Contraceptive care at the time of medical abortion

experiences of women and health professionals in a hospital or community sexual and reproductive health context

ELSEVIER

Contraception xx (2015) xxx – xxx

Contraception

Original research article

Contraceptive care at the time of medical abortion: experiences of women and health professionals in a hospital or community sexual and reproductive health context

Carrie Purcell[a,*], Sharon Cameron[b], Julia Lawton[a], Anna Glasier[b], Jeni Harden[a]

[a]Centre for Population Health Sciences, University of Edinburgh, Teviot Place, Edinburgh EH8 9LN, United Kingdom
[b]Medical School, University of Edinburgh, Teviot Place, Edinburgh EH8 9LN, United Kingdom

Received 8 April 2015; revised 25 September 2015; accepted 29 September 2015

Abstract

Objective: To examine experiences of contraceptive care from the perspective of health professionals and women seeking abortion, in the contexts of hospital gynaecology departments and a specialist sexual and reproductive health centre (SRHC).
Materials and methods: We conducted in-depth semistructured interviews with 46 women who had received contraceptive care at the time of medical abortion (gestation≤9 weeks) from one SRHC and two hospital gynaecology-department-based abortion clinics in Scotland. We also interviewed 25 health professionals (nurses and doctors) involved in abortion and contraceptive care at the same research sites. We analysed interview data thematically using an approach informed by the Framework method, and comparison was made between the two clinical contexts.
Results: Most women and health professionals felt that contraceptive counselling at abortion was acceptable and appropriate, if provided in a sensitive, nonjudgemental way. Participants framed contraceptive provision at abortion as significant primarily as a means of preventing subsequent unintended conceptions. Accounts of contraceptive decision making also presented tensions between the priorities of women and health professionals, around 'manoeuvring' women towards contraceptive uptake. Comparison between clinical contexts suggests that women's experiences may have been more positive in the SRHC setting.
Conclusions: Whilst abortion may be a theoretically and practically convenient time to address contraception, it is by no means an easy time to do so and requires considerable effort and expertise to be managed effectively. Training for those providing contraceptive care at abortion should explicitly address potential conflicts between the priorities of health professionals and women seeking abortion.
Implications: This paper offers unique insight into the detail of women and health professionals' experiences of addressing contraception at the time of medical abortion. The comparison between hospital and community SRHC contexts highlights best practise and areas for improvement relevant to a range of settings.

Keywords: Medical abortion; Postabortion contraception; Long-acting reversible contraception (LARC); Qualitative research

1. Introduction

Around one third of women who have abortions in United Kingdom and half in the United States will go on to have a subsequent abortion [1,2]. Evidence varies regarding the impact of specialist contraceptive counselling at abortion on contraceptive uptake and rates of subsequent abortion [3–5], although evidence that long-acting reversible contraception (LARC) in particular can contribute to reducing subsequent unintended conceptions continues to grow [6–9].

It is thought that women having an abortion may be highly motivated to secure contraception, particularly LARC, and that this may also be a convenient time for them to do so [10,11]. Research addressing the degree to which women want contraceptive care at abortion or feel this is appropriate timing nevertheless reports mixed findings [12,13]. Women's receptivity to contraceptive counselling at that time may be reduced by difficulties reported in managing the volume of information provided at abortion

* Corresponding author. MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, 200 Renfield Street, Glasgow G2 3QB, United Kingdom.
E-mail addresses: carrie.purcell@glasgow.ac.uk (C. Purcell), sharon.cameron@ed.ac.uk (S. Cameron), j.lawton@ed.ac.uk (J. Lawton), anna.glasier@ed.ac.uk (A. Glasier), jeni.harden@ed.ac.uk (J. Harden).

http://dx.doi.org/10.1016/j.contraception.2015.09.016
0010-7824/

[14] and by the misinformation and significant knowledge gaps around (particularly intrauterine) contraception that persist amongst women seeking abortion [15]. Women also report valuing the opportunity to address contraception at abortion and not feeling 'coerced' by doing so [16].

A limited amount of research has addressed women's experiences of contraceptive care at abortion. With respect to contraceptive decision making in general, United States research has found that, whilst women and health professionals' priorities may be largely 'concordant', mismatches occur around the priorities of each, which underscores the importance of shared decision making in this context [17]. Women's preferences have been found to include the desire for an 'intimate, friend-like relationship with their providers' and for 'comprehensive information about options, particularly about side effects' [18].

The location of abortion provision has implications for the contraceptive care offered. In the United States, for example, the politicisation and stigmatisation of abortion has factored in the development of nonhospital-based abortion services [19]. United States providers have been working towards the integration of contraceptive counselling into abortion services but face significant barriers [12,20,21]. In Scotland, abortion is almost exclusively provided through the National Health Service (NHS) and has traditionally been provided in hospital gynaecology departments. However, effective contraceptive counselling is known to be time consuming, making it challenging to address effectively in overburdened hospital settings [14]. In recent years, the appropriateness of community (as distinct from hospital) settings for medical abortion provision in the United Kingdom has been assessed and found suitable [22]. Community-based sexual and reproductive health centres (SRHCs), which integrate genitourinary medicine and family planning services, may offer specialist postabortion contraceptive counselling and provision, which may in turn contribute to increasing uptake and reducing subsequent unintended conceptions [23]. From the perspective of service provision, constraints on addressing contraception at abortion have been found to include added pressure on already busy and complex clinic schedules (particularly where staff are less familiar with methods) and an absence of appropriate training in LARC insertion [24].

Little research to date has looked in depth at health professionals' experiences with providing contraceptive care at medical abortion, and even less brings together the perspectives of women and health professionals. This paper offers a holistic analysis of providing and receiving contraceptive care at medical abortion in a traditional hospital context and a more recently established SRHC setting, offering comparison of experiences in these two clinical contexts. In doing so, it foregrounds concordant and conflicting priorities of women and health professionals and highlights tensions between facilitating women's contraceptive decisions and preventing subsequent unintended conceptions.

2. Materials and methods

2.1. Design

This paper presents one aspect of the data analysis from a qualitative evaluation of NHS medical abortion provision in Scotland, which has since 2012 been offered from a specialist SRHC setting, as well as in its traditional hospital context. We adopted a qualitative research design to offer flexibility to women and health professionals in discussing their experiences in their own words and the opportunity to raise any topics that they considered relevant and that may have been unanticipated by the research team [25]. Two hospitals and one SRHC in the same area of urban Scotland were selected as study sites in order to compare and evaluate provision from the hospital and community contexts. The study was granted ethical approval by the Centre for Population Health Sciences Research Ethics Committee, University of Edinburgh.

2.2. Study participants

We provided all health professionals working in abortion services in the three sites with information on the study and invited them to participate in a confidential in-depth interview. Following an 'opt-in' procedure, willing participants indicated their interest directly to CP who then arranged the interview. Interviews were conducted with 37 health professionals in total — including nurses, doctors, clinical support workers (nursing aides) and sonographers — on experiences of medical abortion provision. Only data from the 17 (11 hospital and 6 SRHC) nurses and 8 (5 hospital and 3 SRHC) doctors in the sample are included here as only they were directly involved in contraceptive counselling and provision. Findings from other aspects of the study will be reported elsewhere.

Specialist health professionals at the same sites provided women presenting for medical abortion (gestation≤9 weeks) with study details by when they attended for assessment for abortion. Women were excluded if there were over 9 weeks pregnant, were having surgical abortion, were under 18 years of age, were unable to provide informed consent, were overly distressed at the time of attendance or spoke insufficient English to participate in an interview. Recruiting staff passed to CP the contact details of women consenting to be contacted at a later date. CP then made contact approximately 2 weeks after their initial clinic assessment. We conducted interviews with 46 women (23 from each clinical setting), up to 6 weeks after medical abortion, in a location of the woman's choosing or by telephone. CP obtained written consent from all study participants prior to the interview. Key characteristics of the sample of women interviewed are outlined in Table 1.

The participating sites use a medical abortion regimen (when gestation≤9 weeks) of oral mifepristone 200 mg, which is provided (if appropriate) at the end of an initial assessment appointment, during which women receive

Table 1
Key characteristics of women who received contraceptive care at medical abortion (gestation≤9 weeks)

	Hospitals (*N*=23)	SRHC (*N*=23)	Total (% of total) (*N*=46)
Mean age (years)	26.2	27.1	**26.6**
Highest education attained			
School	10	4	**14** (30.4%)
College	6	7	**13** (28.3%)
University	7	12	**19** (41.3%)
Relationship status			
Single	6	3	**9** (19.6%)
Cohabiting/married	6	13	**19** (41.3%)
In relationship (not cohabiting)	11	6	**17** (36.9%)
Separated	0	1	**1** (2.2%)
Employment status			
Employed	15	17	**32** (69.6%)
Student	3	5	**8** (17.4%)
Unemployed/looking after home	5	1	**6** (13.0%)
Reproductive history			
Children	8	7	**15** (32.6%)
Previous abortion	0	7	**7** (15.2%)
Previous miscarriage	2	1	**3** (6.5%)
Location of medical abortion completion			
Home (outpatient)	19	22	**41** (89.1%)
Hospital (inpatient)	4	1	**5** (10.9%)
Contraception at conception			
Long-acting reversible method (e.g. IUD,[a] implant)	0	1	**1** (2.2%)
User-controlled method (e.g. OCP,[b] injectable, condom)	11	16	**27** (58.7%)
None	12	6	**18** (39.1%)
Contraception uptake at abortion			
Long-acting reversible method	5	11	**16** (34.8%)
User-controlled method	7	7	**9** (30.4%)
None	11	5	**16** (34.8%)

[a] Intrauterine device.
[b] Oral contraceptive pill.

verbal counselling and written information on their abortion and contraceptive options by an assessing doctor or nurse. A second appointment occurs 24–48 h later during which women receive misoprostol 800 mcg vaginally. Women requesting the contraceptive implant, injectable or user-controlled methods are provided with these at the misoprostol appointment. Women who have not agreed to a method or changed their mind by the misoprostol appointment are provided with further counselling prior to treatment. A 'fast-track' service is provided from the SRHC, if offered to women attending each site whereby they may have an intrauterine method fitted 1 week after medical abortion. The majority of women attending the research sites now return home to pass the pregnancy following the administration of misoprostol (as British abortion law mandates that abortion medication must be administered on licenced premises). The standard follow-up for medical abortion at these sites is a self-performed low-sensitivity urine pregnancy test at 2 weeks [26], meaning that women do not routinely return to the clinics following treatment.

2.3. Data collection

We conducted individual semistructured interviews with health professionals and women using a flexible topic guide [27]. The health professional topic guide addressed areas including participants' current role in abortion care, work satisfaction, quality of care, postabortion contraceptive provision, differences in clinical settings and areas for improvement. The topic guide for women covered reasons for requesting abortion, experiences of care, experiences of passing the pregnancy at home and postabortion contraceptive care and reasons for nonuptake. Interviews lasted 35–135 min, and all were digitally recorded and transcribed in full for in-depth analysis.

2.4. Analysis

Taking a thematic analytical approach informed by the Framework method [28] — a systematic method of qualitative data categorisation and analysis — transcripts were read by CP and JH then discussed to compare interpretations and identify key themes. A coding framework was developed and applied to the transcripts based on initial themes identified. In subsequent meetings, CP and JH compared coding and any coding conflicts were discussed and recoded as relevant. From this descriptive stage, we further interpreted the data in order to identify linkages between themes and explore similarities and differences in accounts: specifically between occupational groups and

clinical settings. We used NVivo 10 qualitative data analysis software (QSR International 2012, Melbourne, Victoria, Australia) to code and manage data. Where quotations are presented, identifiers in brackets refer to the clinic attended/worked in, postabortion contraceptive uptake (women) and clinic role (health professionals).

3. Results

The accounts of women and health professionals in both the hospital and SRHC clinical contexts raised a number of issues relating to experiences of addressing contraception at medical abortion and the significance of health professionals appearing to be nonjudgemental, concerns with preventing subsequent abortions, how and why women accept or reject LARC and reasons for declining contraception at abortion.

3.1. Addressing contraception at medical abortion

More than half the women interviewed said that they had wanted or were happy to address contraception at abortion and suggested that it was an 'obvious' time to do so and that they were 'glad' to talk about it. Those who had already explored options — via internet searches or information supplied by their general practitioner at referral — did not feel they needed to discuss contraception further but were amenable to having their chosen method provided at abortion. Others who had not considered options prior to attending the clinic were happy to have the opportunity to discuss and arrange a method. Several women also commented that the way in which health professionals presented contraception meant that they did not feel 'pressured' or that they were being reprimanded:

> 'We were just using condoms so possibly not as effective as it could have been. I didn't feel like I was being told off for not using a different type of contraception though.' (SRHC, implant)

Others noted that they felt that there was some element of 'force' but that this was not necessarily a bad thing:

> 'That's definitely the time to talk about it, and I think it's really good that they almost force you to make some sort of decision.' (SRHC, intrauterine device)

A minority of women experienced being asked about contraception as implying judgement of their behaviour. Some reported that these feelings may in part have stemmed from their own unease about the abortion:

> 'It sort of makes you feel like they think you're reckless. […] I think that's just me being oversensitive and paranoid, I think they just wanted to get me on like an appropriate form of contraception because prevention is better than cure.' (SRHC, implant)

Others within this minority described more explicitly negative experiences, saying that they felt that they were given little choice regarding future contraceptive use and that this was a disproportionate focus of their abortion consultation. This was pronounced for one woman in the hospital context who felt that, whilst she had explained why she did not want a hormonal method, the doctor continued to press this:

> 'I felt like I had to have it to please [doctor] because he was putting so much pressure on me. He was like "take these [leaflets], you need to have a look at them, you need to really think hard about contraception 'cause you need it, you can't go without". I was just like "give me a break, like, if it's my choice not to have it then it should be my *choice*".' (hospital, none)

Health professionals predominantly felt that abortion is an appropriate time to address contraception because most women are likely to be 'receptive' at that time due to the experience of dealing with an unintended pregnancy. Nevertheless, they also tended to focus on the sensitivities of doing so:

> 'Possibly that's the best time… even though it might be construed as being… you don't want it to come over as being judgemental saying "this wouldn't have happened if you'd used proper contraception". It's more "this is a very stressful time for you and I'm sure you never want to be in this position again. Have you thought about what contraception you would like to use?"' (SRHC nurse)

In this way, appearing 'nonjudgemental' was presented as challenging but also as a key feature of high-quality abortion care in general, as well as a tool in encouraging contraceptive uptake.

In contrast to this, health professionals in both clinical contexts described putting considerable work into creating an atmosphere of joint decision making in a way that made women feel that the choice had been theirs:

> 'I try not to push people into [LARC] but I'll try and kind of manoeuvre them gently and try and make them feel as if it's their idea […] as if it's a kind of joint decision because then I think they're more likely to stick with it' (SRHC doctor)

Nevertheless, health professionals perceived that some women tend to initially agree to contraception in discussion with the doctor at the assessment appointment, only to 'change their minds' by the time of the misoprostol appointment.

3.2. Preventing subsequent abortions

Women who were in favour of addressing contraception at abortion often related this to their desire to prevent subsequent unintended conceptions and abortions:

> 'I got the Depo [injectable] the day that I got the pessary [misoprostol] in hospital. As soon as they said it I was like "I'm taking it. I don't want to go through that again"' (hospital, injectable)

This paralleled health professional accounts, in which the prevention of subsequent abortions was also presented as a

priority, and postabortion contraceptive care were framed as measures 'to make sure this doesn't happen again'. Whilst hospital health professionals tended not to elaborate on this, SRHC staff offered more comprehensive accounts of the significance of postabortion contraception:

> 'It's not just [about] preventing them from having another unplanned, unwanted pregnancy. Of course that's a big part of it, but […] the ability to move on after this procedure, [contraception] is huge in terms of the necessity for people to do that. If they don't move on, what was the point of actually having a termination?' (SRHC nurse)

Health professionals' accounts illustrated tensions between their desire to support women's reproductive autonomy and a belief that abortion should not be used 'as contraception'. Whilst broadly supportive of reproductive 'choice', including the provision of abortion, many health professionals viewed attending 'repeatedly' for abortion as less acceptable than having a first abortion, and unnecessary given the contraceptive options offered. When asked what she found to be the most challenging part of her role, one nurse responded:

> 'Some people just won't listen and you kind of think "well, we will see you back here, I'm sure". And you do. […] It's just *frustrating* because you've tried your best to make them realise that… of course they can have a termination, but you want to try and work with them to… kind of take responsibility for their own contraception.' (SRHC nurse)

As the above quote illustrates, there was a sense in which providers perceived the fact that some women return for subsequent abortions as evidence of individual or service--level failure. They also felt that women's decision not to use contraception (or the most effective method) despite its availability was a missed opportunity to 'take charge of it, take control of your fertility and your contraception and look after number one' (hospital nurse).

These examples highlight the challenges for health professionals of facilitating 'choice' in the face of some resistance to contraceptive uptake whilst also trying to practise what they believe is best for women, both medically and otherwise.

3.3. Choosing LARC at medical abortion

Women commonly framed their accounts of contraceptive decision making in relation to the experiences of friends and relatives, particularly regarding LARC:

> 'They'd spoken to me about getting the coil fitted, but I know quite a few people who've had bad experiences with them and I just thought "actually, no, that's not an option for me"' (SRHC, oral contraceptive)

The space given by women to their *own* prior experiences and familiarity with different methods in their accounts of decision making was also substantial, with several citing as a deterrent to LARC uptake previous problems with and perceived side effects of hormonal methods.

LARC was generally framed by health professionals as the most appropriate contraceptive method for most women following an abortion and thus as something that should be promoted. However, encouraging LARC uptake was presented as a challenge given the knowledge sources that women drew on in making decisions. Some — particularly SRHC — health professionals described working with this knowledge, taking women's 'preconceived ideas' as a starting point for a more in-depth conversation about her needs and preferences. Many health professionals, however, reported finding the significance women give to this information perplexing and frustrating:

> 'A lot of their past experience is driven by what their *friends* have used. That seems to me disproportionately important, so if a friend has had an implant that's given her problems, she won't want to use it, regardless of what the statistics are.' (hospital doctor)

Where providers tended to present LARC as an ideal because it is not user dependent, the longer-acting and implantable nature of LARC was a consideration for some women, as these contrasting quotes illustrate:

> 'The jag [injectable] I think appealed to me more because I don't like knowing that I've got something in my body, like the coil or the rod [implant], and especially because you have to… like, it'll scar you and you have to get it taken out' (hospital, injectable)

> 'Once [injectable] is in your system it's in your system and so if you start taking a reaction to it you're stuck with it until that runs out. So the implant, it's something that can come out if it needs to. It's quite small, it lasts for three years and it's one of the most effective ones out there, and obviously effectiveness was key to me at that point' (SRHC, none)

Whilst the specific concerns of these two women differ slightly, they have in common a concern with a relative lack of user control inherent in LARC. In tandem with the relatively invasive nature of implantable LARC, this led the woman quoted latterly to 'reject' these options at medical abortion. Several women who made negative comments had nevertheless accepted postabortion LARC, as they also perceived advantages — including reliability and 'forgetability' — that highlights the multifactorial complexities of women's contraceptive decision making at abortion. This was chiefly expressed as a matter of weighing up the perceived advantaged and disadvantages noted above, in a way that echoed health professionals' accounts of the same factors.

3.4. Reasons for nonuptake of contraception at medical abortion

Reasons women gave for nonuptake of all methods were complex and context specific. For some women, the level of bodily intrusion in the course of abortion assessment and treatment — including blood tests, sexually transmitted infection swabs, insertion of vaginal tablets, passing the pregnancy and, for some, the experience of being pregnant itself — was as much as they could cope with. This was pronouncedly so when it came to LARC and meant that they decided not to accept a method at that time:

> 'I didn't want any more needles inside me or anything so I rejected the contraception. I'm actually going back tomorrow to get the implant done… dreading it!' (SRHC, none)

Others felt that they were not in a position to make a longer-term decision at the time of medical abortion. For some, this was because they hoped to have a planned pregnancy within the next year and so were not sure that they wanted a longer-term method. The majority of those who declined contraception cited negative prior experiences with perceived unwanted effects from hormonal methods, ranging from weight gain to skin, mood and bleeding problems. Concerns about pain on insertion, fear of needles or embarrassment about having an intrauterine method fitted were also voiced.

Other women said that they had in fact chosen a contraceptive method but that no health professional was available to provide this at medical abortion and that they were instead provided with 'some contraceptive leaflets and things and advised me to speak to my doctor about getting the implant' (hospital, none). Health professionals likewise noted difficulties with addressing contraception in the hospital context due to the significant amount of time required to effectively counsel on and provide contraception and the limited availability of staff trained in counselling and implant insertion. However, providers tended to present nonuptake primarily in terms of women's indecision and reluctance to 'take control' of their fertility.

4. Discussion

The findings presented here are from a small-scale qualitative study and may not be generalisable to other health systems and contexts of abortion provision. Nevertheless, these results do suggest a number of points of interest with the potential to inform research and provision of contraceptive care at abortion. Specifically, these relate to why postabortion contraception is seen as important by women and health professionals, the ways in which their priorities converge and differ and how provision might be best addressed or improved.

Health professionals considered postabortion contraception to be important primarily in relation to preventing subsequent abortions. Scottish sexual health policy explicitly situates contraceptive counselling at abortion as a means of preventing subsequent abortions [29] and this clearly translates into frontline practise in both the emphasis on contraceptive counselling at abortion and the drive to encourage LARC uptake over other forms of contraception. That some women in the study also expressed a desire to prevent further unintended conceptions suggests some concordance here.

However, our analysis also highlights a tension for health professionals between encouraging contraceptive uptake (specifically LARC) in order to prevent subsequent abortions and providing women with choice, including the choice to decline contraception. This tension was evident in what some described as the 'gentle manoeuvring' of women towards making a contraceptive decision before leaving the abortion service. The experiences of women who reported finding some health professionals overly 'pushy' in this respect highlight one way in which nonconcordance of priorities may negatively impact on experiences of care.

Tensions between women's decisions and policy priorities were also acutely evident where women challenged the messages health professionals sought to convey by, for example, prioritising experiential over clinical knowledge. Our findings parallel other research that has highlighted the impact for those providing contraceptive counselling at abortion of the significance women attributed to family and friends' experiences, particularly around less popular LARC methods like the intrauterine device [30]. Health professionals in our study reported this experiential knowledge to be a challenge for contraceptive counselling and a barrier to some women accepting LARC.

Criticisms of health professionals by women in our study — for appearing to pass judgement or being overly forceful — were more commonly levelled at hospital than SRHC providers. Based on a small-scale study, we cannot assert definitively why this was the case, although we do know that the SRHC nurses and doctors had generally engaged in more specialised training and in more regular practise of contraceptive counselling and provision than their hospital counterparts.

Whilst health professionals in both clinical contexts described abortion as an appropriate time to address contraception, there was variability in the degree to which they were equipped to address the many challenges of doing so. Whilst abortion may be a pragmatic time to address contraception — in that women may be motivated to accept a method and are already present at the service — it is by no means an easy time to do so and requires considerable skill and expertise to be managed effectively. Appearing to be nonjudgemental has been identified elsewhere as something that required careful 'emotion work' from health professionals [31,32], the effort and level of skill involved in which is perhaps not formally well recognised or accommodated in every context.

Our data highlight ways in which the challenge of addressing contraception is particularly pronounced at

abortion. In this context, women already have several significant decisions to make and may also feel that they have little agency in the situation, depending on the circumstances of their pregnancy and relationships established with health professionals. Hence — and echoing research that has identified the potential challenge to bodily autonomy that some women experience LARC to present [33] — contraception may represent one part of the process over which they feel able to exercise control. When this results in women 'taking control' of their fertility in the manner proposed by health professionals, any tension between women's decisions and policy priorities is obscured. In contrast, when 'taking control' manifests as women resisting further intervention at the time of abortion, this tension becomes apparent as an issue for health professionals to address.

This study found that the majority of women interviewed considered addressing contraception at the time of medical abortion to be acceptable, providing that it was done in a nonjudgemental way, and that many said that they felt motivated to obtain a reliable method. However, the data from both women and health professionals indicate a tension between the facilitation of 'choice' and the perceived role of contraceptive uptake at abortion in preventing subsequent abortions. This tension may also illustrate different interpretations of patient-centred care in this context. For some, appropriate care involved a stance of empathic neutrality, acknowledging women's views and accepting their right to make decisions even if they differ from those of health professionals. For others, appropriate care involves guiding women towards the 'choice' prioritised by the health professional. Our findings indicate that not all health professionals have the requisite skills and foreground a grey area between 'gentle manoeuvring' and pressure that challenges women's rights to reproductive autonomy in a more fundamental way. Whilst not explicit from our data, this has implications for vulnerable groups in particular. What is required therefore is training for all providers of contraception at abortion that explicitly addresses these tensions and their implications in practise.

Acknowledgements

We would like to thank all participants in the study and the staff at each site for their support with implementing the research. The study was funded by the Chief Scientist Office, which is part of the Scottish Government Health and Social Care Directorates.

References

[1] Information Services Division Scotland. Abortion Statistics: Year Ending 31 December 2014. NHS Scotland 2015. Available at , http://www.isdscotland.org/Health-Topics/Sexual-Health/Abortions/ [Last accessed 12/07/2015].

[2] Cohen SA. Repeat abortion, repeat unintended pregnancy, repeated and misguided government policies. Guttmacher Policy Rev 2007;10(2).

[3] 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.

[4] Schunmann C, Glasier A. Specialist contraceptive counselling and provision after termination of pregnancy improves uptake of long-acting methods but does not prevent repeat abortion: a randomized trial. Hum Reprod 2006;21:2296–303.

[5] Bender SS, Geirsson RT. Effectiveness of preabortion counseling on postabortion contraceptive use. Contraception 2004;69:481–7.

[6] Ames CM, 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;85:51–5.

[7] 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.

[8] Roberts H, Sylva M, Xu S. Post abortion contraception and its effect on repeat abortions in Auckland, New Zealand. Contraception 2010;82:260–5.

[9] Rose SB, Lawton BA. Impact of long-acting reversible contraception on return for repeat abortion. Am J Obstet Gynecol 2012;206:e31–7.

[10] Cameron S. Postabortal and postpartum contraception. Best Pract Res Clin Obstet Gynaecol 2014;28:871–80.

[11] Madden T, Secura GM, Allsworth JE, Peipert JF. Comparison of contraceptive method chosen by women with and without a recent history of induced abortion. Contraception 2011;84:571–7.

[12] Kavanaugh ML, Carlin EE, Jones RK. Patient's attitudes and experiences related to receiving contraception during abortion care. Contraception 2011;84:585–93.

[13] Matulich M, Cansino C, Culwell KR, Creinin MD. Understanding women's desires for contraceptive counseling at the time of first-trimester surgical abortion. Contraception 2014;89:36–41.

[14] Kumar U, Baraitser P, Morton S, Massil H. Peri-abortion contraception: a qualitative study of users' experiences. J Fam Plann Reprod Health Care 2004;30:55–6.

[15] Michie L, Cameron ST, Glasier A, Wellings K, Loudon J. Myths and misconceptions about intrauterine contraception among women seeking termination of pregnancy. J Fam Plann Reprod Health Care 2014;40:36–40.

[16] Powell-Jackson R, Glasier A, Cameron ST. Benefits of using a digital video disk for providing information about abortion to women requesting termination of pregnancy. Contraception 2010;81:537–41.

[17] Donnelly KZ, Foster TC, Thompson R. What matters most? The content and concordance of patients' and providers' information priorities for contraceptive decision making. Contraception 2014;90:280–7.

[18] Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. Contraception 2013;88:250–6.

[19] Sonfield A. Abortion clinics and contraceptive services: opportunities and challenges. Guttmacher Policy Rev 2011;14(2).

[20] Kavanaugh ML, Jones RK, Finer L. How commonly do US abortion clinics offer contraceptive services? Contraception 2010;82:331–6.

[21] Thompson KM, Speidel JJ, Saporta V, Waxman NJ, Harper CC. Contraceptive policies affect post-abortion provision of long-acting reversible contraception. Contraception 2011;83:41–7.

[22] Ingham R, Lee E. Evaluation of early medical abortion (EMA) pilot sites. UK: Department of Health; 2008 [Available online at , http://eprints.soton.ac.uk/185967/1/dh_084617.pdf (last accessed 12/07/2015)].

[23] Cameron ST, Glasier A, Chen ZE, Johnstone A, Dunlop C, Heller R. Effect of contraception provided at termination of pregnancy and incidence of subsequent termination of pregnancy. BJOG 2012;119:1074–80.

[24] Morse J, Freedman L, Speidel JJ, Thompson KMJ, Stratton L, Harper CC. Postabortion contraception: qualitative interviews on counseling and provision of long-acting reversible contraceptive methods. Perspect Sex Reprod Health 2012;44:100–6.
[25] Pope C, Mays N. Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. BMJ 1995;311:42.
[26] Cameron ST, Glasier A, Johnstone A, Dewart H, Campbell A. Can women determine the success of early medical termination of pregnancy themselves? Contraception 2015;91:6–1.
[27] Kvale S. Interviews: learning the craft of qualitative research interviewing. London: Sage; 2009.
[28] Spencer L, Ritchie J, Ormiston R, O'Connor W, Barnard M. Analysis. In: Ritchie J, Lewis J, Nicholls CM, & Ormiston R, editors. Qualitative Research Practice. London: Sage; 2014.
[29] NHS Quality Improvement Scotland. Sexual Health Services Standards. Edinburgh: Health Improvement Scotland; 2008 [Available online at , http://www.healthcareimprovementscotland.org/our_work/reproductive,_maternal_child/sexual_health/standards.aspx (last accessed 28/07/2015).].
[30] Benson LS, Perrucci A, Drey EA, Steinauer JE. Effect of shared contraceptive experiences on IUD use at an urban abortion clinic. Contraception 2012;85:198–203.
[31] Lipp A. Conceding and concealing judgement in termination of pregnancy: a grounded theory study. J Res Nurs 2010;15:365–78.
[32] Wolkomir M, Powers J. Helping women and protecting the self: the challenge of emotional labor in an abortion clinic. Qual Sociol 2007;30:153–69.
[33] Hoggart L, Newton VL. Young women's experiences of side-effects from contraceptive implants: a challenge to bodily control. Reprod Health Matters 2013;21:196–204.