

Contraceptive Care in the Peri-Abortive Context

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Preface

This thesis was devised, designed, implemented, and written by myself (Jocelyn Wiens) under the supervision of Dr. Wendy Sword with the assistance of Dr. Wendy Peterson and Sandra Hooper, a nurse practitioner from Ottawa Public Health with an extensive background in sexual health. My supervisor and thesis committee were actively involved in providing suggestions, feedback, and expertise to assist with the development and completion of this project.

This group of advisors allowed me to complete this research largely autonomously, including the project proposal, literature review, study design and implementation, data analysis, and manuscript writing, but always with advice and scrutiny. The assistance they provided with all portions of this project, especially the study's design (Chapter 3), qualitative data analysis, and editing both manuscripts, was invaluable and all three are included as authors on both articles (See Chapters 2 and 3).

A thesis project proposal was reviewed and approved by all members of the thesis committee and by the Institute for Feminist and Gender Studies (a University of Ottawa requirement for a Specialization in Women's Studies) before the project began. No ethics board approval was required for the literature review portion (Chapter 2), however ethics approval was obtained from the University of Ottawa Health Sciences and Science Research Ethics Board prior to the initiation of recruitment for the qualitative study portion of this thesis (Chapter 3).

Several protections for participants were included as part of this approval. The informed consent process is discussed in Chapter 1. At the end of the interview, participants were given contact information for abortion-support groups and agencies that provide unbiased and non-judgmental post-abortive care and support in order to mitigate the risks of participation in this

study. All participants were reminded at the beginning and end of the interview that they could contact the researcher or her thesis supervisor if they wanted to speak with someone at any time after their participation.

Each participant was assigned an Internet-generated, ten-number/letter identification code. All documents were labeled with these IDs, and the interviews were transcribed verbatim by JW. The master list of participants was stored on a dedicated encrypted USB key available only to JW and all digital data (audio recordings, transcripts, and interview notes) were on a separate encrypted USB key, with the passwords to both known only to JW. Paper copies of consent forms were stored in a locked filing cabinet at JW's home throughout the study and will continue to be for the duration of the University of Ottawa's storage policy (5 years), at which point everything will be securely destroyed. Participants' identifying information will never be used in publicly available documents and randomly generated participant numbers were assigned for any published quotes (Chapter 3).

Abstract

Despite the availability of contraception in Canada, almost half of pregnancies are unintended and account for approximately 95% of elective, induced abortions. Nearly one-third of Canadian women will access an elective abortion in their lifetime and 30-40% of these women will access at least one further termination. Although contraceptive counselling is generally provided as part of abortion care, there is a paucity of research about the effectiveness of peri-abortive counselling methods or women's experiences with this care. This research was designed to better understand peri-abortive contraceptive decision-making through the lens of the Ottawa Decision Support Framework and addressed gaps in previous research. The thesis was completed in two parts, a literature review and the first Canadian qualitative study on this topic. Unlike most of the available research that focused on typical outcomes such as contraceptive uptake or continuation, the data from the interpretive descriptive study described women's informational needs, desired supports, and preferences for peri-abortive contraceptive care. The literature review described the current research and the findings from the qualitative study demonstrated that Canadian women's experiences with peri-abortive contraceptive care are similar to those in studies published in other countries. This thesis contributes to the limited body of knowledge in understanding what women need and want when receiving contraceptive care as part of abortion services.

Acknowledgments

First and foremost, I would like to thank my thesis supervisor Wendy Sword (RN, PhD) and the other members of my thesis advisory committee, Wendy Peterson (RN, PhD) and Sandra Hooper (MScN, NP-PHC), for their support of my graduate studies and research. All three provided an incredible amount of encouragement, feedback, and guidance throughout the development of the proposal, conduct of the study, and the writing of this thesis. I never would have completed this project without them.

An enormous thank-you to my mother, Kelly Wiens (BScN, MSc Health Promotion Studies) for the many (many!) hours she spent editing papers – both coursework and this document – and encouraging me to keep working. Her support was completely invaluable.

I acknowledge and thank the staff at Planned Parenthood Ottawa, Clinique des Femmes de l'Outaouais, and Planned Parenthood Toronto for answering so many questions, providing so much information, and displaying the Invitation to Participate cards.

Thank you to the Canadian Nurses' Foundation (CNF) for supporting my graduate studies with the Military Nurses' Award scholarship and for recognizing me as a CNF Scholar.

To the many friends and colleagues in this program who spent a great deal of time talking me through the research and writing of this thesis – thank you! I am very fortunate to know such a patient, kind, and knowledgeable group of people.

Finally, I would like to express my respect and gratitude to all the anonymous participants in my research study (Chapter 3). It takes courage to speak with a stranger about such personal and sensitive experiences. Without their willingness, openness, and bravery in sharing with me, this thesis would not have been possible. Thank you all so very much.

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Chapter 1: Introduction

Research Problem

Over 40% of all pregnancies in Canada are unplanned, approximately half of which will lead to an elective induced abortion (Black et al., 2015a; Norman, 2012). Unintended pregnancies account for an estimated 90-95% of abortions and 31% of Canadian women* will access an abortion before reaching the age of 45 years (Ames & Norman, 2012; Black et al., 2015a; Finer & Zolna, 2011). Although overall trends demonstrate that Canadian abortion rates have declined over the past 20 years, the rates for low-income women and minority groups have increased by up to as much as 17.5%, assigning a large proportion of abortions to these populations (Black et al., 2015a; Finer & Zolna, 2011; Jones & Kavanaugh, 2011; Norman, 2012).

Abortion is paid for by Canada's universal health care as a medically-necessary procedure; however, contraception provision is a more cost-effective option for the health care system (Ames & Norman, 2012; Black et al., 2015b; Browne & Sullivan, 2005). Contraception is used regularly by only 65% of sexually-active women; the most effective and economical methods of avoiding unintended pregnancy are long-acting reversible contraception (LARC) – intrauterine devices (IUD/IUS) and hormonal implants – which are used by less than 5% of women in Canada (Black et al., 2009, 2015b). The 2015 Canadian Community Health Survey reported that 15.5% of women not wanting to become pregnant did not use any method of contraception at last intercourse (Black et al., 2015a). Reasons for using, or not using, contraception vary widely and the research community has struggled to address the nuances and variables involved in the decision to avoid or to use contraception, and what type of contraception is chosen (Dehlendorf, Krajewski, & Borrero, 2014; Ferreira, Lemos, Figueiroa, & de Souza, 2009). The lowest rates of contraceptive

* The authors recognize that not all persons with a uterus identify as 'women' but have used this term in this research due to the typical binary gender language currently used in healthcare.

use are found among low-income women and those with mental health issues (particularly depression) and/or living in rural or remote areas of Canada (Black et al., 2015a).

Typically, contraceptive counselling is provided as part of abortion services, however women who have accessed an abortion continue to demonstrate no post-counselling increase in contraceptive use and 30-40% of clients will return for at least one subsequent abortion procedure (Black et al., 2015b; Kavanaugh, Jones, & Finer, 2010; Norman, 2012). To date, there has been very little research regarding women's needs, preferences, and values in this specific context (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013; Zapata et al., 2015; Zhang, Che, Chen, Cheng, & Temmerman, 2014). In order to develop client-centred interventions, we must understand women's preferences regarding contraceptive care in the context of accessing an abortion (Dehlendorf et al., 2013; Ferreira et al., 2009).

Thesis Objectives

The purpose of this thesis was to develop a better understanding of women's experiences with and preferences for contraceptive care when accessing an abortion. The objectives of the literature review and subsequent qualitative research study were to:

1. Find and compile available literature related to providing contraceptive care in the context of abortion;
2. Develop an improved understanding of women's decisional needs in regards to contraception when they are accessing an abortion;
3. Understand the preferences of women accessing abortions in regards to receiving contraceptive care; and
4. Identify the supports women describe as desirable in the process of discussing contraception when accessing an abortion.

Relevance to Nursing

Nurses are the largest health care workforce in Canada and work with the population in all areas of care, including direct patient care, health promotion, education, research, and policy development, (Canadian Nurses Association (CNA), 2008, 2015). Provision of contraceptive care to women accessing abortions is frequently the responsibility of nurses. Given the profession's clinical expertise and close interaction with clients at all stages of life, nurses are ideally situated as researchers and educators about contraception. Nurses provide leadership skills, research knowledge, and an ability to collaborate with the varied group of professionals involved in providing care to women accessing abortions (CNA, 2008). As health care providers who can be involved in the direct care of clients accessing abortions, nurses can and should be involved in understanding what women want and need when receiving peri-abortive contraceptive care.

Methodology and Thesis Design

This thesis began with an in-depth literature review (Chapter 2). This review was intended to gather all available research in regard to contraceptive care provided in the context of accessing an abortion. It immediately became evident that no published research on this topic had been completed in a Canadian context and that very few studies considering the experience and preferences of women who had received this care had been undertaken anywhere. The study conducted by the researcher (Chapter 3) examined women's informational needs in regard to contraception, their preferences for receiving contraceptive care, and the supports they described as desirable in the provision of this care.

Ontological and epistemological questions determine what the inquirer believes regarding, respectively, what can be known (ontology) and what the relationship is between the 'knower' and the knowledge (epistemology). The researcher takes a constructivist view of research and the

constructivist paradigm guided this thesis research. The constructivist paradigm takes a relativist view of ontology – there are multiple realities to be found – and a subjectivist and transactional view of epistemology – findings are constructed through interactions between the researcher and participant. The constructivist paradigm lends itself particularly to qualitative methods seeking a deeper understanding of human behavior and motivation in a socially-constructed and context-influenced reality (Guba & Lincoln, 1994).

An interpretive descriptive, qualitative approach was used in this study. This approach was informed by Michael Quinn Patton's additions to defining qualitative evaluation research and Guba and Lincoln's explanation of naturalistic inquiry (Thorne, 2016). Nurse researcher Dr. Sally Thorne developed interpretive description to "work out how we might obtain better understandings [of human subjective experience and behavior and] apply them to the betterment of lives ... in our everyday world of practice" (Thorne, 2016, p.36). Study design, sampling, data collection, and analysis in interpretive description are informed by ethnography, phenomenology, grounded theory, and naturalistic inquiry (Thorne, 2016). Qualitative, and specifically interpretive descriptive, studies are intended to uncover meaning and multiple realities, rather than to generate findings that are generalizable to a population (Polit & Beck, 2012; Thorne, 2016). Interpretive description uses patient-oriented research to examine complex clinical phenomena to develop knowledge and interventions relevant to applied health disciplines (Thorne, 2016).

Interpretive description values subjective and experiential knowledge, prioritizes a naturalistic environment for research, recognizes a socially-constructed and context-influenced 'reality', and acknowledges the inquirer as an active tool of research and the interactive relationship between researchers and participants (Thorne, 2016). In interpretive description, interviewing people about subjective experiential knowledge is not explicitly structured because

it “requires following leads suggested by the study participants ... as you progress through the research” (Thorne, 2016, p.123). This method of inquiry is ideal for the applied sciences of health disciplines because it strives to recognize and understand gaps in knowledge in order to inform better clinical practice (Thorne, 2016).

Situating the Researcher

Because interpretive description “capitalizes on the person who is considered the ‘instrument’ of the research” (p.75), it is essential for the researcher to situate themselves in their own context (Thorne, 2016). Thorne’s position is in line with Guba and Lincoln’s (1982) assertion that intense involvement of the inquirer in the research requires a practice of ‘reflexivity,’ wherein the investigator works to comprehend their personal presuppositions, understandings, and biases.

Although my clinical nursing experience lies in tertiary care, my graduate studies’ focus on family planning and reproductive health stems from a long-standing interest in global health and international development. Foundational to addressing the global status and health of women is addressing reproductive health, rights, and access to family planning. I pursued this interest by completing a Post-Graduate Certificate in Global Health Policy through the London School of Hygiene and Tropical Medicine in 2015-16. This certificate focused on the effects on and changes needed to address health in a globalizing world, particularly as these factors relate to women. Even in a high-income country like Canada with universal health care, nearly half of all pregnancies are unintended: this statistic suggests women’s needs for contraceptive care are both ongoing and unmet (Black et al., 2015a). When I decided to pursue a Master of Science in Nursing (MScN) with a Specialization in Feminist and Gender Studies, I knew I wanted to focus on women’s access to sexual and reproductive health care.

As part of the coursework for the MScN, in 2017 I completed a preceptorship placement with an Advanced Practice Nurse working in the community. Given my interest in sexual health and family planning, this placement was with Sandra Hooper, a Nurse Practitioner who was, at the time, working at the Ottawa Public Health Sexual Health Clinic. I completed a primary health care project focused on the factors leading to multiple abortions. This project was not a research study but rather a series of discussions with health care practitioners and other stakeholders, such as employees at a local sexual health education organization, about their backgrounds and experiences working with women accessing abortions. This assignment did not include discussions with women who had accessed an abortion regarding their personal experiences with contraceptive care. Although the outcome of this project identified several factors believed by stakeholders to contribute to multiple unintended pregnancies and abortions, I wanted to hear from women who had accessed abortions and this focused my thesis research. I designed my thesis research proposal to focus on women's experiences with and preferences and values for contraceptive care provided at the time of an abortion.

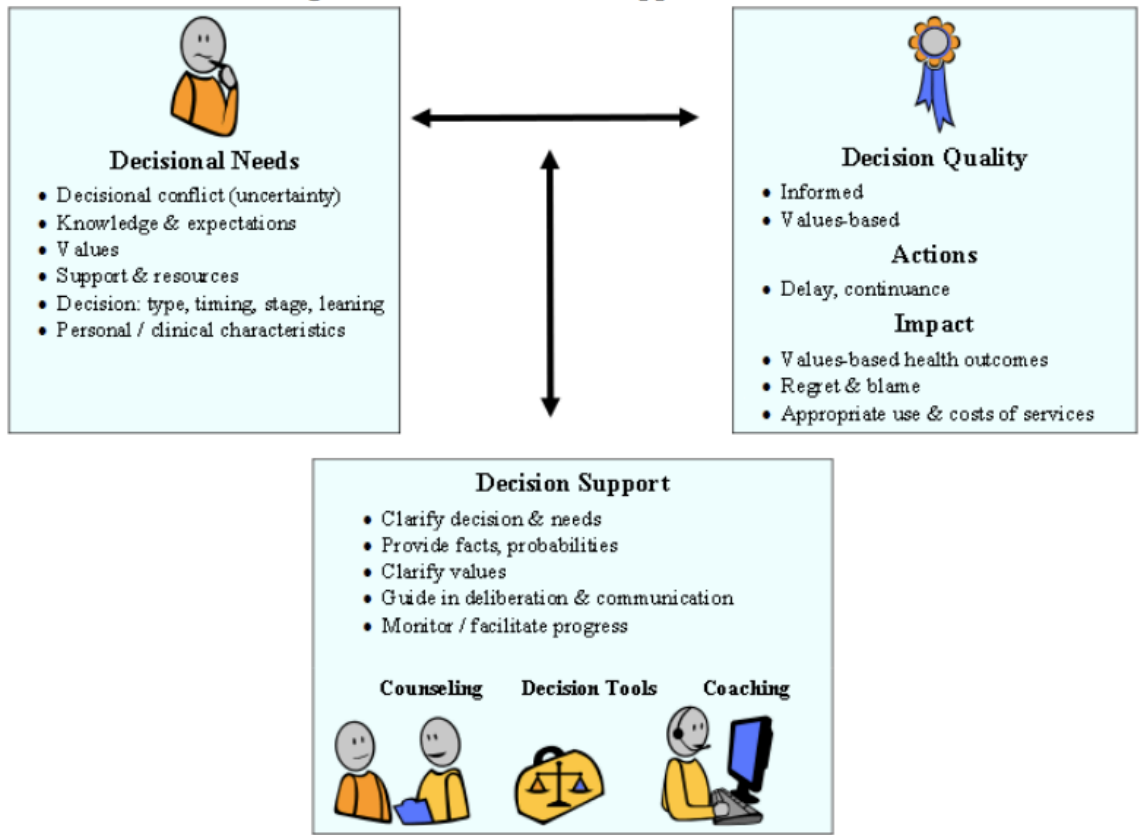
I chose to enroll in the Master of Science in Nursing with a Specialization in Feminist and Gender Studies program, and my personal views were and are influenced by feminist perspectives, theories, and methodologies. As a feminist, I value the individual rights and perspectives of women and other minorities, including the right to utilize family planning. My interest in this topic of research originates from a personal interest in, and value of, the concept of reproductive autonomy. I am pro-choice, believing that women should have the ability to use available measures (including contraception and/or abortions) to plan and control their own bodies, including whether or not to reproduce, how many children to have, and the timing of any births. A potential bias stems from a personal 'pro-contraception' stance, wherein I support increased knowledge, uptake, and adherence to prophylactic family planning measures.

The potential influence of some biases may have been mitigated because the study included women who had exercised reproductive autonomy by accessing an abortion. However, I am aware that choosing to access an abortion does not negate the risk of abortion stigma, from either external sources or from the woman herself. This is exemplified in research that demonstrated some women maintain a belief that abortion is unacceptable even though they justify accessing an abortion in their own circumstances; this population often continues to stigmatize other women who access the same service (Shellenberg et al., 2011).

Theoretical Framework

The Ottawa Decision Support Framework (ODSF) was chosen as a framework for the research (Figure 1). Like interpretive description, this framework was designed for use within a clinical context and strives to help health care practitioners guide clients in making social or health decisions (O'Connor et al., 1998; O'Connor, Jacobsen, & Stacey, 2002). It was developed from research in social psychology, decisional conflict, decision analysis, economic concepts of values, self-efficacy, and social support, and also from the literature in these areas (Murray, Miller, Fiset, O'Connor, & Jacobsen, 2004; O'Connor et al., 1998; O'Connor et al., 2002). The ODSF offers a decision-support intervention guide and was designed for use in new circumstances (such as an unintended pregnancy) that demand value-laden decisions (for example, the decision to continue or terminate a pregnancy) (Murray et al., 2004; O'Connor et al., 1998).

Figure 1 Ottawa Decision Support Framework



(O'Connor, 2006)

According to the ODSF, health and social decision-making is made up of three elements: decision needs, decision quality, and decision support (O'Connor et al., 1998). **Decision needs** encompass matters such as client values, individual personal or clinical characteristics, and knowledge and expectations about possible outcomes, benefits, and risks (O'Connor, 2006; O'Connor et al., 1998). Consideration must be given to matters such as support (or lack thereof) from family or friends, available resources (financial or otherwise), past experience with decision-making and outcomes, motivation, skill in decision implementation, and self-efficacy (O'Connor et al., 1998).

Decision quality addresses whether or not a decision aligns with a client's needs and values, especially in terms of potential harms or benefits (O'Connor et al., 1998). Quality is

determined by the decision-maker based on their experience of making a particular decision – how the person was helped to understand and supported through the process of making a decision – as well as the outcome of the choice they made (O’Connor, 2006). Additionally, decision quality concerns appropriate use and cost of services (O’Connor, 2006).

Finally, *decision support* concerns the role of health professionals who may act as a guide and facilitator as they coach a client through the deliberation of their options (O’Connor et al., 1998). Decision support may involve providing decision tools/aids or coaching in the decision-making process (O’Connor et al., 1998). Durand, Stiel, Boivin, and Elwyn (2008), when describing the assumptions of this framework, state, this “theory [of shared decision-making] postulates that the choice between two courses of actions is biased by the way in which the choices are described or framed” (p.129). Clients are likely to make different decisions based on how they are taught (Durand et al., 2008). A health care practitioner (HCP) who is providing decision coaching should be “supportive but neutral in the decision” (p.3) as they help a client clarify their needs, use evidence-based information to address knowledge deficits, and monitor decision-making progress (O’Connor, 2006).

Although much of the available research in the literature review (Chapter 2) focused on quantitative outcomes such as rates of uptake and continuation of contraception or future unintended pregnancies, the ODSF focuses on all parts of decision-making. The evaluation of the quality of a decision is judged not only by the outcome of a decision, but also by the decision-making process and the supportive interventions provided to the decision-maker (O’Connor et al., 1998). The ODSF is intended to guide HCPs in clinical settings to assess clients’ decision needs, provide support throughout the process of decision-making, and evaluate intervention effectiveness and the overall decision-making process from both the client and HCP perspective

(O'Connor et al., 1998; O'Connor et al., 2002). This framework provided the researcher with an understanding of the components of decision-making and the roles of HCPs.

Study Design

Prior to commencing recruitment, approval was obtained from the University of Ottawa Health Sciences and Science Research Ethics Board (see Appendix A). The researcher aimed to interview between 7 and 15 participants (Polit & Beck, 2012; Thorne, 2016). This sample size range was chosen as interviews were relatively long (approximately one hour) and in order to be feasible within the timeline of a graduate thesis (Polit & Beck, 2012). A small group of participants who have had a particular experience, such as terminating an unintended pregnancy, can provide interviews that are rich in data and describe the phenomena of interest in adequate depth (Thorne, 2016). Thorne (2016) suggests that in interpretive description research it is more important that the sample size sufficiently answers the research questions. Due to the intimate and personal nature of abortion procedures and the stigmatized nature of terminating a pregnancy, volunteer/convenience sampling was necessary to identify potential participants (Polit & Beck, 2012; Thorne, 2016).

An invitation to participate card (see Appendix B) was available to potential participants at one Toronto and two Ottawa sexual health education spaces. This card included general information about the researcher and the study and instructions to contact the researcher by phone or email if interested. Additionally, an invitation (see Appendix B) and a copy of the invitation card were posted without viewing restrictions on the researcher's social media accounts (Facebook, Instagram, Twitter) with permission for others to share these posts if desired. All participants first contacted the researcher by email.

When the researcher received an inquiring email, the potential participant was sent a copy of the consent form (see Appendix E) and encouraged to ask questions. Informed consent was

obtained from each participant before initiation of the interview. The researcher provided time to ask questions both on and off audio recording, before and after each interview. At the start of the recording, the researcher reviewed the consent form by section, giving the participant the opportunity to ask questions and provide verbal confirmation that she still consented to participate. All the women were assured they could revoke consent at any point, including mid-interview. At the end of the interview, participants were emailed a signed copy of the consent form.

After obtaining informed consent, the researcher collected basic demographic data including age, relationship status, and education level from participants to allow the researcher to describe the sample and allow others to determine if the findings were applicable to their context (see Appendix C; results reported in Chapter 3). Semi-structured interviews were undertaken using an interview guide that was informed by the Ottawa Decision Support Framework (see Appendix D) (O'Connor et al., 1998; O'Connor et al., 2002). Each interview was audio-recorded and transcribed verbatim in order to prevent incomplete notes or the insertion of personal views (Polit & Beck, 2012).

Thesis Layout

As described above, the first manuscript (Chapter Two) is a literature review, which addressed the first objective of this thesis. This chapter is written as a formatted article for submission to the Canadian Journal of Human Sexuality and served to provide a background for the design, implementation, and analysis of the qualitative study conducted by the researcher. It provides contextual background and a summary of available research on the provision of contraceptive care in the context of abortion. Most of the research focused on quantitative outcomes without describing the process of decision-making from women's perspectives. One of

the most significant finding from this review was a need for more research about women's preferences and values for contraceptive care provided in the context of accessing an abortion.

Chapter Three describes the findings from the interpretive descriptive study. This study was intended to address the second, third, and fourth objectives of the thesis proposal (listed above). Although the literature identified many gaps in research, the findings of this qualitative study were consistent with the existing qualitative research described in the literature review. This manuscript is formatted for submission for publication in *Qualitative Health Research*.

Lastly, Chapter Four is an integrated discussion analyzing the findings across both manuscripts (Chapters Two and Three), considering implications for the profession of nursing, and identifying future areas for research and policy development.

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Chapter 2: Literature Review Manuscript

Abortion and Contraceptive Care: A Literature Review

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Abstract

Before the age of 45 years, nearly one-third of Canadian women will access at least one elective, induced abortion, many of which are due to imperfect or non-use of contraception. Women in Canada generally demonstrate poor understanding and low knowledge about contraception and underestimation of their own fertility, both of which have been linked to low contraceptive use. Research demonstrates mixed evidence regarding the effect of contraceptive coaching on uptake and continuation of contraception. The purpose of this literature review was to understand the current state of and gaps in research about contraceptive coaching in the context of abortion care. The CINAHL and Ovid (MEDLINE) databases were searched, and the reference lists of relevant articles were hand-searched. Twenty-five English research articles were reviewed. The Ottawa Decision Support Framework (ODSF) was used to frame the available research according to the ODSF's three components: decision needs (clients' values, expectations, and supports), decision quality (how well the decision aligns with clients' expectations, available supports, and preferences), and decision support (the role of health care professionals in providing facts and information, value clarification, and coaching). Although the studies demonstrated mixed findings and were heterogeneous with varied methods, populations, and outcomes, the majority of researchers emphasized the importance of providing individualized, patient-centred care. Few articles addressed clients' preferences for contraceptive counselling in the context of accessing abortion services and no studies were conducted in Canada. In order to develop effective contraceptive coaching interventions further research is necessary.

Keywords: Abortion, contraception, counselling, coaching, decision making, patient preferences, peri-abortive

Abortion and Contraceptive Care: A Literature Review

Introduction and Background

Up to 40% of pregnancies in Canada are unintended and almost 50% of these end in an elective, induced abortion (Black et al., 2015a, 2015b; Norman, 2012). By age 45, 31% of Canadian women[†] will have accessed an abortion and 30-40% of these women will return for at least one subsequent abortion procedure (Ames & Norman, 2012; Black et al., 2015a; 2015b; Norman, 2012). Although overall abortion rates in Canada have declined over the past two decades, more than 80,000 induced abortions were performed in Canada in 2012 (Black et al., 2015a). Furthermore, rates for low-income and minority women have increased by as much as 17.5%, with a large proportion of abortions assigned to these populations; in Canada, Indigenous women have the highest abortion rates (Black et al., 2009; Black et al., 2015a; Finer & Zolna, 2011; Health Canada, 2013; Jones & Kavanaugh, 2011; Norman, 2012).

As a medically-necessary procedure, abortions are paid for by the health care system in Canada, and are a far less cost-effective option than providing contraception free of charge (Ames & Norman, 2012; Black et al., 2015a, 2015b; Browne & Sullivan, 2005). Black and colleagues (2015b) demonstrated that unintended pregnancies cost the Canadian health care system in excess of \$320 million annually, of which approximately two thirds can be attributed to imperfect or absent use of contraception. Unintended pregnancies account for more than 90% of abortions (Black et al., 2015b).

In addition to the high financial cost of unintended pregnancy and abortion, women accessing this procedure face significant risk of experiencing abortion stigma (Cockrill & Nack, 2013; Hanschmidt, Linde, Hilbert, Ridell-Heller, & Kersting, 2016). As defined by Kumar and

[†] The authors recognize that not all persons with a uterus identify as ‘women’ but have used this term in this article due to the typical binary gender language currently used in healthcare.

colleagues (2009), abortion stigma is “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideals of womanhood” (p. 628). As such, abortion stigma involves the negative feelings a woman has towards herself, her perceptions about others’ reactions to her abortion, or the experience of others revealing a prejudice against her decision (Cockrill & Nack, 2013; Hanschmidt et al., 2016). Women may experience feelings of guilt, negative self-perception, shame, anxiety, depression, self-blame, physiological and psychological pain and distress, or social withdrawal or isolation (Astbury-Ward, Parry, & Carnwell, 2012; Ellison, 2003; Hanschmidt et al., 2016; Kumar et al., 2009; Major & Gramzow, 1999). Abortion stigma may impair the well-being and health of the woman, decrease empowerment to ask questions, decrease health-seeking behaviours, and hinder disclosure of abortion to health care professionals (Hanschmidt et al., 2016; Major & Gramzow, 1999; Major et al., 2009; Norris et al., 2011).

Knowledge about contraception in the lay population is generally minimal and this lack of knowledge has been linked to low usage (Black et al., 2009; Black et al., 2015a, 2015b). The 2015 Canadian Community Health Survey found only 65% of women not wanting to become pregnant described consistent – ‘usually’ or ‘always’ – contraceptive use and that 15% of Canadian women reported they never use contraception (Ames & Norman, 2012; Black et al., 2009; Black et al., 2015a; 2015b). Canadian women reporting the lowest use of contraception are those who experience mental health issues (particularly depression), are low-income, and/or live in rural or remote areas (Black et al., 2015a). Reasons for not using, or using, contraception vary widely and researchers have struggled to address the nuances and variables involved in the decisions to avoid or use contraception, and about what method to use (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013; Ferreira, Lemos, Figueiroa, & de Souza, 2009).

Studies and reports show that many women underestimate their own fertility, particularly after an abortion when fertility may return as early as two weeks post-abortion (Bender & Geirsson, 2004; Black et al., 2015a; Kumar, Baraitser, Morton, & Massil, 2004a, 2004b; Moslin & Rochat, 2010; World Health Organization (WHO), 2012). According to Kavanaugh, Jones, and Finer (2010), “women’s quick return to fertility following an abortion justifies the provision of contraceptive information ... as a routine part of abortion care” (p. 335). In the same study, the researchers found that 96% of abortion clinics in the United States incorporated contraceptive education (Kavanaugh et al., 2010).

Although no data about the provision of contraceptive education as part of abortion care in Canada are available, the protocol for one ongoing Cochrane Database systematic review states that a “high level of repeated abortion among women seeking abortion suggests that their contraceptive needs might not be met” (p.1) and therefore contraceptive care must be improved (Zhang, Che, Chen, Cheng, & Temmerman, 2014). Fundamental to contraceptive counselling is the recognition of the complexity and uniqueness of each client and each decision about contraception: whether to use any method, which method to use, and whether or not to continue use of the chosen method (Aiken, Lohr, Aiken, Forsyth, & Trussell, 2016; Dehlendorf et al., 2013; Ferreira et al., 2009; Micks & Prager, 2014; Rogers & Dantas, 2017; Whitaker et al., 2016). There is limited research regarding women’s values and preferences for receiving contraceptive counselling and even fewer studies specifically examining these in the context of abortion (Matulich, Cansino, Culwell, & Creinin, 2014; Zhang et al., 2014).

Framework and Methods

The purpose of this literature review was to understand the current state of and gaps in research about contraceptive care in the context of abortion care. The Ottawa Decision Support Framework (ODSF) was chosen as a framework because it describes the components of decision-

making (O'Connor et al., 1998). This framework was designed to guide health and social decisions that arise in new circumstances (for example, abortion) and are value-laden, therefore requiring thorough deliberation (Murray, Miller, Fiset, O'Connor, & Jacobsen, 2004; O'Connor et al., 1998; O'Connor, Jacobsen, & Stacey, 2002).

According to the ODSF, health and social decision-making consist of three components: (1) decision needs (including client values and understanding), (2) decision quality (whether a decision aligns with a client's values and needs), and (3) decision support (the role of the person providing guidance or coaching to the client) (O'Connor et al., 1998). The literature is discussed based on what is known about decision-making in this context using the three ODSF components: (1) individual characteristics, values, preferences, expectations, knowledge, financial and social supports, motivations, and methods of learning of clients; (2) alignment of a decision with a client's preferences, values, and available supports; and (3) the roles of health care professionals in providing 'interventions' (activities intended to change, modify, support, or encourage women's use of contraceptives) (O'Connor et al., 1998; O'Connor et al., 2002; Zhang et al., 2014). The majority of the research reviewed in this paper focused on quantitative outcomes as the only measure of intervention success. However, the ODSF evaluates decisions by considering the entire process of decision-making, assessing the success of the decision support on the decision-making process, the decision itself, as well as the outcome(s) of the decision (O'Connor et al., 2002).

Searches for English-language articles were conducted using CINAHL and Ovid (MEDLINE) (See Table 1). Given the varied terminology, search results frequently demonstrated either a surplus or paucity of articles. The first author hand-searched the reference lists of relevant articles from the database results to find related articles. This process was continued until no new literature was revealed. Articles were included if: 1) they were available in English and 2)

they discussed contraceptive care provided at the time of abortion – either women’s experiences with this care or outcomes of specific methods of coaching. Articles were excluded if: 1) they were not in English or 2) they focused on increasing use of only a single, specific method of contraception, such as intrauterine devices or hormonal implants.

Article identification was complicated by a lack of common language use. Terminology for contraception, abortion, teaching/educational activities, and timing of interventions ranged widely. There also was a variety of vocabulary used to describe the intervention of discussing contraception with women. Terms included coaching, counselling, directing, educating, guiding, and teaching. When referencing the academic literature in the following discussion, the terms utilized by the referenced study’s authors will be maintained; however, in this paper, the authors utilized the ODSF term of ‘coaching’ to describe generalized contraceptive interventions. Additionally, ‘peri-abortive’ will be used in this paper to describe the variety of points in time when an intervention may have occurred, including before, after, or the same day as an abortion procedure.

Findings

A total of 25 peer-reviewed articles regarding contraceptive coaching and its related components of knowledge, preference, choice, and outcomes specific to the context of abortion care were identified and reviewed. These articles included three systematic reviews, seven randomized controlled trials (RCTs), four sub-analysis or retrospective records reviews, seven survey or questionnaire studies, and four qualitative studies that included in-depth interviews. Research participants were largely from the United States and the United Kingdom but also included women from China, France, Iceland, and Sweden. The three systematic reviews included studies completed in up to seven countries.

Systematic Reviews

Three reviews examined 15 distinct studies; however, only four of the reviewed trials were conducted in high-income countries with populations and health care systems comparable to those found in Canada, such as the United States and the United Kingdom. The earliest review examining contraceptive interventions included three RCTs about contraceptive counselling (Ferreira et al., 2009). Only one RCT found that counselling increased acceptance of contraception; this also was the only study that explained the chosen model of counselling, which was based specifically on the principles of ‘patient-centred care’ that had proven to be effective in other clinical interventions (Ferreira et al., 2009). Overall, the authors concluded that the provision of expert, individualized contraception counselling had no statistically significant effect on the rates of contraceptive continuation four months post-abortion (Ferreira et al., 2009).

Another systematic review by Stewart et al. (2015) included six RCTs that examined three outcomes: 1) risk of subsequent unplanned pregnancy, 2) uptake of long-acting reversible contraception (LARC), and 3) continuation of any chosen contraceptive method at three-month follow up; for all three outcomes no statistically significant difference was found between control and intervention groups. This review reported women in the intervention groups showed more knowledge about contraception compared to those in control groups, but this did not translate to increased contraceptive adherence at three months or a decreased risk of a subsequent unintended pregnancy (Stewart et al., 2015). Stewart and colleagues (2015) stated, “a lack of trials and participants included in each group meant that the overall meta-analysis may have lacked the power to detect a significant result” (p.7) and that several of the included studies had a high risk of bias due to poor randomization, allocation, concealment, and blinding.

A third, more recent systematic review included nine studies from low- and middle-income countries and determined that more information about contraception combined with more options

for types of contraception increased uptake post-abortion (Rogers & Dantas, 2017). This systematic review further concluded that abortion stigma, lack of comprehensive education on a broad choice of contraceptive methods, lack of comprehensive contraceptive counselling, lack of skilled post-abortion health care professionals, and judgmental or perceived judgmental attitudes of care providers were all barriers to contraceptive use; facilitators of contraceptive use included access to a wide variety of contraceptive methods and comprehensive sexual health information and counselling (Rogers & Dantas, 2017).

Randomized Control Trials

An RCT conducted in Iceland examined structured, standardized contraceptive counselling compared to usual care in a sample of 420 women; it found no difference in contraceptive use after abortion between control and intervention groups (Bender & Geirsson, 2004). No information about the timing of the contraceptive counselling – whether before or after the procedure – was provided. In contrast, two other RCTs that examined pre-abortion individualized, client-centred counselling compared to standard group counselling, with sample sizes of 246 and 41 women respectively, found that the intervention groups demonstrated increased understanding and acceptance of contraception (Ferreira, Souza, Pessoa, & Braga, 2011; Nobili, Piergrossi, Brusati, & Moja, 2007). The larger RCT by Ferreira et al. (2011) also reported 41% higher adherence to contraception at a 6-month follow-up among the intervention group compared to the control group.

Schunmann and Glasier (2006) conducted a RCT to assess the effect of specialist contraceptive counselling and provision of contraception in Edinburgh, UK. Three hundred and sixteen women were randomized to receive specialist contraceptive advice and enhanced contraception provision (including speaking with a doctor with specialized contraception training and the provision of a 3 month supply of their preferred contraceptive method) and 297 women received standard care (Schunmann & Glasier, 2006). Women in the intervention group were more

likely to choose a long-acting method (injectable, implant, or intrauterine device (IUD)/intrauterine system (IUS)) and more likely to leave the hospital post-procedure with contraception compared to those receiving standard care; but at 4 months post-procedure there was not a significant difference between the groups in continued use of contraception (Schunmann & Glasier, 2006). The authors concluded that specialist contraceptive counselling and enhanced provision demonstrated a short-term effect on contraceptive uptake and the selection of long-term options but did not seem to prevent future abortions (Schunmann & Glasier, 2006).

Researchers in China conducted an RCT using both a ‘simple intervention’ package for the provision of contraceptive counselling and a ‘full comprehensive’ package that included individual counselling, free contraception, and inclusion of the male partner (Zhu et al., 2009). A total of 2336 women ages 15 to 24 years who had an abortion were randomized from eight matched pairs of hospitals; both intervention packages increased the use of any contraceptive method however, compared to the ‘simple intervention’ package, the comprehensive package demonstrated increased uptake of more effective methods (Zhu et al., 2009). While there was an overall decrease in repeat unintended pregnancies leading to abortions among all participants compared to the general population, there was no statistically significant difference in the results between the two packages of care provided (Zhu et al., 2009). A limitation of this study was the lack of a control group receiving usual care for comparison, thus requiring the use of the ‘general population’ statistics in its place (Zhu et al., 2009).

In the United States, researchers conducted a RCT that examined the uptake of a “very effective contraceptive method” (female sterilization, IUD, or implant) in women accessing vacuum aspiration procedures; notably, they did not distinguish between elective and medically-indicated abortions (Langston, Rosario, & Westhoff, 2010). Structured counselling was provided to 114 women while 108 women in the control group received usual care (Langston et al., 2010).

Overall, researchers found women in the intervention group were no more likely to choose a very effective contraceptive method than those in the control group (Langston et al., 2010). However, the intervention group did trend towards increased 3-month continuation compared to the usual care group (Langston et al., 2010).

A pilot RCT randomized 60 women ages 15-29 years in the United States to compare regular, non-standardized care with motivational interview-based contraceptive counselling (Whitaker et al., 2016). The researchers found no significant difference between groups for uptake of any effective contraceptive method but of those who chose to use contraceptives, women in the intervention group were twice as likely to choose and continue LARC compared to women in the control group (Whitaker et al., 2016). Additionally, more women in the intervention arm reported satisfaction with both counselling and chosen method of contraception than those in the control group (Whitaker et al., 2016).

Retrospective and Sub-Analysis Studies

Yassin and Cordwell (2005) completed a 3-month re-audit at a clinic in the UK after the addition of dedicated pre-abortion contraceptive counselling by family planning nurses with additional counselling training. The original audit of 422 charts prior to the addition of contraceptive counselling found that only 40% of women received post-procedural contraception, mainly Oral Contraceptive Pills (OCP) and condoms (Yassin & Cordwell, 2005). Post-intervention, the follow-up audit of 104 charts showed that 96% of women received post-procedure contraception, including 73% of which were lower user-dependent methods such as IUD, implants, or injectable contraception (Yassin & Cordwell, 2005).

A retrospective case note review in Edinburgh, UK reviewed 898 cases to assess type of post-abortion contraception and incidence of repeat termination of pregnancy (TOP) (Cameron et al., 2012). The authors reported that compared to oral contraceptive pills, women who received a

post-abortive IUD/IUS were 20 times less likely and women with implants were 16 times less likely to return for a TOP; however, they were unable to assess if a further TOP was completed at another location, likely leading to an underestimated number (Cameron et al., 2012).

A population-based study examined the electronic records of 211,215 women in England who had obtained a TOP and were offered counselling and contraception (Aiken et al., 2016). Half (51%) the women chose counselling and also left the clinic with contraception, another third (33%) obtained counselling but chose to get contraception from another source, 7% received counselling but declined contraception, 8% declined both counselling and contraception, and no information on choice was available for the remaining 1% (Aiken et al., 2016). The authors recommended that a full range of education and contraception be offered to all clients accessing abortion care (Aiken et al., 2016).

More recently, Rocca and colleagues (2018) completed a sub-analysis of data from a trial involving 643 abortion patients aged 18-25 years from 17 reproductive health centres across the United States. Although a focus of this study was the impact of educating clinic staff about long-acting reversible contraception (LARC), it was designed specifically to evaluate differences in contraceptive counselling, method choices, and contraceptive use between two populations: vacuum aspiration and medication abortion patients (Rocca et al., 2018). The analysis demonstrated that, compared to women who had vacuum aspiration abortions, women accessing medication abortions were less likely to receive counselling about LARC methods as part of contraceptive coaching and were more likely to choose short-acting reversible contraception (SARC) or condoms (Rocca et al., 2018). This study emphasized that while same-day LARC placement is often available to vacuum aspiration abortion patients, the same is not available to medication abortion patients and this acts as a barrier in choice and uptake of LARC (Rocca et al., 2018).

Questionnaire and Survey Studies

Questionnaires and surveys are frequently used to examine both abortion care and contraceptive coaching. Garg, Singh, and Mansour (2001) used a self-administered questionnaire to assess the contraceptive practices and peri-abortion counselling given to 133 women in the UK, 83 of whom were undergoing a first-time abortion. This study found that at the time of accessing their first abortion, women reported significantly lower use of contraception and higher rates of less-effective methods compared to those undergoing a higher-order abortion (Garg et al., 2001). Participants reported varied content of counselling, with only half of participants learning about the unreliability of barrier methods; fewer than half booked follow-up contraceptive appointments, and even those who chose an “optimal contraceptive method” (p.77) demonstrated poor compliance with that method (Garg et al., 2001). The authors concluded that contraceptive counselling needed improvement, including highlighting the failure rates of OCP and barrier methods (Garg et al., 2001).

A study in the United States by Moslin and Rochat (2010) assessed women’s post-abortion sexual activity and contraceptive use. Seventy-two women were contacted three to five weeks post-abortion by telephone; 54% reported having engaged in sexual activity but only 70% of that group was found to have used any method of contraceptive (Moslin & Rochat, 2010). The only significant predictor of non-use of contraception post-abortion was if a woman had stated on their medical history form at the clinic that they did not want or need information about contraception (Moslin & Rochat, 2010). Recommendations included emphasizing the rapid return to fertility post-abortion, further research regarding reasons for use or non-use of contraception post-abortion, and better access to subsidized contraceptive services (Moslin & Rochat, 2010).

In France, 30 women with a history of two abortions completed questionnaires to assess their knowledge about contraception (Alouini, Uzan, Méningaud, & Hervé, 2002). This study

found that 27 participants (90%) had never heard of emergency contraception, 22 women (73%) accessed at least a third abortion, and nine (30%) reported not knowing what ‘back-up measures’ they should take after missing an OCP dose (Alouini et al., 2002). The researchers concluded that these clients could benefit from both additional information about contraception as well as the provision of free contraception (Alouini et al., 2002).

Two hundred and fifty-seven women who had abortions in the United States were surveyed about their preferences for decision-making about contraception and general health care (Dehlendorf, Diedrich, Drey, Postone, & Steinauer, 2010). Only a fifth (19%) of the women reported wanting autonomous decision-making about their general health but when it came to contraceptive decisions, half (50%) preferred autonomous decision-making (Dehlendorf et al., 2010). Dehlendorf and colleagues (2010) concluded women highly value autonomy when making decisions about contraception even more than general health care and contraceptive providers should assess their clients’ preferences to determine what decisional support they want in order to provide appropriate counselling.

Structured surveys were administered to 542 women who accessed abortion services at five abortion clinics across the United States to examine their attitudes about contraceptive services as part of abortion care; an additional 161 participants who had accessed an abortion in the preceding five years completed an online survey to provide supplementary information (Kavanaugh, Carlin, & Jones, 2011). Over two-thirds (69%) of participants considered the abortion clinic an appropriate setting for receiving information about contraception and the majority of these (66%) reported wanting to leave the clinic with contraception; women accessing a second or higher-order abortion were more than twice as likely to be interested in a LARC method (Kavanaugh et al., 2011). As most women reported an interest in learning about and accessing contraception in the abortion

setting, Kavanaugh and colleagues (2011) recommended that these services be provided in order to meet client needs.

A 2014 study in the United States surveyed 199 women to assess whether or not they wanted to discuss contraception with a health care provider on the same day as their abortion. In contrast to the findings of Kavanaugh et al. (2011), nearly two-thirds (64%) of women reported they did not want counselling on the same day as the procedure (Matulich et al., 2014). In both studies the women who wanted contraceptive education stated a desire for understandable information about easy-to-use methods (Kavanaugh et al., 2011; Matulich et al., 2014). The combined findings of these studies suggest that women consider discussions about contraception as an appropriate part of abortion care but do not necessarily want to receive this counselling the same day as their abortion procedure (Garg et al., 2001; Kavanaugh et al., 2011; Matulich et al., 2014).

Mixed Methods Study

Kavanaugh and colleagues (2010) used a cross-sectional, mixed methods study to assess how often contraceptive services are offered in US abortion clinics. Fifteen semi-structured telephone interviews and 173 structured surveys determined that 96% of clinics provided some form of contraceptive education to clients accessing abortions (Kavanaugh et al., 2010). However, the study also revealed that “the content and extent of this discussion varies widely” (p.333) and only 20% of clinics spent 15 minutes or more on these conversations (Kavanaugh et al., 2010). Additionally, Kavanaugh and colleagues (2010) recognized both that these findings relied on health care providers’ self-report regarding counselling provision, and that there are many reasons why abortion providers may not prioritize contraceptive services as part of care, including time and economic constraints (Kavanaugh et al., 2010). The authors concluded, “assessing abortion patients’ perspectives regarding the desire for contraceptive services in this setting and the manner

in which they should be delivered would be a worthwhile pursuit in future research” (Kavanaugh et al., 2010, p. 335).

Qualitative Studies

Most of the four qualitative studies did not identify the design that was used, but rather only the nature of data collection. In one older UK study, in-depth interviews were completed between 3 and 9 weeks post termination of pregnancy, with 21 women between 16 and 40 years of age with varied ethnicities (Kumar et al., 2004a, 2004b). Researchers found contraceptive risk-taking was high both before and after the abortion and that participants felt that health providers had not explored or discussed contraception in sufficient detail or clarity (Kumar et al., 2004a, 2004b). This study also revealed that many health providers deferred conversations about contraception to post-termination follow-up visits, which were attended by only 57% of participants (Kumar et al., 2004a, 2004b). Kumar and colleagues (2004a, 2004b) emphasized the importance of providing non-judgmental care, support, and information.

In-depth, semi-structured interviews were conducted in the United Kingdom with 25 health professionals working in abortion services and 46 women who had accessed a medication abortion (using mifepristone and misoprostol) before nine weeks gestation (Purcell, Cameron, Lawton, Glasier, & Harden, 2016). More than half of participants believed abortion appointments were an appropriate time and context to discuss contraception, however “a minority of women experienced being asked about contraception as implying judgment of their behaviour” (Purcell et al., 2016, p. 173). Both health professionals and the women accentuated that appearing nonjudgmental is a fundamental feature of good abortion care; health professionals cited lack of time and training as a significant barrier to the provision of optimal counselling (Purcell et al., 2016). Additionally, Purcell and colleagues (2016) emphasized that women’s previous experiences with contraception and those of their friends – both positive and negative – significantly affect their decision in regards

to method. Health professionals in this study described, “taking women’s ‘preconceived ideas’ as a starting point for a more in-depth conversation about her needs and preferences” (Purcell et al., 2016, p.174).

In Sweden, researchers interviewed health professionals involved in providing contraceptive counselling to women accessing abortions (Kilander, Salomonsson, Thor, Brynhildsen, & Alehagen, 2017). Twenty-one midwives (principal health professional involved in contraceptive counselling in Sweden) and gynecologists were interviewed (Kilander et al., 2017). Study participants reported contraceptive counselling at the time of an abortion is particularly complex due to the split-focus of the appointments (terminating the pregnancy and deciding on contraception), the need to build trust with women in this emotionally and physically demanding context, and an insufficient amount of time to provide optimal care (Kilander et al., 2017). They also reported their own limited knowledge and practical training about contraception (e.g., inserting IUDs or implants) and lack of access to contraceptive services as barriers to care in this context (Kilander et al., 2017).

Another study in Sweden used an interpretive phenomenology design. Thirteen women who had experienced an abortion were interviewed about their lived-experiences of contraceptive counselling (Kilander, Beterö, Thor, Brynhildsen, & Alehagen, 2018). The researchers identified two over-arching themes: the need for respectful counselling in such an emotionally charged situation and the need for guidance and access to contraception from their health professional (Kilander et al., 2018). Kilander and colleagues (2018) reported, “women who experienced respect from the [health professional] stated they often developed trust in the [health professional], which facilitated contraceptive decision-making” (p.107) but that a lack of time hindered the development of this trust. Participants in this study also cited previous negative experience with side effects – both personal and that of friends – as a significant consideration when choosing a contraceptive

method as it lead to a fear of using hormones; most specified that this fear was never discussed in their counselling session (Kilander et al., 2018). Women described preferring a respectful health professional who was knowledgeable about contraception, would provide comprehensive information (including about side effects), and could facilitate access to the chosen method (Kilander et al. 2018)

Discussion

When providing contraceptive coaching in the context of abortion care, little is known about decision needs, decision quality, or decision support. The available research is generally focused on limited outcomes: uptake and adherence to contraception, choice of particular types of contraceptives, or future rates of unintended pregnancy and abortion. However, it is the responsibility of health care professionals to ensure their clients are able to make informed decisions, including about contraception (O'Connor, 2006). Although the available research demonstrates that women in Canada have low knowledge about contraception, we know little about women's preferences and values, their preferred methods of decision-making (autonomous, shared, or paternalistic), or how they would like to receive contraceptive coaching (Black et al., 2009; Black et al., 2015a, 2015b; Black et al., 2015d; Norman, 2012; O'Connor, 2006). Most of the research focused on quantitative outcomes, such as contraceptive continuation after an abortion or future unintended pregnancies, but without examining why the interventions were not more successful. No applicable research has been completed in a Canadian context.

Low levels of contraceptive knowledge and the underestimation of fertility have been linked to low use of contraception (Black et al., 2009; Black et al., 2015a, 2015b; Black et al., 2015d; Norman, 2012). Kilander and colleagues (2018) reported that many women's perception of decreased fertility post-abortion affected their plans about contraception. Moslin and Rochat's 2010 study found the only significant predictor of post-abortion non-use of contraception was if a

woman reported not wanting or needing information about contraception. Furthermore, the study conducted by Dehlendorf and colleagues (2010) found that when it comes to decisions about contraception, women are likely to prefer autonomous decision-making. In the one study, women who refused counselling about contraception demonstrated non-use post-abortion, possibly due to a lack of knowledge, and women in the other study stated a desire to make decisions about contraception without health care provider involvement (Dehlendorf et al., 2010; Moslin & Rochat, 2010). Together these findings complicate circumstances for health care professionals: how can knowledge deficits be addressed while also respecting women's preferences for decision-making? What kind of decision support should health care professionals be providing? How can decision needs be addressed in a manner that promotes decision quality?

According to the ODSF, the health care professional's role in providing decision support includes clarifying the client's decision and needs, providing facts and information, and guiding the decision-maker in deliberating towards a decision and accessing relevant support and resources (O'Connor, 2006). In terms of contraceptive coaching, the most pertinent part of this role relates to "facilitating access to evidence-based information, verifying understanding, clarifying values" (p.3) and promoting decision-quality (O'Connor, 2006). To date, there is no research about how to balance the need to provide women with contraceptive coaching with their preference for autonomous decision-making when it comes to decisions about contraception (Dehlendorf et al., 2010; Kilander et al., 2017; Moslin & Rochat, 2010; Purcell et al., 2016).

The literature also revealed that many women agree that abortion clinics are an appropriate setting for contraceptive coaching and they value comprehensive information about easy-to-use methods (Garg et al., 2001; Kavanaugh et al., 2011; Kilander et al., 2018; Matulich et al., 2014; Purcell et al., 2016). Further, the women from the same studies stated they did not want to receive contraceptive coaching the same day as their abortion (Garg et al., 2001; Kavanaugh et

al., 2011; Matulich et al., 2014). However, a significant number of women either do not book or do not attend follow-up appointments at abortion clinics, but instead visit potentially less intimidating settings to see health care professionals who may be unaware of their abortion(s); researchers have hypothesized that this type of avoidance behaviour stems from the culture of silence and stigma associated with abortions (Garg et al., 2001; Kumar et al., 2004b, 2004a; Kumar et al., 2009; Kilander et al., 2017; Major & Gramzow, 1999). Importantly, women also reported contacting an unknown health professional for contraception was a barrier to accessing care (Kilander et al., 2018). More research is needed about women's preferences for timing and setting of contraceptive coaching preceding or following an abortion.

The research demonstrating low attendance at follow-up procedures has led to an increased emphasis on single-visit abortion procedures – where counselling, contraceptive coaching, and the actual procedure occur on the same day. This shift to single-visit abortions may explain why 80% of clinics spend less than 15 minutes on contraceptive coaching (Kavanaugh et al., 2010). Even in the study by Purcell and colleagues (2016) that examined medication abortions where there was a minimum of two visits – allowing for coaching to take place at either or both appointments – health professionals cited lack of time as a barrier. Properly assessing a woman's decision needs, including knowledge, resources, and values and also providing guidance, teaching, and support is likely not plausible in this limited time-frame (Kilander et al., 2017; Kilander et al., 2018). Given the low level of contraceptive knowledge in the general population and low contraceptive use in post-abortion populations, even the 15 minutes provided by 20% of abortion clinics, as cited by Kavanaugh et al. (2010), is an insufficient amount of time to provide adequate contraceptive coaching. The authors of this paper question whether single-visit terminations also lead to more unintended pregnancies and, likely, more terminations with their associated costs (Black et al., 2015d).

The ODSF maintains that decision needs include the decision-maker's knowledge and expectations, values, support and resources, uncertainty, and personal and clinical characteristics (O'Connor, 2006). Few women receive comprehensive education yet the provision of thorough information about available options has been linked to increased satisfaction with coaching and the chosen method; the provision of comprehensive information may also increase uptake and continuation of contraception (Ferreira et al., 2011; Kavanaugh et al., 2010; Kavanaugh et al., 2011; Kilander et al., 2017; Kilander et al., 2018; Kumar et al., 2004a, b; Matulich et al., 2014; Nobili et al., 2007; Rocca et al., 2018; Rogers & Dantas, 2017; Whitaker et al., 2016; Yassin & Cordwell, 2005; Zhu et al., 2009). One study found that 54% of women return to sexual activity within 3-5 weeks of an abortion and 30% of those women reported using no method of contraception (Moslin & Rochat, 2010). Although 96% of abortion clinics reported talking to patients about contraception, women still may not understand their rapid return to fertility, how non-barrier contraceptives work, the difference between different methods, or which methods best meet their needs (Black et al., 2009; Black et al., 2015a; Black et al., 2015d; Kavanaugh et al., Kilander et al., 2018; 2010; Moslin & Rochat, 2010; Norman, 2012).

Decision quality is defined by the decision maker and is affected both by the process of the decision-making and the decision result (O'Connor, 2006). In the case of contraceptive decisions, decision quality includes how the woman is helped to understand the available options and costs, procedures, and possible benefits and harms associated with each method, as well as the consideration of her values and preferred level of involvement in the actual decision-making (O'Connor, 2006). For a decision to be high quality, the choice should align with the informed woman's preferences and values as they relate to potential harms or benefits, costs, and scientific uncertainties (O'Connor, 2006). In the Canadian Contraceptive Consensus (2015), Black et al. stated that, "[in] 2012, over 80,000 induced abortions were performed in Canada ... The

persistent need for abortion services indicates that we are not meeting the contraceptive needs of Canadian women” (Black et al, 2015a, p.55). Health professionals involved in contraceptive coaching to women accessing abortion described the elements of counselling as providing information about methods, finding “the most sustainable method for the individual woman” (p.6), and motivating women to use contraceptives (Kilander et al., 2017).

Regardless of their findings, the majority of researchers emphasized the importance of providing individualized, patient-centred care (Aiken et al., 2016; Bender & Geirsson, 2004; Dehlendorf et al., 2010; Ferreira et al., 2011; Kavanaugh et al., 2010; Kavanaugh et al., 2011; Kilander et al., 2017; Kilander et al., 2018; Nobili et al., 2007; Purcell et al., 2016; Rocca et al., 2018; Whitaker et al., 2016; WHO, 2012; Yassin & Cordwell, 2005). Women are strongly motivated by experiential knowledge – either their own or that of their friends – and their personal background and experience must be assessed in order to address these concerns (Kilander et al., 2017; Kilander et al., 2018; Purcell et al., 2016). Individual coaching based on client preferences and a collaborative relationship between a woman and the health care professional has been shown to increase knowledge about and continuation of contraception (Kavanaugh et al., 2011; Kilander et al., 2018; Nobili et al., 2007; Purcell et al., 2016; Whitaker et al., 2016). In order to develop effective contraceptive coaching methods for women accessing abortion services, it is imperative to understand the context and issues from their own perspectives (Kilander et al., 2018).

Limitations

The little research that does exist has many limitations. Available articles about contraceptive coaching in the context of abortion demonstrated mixed findings; many researchers cited small sample sizes and clinical and methodological heterogeneity as a significant limitation (Ferreira et al., 2009; Rogers & Dantas, 2017; Stewart et al., 2015). The studies are

heterogeneous in that they examined a variety of outcomes (e.g. contraceptive uptake or adherence, participant knowledge, type of contraception chosen, or rates of subsequent unintended pregnancy/abortion), coaching styles (e.g. patient-centred or individualized, standardized, or specialized), and timing of counselling (e.g. before, same-day, after the abortion procedure, or on more than one day). Most of these studies also used inconsistent inclusion criteria, mainly focusing on English-speakers from a variety of ages (e.g. ‘under 45 years’, 18-25 years’, or ‘over 18 years’). In addition to the paucity of available studies, much of the existing research is subject to the biases of recall and social desirability (Black et al., 2009; Ferreira et al., 2009; Nobili et al., 2007; Stewart et al., 2015; Rogers & Dantas, 2017).

Furthermore, none of the studies reviewed were completed in Canada. Although there are many similarities between Canadian populations and those found in the United States and the United Kingdom, there are significant differences between the health care systems, accessibility, and coverage in all three countries. For example, both Canada and the UK have universal healthcare but, unlike Canada, the UK provides contraception free-of-charge to their citizens (Aiken et al., 2016; Black et al., 2009; Black et al., 2015a; Browne, 2005; Cameron et al., 2012). By providing women with free contraception, the UK removes a barrier that is faced by many women in both Canada (excepting residents of Quebec) and the United States (Aiken et al., 2016; Black et al., 2009; Black et al., 2015d; Cameron et al., 2012) However, studies from the United States and the UK may still be applied to a Canadian context, albeit in a limited manner.

Conclusion

Given women’s rapid return to fertility post-abortion, contraceptive coaching should be an integral part of abortion care. However, there are conflicting findings regarding the optimal timing, format and content, and effectiveness of providing adequate decision support to meet women’s decision needs and promote decision quality. Although several studies indicate that contraceptive

coaching in the abortion context has little effect on understanding, uptake, and continuation of contraception, there are other studies that contradict these findings. Furthermore, no studies were found that examined the reasons and/or motivations behind women's non-use of contraceptives post-abortion. Aiken and colleagues (2016) stated in order to develop client-centred interventions health care professionals must understand women's preferences regarding contraceptive coaching in the context of accessing an abortion. More research examining women's preferences and values for this kind of care is needed, particularly research within the Canadian context.

Declaration of Interest

The authors report no conflicts of interest.

Table 1: Search Terms

	Concept 1 (AND)	Concept 2 (AND)	Concept 3 (AND)	Concept 4 (OR)
OR	(Induced) Abortion	Counseling/ Counselling	Contraception/ contraceptive	Unintended pregnancy
OR	Termination of pregnancy	Coaching	Birth control	Unplanned pregnancy
OR	Post-Abortal/ Post- abortion	Teaching	Short acting reversible contraception/ SARC	Unwanted pregnancy
OR	Peri-Abortal	Educating/ Education	Long acting reversible contraception/ LARC	Repeat/ Multiple (unintended /unplanned/ unwanted) pregnancy
OR	Repeat abortion/ Multiple abortion	Guiding/ Guidance	Intrauterine device/ IUD	
OR		Directing/ Direction	Intrauterine system/ IUS	

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Chapter 3: Study Manuscript

Women's Experiences with Peri-Abortive Contraceptive Care: An Interpretive Descriptive Study

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Abstract

Introduction: Despite mixed findings on its effectiveness and a paucity of information about women's experiences, contraceptive counselling is often provided as part of abortion care. This study was designed to improve understanding of women's informational needs, desired supports, and preferences for contraceptive counselling in the context of accessing abortion services.

Methods: Using interpretive description and the Ottawa Decision Support Framework, in-depth interviews were conducted with eight Canadian women who had accessed at least one abortion in the previous 2 years. A combination of constant comparative, interpretive phenomenological, and narrative analysis was used to inform analysis and interpretation of the data. **Findings:** Three major themes were identified: 1) women want to make informed decisions about contraception, 2) person-centred care is fundamental to the provision of good contraceptive care, and 3) women value autonomy in contraceptive decision-making. An additional meta-theme related to participants' negative experiences with stigma and judgement, particularly from health care providers (HCP). **Discussion:** Receiving contraceptive counselling as part of abortion care requires balancing discussions about both the termination and post-abortion contraception. Women want to understand sexual and reproductive health, contraception and, most importantly, the personal implications of a contraceptive method on their own health. Findings from this study are consistent with other research demonstrating women place high value on experiential knowledge and open, non-judgmental care from their HCPs. **Conclusion:** Contraceptive care should be provided in a non-judgmental and supportive person-centred manner that considers women's individual needs, preferences, and values. More research is needed to determine optimal approaches to this care.

**Women's Experiences with Peri-Abortive Contraceptive Care:
An Interpretive Description Study**

Introduction

Contraceptive counselling is often provided as part of abortion care in an effort to prevent additional unintended pregnancies, despite mixed findings on its effectiveness and a paucity of information about women's[‡] preferences and values for this care (Rogers & Dantas, 2017; Stewart et al., 2015). Women who have accessed an abortion in Canada, the United Kingdom, or the United States experience high rates (40-50%) of further unintended pregnancies and abortion (Black et al., 2015a; Department of Health & Social Care, 2018; Guttmacher Institute, 2018). Most existing research accentuates the importance of person-centred care that is individualized for each interaction but few studies have examined women's experiences with contraceptive care in the context of abortion (Kilander, Berterö, Thor, Brynhildsen, & Alehagen, 2018; Kilander, Salomonsson, Thor, Brynhildsen, & Alehagen, 2017; Purcell, Cameron, Lawton, Glasier, & Harden, 2016).

Canada is one of only a few countries that places absolutely no legal restrictions on access to abortion and covers the procedure as medically necessary (Browne & Sullivan, 2005). Nearly one third of Canadian women will access an abortion in their lifetime (Norman, 2012). Although there is a wide availability of contraception in Canada, only 65% of women who state they do not want to become pregnant report using contraception 'always' or 'usually' (Black et al., 2015a). Lack of knowledge about fertility and contraception are linked to low contraceptive use and increased unintended pregnancies, yet there are no reliable data or formal mandates in Canada

[‡] The authors recognize that not all persons with a uterus identify as 'women' but have used this term in this article due to the typical binary gender language currently used in healthcare.

regarding the provision of contraceptive counselling at abortions (Black et al., 2015a; 2015b; Norman, 2012).

While fertility may return as early as two weeks post-abortion, many women expect to be at a lower-than-usual risk for unintended pregnancy and this perception affects their post-procedure contraceptive decisions (Kilander et al., 2018; World Health Organization (WHO), 2012). Recent studies have demonstrated that most women feel contraceptive counselling is an appropriate part of abortion care while emphasizing it must be provided in a respectful manner by a well-informed health care provider (HCP) (Kilander et al., 2017; 2018; Purcell et al., 2016).

Providing effective contraceptive counselling, especially in a situation that many women find emotionally charged, requires a skilled HCP who can balance the dual-foci of discussing the abortion itself and post-procedure contraception (Kilander et al., 2017; 2018). Understanding women's contraceptive knowledge, experiences, and preferred interventions and supports is a fundamental part of developing effective care. This study was designed to improve understanding of women's informational needs, preferences, and desired supports for contraceptive counselling in the context of accessing abortion services.

Methods

An interpretive descriptive design was used. This method of inquiry is ideal for the applied sciences of health disciplines as it strives to recognize and understand gaps in knowledge in order to inform better clinical practice (Thorne, 2016). The Ottawa Decision Support Framework (ODSF) was chosen as a framework for this study because, like interpretive description, it was designed for use within a clinical context (O'Connor et al., 1998; O'Connor, Jacobsen, & Stacey, 2002). The ODSF is intended for value-laden health and social decisions that arise in new circumstances (for example, abortion) (Murray, Miller, Fiset, O'Connor, & Jacobsen, 2004; O'Connor et al., 1998). The ODSF states health and social decision-making

involve many factors including client values, individual characteristics, knowledge and expectations, and available financial and social supports; additionally, health decisions are affected by the role of HCPs who may act as a guide or facilitator by providing information and support as clients consider their options (O'Connor et al., 1998).

Ethics approval was received from the University of Ottawa Health Sciences and Science Research Ethics Board prior to initiating recruitment. Women were eligible to participate if they were over 18 years old, were comfortable being interviewed in English, and had accessed at least one elective abortion in the previous 24 months. Participants were recruited through public invitations on social media (Facebook, Instagram, and Twitter) as well as via invitation cards left at three contraception and sexual health education spaces in Ottawa and Toronto, Canada. JW did not confirm participants' recruitment source or abortion dates.

Data were collected through audio-recorded, in-depth, semi-structured interviews using an interview guide that was designed based on the elements of the ODSF. Interviews started with obtaining informed consent and the collection of demographic data. The interview guide began with questions about participants' comfort-level in discussing contraception, an assessment of contraceptive understanding, and current contraceptive practices. Participants were asked about previous experiences with contraception and factors they consider when choosing a method. Finally, the interview focused on participants' experiences and preferences for contraceptive counselling, particularly within the context of accessing an abortion. After the interview, participants were sent a \$10 coffee gift card to thank them for their time.

Interpretive description asserts that a small number of participants familiar with the phenomenon of interest can provide data-rich interviews (Thorne, 2016). Given the sensitive nature of terminating an unintended pregnancy, it was difficult to recruit participants and

recruitment ceased after surpassing the minimum target of seven. Interviews were transcribed verbatim by JW and then de-identified and securely stored.

The process of analysis in interpretive description is distinctive in that no specific methodological approach is used in its entirety in order to avoid the risk of simply recording and organizing data as opposed to uncovering meaning (Thorne, 2016). JW used prolonged engagement with the data, reading all transcripts multiple times, re-listening to interviews, and marking down notes, impressions, and questions in the margins before considering any formalized data analysis techniques. The other authors, all with backgrounds in women's health, independently completed initial descriptive and in vivo coding of a single transcript for discussion and comparison. Additionally, each author also coded a separate section of the transcripts to be compared with JW's initial coding of the same data sets. A combination of constant comparative, interpretive phenomenological, and narrative analysis were used to inform and guide further analysis and interpretation of the data (Thorne, 2016).

Rather than completing member checks, which Thorne states may falsely validate or reject the investigator's overall interpretations derived from all interviews due to a single participant's experience, the findings from the analysis were discussed with SH, whose expertise and experience lies in clinical sexual and reproductive health (Thorne, 2016). This "thoughtful clinician test" supported that the data and findings were "plausible and confirmatory of 'clinical hunches'" (Thorne, Kirkham, & O'Flynn-Magee, 2004, p.8).

Findings

Study Participants

A total of eight participants ranging in age from 24 to 34 years were interviewed for the study. Seven women elected to complete the audio-recorded interview over the phone and one woman chose Skype[®]. Interviews lasted 43-62 minutes (average 51 minutes) and were conducted

between February and June 2018. Participant demographics and contraceptive use histories are displayed in Tables 1 and 2. Of the ten abortions reported by participants, eight were surgical (vacuum aspiration or D&C) and two medical (misoprostol after either methotrexate or mifepristone). Three participants had HCP backgrounds. In the discussion of findings, all participants were anonymized and quotations were edited for clarity by removing word repetitions, stutters, and verbal tics, while maintaining the intent and meaning.

Themes

The data analysis revealed three major themes that reflected women's needs, desired supports, and preferences for counselling: 1) Women want to make informed decisions about contraception, 2) Person-centred care is fundamental to the provision of contraceptive care, and 3) Women value autonomy in contraceptive decision-making.

A pervasive, overarching meta-theme across all interviews and all themes was related to stigma and judgement. During their interviews, many women reported feeling stigmatized or judged when considering or accessing their termination. Some referenced cultural or societal condemnation of abortion, including the presence of protestors outside the clinic, or the separation of abortion from the rest of health care in stand-alone clinics or locked departments in hospitals. Three participants mentioned specific instances of enacted stigma from an HCP, including two occasions when an HCP expressed disapproval of their decision by trying to convince the woman to not have an abortion. These interactions created further tension and stress and resulted in the clients feeling they were unable to trust their HCP in regards to issues of family planning.

One woman, whose HCP refused to provide further care after she stated her desire to access an abortion, said, *“That’s not how you deal with that situation! ... I am lucky that I’m the*

*sort of person who understands what I need in life but he could have easily changed the mind of anyone else with that statement and that's **not** okay!"* (Participant 2)[§].

Stigma was perceived by many women to have negatively affected the environment of the location where they accessed their abortion. They did not consider clinics and units providing abortions to be positive environments. Women whose procedures took place in a hospital or generalized clinic appreciated the anonymity and privacy allowed to them while those who attended stand-alone abortion clinics reported feeling conspicuous or isolated. Women reported these negative atmospheres significantly decreased the likelihood that they would return to that location for any kind of contraceptive care, even if they felt they needed it. Participant 4 summarized a barrier to having conversations about contraception with HCPs: *"In general there's a lot of stigma around women's sexual health. So, if you're not speaking to [friends] ... there can be a lot of awkward moments or perceived judgment. Or actual judgment. So it can be difficult to really bring that up."*

Societal stigma seemed to have a deep impact on women who access abortion care. One participant reported being particularly bothered by the presence of protestors outside the clinic: *"I think society makes it difficult mentally for us to be there in the first place. If [abortion] was looked at differently maybe going back to the abortion clinic wouldn't be so bad but because there's such a big stigma about that specific location ... it doesn't seem very supportive. It just seems like a freaking place from hell"* (Participant 5).

Women Want to Make Informed Decisions About Contraception

The ODSF describes a decision as informed when the decision-maker understands their own values, the available options, and the potential outcomes of their choices (O'Connor et al., 1998). It became evident through the interviews that participants wanted to be knowledgeable

[§] Participant numbers were randomly generated and are not related to participation order

about contraceptive options and the decisions they made. Women felt comprehensive information about contraception was essential to making informed decisions.

At the start of the interview, most participants self-identified as well-informed about contraception. However, as the interviews progressed most women acknowledged that there were gaps in their understanding and all cited HCPs as a resource they had or wanted to use to provide contraceptive education and counselling. Participants used terms such as “daunting” or “too much” to describe trying to educate themselves about reproductive health and contraception.

All participants reported using the Internet as their main source of contraceptive information, even though they were aware of the prevalence of misinformation online. Formal school instruction was another potential information source, although only one woman described this education as helpful. Importantly, these women also described varied experiences with discussing contraception with their HCPs. Those who had attended a sexual or women’s health clinic at any time reported positive experiences, although one participant specified she felt the information was too “dumbed down” and wanted more “factual information”.

When discussing factors that facilitate better contraceptive care, a participant commented on the importance of well-informed HCPs who have adequate time to provide this care. She stated, *“I get a better level of care because that person really cares about what they’re doing so it’s not a nuisance anymore. It’s something that they want to be doing ... ensuring you’re making the right choices and providing you with the information you need to make those”* (Participant 2).

Of the ten abortion procedures discussed with the participants, nine included the option of contraceptive counselling and six women accepted this offer as part of their abortion care. Those who accepted this counselling reported expecting this care would either affirm or help them make a decision about post-procedure contraception and facilitate access to their preferred method. However, five participants did not feel the counselling provided any additional information or

decision-making support germane to their own situation. The remaining woman who described the counselling as helpful to making a decision about post-abortion contraception said, *“I felt like this was the place where I [could] get all my questions answered ... it was me that directed it into what it became. [The HCP] was prepared for it to go anywhere it needed to go”* (Participant 2).

Participants were asked what they wish they had been taught about contraception. No matter their vocational background, whether in healthcare or not, all participants wanted specific, comprehensive information about the options available to them including mechanism of action, effectiveness, how to start and stop use, possible side-effects, requirements for compliance and adherence, potential long-term risks or benefits, associated costs, and any other important details that might affect them. They wanted HCPs to teach them and consider their unique circumstances: previous experience, preferences about hormonal versus non-hormonal methods, medical history (contraindications), financial resources, and personal capacity to maintain compliance and adherence requirements. Additionally, they needed assistance in facilitating access to contraception, especially to methods that require HCP initiation such as intrauterine devices (IUDs).

Person-Centred Care is Fundamental to the Provision of Contraceptive Care

Nearly all participants considered the idea of contraceptive counselling an appropriate and important part of care at the time of an abortion, however most participants also cited concerns about potential or existing barriers to contraceptive decision-making. All participants felt that consideration of their individual situation, values, and needs was fundamental for this care to be beneficial or effective.

Several participants found addressing both terminating the current pregnancy and discussing contraception to be overwhelming. These women felt that their care providers failed to appropriately address their personal situation by not acknowledging the emotional and stressful

circumstances. Participant 3 commented, *“I think it overwhelms you when you have those decisions to make in that moment when you’re kind of focused on one goal.”* Similarly, Participant 5 stated, *“The stress levels were very high ... It was like it wasn’t real ... it was a just too stressful to take in anything and really think about it.”*

Three women would have preferred receiving this counselling at a separate appointment but also stated they understood most people would be reluctant or unlikely to return. A majority of women found their own counselling session unhelpful and described issues such as insufficient time to discuss both the termination and future contraceptive plans, the stress of an imminent procedure, and HCPs who did not seem well-informed about available methods or how to facilitate access to options.

Women consider decisions about contraception to be intensely personal and intimate. Participants described wanting their HCP to explore and consider their individual circumstances, past experiences, and personal values as part of providing contraceptive care. Study participants placed very high importance on experiences with contraception, including not only their own but also those of their friends and narratives found online. This seemed to be especially true if the stories or experiences of others were negative; ‘horror stories’ of contraceptive complications or side effects were frequently relayed to the researcher during the interviews as a foundation for fears or hesitancy about specific contraceptive methods.

One participant, a health care provider who specialized in sexual and reproductive health, demonstrated advanced knowledge about contraception. It might be expected that, more than most, she was uniquely equipped to make independent decisions about her own contraceptive use. However, despite her significant experience and background, this participant wanted individualized, person-centred contraceptive advice from her HCP to help her decide what method was best for her post-abortion: *“I feel like ... she might have just thought I could figure it*

out on my own and [she] might have not said anything because she thought I had it organized. But I didn't have it organized, that's the point" (Participant 8).

While she knew the pros and cons of the various options, she wanted advice and assistance in her unique circumstances: *"[My doctor] didn't say anything but I wish that she would have because I don't know everything and I also had a lot of fears and qualms about why did my birth control fail, where do we go from here? How do I make sure that this doesn't happen again?"* (Participant 8).

Participants emphasized that while they were eager to receive comprehensive contraceptive counselling, it was essential that this care was provided in a non-judgmental and respectful manner that acknowledged the individual circumstances of each woman. One woman said, *"I think there's real value in just asking what a patient wants, whether it is to be on birth control or not to be on birth control. And if it's not wanting to be on birth control then exploring the reasons behind it in a respectful and, especially, culturally sensitive way. And seeing if there's a compromise that can be made, or an education or learning point that can be interjected into that"* (Participant 3).

A few participants who disclosed skepticism about using prescribed contraception, particularly hormonal methods, felt that if an HCP had provided adequate information and evaluation of their preferences and values, they likely would have chosen a different method. One woman wished her HCP had discussed, *"... more of a broad spectrum ... I don't even really know anything else other than IUDs and [sterilization], so yes. It would be nice to know. Because maybe there's another thing that would have fit me perfectly"* (Participant 1).

Several women described encounters with an HCP where they felt an opportunity for learning was missed when their personal experiences, preferences, or motivations were simply not addressed: *"I don't think there was any kind of back and forth discussion about why I was*

interested or, how it worked or any kind of different options ... she just wrote the prescription” (Participant 1).

Participant 3 said, *“There was definitely an opportunity to, you know, in that time frame between the first and the second [unintended pregnancy] that I could have prevented – possibly prevented – the second one by being better informed and ... not even just having the conversation but feeling like it was okay to have the conversation.”*

In addition to the abovementioned qualities in the individual providing the counselling, women felt the environment itself should be open and supportive. One woman described a positive experience where she received counselling, *“... in a separate room with a couch and a desk and all the information [I] needed”* (Participant 2).

All participants discussed the cost of contraception and considered it to be a barrier or “financial burden”, yet one they were forced to prioritize due to their desire to prevent pregnancy. Several stated that although they currently felt financially able to afford any method, there had been a time in their life when the cost of contraception was prohibitive, or had friends whose choices had been limited by cost. Few participants felt that their personal financial situation had ever been addressed in any way by an HCP and several women described trying to ‘solve’ the issue of cost without support. Some participants referenced clinics with programs for subsidized or ‘compassionate’ contraception but expressed a desire for their HCP to assess their personal financial circumstances.

One participant who had previously struggled with the cost of contraception expressed empathy for women being forced to choose a method based on cost: *“[They’re thinking], ‘Well, I could just go this route that I want to go - the Mirena or another IUD - but it’s cost prohibitive.’ And so they have to make choices that wouldn’t have been their first choice just due to finances. I think that’s kind of odd considering our fairly comprehensive health care”* (Participant 4).

Women Value Autonomy in Contraceptive Decision-Making

Decision-making is often described as occurring on a spectrum, from autonomous, when a client makes the decision with little or no input from their practitioner, to paternalistic, whereby the HCP suggests one particular option based on their own clinical knowledge and experience. Participants in this study emphasized the importance of autonomy in contraceptive decision-making; however, this focus seemed to be a product of negative experiences with a client-versus-HCP priority mismatch and an imbalanced power dynamic. Participant 3 commented, *“With any kind of patient-healthcare provider relationship there is that power dynamic at first and I think you can break it down by talking to the person, but I don’t think I ever had that experience.”*

One woman discussed what she felt were differing priorities between herself and her HCPs: *“I tried to get off the pill [but] every time I tried to get off the pill they would just give me a different pill with a different level of hormones. So I was always actively trying to get off of the pill, but, like I said, the doctors were always recommending it was my best option”* (Participant 5). This participant felt her autonomy was violated by her HCPs’ focus on their own priorities.

One participant described asking HCPs at the abortion clinic for information about vasectomies, as she and her partner were finished having children. The HCPs appeared to ignore her request, continually “pushing” the idea of an IUD without investigating the reasons behind the request. Other participants discussed being offered methods they had already refused. One woman stated, *“I can’t imagine how I would feel if I was just given the exact methods that I had previously ruled out ... maybe I would use condoms for the first little bit but I probably would [stop] again. If I had a negative experience I can’t imagine that - being just re-offered the same thing”* (Participant 1).

The women in this study wanted to trust the HCPs who provided care but in several cases felt the HCP’s approach was characterized by a lack of discussion and a disparity in priorities.

While they stated they wanted input from their HCPs, participants described situations where they felt their HCPs' concerns were different than their own, leading to paternalistic counselling. Some practitioners were described as being narrowly focused on specific issues, with insistence about what was "best" for their clients. A participant recalled her experience: *"I don't even think there was a discussion on the kinds, the different kinds of birth control in general, whether it be like the Nuvaring, or whatever. I think like, because of my age, she just said 'Well, this will work best for you'"* (Participant 3).

As mentioned, previous experience played a very significant role in women's contraceptive decision-making, particularly in terms of side-effects and risks. A negative experience with a method contributed to decreased willingness to consider other prescribed contraception, especially if similar to a method they had refused. Many participants emphasized the importance of considering side effects and risks in their contraceptive decision-making, regardless of their HCP's views on the topic. Participant 1 commented, *"The side-effects very much affected how [I] felt about going back on contraception, ever."*

Most participants felt strongly that these concerns should be integral to any discussion about contraception but that HCPs often 'brushed past' or 'skimmed over' these concerns as if they were not an important consideration. This led to a loss of trust and an increased emphasis on autonomous decision-making. This emphasis stemmed from a desire to prevent HCPs making decisions on their behalf based on priorities that were not those of the woman in question.

Several women felt that hormonal contraception, oral contraceptive pills (OCPs) in particular, had a considerable negative impact on their mental health, causing "mood swings", aggravating anxiety and/or depression, or making them feel "crazy". Having a friend or reading online about someone who had experienced side effects or difficulty with a method also influenced decisions, causing several participants to express hesitancy about that method.

One participant described feeling hormonal contraception had negatively affected her mental health and fertility. She felt her HCPs had ignored her concerns and stated, *“I make the decision about how I want to do my fertility. I don’t give my power away anymore because of the way that I was treated by the system, by the doctors that I asked for help from, so now I take full responsibility for my fertility and my contraceptive choices”* (Participant 5).

One woman reported refusing contraceptive counselling when accessing her abortion because of her fear of judgment and stigma from the HCPs, particularly because she had not been using any birth control prior to the unintended pregnancy. This participant felt her decision not to use contraception was especially “unacceptable” to HCPs and she didn’t want to be judged for her choices. She said, *“I felt uncomfortable because of how I was [perceived as] careless about using contraception and it ended in a pregnancy - it was looked down upon like, ‘you should be more responsible’ ... I think at that time I felt like I just wanted to go in and get it over with and just have the procedure done”* (Participant 3).

Another participant also referenced this idea of increased unacceptability of not utilizing a prescribed method of contraception prior to terminating a pregnancy. She felt she had to emphasize to the HCPs at her abortion that she had experienced a failure of birth control to clarify that she was not *“... too stupid to use birth control”* (Participant 6). Participants felt that if the HCP believed them to be irresponsible, their input and decisions might not be respected.

Overall, women in this study emphasized a desire to be heard, understood, and trusted by HCPs. Although they acknowledged HCPs might have more clinical knowledge and experience with contraception, the women reiterated that each individual was the best person to know what was best for herself. These participants wanted to be supported by their HCP as they made autonomous decisions. Participant 2 summarized her thoughts this way: *“It’s really frustrating to*

work in a system where I am the only person that's truly my best advocate for my health and yet in a system that doesn't trust my judgment."

Discussion

This is the first Canadian qualitative study that examined women's experiences and preferences for contraceptive care when accessing an abortion and contributes to the body of knowledge about women's informational needs, preferences, and desired supports for this care. The findings provide insight into the specific knowledge and support women describe as helpful and desirable as part of contraceptive care provided at the time of an abortion.

Most participants initially considered themselves knowledgeable about contraception but research has shown that women who report not wanting or needing contraceptive information are less likely to use contraception post-abortion (Moslin & RoCHAT, 2010). Further into the interviews, as contraception and experiences were discussed, women in the study began to identify their own deficits in knowledge and indicated they would benefit from further teaching. Significantly, the participant with specialized knowledge in sexual and reproductive health stated she did not know everything. She expected her HCP to help her understand what happened with her contraceptive failure and she wanted support and guidance to determine the best option for her personal circumstances.

Not all contraceptive care demonstrates a positive effect on uptake or continued use of contraception (Ferreira, Lemos, Figueiroa, & de Souza, 2009; Stewart et al., 2015). Theoretical knowledge is not always easy to apply to self. Both this study and previous research found that a decision about contraception is not simply about the method: the intimacy of the nature of the choice has consequences beyond the physical (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013; Ferreira et al., 2009). The findings from this study show that women want to understand sexual and reproductive health, contraception and, most importantly, the personal

implications of a method on their own sexual and reproductive health. Women value non-judgmental, person-centred contraceptive counselling that considers their personal experiences and preferences, and this approach demonstrates increased satisfaction with both the care and the chosen method (Kilander et al., 2018; Whitaker et al., 2016).

Person-centred care is widely accepted as best practice and this is consistent with women's preferences in previous research, as well as the findings from these interviews (Dehlendorf, Krajewski, & Borrero, 2014; Ferreira et al., 2009; Kilander et al., 2018). What was made clear is that women consider contraceptive counselling to be an appropriate part of abortion care, as supported in other literature, and this care should be provided in a person-centred manner (Kavanaugh, Carlin, & Jones, 2011; Kilander et al., 2018; Purcell et al., 2016). In addition, the data illustrate women want to make well-informed decisions that take into account clinical data, experiential knowledge, and their own individual preferences.

Person-centred care should include consideration of the client's available resources. The financial burden associated with prescribed contraception is a significant factor for women making decisions about methods (Black et al., 2009). Canada has universal healthcare but this does not extend to prescriptions (except for Quebec residents), which places an additional responsibility for those needing contraception. Contraceptive costs can be significant: short-acting reversible contraceptives such as OCPs are charged monthly and long-acting reversible contraceptives (IUDs) have high upfront costs, typically several hundred dollars (Black, et al., 2015c). Although participants reported prioritizing this cost, they felt the onus was on them to prevent unintended pregnancies and thus this spending was not elective but out of necessity.

Appearing non-judgmental is fundamental to abortion care and paramount to providing effective contraceptive counselling. Stigma and judgment played a significant role in participants' experiences of abortion care. Their emotions, choices, and experiences were

affected by their perception of being, or not being, stigmatized. Furthermore, the study findings revealed the risk of compounded judgment against those who choose not to use contraception and then terminate, a finding consistent with other studies (Shellenberg et al., 2011).

Findings from this study are also consistent with other research demonstrating that women place high value on experience or ‘experiential knowledge’, even if it is not a first-hand occurrence (Kilander et al., 2017; 2018; Purcell et al., 2016). Participants in this study professed reluctance to use contraceptive methods they themselves had never tried if they knew of someone who had reported a negative experience, particularly with hormonal methods. This concern did not appear to be less even if the account was relayed by a stranger; “horror stories” seem to be widely influential in contraceptive decision-making.

Implications for Practice

The participants who had attended a sexual or women’s health clinic at any point considered the experience to be beneficial to their knowledge and subsequent decisions. However, most of the participants in this study cited at least one instance where a HCP missed an opportunity to provide contraceptive counselling. As most of these examples occurred outside the context of accessing an abortion, this finding is meaningful for all HCPs who work in women’s health care. Evaluating a woman’s contraceptive experience, current use, and preferences should open conversations where any misconceptions or gaps in knowledge can be identified and addressed. Few HCPs demonstrate consistent accurate and comprehensive knowledge about contraception and this lack of knowledge impedes their ability to provide high-quality contraceptive counselling to their clients (Dehlendorf, Levy, Ruskin, & Steinauer, 2010).

Receiving contraceptive counselling as part of abortion care can be overwhelming and requires balancing the discussions about both the termination and the options for post-procedure contraception. It takes considerable skill of the HCP to manage both conversations effectively

while also conveying respect and openness (Kilander et al., 2017; Purcell et al., 2016). These are not innate skills and HCPs who work in abortion care need to be adequately prepared for the complexity of these interactions based on abortion care best practice guidelines, such as those of the World Health Organization and the Royal College of Obstetricians & Gynaecologists (RCOG) (RCOG, 2015; WHO, 2012).

Clients benefit when HCPs have comprehensive education about contraception and are then able to pass this accurate knowledge along to clients. HCPs must also have opportunities to develop the necessary skills involved in initiating and providing effective, person-centred contraceptive counselling. Recognizing that there may be differing priorities and that a power differential exists between HCPs and clients is fundamental to addressing these issues. HCPs need access to resources to address the complexities of the HCP-Client relationship, to learn about contraception, including how to decrease financial barriers, and to develop proficiency in the provision of contraceptive counselling. More research is needed to better understand the experiences and needs of HCPs and the supports they require to address any barriers they face in providing contraceptive care.

Limitations

This study included eight Canadian participants, seven (87.5%) of whom self-identified as Caucasian. Seven spoke English as their first-language and seven had completed some level of post-secondary education. This sample is not representative of the Canadian population and therefore these findings are transferable only to contexts similar to those reflected in this study.

Finally, all data relied on participant reporting, and the results are liable to bias based on recall, reporting, and social desirability. Participants may have inaccurately recalled details about their own experiences with HCPs and contraceptive care. However, both constructivism and interpretive description embrace the notion that reality is constructed between the researcher and

the participant. The stories recalled by the participants reflect the reality they believe and live, so whether they are completely factual is immaterial.

Conclusions

The women who participated in this study generally believed that contraceptive counselling was an appropriate and important part of abortion care but emphasized that it was fundamental that the HCP be non-judgmental, open, and knowledgeable. They also believed contraceptive care should be provided in a person-centred manner that considers women's individual needs, preferences, and values. It was recognized that HCP values may differ from those of their clients. Additionally, power imbalance must be acknowledged and HCPs should strive to mitigate any potential negative effects of this differential. The findings suggest HCPs must be adequately prepared with sufficient contraceptive knowledge and counselling skills, both within abortion care and in other women's health care contexts.

Declaration of Interest

The authors report no conflicts of interest.

Acknowledgements

The authors would like to thank all participants in the study, Planned Parenthood Ottawa, Planned Parenthood Toronto, and Clinique des Femmes de l'Outaouais for displaying the invitation to participate cards and for the time and assistance they provided. We would also like to thank Kelly Wiens (BScN, MSc Health Promotion Studies) for assistance with editing this manuscript. Furthermore, thank you to the Canadian Nurses Foundation (CNF) for supporting JW's graduate studies with a CNF scholarship.

Table 1: Participant Demographic Data

Age in years	Mean (<i>range</i>) 30.5 (24-34)
Education (highest achieved)	n (%)
High School Diploma	1 (12.5)
Some College/University	2 (25)
Undergraduate/Bachelor's Degree	2 (25)
Some Graduate Studies	1 (12.5)
Graduate Degree	2 (25)
Ethnicity (self-identified)	
Caucasian	7 (87.5)
Indigenous	1 (12.5)
Obstetric History	Mean (<i>range</i>)
Gravidity	2.125 (1-3)
Abortions**	1.25 (1-2)
Living Children	0.875 (0-2)

Table 2: Participant's Contraceptive Use

Contraceptive Used at Time of Pregnancy Leading to Termination	n (%)
Coitus Interruptus/Withdrawal	1 (12.5)
Copper IUD	1 (12.5)
Fertility Awareness Method	3 (37.5)
Oral Contraceptive Pill	1 (12.5)
Vaginal Ring	1 (12.5)
No Method	1 (12.5)
Contraceptive In Use at Time of Interview	
Abstinence	1 (12.5)
Fertility Awareness Method	2 (25)
Mirena IUD	3 (37.5)
Vaginal Ring	1 (12.5)
Vasectomy	1 (12.5)
Contraceptives Ever Used	
Coitus Interruptus/Withdrawal	6 (75)
Condom	8 (100)
Contraceptive Patch	1 (12.5)
Depo-Provera Injection	1 (12.5)
Emergency Contraceptive Pill	1 (12.5)
Fertility Awareness Method	4 (50)
IUD Copper	1 (12.5)
IUD Mirena	3 (37.5)
Oral Contraceptive Pills	7 (87.5)
Vaginal Ring	2 (25)
Vasectomy	1 (12.5)

** All reported abortions were induced, not spontaneous

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Chapter 4: Integrated Discussion and Conclusion

This thesis was intended to examine what is known about providing contraceptive care in the context of abortion and to develop a better understanding of women's experiences with this care, including their informational needs, preferences, and desired supports. I completed a literature review of the existing research and conducted an interpretive descriptive study in which I interviewed women who had accessed abortions. The literature review described the current state of knowledge, and the study is the first known in Canada to examine peri-abortion contraceptive care from women's perspectives.

This chapter is an integrated discussion of the findings of the literature review and the study and the implications for nursing. First, there is a summary of the literature review and the qualitative study and discussion of the Ottawa Decision Support Framework and chapters 2 and 3. Next, I address the relevance to the profession of nursing in terms of implications for practice, education, policy, and future research directions. Finally, I provide remarks about the experience of conducting this research and overall conclusions.

Summary of Literature Review Findings

This review examined the available literature, both quantitative and qualitative studies, with the objective of compiling all relevant peer-reviewed articles about contraceptive care for women accessing abortions. In total, 25 studies with a variety of methodologies and study designs, from systematic reviews and randomized controlled trials to in-depth interviews conducted from an interpretive phenomenological perspective, were reviewed. All literature was published in English and all but two articles – those by Rogers and Dantas (2017) and Zhang and colleagues (2014) – covered studies conducted in high-income countries. No similar research has been conducted in Canada. Chapter 2 addressed the first objective of this thesis, which was to

consolidate the available literature related to providing contraceptive care in the context of abortion.

Overall, the authors of the extant literature conclude that contraceptive care should be provided to women accessing abortions. Research has demonstrated that many women in Canada have a poor understanding of fertility and contraception; this is linked to low contraceptive use, a leading cause of unintended pregnancies (Black et al., 2009; Black et al., 2015a, 2015b; Norman, 2012). However, there is a paucity of information about women's experiences and preferences for the contraceptive care provided when accessing abortion services, and the optimal content or format for the provision of this care.

Most of the available research recommended "patient-centred care" but few studies detailed what this meant in practical terms for health care providers (HCPs). Only a few studies examined the experiences of providing or receiving peri-abortion contraceptive care, yet nearly all emphasized the important role of understanding this care from women's perspectives. The researchers stated that in order to develop effective, individualized approaches for contraceptive care as part of abortion services, there must be a better understanding of women's perspectives, HCP versus client priorities, and the power dynamic that exists between HCPs and clients. More research is needed to explore these issues. Additionally, research is required to better understand the complexities experienced by HCPs when providing peri-abortion contraceptive care so that HCPs can be well-prepared for this role.

Summary of Interpretive Descriptive Study

The first author (JW) conducted in-depth semi-structured interviews using an interview guide (see Appendix D). This guide was based on the Ottawa Decision Support Framework (ODSF). According to the ODSF, decision-making is made up of three components: decision needs, decision quality, and decision support and the interview guide was designed with the

intent of eliciting information and narratives that specifically addressed these components (O'Connor et al., 1998). A total of eight Canadian women participated, each having accessed at least one abortion in the preceding two years.

This study addressed the second, third, and fourth objectives of this thesis. These objectives were to: 1) Improve understanding of women's decisional needs in regards to contraception when they are accessing an abortion, 2) Understand the preferences of women accessing abortions in regards to receiving contraceptive care, and 3) Identify what women consider to be desirable supports when discussing contraception as part of abortion care.

As accepted in interpretive description, constant comparative, interpretive phenomenological, and narrative analysis were used in combination to analyze the data. Three distinct themes emerged in the analysis: 1) Women want to make informed decisions about contraception, 2) Person-centred care is fundamental to the provision of good contraceptive care, and 3) Women value their autonomy in contraceptive decision-making. An overarching meta-theme related to stigma and judgment was found across all interviews and the above themes.

The study participants considered contraceptive care to be an important part of accessing an abortion but most had not found their own experiences of contraceptive counselling to be beneficial. Women cited concerns such as the lack of time, the complexity of simultaneously making decisions about termination and post-abortion contraception, judgment and stigma from HCPs, and a mismatch in their own and their HCP's priorities. Only one woman in this study considered the contraceptive care she received as part of her abortion care to have been helpful to her own understanding and decision-making process. Despite the concerns and barriers identified by participants, women specified that they wanted and needed contraceptive care as part of accessing an abortion.

Overall, the women reported wanting to receive comprehensive information from a HCP with a good understanding of contraception and the available resources to facilitate their access to chosen methods. For example, women with financial barriers to affording contraception wanted their HCP to provide referrals to clinics with subsidized or free contraception. Participants who had attended specialized sexual health clinics reported positive experiences with contraceptive care outside the context of their abortion(s), even if they did not find their peri-abortion counselling beneficial. Most importantly, participants emphasized that all contraceptive care should be provided by a non-judgmental HCP who respected their individuality, autonomy, and ability to make their own contraceptive decisions.

Discussion

Chapter 2 and Chapter 3 contribute to the available body of knowledge regarding providing contraceptive care to women accessing abortions. The literature review (Chapter 2) was the first to compile the available research about peri-abortion contraceptive care. The interpretive descriptive study (Chapter 3) was the first Canadian study and one of only a few qualitative studies on this topic. Both of these manuscripts are intended for publication in order to disseminate the results.

The Ottawa Decision Support Framework

The Ottawa Decision Support Framework (ODSF) was the framework used in both the literature review and the qualitative study. This framework is particularly germane in the context of value-laden decision-making that women experience when being asked to choose a contraceptive method in a situation they described as stressful - accessing an abortion (O'Connor et al., 1998; O'Connor, 2006). The focus of the ODSF is the process of decision-making and it considers the outcome of the decision itself to be only one part of evaluating the success of the process (O'Connor et al., 1998). In the context of this research, an indirect measurement of

outcome includes continuation of their chosen method of contraception as well as future unintended pregnancies or abortions. Discontinuation of contraception or a future unintended pregnancy may indicate a woman's dissatisfaction with the decision, a lack of understanding, or that the method was untenable for her. For example, a woman may be satisfied with the contraceptive method but unable to afford its continued use.

In Chapter 2, the description of the ODSF components of decision-making highlights the gaps in the existing research. Only one quantitative and two qualitative studies examined women's experiences with or preferences for peri-abortion contraceptive care (Dehlendorf, Diedrich, Drey, Postone, & Steinauer, 2010; Kilander, Beterö, Thor, Brynhildsen, & Alehagen, 2018; Purcell, Cameron, Lawton, Glasier, & Harden, 2016). Most of the studies examined the effectiveness of various contraceptive counselling methods using specific outcomes such as uptake and continuation of contraception post-abortion.

Although understanding the effectiveness of a method of contraceptive counselling may provide insight into decision quality, this knowledge is less clinically applicable if HCPs do not understand the process of decision-making in this context. In Chapter 2, many of the studies referenced quantitative outcomes such as contraceptive uptake or continuation. Although few interventions improved these measurable outcomes, the reasons why the interventions were unsuccessful were not investigated. Very little research has been undertaken regarding contraceptive care provided at the time of abortion, and almost none with the objective of better understanding decision needs, decision quality, or decision support. By using a framework like the ODSF to understand the components of decision-making, researchers can develop a better understanding of what kind of decision support should be provided.

The qualitative study in Chapter 3 was designed to better understand peri-abortion contraceptive decision-making through the lens of the ODSF and therefore addressed a gap in

previous research. Rather than focusing on typical outcomes such as contraceptive uptake or continuation, the study data described women's informational needs, desired supports, and preferences for this care. This research contributes to the extremely limited existing body of knowledge in understanding what women need and want when receiving contraceptive care as part of abortion services.

Reflection on Findings

The findings of this thesis are consistent with the available research. Much of the research reviewed in Chapter 2 is consistent with other research conducted about contraceptive care outside the context of abortion provision. The findings presented in Chapter 3 are congruent with those from the literature review, and particularly with the two recent qualitative studies about women's experiences with peri-abortive contraceptive care. Additionally, the qualitative study (Chapter 3) was the first known study completed in Canada that examined women's personal experiences, preferences, values, and desired supports for peri-abortive contraceptive care.

Given the research completed before writing the thesis proposal and the 2017 project completed in my MScN practicum at the Ottawa Public Health Sexual Health Clinic (see p.5, Chapter 1), the findings from the literature review and study were surprisingly consistent with my understanding and knowledge on the topic. They also aligned with what other HCPs communicated to me as I prepared to complete this project.

Nurse Practitioner Sandra Hooper (SH) spent many years working in sexual health and was the preceptor who supervised my practicum. As part of the project interviewing stakeholders about perceived factors leading to multiple abortions, I spoke with her, several other HCPs, and local sexual health educators. The ideas and anecdotes that they shared in those interviews were later reflected in the interviews I conducted with my study participants, albeit from opposite sides of the experience.

Most of the stakeholders interviewed in the 2017 course project discussed the barriers they perceived their clients faced: women's lack of contraceptive understanding and knowledge, the overwhelming nature of simultaneous decision-making around termination and post-abortual contraception, minimal time for counselling, insufficient HCP knowledge about contraception and available supports (e.g. accessing subsidized or free contraception), and the prevalence of misinformation about contraception and sexual and reproductive health (especially from online resources).

As I began analyzing the data from the interpretive descriptive study, I was initially concerned about finding only what I expected to find based on my background knowledge. It seemed as if the themes found through my research, as well as the qualitative studies from the literature review, reflected what was anecdotally known in the HCP and sexual health educator communities. My initial notes and thoughts as I read the transcripts felt almost excessively congruent with previous research and my own course project. I challenged these concerns through discussing them with my thesis advisory committee, other HCPs, and especially SH, given her lengthy experience in the field. I also practiced prolonged engagement with the data: listening to the interview recordings multiple times and reading through the transcripts and searching for other possible explanations and meanings. As analysis progressed, however, it became clear that the findings were consistent with and confirmed previous research. The findings demonstrate that Canadian women's experiences with peri-abortive contraceptive care are similar to those in previous studies published in other countries.

Relevance to Nursing

Nurses constitute the largest health care workforce in Canada and are present at all levels of health care, from bedside nursing to health research to policy development (Canadian Nurses Association (CNA), 2008a). This thesis contributes to the body of nursing knowledge informing

nursing care in the Canadian context. This project is intended to provide evidence that can be used to inform clinical practice, not to simply remain as theoretical knowledge.

Abortion care requires an interprofessional team that involves physicians, nurses, and other HCPs, and may require supports from other disciplines and professions. Nurses are “agents of change” whose knowledge and expertise enables them to seek ways to improve health care delivery and influence policy development in order to help the public (CNA, 2008b). As front-line professionals, nurses work closely with clients, including women accessing abortions. The understanding gained from this proximity and experience should influence the research in order to contribute to the knowledge that informs clinical practice and policy related to women’s and reproductive health.

Nurses provide a high level of clinical expertise, leadership skills, understanding about conducting research to synthesize new knowledge, and the ability to consult and collaborate, both interprofessionally and intersectorally (CNA, 2008b). The CNA uses ‘advanced nursing practice’ as “an umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge, and expertise in meeting the health needs of individuals, families, groups, communities, and populations” (CNA, 2008b, p.10). Graduate prepared nurses are qualified to be leaders in research and knowledge dissemination usable by all nurses and other HCPs. Nurses are well-prepared to be educators and advocates who work in collaboration with other professionals and the communities they serve, and are ideally situated to understand the many factors affecting sexual and reproductive health and how these issues can be addressed.

Implications for Nursing Practice

Throughout the study described in Chapter 3, stigma and judgment emerged as a meta-theme, across all other themes and in each interview. The participants described experiences of

societal stigma (e.g. protestors outside the clinics), systemic stigma in healthcare (whereby abortion care is isolated from the rest of healthcare, even women's healthcare, in stand-alone clinics or locked hospital wards), and stigma enacted by their own HCPs (such as expressing disapproval about terminating a pregnancy or refusing to provide further care). Stigma and judgment created negative environments that the women reported wanting to avoid even if they needed further help, broke trust in HCP-client relationships, and pushed women to rely solely on themselves to make decisions. Participants in the qualitative study (Chapter 3) reported their reluctance to access contraceptive care from HCPs increased the likelihood of them trying to find information from other resources, including from friends or the Internet, despite an awareness of the commonality of contraceptive misinformation.

The College of Nurses of Ontario (CNO) considers a therapeutic nurse-client relationship to be at the foundation of the profession and practice of nursing (CNO, 2006). Furthermore, the CNO states the five components of the nurse-client relationship – trust, respect, professional intimacy, empathy, and power – are always present in every nursing context and interaction (CNO, 2006). As the most numerous HCPs involved at all levels of health care, nurses must be aware of the potential barriers and consequences of stigma and judgment. Nurses are often the HCPs who spend the most time with clients, assessing informational needs, past experiences, preferences, and desirable supports. The specific process of contraceptive counselling and provision may also be provided by a nurse. If this care cannot be provided in a non-judgmental manner, the nurse risks losing the trust of their client, which potentially creates a barrier to providing effective contraceptive counselling and care. By establishing and maintaining therapeutic relationships with their clients, nurses can earn their trust and confidence.

The CNA Code of Ethics includes promoting and respecting informed decision-making and providing compassionate care (CNA, 2015). Even if a HCP holds views that oppose a

woman's decision to terminate a pregnancy, it is fundamental that this is never communicated to a client – nurses need to, at the very least, appear non-judgmental and supportive of the client's decisions. The best nursing care in this context will provide an open and non-judgmental environment wherein the client feels safe discussing intimate decisions. Clients want to be heard, understood, and trusted by their HCPs.

Nursing Education

Both the literature review and the interpretive descriptive study revealed that many HCPs are not adequately educated about contraception, providing contraceptive care in the context of abortion, or what resources are available to support women in accessing their chosen method. The lack of preparation was both self-reported by HCPs and identified by clients who reported being dissatisfied with their contraceptive care. This finding is also consistent with research about contraceptive care provided outside the context of abortion care that demonstrated HCPs' insufficient knowledge about contraceptive evidence is a barrier to high-quality care (Dehlendorf et al., 2010).

HCPs must be educated about how to provide comprehensive contraceptive counselling to their clients (Black et al., 2015a; 2015b). Low levels of HCP knowledge about contraception, especially highly-effective methods, can lead to a vicious cycle: 1) HCPs with low contraceptive awareness are unlikely to introduce or sustain conversations about contraception with their clients; 2) HCP hesitation or uncertainty decreases client comfort and trust with these discussions; 3) HCPs are less likely to prescribe contraception and clients are less likely to ask questions (Black et al., 2015a, 2015b; Dehlendorf et al., 2010). Nurses should advocate for curricula and professional development for HCPs that include comprehensive education about sexuality, contraception and abortion, and how to best convey this information to clients. This education should be part of curricula at both the undergraduate and graduate levels.

There is a misconception among both the lay and HCP populations that abortion is a rare procedure, despite the statistics demonstrating that one in three Canadian women will access at least one abortion in their lifetime (Ames & Norman, 2012). This misconception both arises from and contributes to the stigmatized nature of sexual health, contraception, and abortion (Cockrill & Nack, 2013; Norman, 2012). It is fundamental that contraceptive care is provided in a non-judgmental manner. Nursing education should include comprehensive education about sexuality and family planning and this education should further support nurses learning how to provide non-judgmental care. Furthermore, nurses should be educated about how to address stigma and misunderstandings among both other HCPs and the lay-population through intentional teaching, client interactions, and informal opportunities as they arise.

Policy

Currently, Canada does not have holistic guidelines that cover the comprehensive experience of providing abortion care, both the technical details of the termination itself and the associated care of the woman. A limited body of knowledge makes it difficult to develop and implement evidence-informed policies and guidelines. Although Canada has the 2006 *Society Of Gynecologists of Canada (SOGC) Clinical Practice Guidelines: Induced Abortion Guidelines*, which focus on the actual termination of pregnancy, contraceptive care has only a cursory mention in this 14 page document: that it should be provided (SOGC, 2006). This document about abortion provision (medical or surgical) has not been updated recently and refers HCPs to the SOGC's 2004 Canadian Contraceptive Consensus. Since the creation of the SOGC's 2006 guideline, medical abortions in Canada have changed with the 2015 approval of mifepristone. The SOGC's 2016 *Clinical Best Practice Guideline: Medical Abortion* addressed this update and includes more information about contraception but is focused on safety and efficacy of

contraceptive methods without referring to any other documents about providing contraceptive counselling (SOGC, 2016).

Research appears to be moving in the direction of conducting further qualitative studies: examining both women's and HCP's experiences with peri-abortive contraceptive care, as evidenced by Whitaker and colleagues' 2016 pilot study in advance of a larger study examining the use of motivational interviewing, a study by Purcell and colleagues (2016), and two studies completed by Kilander and colleagues (2017 and 2018). An expanded body of knowledge will lead to a better understanding of women's needs, preferences, and values for this care, supporting future development of evidence-informed policies and guidelines.

The United Kingdom's Royal College of Obstetricians and Gynaecologist's (RCOG) *Best Practice in Comprehensive Abortion Care* (2015) provides guidance to HCPs. This guideline is consistent with the World Health Organization's (WHO) report, *Safe Abortion: Technical and Policy Guidelines for Health Systems* (2012) in that both documents promote informed decision-making and client-centred care, and emphasize the importance of non-judgmental care and comprehensive contraceptive counselling as a standard part of abortion care. Furthermore, both the WHO and RCOG guidelines recommend providing the contraceptive method chosen by the client at the abortion appointment (cost-free, if possible) as a way to mitigate barriers that might prevent choice and/or uptake of contraception. The WHO and RCOG documents and the growing body of research should be used to develop updated guidelines that cover the provision of comprehensive abortion care.

The findings from the literature review and the interpretive descriptive study completed for this thesis are congruent with the suggestions provided by the RCOG and WHO guidelines. One study is not sufficient evidence to create guidelines or policy, but evidence-informed resources from other countries (particularly those with similar health care systems) can be used to

develop Canadian guidelines and policy. Additionally, a growing body of research with findings that are echoed in these two sets of guidelines provides support for the use of these documents. To provide perspective for the importance of this research and guideline development, Canada continues to report approximately 80,000 abortions annually (Black et al., 2015a).

The CNA Code of Ethics (2008c) states, “nurses endeavour to maintain awareness of aspects of social justice that affect health and well-being and to advocate for change” (p.2). Nurses are described as ‘moral agents’ and ‘promoting justice’ is included as a core primary value; as such, the profession of nursing has a responsibility to support policy and program changes to improve Canadians’ health (CNA, 2015). Nurses should be amongst those advocating for the creation of new evidence-informed policies and guidelines related to sexual and reproductive health and abortion care.

Future Research Directions

The findings from this thesis present many directions for future research. The previous research discussed in the literature review (Chapter 2) indicated there are many topics that require further investigation. Generally, there is a scarcity of research about contraceptive care provided as part of abortion care: any and all thoughtful research on the topic will contribute to the body of knowledge.

Only a few qualitative studies have been completed that examined the experiences of providing and receiving peri-abortive contraceptive care. More research should be conducted about women’s experiences in order to improve understanding about their informational needs, preferences, and what supports they consider desirable. Studies should additionally consider the experience of HCPs providing care. The limited available literature demonstrates that many HCPs feel unprepared both in terms of knowledge about contraception and available resources to facilitate access, and also how to provide contraceptive care in the complex circumstances of

terminating a pregnancy. This thesis and future research will help clarify what information HCPs need to provide effective contraceptive care and how this care should be provided.

With a better understanding of both women's and HCPs' experiences, contraceptive counselling methods can be designed and assessed for use in clinical settings. Beyond the effectiveness of the counselling, more research is needed to assess women's experiences with receiving a specific method of contraceptive counselling. Methods of providing contraceptive counselling, such as specific structured methods or motivational interviewing, should be evaluated for effectiveness in improving women's knowledge, uptake, and continued use of contraception after an abortion. Some research has shown promise for both the effectiveness and women's experiences with both structured and client-centred methods, such as the Contraceptive CHOICE method and motivational interviewing, but more research is needed (Secura, Allsworth, Madden, Mullersman, & Peipert, 2010; Whitaker et al., 2016). Research completed in Canada is especially pertinent.

Conclusion

This thesis had four objectives: 1) Find and compile available literature related to providing contraceptive care in the context of abortion, 2) Develop an improved understanding of women's decisional needs in regards to contraception when they are accessing an abortion, 3) Understand the preferences of women accessing abortions in regards to receiving contraceptive care, and, 4) Identify the supports women describe as desirable in the process of discussing contraception when accessing an abortion. The first objective was addressed in the literature review (Chapter 2) and the remaining objectives by both the review of the literature and the interpretive descriptive study (Chapter 3).

Completing this thesis was some of the hardest yet most rewarding work I have ever done. Researching a complex and potentially controversial topic that, to date, has received

relatively little attention in the academic and clinical literature was challenging. The stigma and judgement that continues to negatively affect and constrain women who access abortions added a high level of complexity to recruiting participants and gaining their trust. The process forced me to examine my personal and professional background, assumptions, and biases, and helped further develop my critical thinking. Acknowledging potential biases and ensuring all interviews were conducted in a manner that developed and maintained trust with participants was a complex process. This project suggests that considerable time and effort will be required to research and develop optimal methods for providing contraceptive care in the peri-abortion context.

In Canada, nearly a third of women will access abortion care during their reproductive years, meaning this thesis research is directly applicable to approximately one-sixth of Canadians (Black et al., 2015a; Norman, 2012). When accessing abortion care, women value person-centred, non-judgmental, and comprehensive counselling about contraception. Nurses are the largest healthcare workforce, both in Canada and globally, and the profession has immense capacity to innovate and influence clinical care, research, and policy.

This research was and is not intended to remain simply theoretical, but rather to inform clinical practice and policy development. The qualitative study was the first study about women's experiences with peri-abortion contraceptive care conducted in Canada; the findings suggest that the experiences of Canadian women accessing abortion care are similar to those of women from other high-income countries, such as the United Kingdom and Sweden. This thesis provides initial evidence that guidelines and policies from these countries may be critically examined for application in Canada. Overall, the findings contribute to the available body of knowledge about peri-abortion contraceptive care and provide directions for future research.

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Appendix A: Research Ethics Board Approvals

File Number: H11-17-09

Date (mm/dd/yyyy): 01/12/2018



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Certificate of Ethics Approval

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Wendy	Sword	Health Sciences / Nursing	Supervisor
Jocelyn	Wiens	Health Sciences / Nursing	Student Researcher

File Number: H11-17-09

Type of Project: Master's Thesis

Title: Peri-Abortive Women's Experiences with Contraceptive Coaching: An Interpretive Descriptive Study

Approval Date (mm/dd/yyyy)

Expiry Date (mm/dd/yyyy)

01/12/2018

01/11/2019

Special Conditions / Comments:

N/A

File Number: H11-17-09

Date (mm/dd/yyyy): 01/12/2018



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Germain Zongo
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB



Université d'Ottawa University of Ottawa

Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Health Sciences and Science Research Ethics Board

APPROVAL OF MODIFICATIONS

January 31, 2018

Jocelyn M. Wiens

Wendy Sword
School of Nursing
Faculty of Health Sciences
University of Ottawa
451 Smyth Rd
Ottawa, ON K1H 8M5

RE: Peri-Abortive Women's Experiences with Contraceptive Coaching: An Interpretive Descriptive Study (H 11-17-09)

Dear Ms. Wiens and Professor Sword,

The Health Sciences and Science Research Ethics Board has examined your request for ethics approval of the following modifications to your research project:

- Researcher will also conduct interviews via Skype, Face Time, or telephone.
- Verbal consent will be obtained from those who participate remotely.

Your request has been accepted. The certificate of ethics approval issued on January 12, 2018 and valid until January 11, 2019 covers these modifications.

During the course of the study, any further modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

If you have any questions, please do not hesitate to contact me at extension 1682.

Sincerely yours,

Germain Zongo
Protocol Officer for Research Ethics
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB



Université d'Ottawa University of Ottawa

Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Health Sciences and Science Research Ethics Board

APPROVAL OF MODIFICATIONS

March 28, 2018

Jocelyn M. Wiens

Wendy Sword
School of Nursing
Faculty of Health Sciences
University of Ottawa
451 Smyth Rd
Ottawa, ON K1H 8M5

RE: Peri-Abortive Women's Experiences with Contraceptive Coaching: An Interpretive Descriptive Study (H 11-17-09)

Dear Ms. Wiens and Professor Sword,

The Health Sciences and Science Research Ethics Board has examined your request for ethics approval of the following modifications to your research project:

- Participants will be recruited at the Planned Parenthood Ottawa and the Planned Parenthood Toronto. The institutions will make the recruitment text available to their clients.

Your request has been accepted. The certificate of ethics approval issued on January 12, 2018 and valid until January 11, 2019 covers these modifications.

During the course of the study, any further modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

If you have any questions, please do not hesitate to contact me at extension 5387.

Sincerely yours.

Germain Zongo
Protocol Officer for Research Ethics
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB

550, rue Cumberland Ottawa (Ontario) K1N 6N5 Canada 550 Cumberland Street Ottawa, Ontario K1N 6N5 Canada

(613) 562-5387 • Téléc./Fax (613) 562-5338
<http://www.research.uottawa.ca/ethics/index.html>



Université d'Ottawa University of Ottawa

Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Health Sciences and Science Research Ethics Board

APPROVAL OF MODIFICATIONS

April 11, 2018

Jocelyn M. Wiens

Wendy Sword
School of Nursing
Faculty of Health Sciences
University of Ottawa
451 Smyth Rd
Ottawa, ON K1H 8M5

RE: Peri-Abortive Women's Experiences with Contraceptive Coaching: An Interpretive Descriptive Study (H 11-17-09)

Dear Ms. Wiens and Professor Sword,

The Health Sciences and Science Research Ethics Board has examined your request for ethics approval of the following modifications to your research project:

- Participants will be recruited at Cliniques des femmes de l'Outaouais and at the Planned Parenthood Newfoundland and Labrador Sexual Health Centre. The institutions will make the recruitment text available to their clients.

Your request has been accepted. The certificate of ethics approval issued on January 12, 2018 and valid until January 11, 2019 covers these modifications.

During the course of the study, any further modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

If you have any questions, please do not hesitate to contact me at extension 5387.

Sincerely yours,

Germain Zongo
Protocol Officer for Research Ethics
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB

550, rue Cumberland Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street Ottawa, Ontario K1N 6N5 Canada

(613) 562-5387 • Téléc./Fax (613) 562-5338
<http://www.research.uottawa.ca/ethics/index.html>

Appendix B: Invitations to Participate

Social Media Invitation: Facebook/Instagram

Have you (or somebody you know) accessed an abortion in the past two years? As part of my Master's of Nursing, I am interviewing English-speaking women ages 18 to 45 years old about their personal experiences with contraceptive coaching as a part of accessing an abortion. These audio-recorded interviews will help health care workers better understand women's individual experiences and preferences for this part of abortion care. Participants will also receive a \$10 gift card to Tim Horton's as a thank you for their participation and time. All personal and/or identifying information will be kept strictly confidential. Potential participants, or anyone with questions, can contact me by email at [@uottawa.ca](mailto:jocelyn@uottawa.ca).¹

Social Media Invitation: Twitter

“UOttawa research nurse holding interviews to learn more about contraceptive teaching at abortion appts. Email Jocelyn @ [@uottawa.ca](mailto:jocelyn@uottawa.ca)”^{††} (139 characters)

The attached images are the approved hard-copy invitations for participation given to potential participants. They were printed in full-colour, as postcards. (For text, see below).

Front of postcard:

^{††} Photo of Invitation to Participate postcard will be included in post.



Back of postcard:



Postcard Text (Front):

- You are invited to participate in a research study: “Women’s experiences with contraceptive coaching”
- Who: Women ages 18-45 who have had an abortion in the past two years and can communicate in English.
- Researcher: Jocelyn Wiens, RN, MScN Student, Supervised by Professor Wendy Sword, RN, PhD
- Questions? Send me an email at @uottawa.ca

Postcard Text (Back):

- University of Ottawa, School of Nursing, Faculty of Health Sciences
- What is the goal of this research? To understand what women feel and think about the birth control coaching they received when going to an abortion clinic. *(Grade 9.2)^{‡‡}*
- Why participate? Your thoughts and ideas will help health care workers understand women’s experiences and what kind of coaching they prefer. *(Grade 8.5)²*
- Who is the researcher? Jocelyn is a registered nurse. She started her master’s at the University of Ottawa in September 2016. *(Grade 10.6)²*
- What do you need to do? You will have a personal talk (interview) with Jocelyn. She will ask you about what you knew about birth control before your procedure, what you learned from the coaching session, and about what and when you prefer to learn this information. This interview will be audio-recorded (sound only) but all your personal details will be kept strictly private. *(Grade 8.8)^{‡‡}*
- How do you get involved? Contact the researcher (Jocelyn) by phone or email to arrange a time that is convenient for you. As a thank you for your time and participation you will receive a \$10 Tim Horton’s gift card. *(Grade 7.6)²*

^{‡‡} Indicates reading level required for understanding

Appendix C: Demographic Data

Demographic	Categories
Age	Precise; can be grouped at a later time if needed.
First Language	Precise; can be grouped at a later time if needed.
Citizenship ^{§§}	Canadian Citizen Permanent Resident (Landed Immigrant) Citizen of Another Country with Work or Study Permit
Ethnicity ^{§§}	Aboriginal Peoples of North America (First Nations, Métis, or Inuit) Arab/West Asian (Afghan, Iranian, etc.) Black/African or Caribbean Canadian Chinese Latin American South or Southeast Asian (Cambodian, Filipino, Indian, Pakistani, Vietnamese, etc.) White/Caucasian Other (please specify)
Relationship Status ¹	Single In a Relationship Married or Domestic Partnership Separated Divorced Widowed
Employment/Occupation	Unemployed Employed (Part-Time) Employed (Full-Time) Homemaker Student (Part-Time) Student (Full-Time) Unable to Work
Education (highest level achieved) ¹	Less Than High School Some High School High School Diploma Some Post-Secondary Trade Certificate or Journeyman's Ticket/Certificate Undergraduate/Bachelor's Degree Some Graduate or Doctoral Studies Graduate or Doctoral Degree
Obstetric History	Gravidity (Times a person has been pregnant) Term (Pregnancies carried to 37+ weeks) Premature (Delivery before 37 weeks) Abortions (Spontaneous and induced) Living (# of living children)

^{§§} Categories per Statistics Canada (<http://www.statcan.gc.ca/>)

Appendix D: Interview Guide

Component of ODSF	Baseline	References
Current Practice	<ul style="list-style-type: none"> a) Who, if anyone, do you usually talk to about birth control? b) Tell me about what makes it easier or harder to have conversations about birth control. c) Right now, how well do you feel like you understand birth control – what options there are, how they work, how to use them, where to get them, etc.? d) Do you want to become pregnant within the next year? e) <i>(No)</i> Tell me about what you are currently doing for birth control/ <i>(Yes)</i> Tell me about what you usually did for birth control. f) Tell me about your partner(s) role(s) in preventing pregnancy. 	<p>Black et al., 2009, 2015a, 2015b; Dehlendorf et al., 2014a; Norman, 2012; O’Connor et al., 1998, 2002</p>
Decisional Needs <ul style="list-style-type: none"> - Informed - Values - Support (Internal, external, advice) 	<ul style="list-style-type: none"> a) Tell me about what you understand about birth control. b) What are things you consider when choosing birth control (<i>Possible prompts:</i> previous experience, side effects, safety, effectiveness, ease-of-use, ability to stop, visibility (patch/implant), etc.)? c) Tell me about your previous experience with birth control. d) Tell me about how you decided what kind(s) of birth control to use. e) What were some of the things you liked and disliked about your previous method(s) of birth control? f) <i>(If not using any method despite not wanting to become pregnant)</i> Why did you decide not to use birth control? g) What kind of financial ability do you have to afford birth control? h) Where do you seek/find information that helps you make your decisions about birth control? i) Does anyone help you make your decisions about birth control? 	<p>Black et al., 2009, 2015b; Dehlendorf et al., 2014b; Donnelly et al., 2014; Ferreira et al., 2009, 2011; Lee et al., 2011; O’Connor, 1998; Secura et al., 2010; Sundstrom et al., 2015; WHO, 2012</p>
Interventions	<ul style="list-style-type: none"> a) Were you using any form of birth control when you had the abortion? b) <i>(Yes)</i> Tell me about what you were doing to 	<p>Black et al., 2009; Dehlendorf et al., 2010a,b, 2013; Ferreira et al., 2011;</p>

	<p>prevent pregnancy.</p> <p>c) Have you ever received any kind of information or teaching about birth control?</p> <p>d) <i>(Yes)</i> Who provided the information/teaching?</p> <p>e) <i>(Yes)</i> Tell me about what you liked and disliked about the information/teaching you received.</p> <p>f) <i>(No)</i> What kind of teaching or information you would have liked to receive?</p>	<p>Gomez et al, 2014; Kavanaugh et al., 2009, 2011; Matulich et al., 2014; Nobili et al., 2007; Sundstrom et al., 2015; Pazol et al., 2015; WHO, 2012; Zapata et al., 2015; Zhang et al., 2014</p>
Support	<p>a) <i>(If received peri-abortion contraceptive coaching)</i> Tell me about the teaching/information you received at your abortion appointment(s).</p> <p>b) What were the best things about this teaching/information?</p> <p>c) Is there anything you would like to see changed in the teaching/information provided at abortion appointments?</p> <p>d) <i>(Yes)</i> Tell me about the changes that you would like to see.</p> <p>e) What things could health care providers (doctors, nurses, etc.) do to help you better understand birth control?</p> <p>f) What things could health care providers do to help you better understand how to access birth control?</p>	<p>Dehlendorf et al., 2014a; Kavanaugh et al., 2011; Matulich et al., 2014; O'Connor et al., 1998, 2002; Pazol et al, 2015; Zapata et al., 2015; Zhang et al., 2014</p>
Conclusion	<p>g) Is there anything else you'd like to add to what you've already told me?</p> <p>h) <i>(If yes, clarifying questions may be required):</i> Tell me a little more about that. What do you mean by that? Why do you think that is? Could you give me an example?</p>	

Benefits: My participation in this study aims to help health care providers better understand the needs and preferences for birth control teaching of women having abortions. This information can be used to improve the ways that this information is provided.

Confidentiality and anonymity: The information I will share will remain strictly confidential. I understand that it will be used only for the researcher's thesis about birth control coaching and that my personal information will be protected. If the researcher chooses to quote my words in any documents, they will use a pseudonym (false name) in order to keep my participation and information confidential.

Anonymity will be protected in the following manner: Any information about me will have a number on it instead of my name. Only the researcher and their supervisor will know what my number is and they will lock up that information with a lock and key. It will not be shared with or given to anyone. My name and any identifying information will never be printed in any publicly available documents or in the final publications.

Conservation of data: The data, including the digital recording and transcripts of the interview, and any notes taken by the researcher, will be kept safely in a locked filing cabinet and any digital data will be encrypted. All material will be stored securely in a locked filing cabinet for five years, at which point it will be destroyed.

Compensation: A \$10 Tim Horton's gift card will be given to me at the time of my meeting with the researcher for the interview. This will be mine to keep even if I do not complete the interview or if I change my mind at a later date and choose to withdraw (not to participate) from the study.

Voluntary Participation: I can decide to participate in this research study or not. If I choose to participate, I can change my mind later and stop participating, even if I agreed earlier. If I choose to withdraw, all the information I shared will be deleted (digital recordings) and/or destroyed (transcripts and researcher's notes) but the incentive received (gift card) will still be mine to keep.

Acceptance: I, *(Name of participant)*^{***}, agree to participate in the above research study conducted by Jocelyn Wiens of the School of Nursing in the Faculty of Health Sciences at the University of Ottawa, under the supervision of the professor Dr. Wendy Sword.

If I have any questions about the study, I may contact the researcher or their supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.: (613) 562-5387 Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: *(Signature)*

Date: *(Date)*

Researcher's signature: *(Signature)*

Date: *(Date)*

^{***} Yellow highlighting denotes sections that must be updated on actual form(s) given to participant(s).

Appendix F: Support Information for Participants

To mitigate the risk of psychological harm involved in being a participant in this study, all participants were given contact information for both local and national support groups. These were printed in full-colour, as postcards. (For text, see below).



Postcard Text:

- Thank you for participating!
- Sometimes these topics can bring up unwanted memories or emotions. If you feel it would help, there are people you can talk to. (Grade 5.8)^{†††}

^{†††} Indicates reading level required for understanding

- For non-emergency questions, concerns, or conversations:
- Planned Parenthood Ottawa (<https://ppottawa.ca/>); #404, 222 Somerset Street West;
Phone: 613.226.3234 (press 1 for ‘Options’); Email: rcharles@ppottawa.ca
- National Abortion Federation (<https://prochoice.org/>) Hotline Phone Number:
1.800.772.9100 (Monday to Friday 8am-9pm; Saturday 9am-5pm)
- For a mental health crisis: The Ottawa Mental Health Mobile Crisis Team at
613.722.6914 or 1.866.996.0991