

Postabortion Contraception: Qualitative Interviews On Counseling and Provision of Long-Acting Reversible Contraceptive Methods

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CONTEXT: Long-acting reversible contraceptive (LARC) methods (IUDs and implants) are the most effective and cost-effective methods for women. Although they are safe to place immediately following an abortion, most clinics do not offer this service, in part because of the increased cost.

METHODS: In 2009, telephone interviews were conducted with 20 clinicians and 24 health educators at 25 abortion care practices across the country. A structured topic guide was used to explore general practice characteristics; training, knowledge and attitudes about LARC; and postabortion LARC counseling and provision. Transcripts of the digitally recorded interviews were coded and analyzed using inductive and deductive processes.

RESULTS: Respondents were generally positive about the safety and effectiveness of LARC methods; those working in clinics that offered LARC methods immediately postabortion tended to have greater knowledge about LARC than others, and to perceive fewer risks and employ more evidence-based practices. LARC methods often were not included in contraceptive counseling for women at high risk of repeat unintended pregnancy, including young and nulliparous women. Barriers to provision were usually expressed in terms of financial cost—to patients and clinics—and concerns about impact on the smooth flow of clinic procedures. Education and encouragement from professional colleagues regarding LARC, as well as training and adequate reimbursement for devices, were considered critical to changing clinical practice to include immediate postabortion LARC provision.

CONCLUSIONS: Despite evidence about the safety and cost-effectiveness of postabortion LARC provision, many clinics are not offering it because of financial and logistical concerns, resulting in missed opportunities for preventing repeat unintended pregnancies.

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The unintended pregnancy rate in the United States is among the highest in the developed world;¹ an estimated 49% of pregnancies are unintended, and approximately half of these end in abortion.² Women who have abortions are at high risk of repeat unintended pregnancies in the subsequent year.^{3,4} Long-acting reversible contraceptive (LARC) methods—IUDs and implants—are the most effective reversible methods available, and are deemed top-tier for effectiveness by the Centers for Disease Control and Prevention.⁵ They are safe for a wide range of women, including those who are nulliparous or adolescent, or have a history of pelvic inflammatory disease.^{5,6} Research has documented the safety of immediate postabortion LARC provision,⁷ which avoids the loss of patients who do not return. One study showed that only 26% of women who wanted an IUD returned for a follow-up insertion by six weeks postabortion.⁸ Many of the women who do not attend follow-up contraceptive appointments are at high risk of unintended pregnancy.⁹ Aside from benefiting the individual patient, IUD use offers substantial public health benefits, including reduced cost and decreased occurrence of repeat abortions, when compared with the use of many other methods.¹⁰ According to one estimate, if 20% of U.S. women getting abortions had immediate placement of an

IUD, 43,000 unintended pregnancies could be prevented annually.¹¹

Despite clear evidence of the safety and effectiveness of postabortion provision of LARC, nationally representative survey data show low rates of LARC counseling and provision among abortion providers.^{12,13} Thompson et al.¹³ found that only 36% of providers offer immediate postabortion placement of IUDs, and only 17% offer implants. Fewer than half of abortion patients receive counseling and information about LARC methods, and almost one-third of clinics do not offer these methods at all, even at follow-up visits.¹³ Because U.S. women have low knowledge of LARC,^{14–16} a better understanding of clinic practices and increased support for evidence-based provision of LARC in the abortion care setting are in the public interest. Provider knowledge of and comfort in providing these methods are known to be associated with use rates,¹⁷ so we sought to explore the perceptions of those who could most easily address these issues—health educators and postabortion contraception providers.

Qualitative research can help explain why LARC provision is low in settings serving women at elevated risk of unintended pregnancy. We conducted semistructured interviews with health educators and clinicians providing

postabortion contraceptive care to understand why some providers routinely include LARC methods in their clinical practice and others largely omit them. We also aimed to identify factors that could help clinics transform their practices to begin postabortion LARC provision. We believe this is the first study to include both health educators and clinicians in a comprehensive review of LARC practices, and the potential for change, in the abortion care setting.

METHODS

This study was the second part of a mixed-methods study, the quantitative portion of which has already been published.¹³ The overall study sampling frame was the 326 U.S. members of the National Abortion Federation (NAF). In general, NAF members include many practices that perform a high number of abortions and relatively few private-practice physicians;¹⁸ approximately half of U.S. abortions are provided at NAF member facilities.¹⁹ In the quantitative study, an online survey was sent to all NAF members. Telephone interviews were conducted in 2009 with a subsample of 25 clinical sites from the initial study. Sites were selected through purposive sampling to encompass a range of clinical settings (stand-alone abortion clinics, private practices and hospitals), postabortion LARC practices (several sites with high provision rates were intentionally chosen) and state policies regarding public funding for contraceptive services. We selected a variety of practice sizes in 17 states across the country and the District of Columbia.*

At each site, telephone interviews were attempted with a health educator, a clinician, the clinic manager and a billing person. Trained interviewers followed structured topic guides covering general practice characteristics, training in LARC provision, knowledge and attitudes about LARC, current practices and barriers to immediate postabortion LARC provision. The health educator topic guide focused on patient education, communication barriers, appropriate LARC candidates, patient concerns and receptiveness to learning about LARC. The clinician topic guide emphasized clinical components of LARC, such as risks and side effects, techniques for difficult insertions and clinical protocols. Topic guides for clinic managers and billing staff were relatively brief, and covered clinic practices and financial and reimbursement issues. The guides comprised open-ended questions, and were developed using previous research and in consultation with contraceptive care experts.^{12,17} After the guides were pilot-tested, interviews were conducted with 24 health educators and 20 clinicians, as well as 44 clinic managers and billing staff. Five clinicians were unwilling or unable to participate; no health educators refused to participate (though one could not be contacted). Interviews with clinicians and educators lasted half an hour, on average. Those with clinic managers and billing staff lasted approximately 15 minutes; information collected from these personnel was used only for descriptive purposes, to give context to the data collected from the educators and clinicians.

Clinics at which at least three interviews were successfully conducted received \$200. The study was approved by the University of California, San Francisco, Committee on Human Research.

Analysis

Digital interview recordings were transcribed verbatim, and participants' identifying details were removed. Both deductive and inductive methods of data coding were used. Deductively derived themes were determined a priori by interview question topics, and other codes were added inductively as unanticipated themes arose in the transcripts. Two researchers coded the data using the software program ATLAS.ti 5.5, and cross-coding ensured the consistency of coding between the two analysts. This analysis allowed for comparison of responses across sites and participants, and for exploration of opinions across themes. After coding was completed, coauthors identified dominant themes and prevailing insights.

RESULTS

Among the clinicians interviewed, 14 were physicians, four were advanced practice clinicians and two were physician assistants. The median age among clinicians was 48 (range, 29–73), whereas the median among health educators was 32 (range, 22–60). Median patient volume (abortions performed per year) at the sampled clinics was 1,804 (range, 101–10,155); 17 of the facilities were stand-alone clinics, four were high-volume hospital-based clinics and four were private practices. Facilities were distributed across the country: eight in the South, four in the Northeast, four in the Midwest and nine in the West. Half of clinics offered LARC immediately after an abortion, and seven received assistance from programs that provide LARC methods free of charge to qualified low-income patients.†

Our findings illuminated myriad aspects of LARC provision and ways in which provision is either helped or hindered by staff attitudes, knowledge and practices. We also assessed factors such as protocols, clinic flow (the coordination of procedures) and cost. Five themes were identified: LARC counseling, use of follow-up visits, perceptions about method safety and risk, barriers to postabortion provision and expansion of LARC provision.

*Facilities were located in the Northeast (Massachusetts, New York, Pennsylvania), South (District of Columbia, Florida, Georgia, Maryland, Texas, Virginia), Midwest (Illinois, Michigan, Ohio, Wisconsin) and West (Arizona, California, Colorado, Utah, Washington).

†A number of programs make it possible for clinics to provide these methods to women who cannot afford them. The LARC Program, supported by a private foundation, provides LARC methods free of charge to low-income patients at clinics associated with the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning for residents, fellows, or medical or nursing students. The nonprofit Arch Foundation mails Mirena IUDs to clinics for a small number of women who can document their low income and lack of insurance coverage. The manufacturer of ParaGard has a similar program for low-income patients, as well as an installment payment option.

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LARC Counseling

In the abortion care setting, contraceptive counseling usually takes place before the clinician interacts with the patient. Typically, patients make contraceptive choices during the preabortion counseling session with a health educator and then undergo the formal consent with a clinician. Regarding the content of the counseling and different approaches to patients, one health educator noted, “Everybody has their own method [in] how they do the counseling session.” Educators related that when they saw patients who were emotional and not able to absorb much contraceptive information, they encouraged them to revisit the information at home and return for contraceptive care. Some patients were resistant because of partner pressure or general doubts about contraception. For the most part, however, educators saw patients who were receptive to contraception, and who left the clinics with a method—most frequently, a one-month sample of oral contraceptives.

Educators were keenly aware of pill failures, and frequently talked about patients’ missing pills and the difficulty of daily adherence. Nevertheless, top-tier effective methods, such as LARC, were not always covered in counseling. One nurse practitioner described the routine counseling and prescribing practices at her clinic, which seemed common to many: “Typically, we start abortion patients off with pills. That is the most common method, I’d say, in the beginning. . . . Eventually, if the patients are having problems, we can switch them to any other method.” A health educator at a different clinic described another common approach—continuing what the patient has used in the past: “Normally, we’ll ask them, ‘Were you using birth control, or have you used it in the past?’ And if they liked what they were using before, we’ll try and keep them on that.”

Counseling varied with exposure to evidence-based education and clinical training on LARC provision. In the clinics with special LARC interventions, such as dedicated clinician training and free devices, patient counseling on LARC methods was generally routine. Health educators who had attended LARC sessions at conferences were more likely than others to include these methods in counseling, and perhaps even to prioritize counseling by level of method effectiveness. As one health educator who had been to such trainings noted, “We talk to [patients] about what would they like to do. Is this the method that they would like to continue, or are they looking at a different method? And we try to get through all of the methods that are available, starting with long-acting reversible contraceptive methods first, talking about IUDs and Implanon.”

While counseling practices on LARC varied widely, educators consistently expressed that their patients appeared very receptive to learning about the methods. Educators believed that young women who did not know about LARC methods were particularly appropriate candidates for such information. According to one health educator, “A lot of them don’t really know anything other than the pill. So I think it’s good to inform them about other things

that have a higher typical effectiveness rate. . . . Whatever the reasons were they got pregnant, they need to know how to prevent that from happening again.”

Follow-Up Visits

In half of the practices, LARC methods were available only at follow-up, rather than on the same day as the abortion visit. Because of clinical protocols regarding infection screening, several clinics required two additional visits for patients who wanted an IUD insertion. Health educators and clinicians frequently mentioned that the pregnancy risk is high for women who have to return for an IUD, both because of the interim exposure and because the follow-up rate is low. Across the sample, participants noted the low follow-up rates after an aspiration abortion (generally around 35–45%). Rates were higher among medication abortion patients (approximately 80%), but very few practices offered LARC to these patients at their follow-up visit. One obstetrician-gynecologist expressed frustration that was shared by other clinicians and health educators: “I don’t have any exact number, but an amazing percentage of people [whom] I tell . . . ‘No sex until I see you for your follow-up’ don’t pay any attention to me. They may come back pregnant, and then they don’t get their birth control either.”

The clinicians and health educators who worked at clinics that did provide LARC immediately postabortion considered that initial visit to be a crucial opportunity for women’s contraceptive care. As one obstetrician-gynecologist noted, “They have the doctor’s attention or medical attention at that time, and they may not see it any other time afterwards. It’s our obligation to offer as much as we can during that visit.”

Perceptions About Safety and Risk

Beliefs about the safety and efficacy of LARC methods were overwhelmingly positive. All respondents recognized the overall safety of LARC, but views of appropriate candidates for IUDs and implants, as well as of the potential risk of insertion procedures, varied widely depending on their practice background. Misperceptions about who is an appropriate candidate for LARC, primarily regarding nulliparous women and teenagers, were typical among educators at clinics with low or no provision of these methods. In practices with limited LARC provision, few patients received LARC counseling, and restrictive views on who can safely use the methods were common, as demonstrated by the concern of a physician’s assistant, who noted, “The only problem is the IUD is not a good choice for abortion patients. Our clientele tends to be very young here, and IUDs are for a typical demographic which does not include our little 17-, 18-year-olds.” Health educators at clinics that offered limited provision held similar misperceptions about appropriate candidates. One stated, “People who have had at least one child . . . are a better candidate, and people who don’t have any history of yeast or bacterial infections can be good candidates.”

Clinicians and health educators at practices that did not routinely offer LARC were also more likely than others to express concern about risks such as IUD expulsions, infection or perforation. Furthermore, they worried that IUD placement immediately after a surgical procedure or at a follow-up visit after a medication abortion would complicate the management of routine symptoms and was therefore not appropriate.

The required clinician training for single-rod implant insertion was not widespread among respondents, which limited the provision of implants at many sites. Health educators and clinicians who were relatively experienced with the method were more willing than others to discuss the implant with all patients and were more positive about its use. They appropriately cited irregular bleeding as their main concern. At clinics that did not offer this method, respondents voiced greater worries about inserting a foreign object in patients and held non-evidence-based views of appropriate candidates. Health educators with low familiarity with the method often requested further information during the interviews, demonstrating interest in learning about these LARC methods.

In contrast, at practices that offered postabortion LARC provision, clinicians perceived far less risk and had no technical concerns about IUD or implant insertions. One such obstetrician-gynecologist voiced a sentiment expressed by several with significant experience, saying, “I don’t know that I’ve had a difficult IUD insertion.” In these practices, staff were far more likely to hold evidence-based views of who were appropriate candidates for the methods, and many explained how their views had changed in recent years for IUDs to include teenagers and women who did not have children. These health educators realized that misperceptions about the methods exist, but they themselves did not hold them. As one stated, “I think there [are] a lot of misconceptions about IUDs that are out there, a lot of wives’ tales about IUDs and when you can and can’t get IUDs. But we put [them in] a wide range of women. We put them in nulliparous women, we put them in women that have 10 kids, we put them in women that are not married.”

Barriers to Postabortion LARC Provision

The most commonly mentioned barriers to postabortion LARC provision were cost—both to the patient and to the clinic—and concerns about clinic flow. Cost came up repeatedly as an important factor affecting whether patients could get LARC immediately postabortion, even in discussions seemingly unrelated to it. As one health educator noted, reflecting sentiments expressed by many, patients seem to be very receptive to learning about IUDs, but “once they learn the cost, . . . you can see kind of a glaze go over their eyes, where it’s like, ‘How attainable is that for me?’”

In naming disadvantages of postabortion LARC provision, one clinician said, “The disadvantages are number one, the cost; number two, the cost; number three,

the cost.” Although providers recognized the burden of the high up-front costs, they also understood the cost-effectiveness of LARC over time. As one obstetrician-gynecologist stated, “If somebody can afford to pay for an IUD up front, I think I calculated for a ParaGard IUD [that] if you actually keep it for 10 years, . . . it costs you about 13 cents a day.”

Clinics struggled with how to cover their costs for postabortion LARC provision, particularly for low-income patients. Although federal Title X funds are available for family planning services, they cannot be used in programs that provide abortion services, and this severely limits the assistance available to help poor women pay for postabortion contraceptives. Many clinics do not take insurance—either because so few of their patients have coverage or because the contract negotiation and reimbursement processes are too cumbersome.¹³ Clinicians frequently expressed concern about patients’ ability to pay for their care, particularly since patients often pay out of pocket for both the abortion and contraceptives. Among respondents who discussed insurance coverage, the negative sentiments were quite strong; one nurse practitioner stated, “I’m so frustrated with insurance companies and all their ridiculous requirements and their lack of coverage for birth control for women.” Even staff at clinics that had contracts with private carriers said the insurance did not necessarily cover all of the costs. As one health educator explained, just because the device is covered does not mean the clinic will get all costs reimbursed: “We do not get reimbursed for the doctor’s time [for] an IUD insertion at the time of an abortion. . . . So, some of this is [about] whether the physician’s willing to basically donate their time or not for doing it.”

Concerns about how postabortion LARC provision would alter clinic flow also arose. On days when aspiration abortions are being performed, practices must follow a complex clinic schedule. For example, a patient may see a billing person, a health educator for counseling, a nurse for intravenous catheter placement and lab draws, an advanced practice clinician for a medical history review and finally a physician for the procedural consents and actual procedure. Given the coordination required to keep this process moving efficiently, respondents worried that adding time-intensive LARC counseling and consent could disrupt clinic flow. One obstetrician-gynecologist expressed the views articulated by many: “There’s just some concern that we have this very finely balanced, finely tuned machine, and little things can throw it off. And the insertion of an Implanon or an IUD is nothing, but at what point do we counsel these people and get them consented?”

Participants noted that counseling and consent take longer when staff members are unfamiliar with the process. Moreover, patients electing implants must complete the manufacturer’s consent form in addition to the clinic’s paperwork. Almost all clinics that offered immediate postabortion implant placement had advanced practice clinicians placing implants in a different room after the

Cost was the most frequently discussed barrier to provision of LARC methods.

abortion, to avoid tying up a procedure room or the physician's time. As one nurse practitioner, who also served as clinic director, stated when asked how her clinic could begin to offer postabortion implant insertions: "I don't know if the docs are going to slow down enough to do it.... In order to offer Implanon, I would probably have to have a nurse practitioner [in the clinic] on that particular day."

Many clinicians commented that patient care—and the decision about whether to offer postabortion LARC provision—was being made for administrative or logistical reasons, not medical ones. According to one obstetrician-gynecologist, the approach of scheduling LARC services for a different day from the abortion is "only a logistical decision [and] has nothing to do with any medical reason" not to provide those services immediately postabortion.

Expanding Postabortion LARC Provision

Several health educators and clinicians identified specific experiences that had allowed them or their clinics to begin providing LARC methods postabortion. Some identified changes in clinic protocols, such as removing a Pap smear requirement. More commonly, they mentioned that education—through a conference or meeting with a trusted colleague or expert—had motivated them to expand their LARC provision. Several obstetrician-gynecologists had been motivated by data presented at conferences on the safety of immediate postabortion insertion of IUDs, and they specifically mentioned information regarding infection and IUD use for nulliparous women. A nurse practitioner remarked that her medical director had been motivated to offer IUDs postabortion by a friend who is a national leader in contraceptive research. Others mentioned that colleagues at professional conferences had encouraged them to initiate postabortion provision at their clinics. For example, one obstetrician-gynecologist related, "We actually had one patient recently in whom I put an IUD at the same time as the termination was done. It was the first time that had ever been done in that clinic, and I'll have to admit, as old as I am, it's the first time I've ever done it. I've had some fairly long-held views about certain aspects of IUD use, and as a result of a [recent] meeting.... I was willing to give it a go and put it in, and things went fine."

Both health educators and clinicians expressed the importance of further education and training. Those in practices that received training regarding LARC and that provided low- or no-cost devices tended to view insertions as far less risky and to employ more evidence-based practices than others. They also were more likely to offer medication abortion patients a LARC method at the follow-up visit. Several respondents said that grant programs and training programs were critical to improving low-income patients' access to LARC methods following an abortion. As one family physician noted, "Without the grants, many of our patients just couldn't afford an IUD." For some women, these assistance programs were the only way they had access to effective contraceptives, even if they had

insurance. One obstetrician-gynecologist commented, "Until we had that LARC program, I had one woman who came back for four medical abortions in a row because her insurance program didn't cover an IUD." Practitioners in clinics without special programs were aware that access was restricted for their patients. As one health educator reported, "I wish that we had the ability or the funds or whatever means available to offer [immediate postabortion LARC provision] to every patient.... I think that we would find that the majority of our patients would go ahead and opt for that instead of coming back."

From our interviews, we found that clinician training is essential for initiating postabortion LARC provision. For IUDs, education about appropriate candidates is needed, as well as up-to-date information on the risk of expulsions, perforations and infections. Most providers employing evidence-based practices seemed to have gotten their information from presentations or colleagues at conferences or training workshops. For implants, the Food and Drug Administration (FDA) mandates hands-on insertion training, and many practices do not have clinicians who have completed the training. Those who have been trained consider the method extremely safe, easy to insert and remove, and appropriate for most women, although limited by its high cost and association with irregular bleeding. In practices that had integrated LARC services into postabortion care, health educators and clinicians alike spoke positively of the change.

DISCUSSION

Our interviews with health educators and clinicians in abortion clinics around the country suggest that, in keeping with the evidence, they believe immediate postabortion LARC provision is safe and reliable. However, half of the surveyed clinics did not offer postabortion LARC services, mainly for nonmedical reasons. Virtually all U.S. abortion clinics offer oral contraceptives, which have higher failure and discontinuation rates^{12,20–22} than LARC methods. Cost was the most frequently discussed barrier to provision of LARC methods—because of both the high up-front costs to patients and clinics' inadequate reimbursement for the devices and placement procedures. Although logistical barriers related to clinic flow were also mentioned, some clinics were able to surmount these barriers by altering clinical protocols in ways that allowed them to maintain efficiency. Often these changes were initiated by a clinician who had been inspired by colleagues who were offering their patients postabortion LARC services.

The cost issues raised by many respondents have financial implications at both the policy and the health systems levels. Pricing of methods is driven—in part—by the manufacturers, who maintain patent rights to their devices, allowing them to keep prices well above costs. Although a progestin-containing IUD that will be significantly cheaper than what is currently available is under development by a nonprofit organization, it is not expected to be FDA-approved and market-ready for several years. Aside from

the price of these devices, many patients must bear the cost of the abortion procedure (\$450–1,500²³) and possibly a LARC placement fee. Because placement is infrequently offered immediately postabortion, many patients must return for a follow-up visit, which incurs additional costs in both money and time. These cost factors make it difficult for women to use the methods that are most effective at preventing unintended pregnancies, likely resulting in public health and societal costs that are preventable.¹¹

These financial barriers to postabortion LARC provision are exacerbated by systems barriers that limit women's contraceptive options. For example, fewer than one-third of women who have abortions have private insurance coverage.²⁴ Thus, most women getting abortions must either pay out of pocket or rely on public funds, not only for their procedures, but also for their postprocedure birth control. Clinics offering Title X–funded services cannot extend federal discounts or coverage for contraceptives to abortion patients, and the result is prohibitive costs for immediate postabortion LARC provision for poor women.^{13,25} In states with mandated private insurance coverage for contraceptives or Medicaid family planning expansions, clinics can provide LARC services, even after an abortion, so some of these cost and reimbursement problems are attenuated. However, at the many clinics that struggle with regulations that require a separation of abortion and contraceptive care, patients cannot receive LARC immediately postabortion because of cost barriers. Legislative mandates requiring separate funding sources for poor women complicate patient care by forcing abortion patients who wish to use LARC methods to get them from a different provider or on a different day. As a result, many women known to be at high risk of repeat unintended pregnancies do not obtain a LARC method, and some obtain less effective contraceptives.

For insured women, some of these financial barriers may become less onerous. Under the Affordable Care Act, the Institute of Medicine was asked to determine what “basic preventive services” should be covered—at no cost—by all new insurers. Its recommendations included all FDA-approved contraceptive supplies and services. If implemented, this recommendation could have a significant impact on access to postabortion LARC care for the one-third of abortion patients who have insurance. Results of a study in St. Louis suggest that when cost is not an issue and trained providers and counselors offer LARC to patients as top-tier methods, two-thirds of women prefer a LARC method.²⁶

Although the Institute of Medicine recommendations may address some of the patient-level concerns, it is unclear how they will be implemented and if they will address the clinic- and provider-level concerns. Many providers described financial disincentives to postabortion LARC provision—namely, low levels of reimbursement and time-consuming and inefficient processes for obtaining reimbursement. If implemented, the new recommendations would remove some of the financial disincentives

and would allow for postabortion LARC placement with more adequate remuneration.

This study has limitations. Contraceptive counseling and provision practices were reported by the health educators and clinicians themselves, so social desirability bias likely influenced our findings. We might expect these respondents to report more forward-thinking and ideal practices than are the norm, given the time and resource realities in most clinic settings. Furthermore, we selected clinics that had relatively high rates of postabortion LARC provision, to shed light on how these services can be successfully integrated into clinic practice; therefore, the availability of postabortion LARC services, and perhaps the open-mindedness of clinicians and educators, may not be as widespread as suggested by our sample.

Nevertheless, the overarching message from these interviews is that decisions regarding patient care and contraceptive services are sometimes made for nonmedical reasons. Contraceptives are highly cost-effective for individual women, as well as for health systems, and LARC methods are the most cost-effective of all reversible methods.^{27–29} In this era of evidence-based medicine, this is an arena where clinical practice is deviating from the best evidence. It is in the best interest of abortion patients, as well as public health, to have the most effective and cost-effective methods of contraception available to reduce the risk of recurring unintended pregnancy and repeat abortion.

REFERENCES

1. Singh S, Sedgh G and Hussain R, Unintended pregnancy: world-wide levels, trends, and outcomes, *Studies in Family Planning*, 2010, 41(4):241–250.
2. Finer LB and Henshaw SK, Disparities in rates of unintended pregnancy in the United States, 1994 and 2001, *Perspectives on Sexual and Reproductive Health*, 2006, 38(2):90–96.
3. Creinin MD, Conception rates after abortion with methotrexate and misoprostol, *International Journal of Gynecology & Obstetrics*, 1999, 65(2):183–188.
4. Goldberg AB et al., Post-abortion depot medroxyprogesterone acetate continuation rates: a randomized trial of cyclic estradiol, *Contraception*, 2002, 66(4):215–220.
5. Centers for Disease Control and Prevention, U.S. medical eligibility criteria for contraceptive use, 2010, *Morbidity and Mortality Weekly Report Early Release*, 2010, Vol. 59.
6. World Health Organization (WHO), *Medical Eligibility Criteria for Contraceptive Use*, third ed., Geneva: WHO, 2004.
7. Grimes D, Schulz K and Stanwood N, Immediate postabortal insertion of intrauterine devices, *Cochrane Database of Systematic Reviews*, 2002, Issue 3, No. CD001777.
8. Stanek AM et al., Barriers associated with the failure to return for intrauterine device insertion following first-trimester abortion, *Contraception*, 2009, 79(3):216–220.
9. Heikinheimo O, Gissler M and Suhonen S, Age, parity, history of abortion and contraceptive choices affect the risk of repeat abortion, *Contraception*, 2008, 78(2):149–154.
10. Ames CM and Norman WV, Preventing repeat abortion in Canada: Is the immediate insertion of intrauterine devices postabortion a cost-effective option associated with fewer repeat abortions? *Contraception*, 2012, 85(1):51–55.

11. Reeves MF, Smith KJ and Creinin MD, Contraceptive effectiveness of immediate compared with delayed insertion of intrauterine devices after abortion: a decision analysis, *Obstetrics & Gynecology*, 2007, 109(6):1286–1294.
12. Kavanaugh ML, Jones RK and Finer LB, How commonly do US abortion clinics offer contraceptive services? *Contraception*, 2010, 82(4):331–336.
13. Thompson KM et al., Contraceptive policies affect post-abortion provision of long-acting reversible contraception, *Contraception*, 2011, 83(1):41–47.
14. Whitaker AK et al., Adolescent and young adult women's knowledge of and attitudes toward the intrauterine device, *Contraception*, 2008, 78(3):211–217.
15. Hladky KJ et al., Women's knowledge about intrauterine contraception, *Obstetrics & Gynecology*, 2011, 117(1):48–54.
16. Fleming KL, Sokoloff A and Raine TR, Attitudes and beliefs about the intrauterine device among teenagers and young women, *Contraception*, 2010, 82(2):178–182.
17. Harper CC et al., Challenges in translating evidence to practice: the provision of intrauterine contraception, *Obstetrics & Gynecology*, 2008, 111(6):1359–1369.
18. Henshaw SK and Finer LB, The accessibility of abortion services in the United States, 2001, *Perspectives on Sexual and Reproductive Health*, 2003, 35(1):16–24.
19. Jones RK et al., Abortion in the United States: incidence and access to services, 2005, *Perspectives on Sexual and Reproductive Health*, 2008, 40(1):6–16.
20. Frost JJ, Singh S and Finer LB, U.S. women's one-year contraceptive use patterns, 2004, *Perspectives on Sexual and Reproductive Health*, 2007, 39(1):48–55.
21. Vaughan B et al., Discontinuation and resumption of contraceptive use: results from the 2002 National Survey of Family Growth, *Contraception*, 2008, 78(4):271–283.
22. Raine TR et al., One-year contraceptive continuation and pregnancy in adolescent girls and women initiating hormonal contraceptives, *Obstetrics & Gynecology*, 2011, 117(2 Pt. 1):363–371.
23. Jones RK and Kooistra K, Abortion incidence and access to services in the United States, 2008, *Perspectives on Sexual and Reproductive Health*, 2011, 43(1):41–50.
24. Jones RK, Finer LB and Singh S, *Characteristics of U.S. Abortion Patients*, 2008, New York: Guttmacher Institute, 2010.
25. Cohen S, Repeat abortion, repeat unintended pregnancy, repeated and misguided government policies, *Guttmacher Policy Review*, 2007, 10(2):8–12.
26. Secura GM et al., The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception, *American Journal of Obstetrics & Gynecology*, 2010, 203(2):115.e1–115.e7, <[http://www.ajog.org/article/S0002-9378\(10\)00430-8/abstract](http://www.ajog.org/article/S0002-9378(10)00430-8/abstract)>, accessed Apr. 9, 2012.
27. Trussell J, The cost of unintended pregnancy in the United States, *Contraception*, 2007, 75(3):168–170.
28. Foster DG et al., Cost savings from the provision of specific methods of contraception in a publicly funded program, *American Journal of Public Health*, 2009, 99(3):446–451.
29. Trussell J et al., Cost effectiveness of contraceptives in the United States, *Contraception*, 2009, 79(1):5–14.

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