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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