



Breaking the silence in the primary care office: patients' attitudes toward discussing abortion during contraceptive counseling

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ABSTRACT

Objectives: Abortions are common health experiences in the United States, yet they are siloed from mainstream health care. To provide guidance on how clinicians could break down these silos, normalize conversations about abortion, and potentially improve patient experience and contraceptive decision-making, we sought to understand patient attitudes regarding discussing abortion during contraceptive counseling.

Study design: In 2018, we completed in-depth semi-structured interviews with reproductive-aged women recruited from primary care clinics of two politically disparate regions within California. We elicited acceptability, preferences, and implications of clinicians mentioning abortion during contraceptive counseling. Using directed content analysis, we coded transcripts for inductive and deductive themes.

Results: We achieved thematic saturation after 49 interviews. Interviewees were diverse in reproductive history, race/ethnicity, religiosity, and abortion attitudes. Participants with diverse attitudes about abortion reported that having abortion mentioned during contraceptive counseling was generally viewed as acceptable, and even helpful, when delivered in a non-directive manner focused on information provision. For some patients, mentioning abortion may reduce abortion stigma and help contraceptive decision-making. Careful attention to a non-judgmental communication style is critical to safeguard against potential contraceptive coercion.

Conclusions: Discussing abortion during contraceptive counseling was acceptable among this diverse population, and our findings suggest ways to best structure such counseling. Coupled with research on clinician perspectives, our findings can inform development of patient-centered contraceptive counseling approaches that integrate abortion in an attempt to facilitate patient care and reduce stigma.

Implications: Mentioning abortion during contraceptive counseling can be acceptable, and even helpful, to patients when delivered in a non-directive manner focused on information provision, even among patients who believed abortion should be illegal in all or most cases. For some patients, mentioning abortion may reduce abortion stigma and help contraceptive decision-making.

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1. Introduction

Abortions are a common health experience in the United States, experienced by one in four women in their lifetime [1]. Despite this fact, abortion care is set apart from the rest of health care in several ways. Abortions are under a heightened level of legislative interference [2,3],

and payment for abortion care is treated distinctly in many health insurance plans [4–6]. Clinics that provide the majority of abortions are structurally isolated from buildings where other gynecologic care is provided [7,8], and a majority of obstetricians and gynecologists do not provide abortions [9–11]. In addition, many primary care providers report failing to include abortion in their discussion of pregnancy management options for patients with new pregnancies [12].

The siloing and stigmatization of abortion not only threatens access to and quality of reproductive health care for pregnant people [13–15] but also affects the degree to which people have access to high quality information about abortion when they are not pregnant. One way to start eliminating the current silos surrounding abortion care is to integrate the topic of abortion into other reproductive health visits [13],

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such as contraceptive counseling. The interconnectedness of the topics of abortion and pregnancy prevention make their integration feasible [16,17] and may allow health care providers to communicate that abortion is part of routine health care [13]. This type of discussion may facilitate timely care for abortions, if and when needed [18], and also reduce the stigma surrounding abortion and unplanned pregnancies. Additionally, these discussions may enhance the experience of contraceptive decision-making, as explicit communication about the possibility of pregnancy may improve understanding of contraceptive effectiveness and help patients choose methods that best meet their preferences.

Because of the historical siloing and stigma around abortion, including within medical education [19–21], engaging in these conversations is potentially challenging for health care providers. To address one aspect of this, an organization called *Provide* trains clinicians in how to offer informed and non-judgmental referrals for abortion when needed [22]. Despite some efforts to support clinicians in discussing abortion with pregnant patients, limited research exists on how non-pregnant patients view the idea of discussing abortion with health care providers. At one family medicine clinic that has integrated abortion care, women participating in a study found it acceptable to hear about available abortion services during their well-woman and contraception visits [16]. The study participants did caution, however, that the topic of abortion may be sensitive and clinicians should “tread lightly” if they sense patient discomfort [16].

In this study, we sought to understand reproductive-aged women’s attitudes toward routine integration of a conversation about abortion in the contraceptive counseling visit. Additionally, if acceptable, we sought to understand how this type of conversation could best be accomplished in a way that would both normalize health care conversations about abortion and enhance the contraceptive decision-making experience.

2. Methods

Between August and December 2018, we conducted a qualitative study using semi-structured, in-depth interviews in two politically disparate regions of California.

2.1. Sample

We recruited participants from waiting rooms of family medicine clinics affiliated with residency programs, using two purposive sampling strategies: criterion sampling, which restricted inclusion to those identifying as a woman, age 18–45, and English-speaking; and maximum variation sampling at the clinic level to capture participants with a broad spectrum of abortion attitudes [23]. Guided by the Public Policy Institute of California’s political maps, we chose one site in California’s San Francisco Bay Area, where less than 21% of people desire more restrictive abortion laws, and another in California’s Central Valley Region, where 41–45% of people desire more restrictive abortion laws [24]. We excluded adolescents due to the increased complexity of consenting and scheduling interviews with minors under the time constraints of the study.

Other qualitative studies that assessed patient preferences around mentioning abortion in reproductive health contexts reached thematic saturation after 20–30 interviews [16,25]; because our sampling strategy included two politically disparate regions, we increased our estimated sample size to 40–50 individuals.

2.2. Data collection

We developed the interview guide with input from a three-member patient advisory group comprised of local reproductive-aged women and a multidisciplinary group of clinicians involved in abortion and primary care. The interview guide started with broad questions exploring past experiences with contraceptive counseling and conceptualizations of the relationship between contraception and abortion. We then asked

interviewees to envision how a health care provider could mention abortion during contraceptive counseling in ways that would be helpful or unhelpful, and if not helpful, then acceptable. In order to obtain concrete feedback, we solicited responses to specific examples (Table 1) of abortion being mentioned during contraceptive counseling. We probed whether different examples affected acceptability, what qualities were helpful or unhelpful and why, and whether these examples affected how they thought about abortion, contraceptive effectiveness, and contraceptive decision-making. We developed the specific examples (titled Examples 1, 2, and 3) with input from those who helped develop the interview guide, and we added another example (Example 4) two-thirds of the way through the interviews based on early interviewees’ feedback on elements they liked about Example 1 and disliked about Example 2. Our demographics survey included questions about religiosity and abortion legality attitudes, which participants answered after their interview to avoid priming their interview responses. The term “health care provider” referred to anyone who provides contraceptive counseling.

Authors SD and IS, neither of whom had any prior relationship with the participants, conducted interviews independently, in person. SD is a family physician and IS is a former reproductive health counselor; both introduced themselves in their presenting role as researchers. In preparation for the interviews, SD and IS conducted mock interviews to ensure consistency in approach and practice attenuating the common tendencies of their positionalities, which required refraining from validating responses or correcting participants’ misconceptions. We approached potentially eligible patients and assessed their interest in private regarding participating in a study “that will help us understand how people would like their doctors to talk to them about birth control and abortion topics.” We obtained oral consent and gave each participant a \$30 gift card for their time. The Institutional Review Board at the University of California, San Francisco, reviewed the study protocol and certified it exempt.

We documented interviews with handwritten field notes and audio-recordings. Following each interview, the interviewer recorded a brief synopsis. The interviewers met daily to exchange synopses, reflect on how their positionalities may have affected the interviews, and discuss new potential themes. Through this dynamic process, and in consultation with the team, the interviewers iteratively expanded the interview guide. For instance, when interviewees made suggestions about how they would prefer physicians to discuss abortion, we solicited feedback from subsequent participants regarding the new suggestions. After we no longer identified new themes in our daily briefs ($n = 44$), we recruited five more participants to confirm that we had reached thematic saturation.

2.3. Analysis

A HIPAA-compliant professional service transcribed the audio-recordings verbatim. Using a deductive-inductive directed content analysis approach [26], SD and IS developed a preliminary codebook with a priori response categories based on the interview guide’s domains of inquiry and themes identified during transcript review. They coded the same two transcripts using NVivo 12, resolved disagreements in discussions with KH, and updated the codebook. They continued this process iteratively until they achieved inter-coder agreement using a finalized codebook. SD and IS then each coded half of the transcripts independently and IS summarized relevant code output. SD reviewed the summarized output and resolved discrepancies in interpretation with IS. We labeled response categories and themes as “dominant” or “minor” based on the frequency of their appearance across transcripts. For each response category or theme, we selected a representative quote that most succinctly communicated participants’ ideas. When two quotes were equally salient, we chose the quote of a participant who had not already been quoted. We assigned participants unique pseudonym initials in the manuscript. We organized the results by domains of inquiry (Sections 3.1–3.3) and presented relevant themes within domains. Additionally, we presented a “minor” theme with elevated attention

Table 1

Example approaches of integrating abortion into contraceptive counseling. Helpful and unhelpful qualities identified for each Example

Example 1: Mention of abortion as back-up method		
Imagine a patient who goes to the doctor to talk about birth control options. The doctor reviews a list of birth control methods: the pill, the patch, condoms, the IUD, the implant, the ring, Plan B, withdrawal, etc., and at the end, the doctor says, "I want to remind you that even though people use birth control, they sometimes get pregnant when they don't want to be. If that happens, then your options would be to continue the pregnancy to parent a child, continue the pregnancy and make an adoption plan, or to end the pregnancy with an abortion."		
Salient quality	Representative quote	
Helpful (Dominant)	Non-directive	"...it don't seem too harsh. Well, they explain it pretty good about, like, if you did get pregnant on accident or whatever, basically, that you could – 'cause they also explained adoption and stuff, so it's not just flat abortion. Giving you the other options, also, ... I think [this approach] is helpful no matter what." CB, age 37, California Central Valley, believed abortion should be illegal in most cases, completed some high school
	Non-directive	"... she's not imposing her personal opinion like, well, you know, 'I, personally, wouldn't do that,' you know? She's giving you the option with putting abortion in there... She's including that in there to give that woman that right to make that choice." EZ, age 34, San Francisco Bay Area, believed abortion should be legal in all cases, completed some college
	Destigmatizing	"... it's helpful because say that does happen, you have a mistake. [...] you already know that your doctor is understanding that things do happen and [...] he or she already has discussed with you your three options. So, [...] that is a little bit more approachable [...] – because it's scary if you do have an unplanned pregnancy. So, maybe just having this already in your ear; [...] you could go back and let them know, you know, a mistake did happen, and I want to now talk about my plan with my pregnancy." TW, age 34, California Central Valley, believed abortion should be legal in all cases, completed some college
Unhelpful	Irrelevant	"I feel like it's jumping the gun [...] if I'm just coming for birth control, like I'm not pregnant. And so the fact that I'm not even pregnant, we don't need to discuss adoption. We don't need to discuss abortion. [...] I feel like it's not there yet. Um, so it's like it's too soon. [...] It's not coming at the discretion of the patient." SW, age 24, San Francisco Bay Area, missing abortion legality opinion, completed 4-year college
	Destigmatizing	"I don't think a doctor would even have to bring that up. People know, you know, what they're doing. I mean, people know that you can either be a parent, or abort the child, or – like give the child up for adoption. [...] I think if the doctors continue to say that to people, then [...] people would just be more irresponsible. [...]" EB, age 41, San Francisco Bay Area, believed abortion should be illegal in most cases, completed high school
Example 2: Mention of abortion to assess acceptability of pregnancy management options		
Imagine a patient who goes to the doctor to talk about birth control options. The doctor says, "before we talk about birth control options, I'd like to frame our conversation by asking you what you would do if you became pregnant in the next few months. Your options would be to continue the pregnancy to parent a child, continue the pregnancy and make an adoption plan, or to end the pregnancy with an abortion." And the doctor says to the patient, "Thinking for yourself, which of these would be acceptable to you?"		
Salient quality	Representative quote	
Helpful (Co-dominant)	Customizable	"I mean, I feel like, that could be useful, as well, because [...] you wanna build a relationship with your patient, and [...] it would be good to get a sense of what they want or what their plans are in terms of, like, you know, getting pregnant or starting a family..." LD, age 33, San Francisco Bay Area, believed abortion should be legal in all cases, completed some college
	Thought-provoking	"[...]this one is helpful because] first they're letting you – like everybody knows that if you have sex, there's always gonna be like the possibility of [...] getting pregnant. But probably like the first-timers, they would probably make them think a little bit more about like if you do have sex, then this is what could happen if you're not careful, [...] they're probably gonna make you think like if [...] you're ready for that at that point in your life." HG, age 27, California Central Valley, believed abortion should be illegal in most cases, completed high school
Unhelpful (Co-dominant)	Irrelevant	"It seems like, 'what does this have to do with anything?' [...] What if before I tell you whether or not you have cancer, [I asked] what if you did have cancer? [...] I guess it would make me think about what I would do, [...] but things are actually different whether – when you're in the situation than before the situation. So again, seems kind of [...] unhelpful." CH, age 31, San Francisco Bay Area, believed abortion should be legal in most cases, completed 4-year college
	Centers pregnancy	"It just put a bad stigma on the whole overall thing, you know, birth control, sex, pregnancy... I wouldn't even want to talk about birth control. [...] because she just scared the shit out of me. Like, let's spring your question around you gettin' pregnant in the next few – I don't think some doctors understand how hard it is for a woman to even open up about things about birth control, pregnancy, terminating pregnancies, and what their options is." EZ, age 34, San Francisco Bay Area, believed abortion should be legal in all cases, completed some college
	Stigmatizing	"I would definitely be thrown off because I'm coming to my provider for options to prevent, not to be questioned. [...] they're not bad questions, but I would definitely [...] already feel like he is ready to judge." MM, age 32, San Francisco Bay Area, believed abortion should be legal in most cases, completed some college
Example 3: Mention of abortion as a birth control method		
Imagine a patient who goes to the doctor to talk about birth control options. The doctor reviews the birth control options with the patient: the pill, the patch, condoms, the IUD, the implant, abortion, the ring, Plan B, withdrawal, etc. This doctor lists abortion as one of the birth control methods.		
Salient quality	Representative quote	
Helpful	Destigmatizing	"I guess, I would be like, 'Oh, yea, I guess that is a form of birth control.' Like it would just remind me that it's out there. You know what I mean? 'Cause when I'm thinking of birth control, I'm not thinking about abortion. I'm thinking, you know, the other things [...] it's helpful that] it's listed as an option." BL, age 34, San Francisco Bay Area, believed abortion should be legal in all cases, completed high school
Unhelpful (Dominant)	Destigmatizing	"...that's like giving somebody a free pass... I've seen it for myself, like, I don't take these pills, we don't use condoms, if I get pregnant, I can just go to the clinic and... you know what I mean?" MV, age 39, California Central Valley, believed abortion should be legal in all cases, completed some college
	Destigmatizing	"Um, it seems like it shouldn't be there. [...] not even thinking about the moral implications—[abortion] as a birth control method is the most invasive and, like, as a health care provider, [...] suggesting an option that is the most invasive seems like the wrong way to go about it." CH, age 31, San Francisco Bay Area, believed abortion should be legal in most cases, completed 4-year college
Example 4: Mention of abortion while discussing effectiveness (only presented to one-third of interviewees)		
Imagine a patient who goes to the doctor to talk about birth control options. The doctor says, "You have lots of different options for birth control methods. There are also different factors to think about, like how effective each method is, how easy it is to use, and side effects. For example, when we think about effectiveness, some birth control methods are better at preventing pregnancy than other methods. When used correctly, some methods are over 90% effective, and some are even better, like 99% effective at preventing pregnancy. One thing people consider is how they would feel if their method didn't work and they got pregnant, if they would continue their pregnancy or have an abortion. However they feel about that situation can affect the birth control method they choose."		
Salient quality	Representative quote	
Helpful (Dominant)	Comprehensive	"This really does lay down most of the ground knowledge for birth control. It tells people that, you know, it's not 100%, we can't promise anything. It-it's very honest and, uh, straightforward." JF, age 20, California Central Valley, believed abortion should be legal in all cases, completed some college
Unhelpful	Confusing	"They confused me. [...] I'm not going to come in and get birth control if I'm not going to make sure it's at least, you know, [...] 99 percent effective..." PO, age 24, California Central Valley, believed abortion should be illegal in most cases, completed high school

(Section 3.4) due to the importance of its content in relation to each of the domains of inquiry.

3. Results

We completed 49 interviews ranging 24–72 minutes in length (median 42). Participants had a mean age of 31. They had experienced various reproductive life events and identified with a range of race/ethnicity categories, religiosity, and abortion legality attitudes (Table 2).

3.1. Acceptability of hearing about abortion during contraceptive counseling

First, we explored interviewees' acceptability of hearing about abortion during contraceptive counseling, in any way they could imagine the

Table 2
Participants' demographic characteristics, religiosity, reproductive history, and opinions about abortion legality (n = 49)

Participant characteristics (n = 49)	n	Percent
Age (years)*		
18–25	12	24
26–35	22	45
36–45	13	27
Mean age: 31 years	--	--
Race/Ethnicity*		
Latina/ Hispanic	16	33
White	15	31
Black/African American	10	20
Other answers collapsed	7	14
Region**		
San Francisco Bay Area	29	59
California Central Valley	20	41
Education		
8th grade or less	0	0
Some high school, but have not graduated	6	12
High school graduate or GED	22	45
Some college or 2-year degree	16	33
4-year college graduate or more	5	10
Parents' highest-achieved education		
8th grade or less	8	16
Some high school, but have not graduated	7	14
High school graduate or GED	21	43
Some college or 2-year degree	7	14
4-year college graduate or more	5	10
Religiosity (Answered True given choice True/False)		
I try hard to carry my religious beliefs through all aspects of my life.	23	47
My approach to life is entirely based on my religion.	8	16
My approach to life is based on moral principles and not on the values of an organized religion.	39	80
Attends religious service*		
Never	16	33
Once a month or less	16	33
Twice a month or more	16	33
Reproductive history (Yes)		
Ever had sex	46	94
Ever talked to a clinician about birth control methods	44	90
Ever had a pregnancy	35	71
Ever had a birth experience	30	61
Ever had an abortion experience	16	33
Currently trying to prevent pregnancy	34	69
Abortion legality opinion*		
Abortion should be legal in all cases	22	45
Abortion should be legal in most cases	10	20
Abortion should be illegal most cases	10	20
Abortion should be illegal in all cases	3	6

* Sum of % column is less than 100% due to missing data.

** In the San Francisco Bay Area, less than 21% of people desire more restrictive abortion laws. In the California Central Valley, 41–45% of people desire more restrictive abortion laws. Reported by the Public Policy Institute of California [24].

two topics integrated. We categorized responses as “acceptable” or “unacceptable,” based on their response to the respective question stem. The dominant response was that mentioning abortion during contraceptive counseling was “acceptable.” Responses notably did not correspond to the participants' opinions on the legality of abortion. In participants' explanations of what may be helpful or unhelpful about mentioning abortion during contraceptive counseling, we identified three themes:

- (1) Accurate information about abortion is helpful. Some interviewees, including those who believed abortion should be illegal in all or most cases, specifically said that receiving information about abortion from a health care provider was “important.” They recognized that abortion is a reality for many people and the information may become pertinent in the unpredictable future, particularly for young people who may lack reliable sources of information. One young participant put it this way: “... abortion is one thing that I feel so strongly about. Because it shouldn't be so hard to do. [...] I could ask all my friends. I bet none of them will know what to do or how to get one... [...] you hear it on the news, and it's like, ‘Can I even get one? Is it even legal? Where do I go? How much is it?’ [If I knew information in advance and my contraceptive method failed,] then I'd know what to do and be more prepared, instead of being stressed and panicked.” CP, age 19, San Francisco Bay Area, believed abortion should be legal in all cases, completed some college.
- (2) Mentioning abortion normalizes health care conversations about abortion, which may be helpful or unhelpful. Those who thought this was helpful believed that mentioning abortion during contraceptive counseling would allow patients to ask questions and seek care more comfortably. They described abortion as a potentially scary or embarrassing topic that could feel more approachable if a health care provider initiated the conversation or mentioned it specifically alongside the more familiar topic of contraception. One interviewee said,

“...it would make people more comfortable in the topic. And it's being a little bit more normalized than a little bit taboo, because just people stating the word ‘abortion,’ people sometimes tense up. But stating it in something that you're used to hearing, like the pill, patch, condoms, IUD, and then stating that abortion is in there, it releases more tension towards that term.” WR, age 22, San Francisco Bay Area, believed abortion should be legal in all cases, completed some college.

Those who were personally opposed to abortion commonly said that it felt acceptable for them to listen to the parts of the contraceptive counseling that were relevant to them and filter out the part about abortion that felt irrelevant. For example,

“It wouldn't bother me [to hear about abortion as an option ...] because I know they're supposed to talk to you about your options, and so they're not doing it just to upset you or anything like that. They're doing their job. [...] I guess it's a good thing. I mean, not everybody is like me. [...] Everybody is different.” CB, age 37, California Central Valley, believed abortion should be illegal in most cases, completed some high school.

Further among those who found the integration of topics acceptable, when asked to consider what could be potentially unhelpful about this, some said that mentioning abortion during contraceptive counseling could destigmatize it “too much.” They feared that this could lead to more “irresponsible” unprotected sex and subsequently more abortions, which they perceived could have physical, psychological, or moral harms. Notably, most did not perceive this as a reason to consider the conversation “unacceptable,” because they prioritized the helpful aspects they had identified.

- (3) Interpersonal communication style is a key factor in acceptability. Regardless of views on acceptability, participants noted the necessity of non-judgmental verbal and non-verbal communication that was responsive to the patients' needs. A few participants added further that the health care provider should

mention abortion even if they are unable to mention it without judgment; this would reveal the health care providers' biases and allow the patient to switch providers if desired. One interviewee explained,

"... it really depends a lot on the tone and the body language of the provider when they say "abortion." Are they, like, whispering? Are they raising an eyebrow when they say "abortion?" Because if they say "abortion," they give me that as an option and they don't believe in it, I'm not gonna feel comfortable. [...] I would feel guilty. Then again, they don't have to believe in it. [...] that provider probably wouldn't really work for me because who knows what other things they might not be comfortable with, you know?" MM, age 32, San Francisco Bay Area, believed abortion should be legal in most cases, completed some college.

Finally, among the few respondents who found it unacceptable to mention abortion during contraceptive counseling, we further categorized responses as finding the integration of the topics "irrelevant" or "unnecessary." Those who found abortion irrelevant to contraceptive counseling described it as reactive behavior while contraception is proactive behavior, and these are separate topics to be addressed at separate times. Those who found the integration unnecessary believed that people already know their options and will initiate conversations about abortion if they want to talk about it with their health care provider. These participants found few helpful qualities in the integration of abortion with contraceptive counseling.

3.2. Preferences for approach of incorporating abortion into contraceptive counseling

When given concrete examples (Table 1) for how abortion could be mentioned during contraceptive counseling, participants expressed clear preferences. Table 1 has sample quotes of participant responses, indicates whether participants found each example to be predominantly helpful or unhelpful, and lists specific qualities that participants identified as helpful or unhelpful.

When asked which approach they would like their doctor to apply to them, Example 1 was most preferred and Example 3 was least preferred. Most participants preferred for abortion to be presented as the next step one could consider if their contraceptive method did not work (Example 1). When comparing the examples, they emphasized the importance of the discussion to be non-directive, specifically by including all pregnancy management options, like Example 1. Another uniquely helpful quality noted about Example 1 was its destigmatization of unplanned pregnancy and abortion. Further, participants noted the importance of centering the patients' needs by addressing their agenda of contraception first (as in Example 1), rather than centering pregnancy management options before discussing contraception (Example 2).

While participants expressed favorable qualities about Example 2, such as it being thought-provoking and allowing for more customization, they disliked that it puts patients on the spot to answer hypothetical questions about what they would do if they became pregnant in the near future; future decisions felt unpredictable and irrelevant to the present. The dominant response to Example 3 was that abortion should not be presented as a birth control method, because conflating abortion with contraception is misleading. There were a few interviewees who liked Example 3 because they found this to be normalizing of abortion and consistent with their conceptualization of how abortion and contraception are related.

We crafted Example 4 to incorporate qualities that participants identified as desirable when discussing the first three examples. All the interviewees who evaluated Example 4 found it to be helpful as a concrete and honest way to understand variations in contraceptive effectiveness. Additionally, they found Example 4 helpful in its destigmatization of abortion. When asked for their favorite example, many cited a combination of Examples 1 and 4, preferring the gentler and easier-to-understand

wording of Example 1 and the more detailed discussion of method effectiveness initiated in Example 4.

3.3. Effect on contraceptive decision-making

For each example approach, we asked participants how the particular approach might affect their perception of contraceptive effectiveness and their choice of method. One common response, specifically in reference to Examples 1 and 4, was that it was desirable and instructive to hear explicitly that no contraceptive method is 100% effective. Some already knew this but still found it important to discuss in the context of contraceptive decision-making. Many, like this interviewee, described the experience of hearing this information as realistic and honest, although potentially difficult to hear:

"...that does worry me a little bit 'cause it's saying the birth controls aren't a guaranteed thing sometimes. [...] That is something good to hear [...] They shouldn't hide anything from you. They should always let you know the truth and the possibilities that stuff won't happen and will happen. Although, for some people, it might worry them a little bit like it worries me, but I would definitely rather have heard it than not heard it." MK, age 21, California Central Valley, believed abortion should be legal in all cases, completed high school.

Many reported that hearing the explicit mention of the possibility of pregnancy, and subsequent pregnancy management options, would lead them to choose either the most effective contraceptive method or add condoms to their method. Others felt that a mention of abortion would not affect their contraceptive decision-making, because they were either already using one of the most effective methods or the method that was the best fit for them, and they felt comfortable with what they would do if they became pregnant.

One theme we identified specifically among responses to Examples 1–3, but not Example 4, was that these counseling approaches could induce fear and stress about the futility of contraception. Participants described feeling helpless in the face of having to choose a method and knowing that no method is 100% effective. A few said the newly perceived futility of contraceptives would lead them to choose less effective methods that were more in line with their preferences. A few others highlighted that Examples 1–3 over-emphasized the chance of pregnancy for methods that are known to be >99% effective and suggested that these should have a more realistic qualifier, "it's a very small chance, but it can happen."

3.4. Important potential pitfall: contraceptive coercion

We identified a theme from a minority of interviews that there is a risk that these counseling approaches could introduce coercion toward the most highly effective methods in contraceptive decision-making, because they combine an emphasis of potential method failure with the potentially stigmatizing topic of abortion. A few interviewees shared personal experiences from past health care encounters of feeling pressured into a contraceptive decision they would not otherwise make. One specifically had received unsolicited advice to get an abortion in case of a future pregnancy and then felt rushed into making a decision about a long-acting reversible contraceptive method without first having all her questions answered. A minor theme was that the word "abortion" can evoke strong emotions for some people, whether because they had a challenging past personal experience surrounding abortion or held moral or religious beliefs opposing abortion. One interviewee noted that even if the contraceptive counseling is comprehensive and includes all pregnancy management options, simply hearing the word "abortion" can be perceived as directive by those whose strong emotions were triggered by hearing the word.

Those who carried a concern for potential contraceptive coercion made suggestions for how a health care provider could communicate non-directiveness. Beyond ensuring that all pregnancy management options are presented, they suggested using open-ended questions

and giving the patient more control of the conversation by asking for permission before broaching topics that may be unexpected. For example, before the health care provider mentions abortion or pregnancy continuation, they could say a phrase to this effect: "If you became pregnant, you would have a few options. Would you like to hear more about that now?" They also suggested explicitly communicating that no decisions need to be made right now, that the health care provider is sharing information and resources for the patient to do with as they wish, that they will be supported in whatever they decide, and they can return to talk about any options later.

4. Discussion

4.1. Review of findings

Our findings suggest that the mention of abortion during contraceptive counseling may be acceptable to and helpful for patients when delivered in a non-directive, non-judgmental, and informational way that includes all pregnancy management options. Importantly, we found this acceptability to be relatively consistent, even among participants who believed abortion should be illegal in all or most cases. In addition, discussions with some participants indicated that certain approaches to mentioning abortion during contraceptive counseling may reduce the stigmas surrounding abortion and unplanned pregnancy. Explicit conversations about the possibility of pregnancy and pregnancy management options may improve understanding of contraceptive effectiveness and help patients choose methods that best meet their preferences. However, mentioning abortion during contraceptive counseling requires careful attention to communication style and phrasing to safeguard against potential perceived or actual pressure to use the most highly effective contraceptive methods.

While there are different approaches to incorporating the topic of abortion into contraceptive counseling, and participants had diverse opinions, we were able to identify general themes for how to conduct these conversations. Overall, participants found approaches most acceptable and helpful if they (1) included discussion of abortion as an option if contraception were to fail (Examples 1 and 4), (2) described that some women consider their feelings about pregnancy management options when considering contraceptive method effectiveness (Example 4), and (3) first addressed contraceptive options rather than pregnancy management options, in order to center the patient's present needs (Examples 1 and 4). The qualities that participants identified as undesirable were conflating abortion and contraception (Example 3) and putting patients on the spot to describe their reactions to hypothetical situations (Example 2).

4.2. Implications for care

Contraceptive counseling that incorporates the topic of abortion may allow health care providers to reinforce the concept that abortion is part of routine health care. This may help to facilitate timely abortion care [18] and allow for more patient-centered abortion care [13]. Health care providers who begin to initiate conversations about abortion more frequently may need additional skills to be able to answer questions, clarify misconceptions, and facilitate care. It may be particularly important for health care providers to identify themselves proactively as a resource to patients at times of policy change when the status of state laws can be difficult to decipher [18]. A timely abortion may not actually be feasible for those who encounter misinformation, and therefore delays, in the process [27]. Health care providers who have made themselves a known resource in advance may be able to refer patients to organizations that could help navigate their state laws, provide accurate information regarding available services, and connect them with sources of financial assistance.

While acceptability of mentioning abortion during contraceptive counseling was high among our study participants, it is important to acknowledge that a small minority of participants, representing a diversity

of abortion attitudes, found it either unacceptable or had concerns about its potential for coercion toward specific contraceptive methods, if implemented poorly. This finding highlights the need for health care providers to use emotional intelligence and open-ended questions to be able to tailor conversations about abortion to different patients' needs and reactions. Importantly, the concern for coercion must be considered in light of the unjust history and ongoing experiences of stratified reproduction in the United States, in which dominant society, through its formal and informal policies and practices, has systemically placed lower value on the fertility of women of color and poor women, among other groups, compared to that of women with more societal privilege [28–31]. In this context, the risk for contraceptive counseling practices to appear, or in fact to be, differentially coercive requires explicit attention and mitigation. Standardization of practice (i.e., integrating abortion into contraceptive counseling routinely, rather than for select patients) may help to reduce biases that could otherwise promote inequity, while maintaining flexibility in counseling in order to support, honor, and respond to each individual patient's expressed needs.

4.3. Limitations

Though participants were diverse in their religiosity and abortion legality opinions, the results represent only people living in California, a state with some of the least restrictive abortion laws in the country, and this may have affected interviewees' responses. For example, one of the themes presented was that health care providers do not need to mention abortion because everybody knows it is an option if they become pregnant; this perception may represent the relatively easy geographic and financial access to abortion in California compared to other places. This may limit the applicability of these findings to other settings. Similarly, the study participants were patients at primary care clinics that offered comprehensive contraceptive services and all patients had health insurance. The reality and potential for contraceptive counseling may be different in settings where many are uninsured and clinics are unable to offer the full range of methods.

We also recognize the strengths and limitations inherent in the research team's positionality of being reproductive health care providers and researchers who focus on family planning care. Our experience in the field is a strength: it makes us fluent and comfortable discussing abortion and contraception, and this likely facilitated the richness of our conversations with participants. On the other hand, our sense of normalcy in discussing abortion may have set a tone that made participants more accepting of discussing abortion compared to the reality of discussing abortion with their primary care provider, who may not communicate with as much a sense of normalcy.

Finally, we did not interview adolescents, a population that faces unique barriers to abortion access in certain states. Adolescents could have particular needs and preferences for counseling and information delivery that our findings do not fully represent. This is an area for future research.

4.4. Conclusion

Integrating a discussion of abortion into contraceptive counseling is a novel approach with a potentially important role in normalizing health care conversations about abortion. It may be possible to develop standardized interventions to incorporate abortion into contraceptive counseling, but flexibility will also need to be incorporated to meet patients' particular needs. Before widespread implementation, health care provider attitudes toward the intervention should also be assessed to develop a counseling approach acceptable to both patients and providers.

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