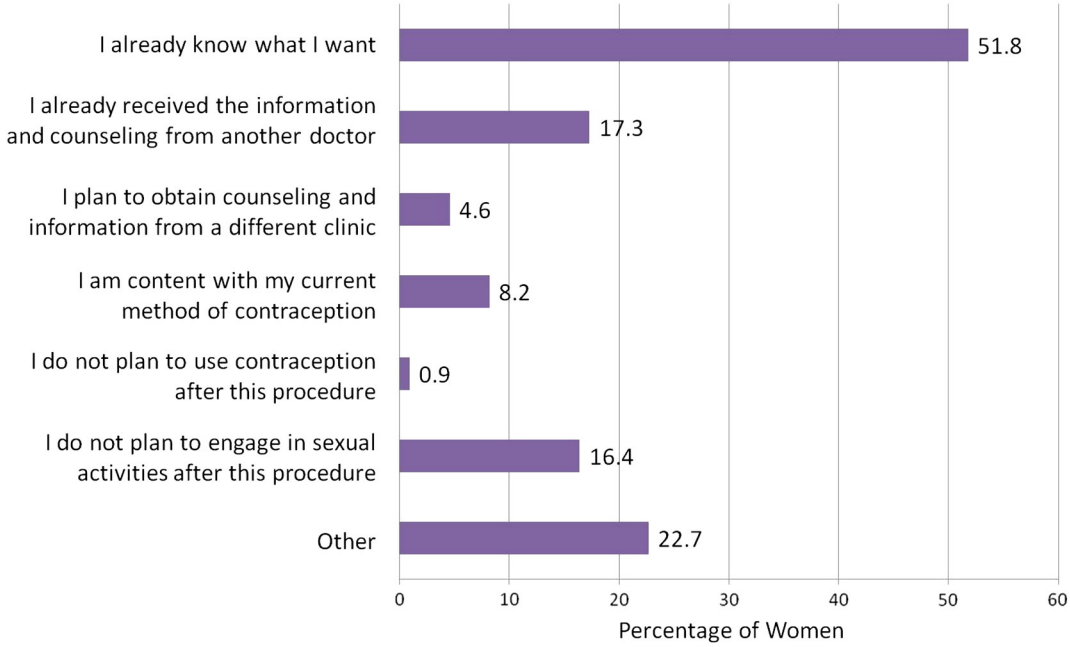

Fig. 2. Reasons why women did not want to engage in contraceptive counseling on the day of a first-trimester surgical abortion.

unintended pregnancy ending in abortion as a sign of failure on the part of the couple, thereby requiring counseling to prevent similar future events, women may commonly not share this view. Alternatively, women may just feel that the day of the abortion is not the best time to deal with contraception, considering the focus of the visit to be completion of the procedure. Conceivably, the results may be different if the women were receiving abortion services from their own gynecologist; women who go to an abortion clinic may view the abortion provider as simply that and would rather receive contraceptive counseling from their gynecologist or primary care physician. Of particular interest is the finding that women in the rural clinic were more likely to not desire contraceptive counseling; given that prior studies [8] used large-volume clinics which are likely not to be rural, this finding deserves further exploration in future studies.

Still, almost 30% of women were interested in contraceptive counseling on the day of their procedure. This result should not be dismissed as it proves that some women do want to use their abortion provider as a resource for postabortal contraception. The number of women who desired to discuss contraception was too small to perform accurate and relevant multivariable analyses to understand what characteristics were related to their desire to discuss contraception.

This study had several limitations. The small sample size limits the precision of the estimates presented. Both the homogenous population of primarily low-income, unmarried, non-Hispanic, Caucasian women and the lack of representation of one of the four clinics narrow the generalizability of our findings. Most importantly, our findings, primarily from three northern California clinics, may not represent the general population of women seeking abortion in the United States. Additionally, all of the women in this study were seeking surgical abortion, so the findings may not apply to women seeking medical abortion.

These limitations suggest important next steps in better understanding what women want in relation to contraceptive services at the time of abortion. First, a multicenter study is needed to understand potential variation amongst women in different locations as well as to understand if women who choose surgical or medical abortion have different desires for contraceptive counseling. In addition, learning more about the reasons behind a woman's desire to discuss or not discuss contraception may be better addressed through qualitative research.

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