Original Research Article in *Contraception* – Author Version

How commonly do U.S. abortion clinics offer contraceptive services?

Megan L. Kavanaugh,* Rachel K. Jones, Lawrence B. Finer

Research Division, Guttmacher Institute, New York, New York, 10038, USA

Received 27 January 2010; revised 7 April 2010; accepted 12 April 2010

doi:10.1016/j.contraception.2010.04.010

Abstract available on *Contraception* website:

http://www.contraceptionjournal.org/article/S0010-7824%2810%2900147-2/abstract

***Corresponding Author**

Megan L. Kavanaugh
Guttmacher Institute
125 Maiden Lane, 7th Floor
New York, NY 10038 USA
Phone: 212-248-1111 x2225
Fax: 212-248-1951
Email: mkavanaugh@guttmacher.org

Declaration of Conflicting Interests

The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

Running Head: Contraceptive services in U.S. abortion care settings

Abstract

Background: About half of U.S. women having abortions have already had at least one prior abortion. Facilitating access to contraception may help these women avoid subsequent unintended pregnancies. Information is needed to document the availability of contraceptive services in abortion care settings in the U.S.
Study Design: Data for this cross-sectional mixed-methods study were collected between December 2008 and September 2009 and come from two sources: 15 semi-structured telephone interviews and 173 structured questionnaires administered to a nationally representative sample of eligible facilities. Respondents were administrators at large (400+ abortions per year), non-hospital facilities that provide abortion services in the United States.
Results: Virtually all (96%) abortion clinics incorporate contraceptive education into abortion care, and the three most common methods reported to be distributed are the birth control pill (99%), the vaginal ring (61%) and Depo-Provera (58%). Almost one-third reported being able to offer post-abortion intrauterine device insertion. Most facilities (82%) accept some form of insurance for either contraceptive or abortion services, and those with a broader family planning focus are significantly more likely to do so. Administrators at the majority of facilities (56%) report that patients most commonly do not pay additional fees for contraceptive services because they are included in the cost of abortion services.
Conclusion: Although almost all large, non-hospital abortion providers in the United States are able to provide some level of contraceptive care to their abortion patients, the degree to which they are able to do so is influenced by a wide range of factors.

1. Introduction

Among women having abortions in the United States, about one-half have already had a prior abortion [1]. Women returning for a subsequent abortion are slightly more likely than first time abortion patients to have become pregnant while using a hormonal method [2]. Among abortion patients who were not using contraception when they became pregnant, women having a repeat abortion are more likely than first time abortion patients to indicate that problems with methods in the past were a reason for nonuse [2]. One potential avenue for addressing these contraceptive difficulties is to recognize abortion patients as a population at risk for subsequent unintended pregnancies and capitalize on the abortion care setting as an ideal one for intervening to help women avoid subsequent unintended pregnancies. However, the political climate surrounding abortion in the U.S. has led to a system in which abortion services are often provided in isolation from family planning and other medical care [3].

Information is needed on the extent to which abortion providers are currently able to work within this constraining system to provide contraceptive services to their patients. Anecdotal information suggests that contraceptive services vary greatly across abortion providers in the United States. However, little is known about contraceptive services at abortion clinics, which provide the majority of abortion services to women in the United States. Thus, this study provides an overview regarding the extent to which facilities that provide the majority of abortion services in the United States are able to provide contraceptive services to their abortion patients.

2. Materials and methods

Data for this cross-sectional mixed-methods study come from two sources: semi-structured interviews that yielded qualitative data and structured surveys that yielded quantitative data, both with administrators from facilities that provide abortion services in the United States. The primary goal of the semi-structured interviews was to better understand current contraceptive provision in abortion care settings for the purposes of developing a structured survey instrument. Our sample was drawn from a regularly updated database of all known U.S. abortion providers [4]. For this study, the universe was restricted to non-hospital facilities with caseloads of 400 or more abortions per year (N = 569) to create our sampling frame. While these facilities account for only 35% of all known abortion providers, they provide 91% of all abortions in the United States [4]. For the semi-structured interviews, facilities were purposively selected from the sampling frame to represent diversity across provider types, region in the U.S., abortion caseload, availability of state Medicaid funding for abortion services and mandated abortion counseling. For the structured survey, the sampling frame was stratified according to geographic region and abortion caseload and a representative sample of 251 facilities was randomly selected.

From December 2008 to February 2009, 15 semi-structured telephone interviews, most lasting 30 to 45 min, were completed with a staff member or members designated by the administrative manager of each facility. Respondents were most often the clinic director or manager and they were each offered a monetary honorarium towards their facility for participation in the interview. All 15 interviews followed a semi-structured interview guide that asked administrators about contraceptive practices in the context of abortion care in their facility: how they discuss and provide it to patients, barriers to integrating contraceptive services into

abortion care and strategies for better integrating these two services. All semi-structured interviews were recorded and later transcribed and reviewed for thematic content.

Based on information from the semi-structured interviews, we developed a five-page survey instrument that included questions on the logistics and characteristics of contraceptive services. Questions were primarily closed-ended and were divided into four sections: facility and patient characteristics, contraceptive practices and protocols, fees and payment options, and integration of abortion and contraception services. Questionnaires were pilot-tested with administrative managers from seven facilities and revised to reflect their feedback.

We mailed the final questionnaire to administrative managers at the 251 facilities in our sample and asked them to give it to the staff person most familiar with the contraceptive counseling, provision and billing practices in the facility. We sent a second mailing of the questionnaire and made follow-up telephone calls to maximize the response rate. Twelve of the original 251 facilities in the sample were considered ineligible because they had closed or reported that they no longer provided abortion services. Data collection for the structured survey occurred between May and September 2009. This study was considered exempt by our organization's Institutional Review Board.

Survey data were double-entered and validated in an Excel spreadsheet by two research assistants before being imported into SPSS version 11.1 for data management and analysis. We examined differences in contraceptive practices by facility characteristics using chi-square tests to assess differences in categorical outcomes. Results were considered significant at $p<0.05$. We present quotes from the semi-structured interviews to further illustrate structured survey findings, when appropriate.

In the structured questionnaire we defined contraceptive education as a discussion about one or more contraceptive methods between facility staff and patients. For these analyses, we distinguish between facilities that specialize in abortion services, defined as having 50% or more of client visits for abortion services, and clinics that are more broadly focused on reproductive health services, typically family planning. For provider reports of methods with which abortion patients leave their appointments, we consider reports of at least 75% of abortion patients leaving with a particular method as a "typical" practice. For the four facilities that did not provide information on the questionnaire about proportion of patient caseload accounted for by abortion services, we relied on 2005 reports from these facilities for this information [4].

3. Results

3.1. Overview of facilities

Administrators at 173 eligible facilities responded to the questionnaire, for a response rate of 72%. Our final sample resembles the universe of U.S. non-hospital facilities that have caseloads of 400 or more abortions per year on all characteristics, with one exception: Planned Parenthood facilities were slightly overrepresented, comprising 27% of the population of abortion providers doing 400 or more abortions in 2005 but 36% of all facilities that participated in our study (Table 1). Nearly half of facilities were located in states where state Medicaid funds for abortion services are available (42%),[1] but most were in states where state-mandated waiting

[1] Policy or court decisions in 17 states require the use of state funds to cover all or most medically necessary abortions for low-income women enrolled in Medicaid. Nonetheless, two states under court order to fund abortion services (Arizona and Illinois) report very few procedures. (Source: Sonfield A, Alrich C and Gold RB, Public

periods for receiving abortion services are not in place (66%). Almost two-thirds (62%) of the facilities are abortion-focused, with the majority of patient visits for abortion services.

3.2. Provision of contraceptive information and education

Virtually all (96%) abortion clinics incorporate contraceptive education into abortion care, but the content and extent of this discussion varies widely (data in this paragraph not shown in tables). Sixty percent report spending between 6 and 15 min total discussing contraception with abortion patients over the course of the patients' visits and one in five (23%) spend more than 15 min discussing these issues. Although only 15% of all facilities in the structured survey reported that contraceptive education occurs in a group setting, facilities that specialized in abortion services were significantly more likely to report using this format than facilities with a broader family planning focus (22% vs. 5%, $p<0.01$).

3.3. Contraceptive methods provided

The three most common methods reported to be distributed to abortion patients were the birth control pill (99% of facilities reported this method was one of the three most common methods distributed to abortion patients), the vaginal ring (61%) and the depotmedroxyprogesterone acetate injectable (58%) (Table 2). Most facilities were able to provide samples of birth control pills (76%) and condoms (62%) to at least some abortion patients at no cost. Facilities specializing in abortion services were more likely to provide *samples* of pills, the vaginal ring and the birth control patch, while facilities that were more broadly focused on family planning were more likely to offer free samples of condoms and emergency contraception (EC). These broadly focused facilities were more likely to have a full range of contraceptive methods available onsite *at a cost* for abortion patients.

More than half of the facilities (56%) reported that abortion patients typically leave the facility with supplies of some type of contraceptive method other than condoms. Over one-third of abortion providers report that patients typically leave with condoms (often in addition to supplies of another method), and this practice was more common among broadly focused family planning facilities. Slightly more than one-third of facilities reported that patients typically leave with a prescription, most often in addition to supplies of another method. Approximately one quarter of the sample indicated that abortion patients typically leave their appointments with EC or a prescription for EC, and this practice was significantly more common among broadly focused family planning facilities. According to data from the semi-structured interviews, some facilities provide a one- or two-month supply of a method in sample form and supplement this with a prescription for one to two more months, while others provide two to three months' supply of a method at the time of the procedure.

Many facilities reported having adopted more recent, evidence-based strategies for provision of certain contraceptive methods to their abortion patients (Table 3). For example, half of sampled facilities indicated that they routinely offer EC or a prescription for EC to abortion patients for future needs (compared to the one-quarter who say patients typically take it). Slightly

---

funding for family planning, sterilization and abortion services, FY 1980-2006, Occasional report, New York: Guttmacher Institute, 2008, No. 38, Table 3.9, http://www.guttmacher.org/pubs/2008/01/28/or38.pdf, accessed March 16, 2010.) As a result, for analyses that distinguish between facilities in Medicaid and non-Medicaid coverage states, we do not include Arizona or Illinois in the former.

less than a third of facilities reported using the quick-start contraceptive pill initiation (having patients take the first pill while still at the facility) or offering immediate post-abortion insertion of intrauterine devices (IUDs) and/or Implanon to their abortion patients. For all three of these provision strategies, broadly focused family planning facilities were significantly more likely to have adopted these practices.

3.4. Payment for contraceptive services

Providers were also asked to estimate the percentage of abortion patients at their facility that paid for contraceptive services (including time spent discussing contraception and the contraceptive method or prescription itself) according to source of payment (Table 4). Most commonly, abortion patients were not charged for contraceptive services because these services were included in the cost of receiving abortion services (56%). Among facilities where contraceptive services are not included in the cost of the abortion, the most common strategy was to rely on Medicaid to cover these costs (26%) or to provide them at low or reduced fees (10%). Most facilities specializing in abortion services are able to offer additional free or discounted contraceptive supplies to abortion patients who return for a follow-up visit (63%).

During the semi-structured interviews, several respondents indicated that staff at their facilities try to be cognizant of patients' financial situations.

Most facilities (82%) accept some form of insurance for either contraceptive or abortion services, and those broadly focused on family planning are significantly more likely than specialized abortion clinics to do so. Out of those that do accept some form of insurance, abortion-focused clinics are also less likely to accept Medicaid for contraceptive services during abortion care.

4. Discussion

We believe this study to be the first to provide a national snapshot of the contraceptive services provided to the majority of women accessing abortion care in the United States. An overwhelming majority of clinics that provide abortion services are able to offer contraceptive information and supplies, and, in some cases, a wide range of methods. The extent of these services and their prioritization in relation to abortion services being provided varies among the facilities, particularly according to whether or not the facility specializes in abortion services or is more broadly focused on general family planning services.

Although the majority of facilities that specialize in abortion services engage in contraceptive counseling, offer access to multiple contraceptive methods and report that most abortion patients leave with a contraceptive method, they are less likely than broadly focused family planning clinics to engage in these activities. Alternately, these more generalized family planning facilities are typically better equipped to offer comprehensive contraceptive services to abortion clients and to manage complex insurance billing and reimbursement systems, as demonstrated by having supplies of a broader range of contraceptive methods available onsite and higher likelihoods of accepting insurance coverage. In addition, facilities with greater organizational resources are presumably better able to meet federal funding guidelines requiring distinct and separate funding streams (and therefore separation of services) between contraceptive services for low-income women (e.g. Title X) and other funds that subsidize abortion services in these settings.

Long-acting reversible contraception, such as IUDs and implants, represent a newly "rediscovered" strategy for reducing unintended pregnancy. These methods are highly effective, require minimal user involvement and can be used for long periods of time [5]. Given that the IUD resurgence is less than a decade old and that the single implant only received Food and Drug Administration approval in 2006, it is notable that more than half of abortion clinics report regularly discussing these methods with patients. Importantly, fewer providers are able to offer these methods to patients, but many are able to refer interested patients to health care facilities that can. It is also encouraging that at least a third of all facilities that provide abortion services report that they incorporate the more novel strategies of providing the quick start protocol for oral contraceptive pills [6], providing EC in advance [7] and/or inserting IUDs or implants immediately following the abortion procedure [8], though the extent to which abortion patients actually elect to receive methods through one of these avenues is still unclear.

Our study is not without limitations. Because we rely on providers' self-reports of their contraceptive services and practices, our data may be biased and reflect more socially desirable practices rather than actual clinical practice. Although we explicitly asked respondents about contraceptive services for abortion patients, the reported high rates of provision of contraceptive information and of a wide range of methods at generalized family planning facilities may indicate that respondents at these facilities were reporting services for all patients rather than just abortion patients. It is also important to note that providers were typically reporting on contraceptive services *available* at their facility, not what women actually chose or used.

Women's quick return to fertility following an abortion [9] justifies the provision of contraceptive information and offering of contraceptive supplies as a routine part of abortion care. Yet there are several reasons that abortion providers may not prioritize incorporation of a wide range of contraceptive services and methods. First, a single provider may be the sole source of abortion services within a large geographic area, while availability of contraceptive services in that same area is much more widespread, and may therefore prioritize the provision of abortion services over contraceptive and other services. Additionally, many provide abortion services in an environment in which they are subjected to harassment, legislative barriers and economic constraints.

While provision of contraceptive services seems like a practical and intuitive strategy to help reduce subsequent unintended pregnancies among a population of women known to be fertile, there is little evidence to suggest this strategy is effective [10, 11]. A recent review of the effectiveness of contraceptive counseling for women undergoing abortions concluded that counseling about contraception during abortion does not increase the acceptance or use of contraceptive methods following abortion services [10]. A more comprehensive review of counseling practices intended to reduce unintended pregnancy (based on 74 studies and not restricted to women obtaining abortions) failed to find programs that provide strong guidance for these types of interventions [11]. Development of new strategies, particularly those involving newer methods, is warranted.

Although there is no established national standard of care requiring provision of contraceptive services as part of abortion care in the United States, it is clear that the large majority of abortion facilities do incorporate these services in some capacity. Recognizing that there has been a recent trend towards more patient-centered care in abortion service delivery [12], 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. Such research would make it possible to incorporate women's perspectives into

the provision of post-abortion contraception and help to determine how best to move towards the ultimate goal of assisting abortion patients to avoid subsequent unintended pregnancies and abortions.

Acknowledgements
The authors thank Cynthia Harper and Kirsten Thompson for their input on the interview guide and survey instrument, Liz Carlin, Luciana Hebert and Lori Frohwirth for providing research assistance, and Susheela Singh and Rachel Benson Gold for reviewing drafts of the article. The research on which this article is based was supported by the Charlotte Ellertson Social Science Postdoctoral Fellowship in Abortion and Reproductive Health, an Ibis Reproductive Health program.

References

[1] Jones RK, Darroch JE, Henshaw SK. Contraceptive use among U.S. women having abortions in 2000-2001. Perspect Sex Reprod Health 2002;34:294-303.

[2] Jones RK, Singh S, Finer LB, Frohwirth LF. Repeat abortion in the United States. New York: Guttmacher Institute; 2006. Report No.: 29. 65p.

[3] Cohen SA. Repeat abortion, repeat unintended pregnancy, repeat and misguided government policies. Guttmacher Policy Rev 2007;10:8-12.

[4] Jones RK, Zolna MR, Henshaw SK, Finer LB. Abortion in the United States: incidence and access to services, 2005. Perspect Sex Reprod Health 2008;40:6-16.

[5] Grimes DA. Intrauterine devices (IUDs). In: Hatcher RA, Trussell J, Stewart FH, Nelson AL, Cates W, Guest F, editors. Contraceptive Technology. New York: Ardent Media, Inc, 2004. p. 490-521.

[6] Westhoff C, Heartwell S, Edwards S, et al. Initiation of oral contraceptives using a quick start compared with a conventional start: a randomized controlled trial. Obstet Gynecol 2007;109:1270-6.

[7] Polis CB, Schaffer K, Blanchard K, Glasier A, Harper CC, Grimes DA. Advance provision of emergency contraception for pregnancy prevention: a meta-analysis. Obstet Gynecol 2007;110:1379-88.

[8] Goodman S, Hendlish SK, Reeves MF, Foster-Rosales A. Impact of immediate postabortal insertion of intrauterine contraception on repeat abortion. Contraception 2008;78:143-8.

[9] Lähteenmäki P. Postabortal contraception. Ann Med 1993;25:185-9.

[10] Ferreira AL, Lemos A, Figueiroa JN, de Souza AI. Effectiveness of contraceptive counselling of women following an abortion: a systematic review and meta-analysis. Eur J Contracept Reprod Health Care 2009;14:1-9.

[11] Moos MK, Bartholomew NE, Lohr KN. Counseling in the clinical setting to prevent unintended pregnancy: an evidence-based research agenda. Contraception 2003;67:115-32.

[12] O'Connell K, Jones HE, Simon M, Saporta V, Paul M, Lichtenberg ES. First-trimester surgical abortion practices: a survey of National Abortion Federation members. Contraception 2009;79:385-92.

Table 1. Characteristics of facilities participating in contraception survey and of universe

	Sample (N=173)		Universe (N=569)	
Region	N	%	N	%
Midwest	35	20	96	17
Northeast	42	24	124	22
South	60	35	202	36
West	36	21	147	26
Affiliation				
Planned Parenthood facility	62	36	154	27
State Medicaid funds cover abortion services	72	42	250	44
State mandated waiting period	59	34	186	33
Abortion caseload				
400-999	54	31	203	36
1000-4999	107	62	348	61
5000 or more	8	5	18	3
Missing	4	2		
% client visits for abortion				
<50%	65	38	230	40
50% or more	108	62	339	60

Table 2. Percentage of large US abortion service facilities, by selected characteristics of contraceptive methods, according to abortion service caseload

	All (n=173)	Abortion service caseload		
Most common methods received by patients		<50% abortions	50% or more abortions	p
Pill	99	98	100	0.193
Ring	61	52	66	0.066
Depo	58	58	58	0.947
Methods provided as samples by facilities				
Pills	76	56	87	0.000
Condoms	62	75	53	0.004
Ring	51	26	67	0.000
Patch	27	16	35	0.007
EC	15	28	6	0.000
Methods provided for cost by facilities				
Depo	76	77	76	0.886
IUD	61	75	52	0.004
EC	57	63	54	0.277
Pills	33	59	17	0.000
Patch	31	50	18	0.000
Implanon	30	50	19	0.000
Ring	30	48	19	0.000
Condoms	12	25	4	0.000
Sterilization	7	8	6	0.612
Methods with which abortion patients typically* leave facility				
Contraceptive method other than condoms	56	65	51	0.079
Contraceptive prescription other than EC	38	32	42	0.211
Condoms	37	57	24	0.000
EC or and EC prescription	22	36	13	0.001

* Reports of at least 75% of all abortion patients leaving facility with method are considered typical practice

Table 3. Percentage of large US abortion service facilities adopting novel strategies for contraceptive provision during abortion care, according to abortion service caseload

	All (n=173)	Abortion service caseload		
Contraceptive method provision strategy		<50% abortions	50% or more abortions	p
Provide/prescribe EC in advance	51	75	36	0.000
Offer quick-start contraceptive pill initiation protocol	29	41	22	0.010
Provide immediate post-abortion insertion of IUDs and/or implant	32	46	24	0.003

Table 4. Percentage of large US abortion service facilities, by selected characteristics of payment for contraceptive methods, according to abortion service caseload

	All (n=173)	Abortion service caseload		
		<50% abortions	50% or more abortions	p
Most common source of payment for contraceptive services				
No additional fee (contraception included in abortion cost)	56	37	67	0.000
Medicaid or state equivalent	19	34	9	0.000
Full fee out-of-pocket (may or may not be reimbursed by insurance)	10	5	13	0.074
Reduced fee or no fee because of low income	7	11	5	0.124
Private (employment-related) insurance plan billed directly	2	3	1	0.294
Accepts insurance	82	95	73	0.000
Medicaid for abortion services (in cases *other* than rape, incest or life endangerment) †	61	77	48	0.004
Medicaid for contraceptive services†	69	89	51	0.000
At least some types of private health insurance for abortion services†	86	93	80	0.027
At least some types of private health insurance for contraceptive services†	81	90	73	0.013
Discounts				
Provide discounted or free contraception (not including condoms) to patients during abortion visit	78	85	74	0.105
Offer additional discounted or free contraception (not including condoms) to patients who return for follow-up visits	66	70	63	0.344

† These variables are reported for the 141 facilities that indicated that they accept some form of insurance.