Contraception

Contraception 92 (2015) 458–462

Original research article

The influence of trust in health care systems on postabortion contraceptive choice

Rachel E. Stacey, Angela Dempsey*

Department of Obstetrics and Gynecology, Medical University of South Carolina, 96 Jonathan Lucas Street, Suite 634, Charleston, SC 29425, USA

Received 26 January 2015; revised 6 July 2015; accepted 6 July 2015

Abstract

Objectives: This study investigates whether trust in the health care system or other patient-level characteristics are associated with interest in immediate initiation of long-acting reversible contraception (LARC) after abortion.

Study design: A structured, self-administered survey was provided to English-speaking women 18 years or older presenting to a reproductive health center in the Southeastern United States for first-trimester surgical abortion. The survey collected information about patient characteristics, choice of postabortion contraception, health literacy and trust in the health care system. Trust was measured using a 17-item, previously validated survey and was treated as the primary independent variable. Our primary outcome variable is interest in immediate LARC placement postabortion. Statistical analysis was performed using Chi-square tests, Student's *t* tests and logistic regression with SAS® 9.2.

Results: Of 162 respondents who completed the survey, 24% planned to use LARC postabortion, which increased to 37% if LARC placement was available on the day of their abortion. The mean trust score was 59±8 (possible score of 17–85) and did not differ significantly between women who indicated an interest in immediate LARC placement postabortion and those who did not (p=.9). Women with a history of a prior birth were 3.4 times more likely to indicate interest in immediate postabortion LARC than others (adjusted odds ratio 3.42, 95% confidence interval 1.63, 7.18).

Conclusion: Desire to accept LARC immediately postabortion is associated with history of a prior birth but not with trust in the health care system or other demographic variables. Participant interest in postabortion LARC varied based on immediate device availability.

Implications: This research underscores the importance of policies and clinical practices that promote access to LARC methods on the day of an abortion. Further research is needed to elucidate factors that correlate with choice of LARC postabortion.

Keywords: Long-acting reversible contraception (LARC); Trust; Contraceptive decision-making; Birth control; Abortion; Highly-effective contraception

1. Introduction

Incorrect and inconsistent use of contraception is associated with a significant proportion of the 3 million unintended pregnancies that occur annually in the United States [1]. Women with a prior abortion have higher risk for unintended pregnancy [2]. Over half of women presenting for abortion report using contraception during the month they conceived [3].

Some women desire to leave their abortion appointment with a contraceptive plan, and a significant proportion want to initiate highly effective contraception after an abortion [4–7]. Long-acting reversible contraception (LARC) including implants and intrauterine devices (IUDs) are highly effective methods of contraception with efficacy that is independent of individual user behavior [8]. IUDs and implants are safe to use immediately postabortion [9], and rates of unintended pregnancy following abortion are lower in LARC users versus nonusers [10]. Over half of abortion clinics did not offer LARC immediately postabortion in a recent national survey [7].

Little is published on factors associated with choice of the most highly effective methods including IUDs and implants immediately postabortion. Women may be more likely to choose IUDs and implants postabortion when these devices are offered free of charge [5]. Interest in LARC postabortion varies by race and ethnicity, with black women being less likely than women of other races/ethnicities to indicate

* Corresponding author. Tel.: +1-843-792-4500.
E-mail address: dempsear@musc.edu (A. Dempsey).

http://dx.doi.org/10.1016/j.contraception.2015.07.006
0010-7824/

interest in LARC [4]. This racial disparity is not well understood by current medical professionals [11]. Unlike other methods, LARC devices require interaction with a health care provider for insertion and removal. It is plausible that a significant level of trust in providers is inherent in the decision to choose an implant or IUD postabortion.

Trust in health care is the belief that a doctor or system is working in a patient's best interests [12]. A survey conducted among people seeking primary care revealed that women and minorities had lower levels of trust in the health care system, as measured by a validated trust scale [12]. Medical mistrust is higher among black women in the primary care setting in part due to a history of unethical medical practices such as involuntary sterilization of minorities [13]. Further exploration of the relationship between trust and contraceptive choice may improve contraceptive counseling practices and inform interventions to increase postabortion initiation of LARC.

This study seeks to evaluate the impact of trust in the health care system and other patient-level factors, such as demographic characteristics and health literacy, on postabortion choice of LARC. We hypothesized that women with a higher trust score in the health care system would be more likely to report desire to use LARC immediately postabortion.

2. Materials and methods

We conducted a cross-sectional study of women presenting to a free-standing abortion clinic in the Southeastern United States. Potential participants were approached after completing the standard ultrasound portion of their visit in order to confirm pregnancy and gestational age. On days that participants were recruited, brief contraception and abortion counseling was provided at the time of ultrasound per usual clinic practice, though this was not standardized by clinic protocol or between providers. A trained research coordinator provided education about the study and obtained written consent. The research coordinator monitored as participants completed the self-administered, anonymous survey on an electronic tablet prior to their abortion procedure. Study approval was obtained from our university's institutional review board.

Women were eligible for recruitment if they were 18 years or older, English speaking, pregnant with an intrauterine pregnancy less than or equal to 14 weeks gestation by ultrasound dating on day of enrollment and elected for surgical abortion. Women were excluded if they had a contraceptive implant at the time of presentation. Participants were informed that the purpose of this study was to better understand how women make choices about which birth control to use immediately after an abortion. Based on the clinical site's current practices, women may receive a prescription for short-acting birth control methods such as pills, patch, vaginal ring or depot medroxyprogesterone acetate injection prior to discharge if desired. Long-acting reversible methods were not available for insertion at this clinical site. Referrals to a nearby facility for LARC insertion could be provided for interested participants.

For this study, we adapted a survey instrument already in use in a study evaluating the impact of trust in the health care system on postpartum contraceptive choice. When possible, questions were taken from previously validated questions used in national surveys that are currently available in the public domain, including the Behavioral Risk Factor Surveillance System [14] and the Pregnancy Risk Assessment Monitoring System [15] administered through the Centers for Disease Control and Prevention as well as the 2009 National Survey of Reproductive and Contraceptive Knowledge administered by the Guttmacher Institute [16]. Question stems were adapted as necessary for relevance to our survey. Finally, in instances when no previously validated question was available to measure a variable of interest, a new question was created. The questionnaire collected information regarding a participant's trust in the health care system, contraceptive plans, health literacy, demographics, contraceptive and reproductive history, future pregnancy intentions and baseline knowledge about contraception, which were treated as independent variables of interest in our analysis.

We used a validated scale developed by Egede and Ellis [12] to measure individual trust in health care systems, divided into three domains: health care providers, institutions and payers. The trust scale included 17 questions scored on a 5-point Likert scale (total scale of 17–85): 10 measuring trust in the health care provider, 3 in the health care institution and 4 in the health care payer [12]. Health literacy was measured using the validated Rapid Estimate of Adult Literacy in Medicine-Revised (REALM-R) questionnaire [17]. REALM-R is a brief 8-item measure that provides an estimate of patient reading ability, displays excellent concurrent validity with standardized reading tests and is a practical instrument for busy primary care settings. REALM-R was administered and scored according to published instructions, and poor literacy was defined as a score of less than or equal to 6 (on a scale of 0–8) [17].

The primary outcome of interest was desire to receive LARC insertion immediately postabortion. Because same day insertion was not possible at the study site, we asked each participant whether they would choose an IUD or implant immediately after their procedure if it were available. We conducted descriptive analysis including frequencies and proportions to report baseline characteristics of the population studied, the distribution of predictor variables and the frequency of outcomes of interest. Women who indicated intent to use LARC immediately postabortion were compared to those who did not using Chi-square tests for categorical variables, t tests for continuous normally distributed variables or Wilcoxon rank-sum tests for continuous nonnormally distributed variables.

In the study that validated the trust scale we used, the mean trust score was 63 with a standard deviation of 8.8 [12].