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An exploration of perceived contraceptive coercion at the time of abortion

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Abstract

Objective: To explore patient experiences of contraceptive coercion by healthcare providers at time of abortion.
Study Design: We conducted a qualitative study of English-speaking women seeking abortion services at a hospital-based clinic. We used the Integrated Behavioral Model and the Reproductive Autonomy Scale to inform our semi-structured interview guide; the Scale provides a framework of reproductive coercion as a lack of autonomy or power to decide about and control decisions relating to reproduction. We enrolled participants until thematic saturation was achieved. Two coders used modified grounded theory to analyze transcribed interviews with Nvivo 11.0 (K=0.81).
Results: The 31 women we interviewed from June 2016 to March 2017 were all in the first trimester, and predominantly young (mean age 27±5 years), non-Hispanic Black (52%) and Medicaid-insured (68%). Some participants (42%) reported feeling "pressured" into choosing some form of contraception. A subset of participants (26%) voiced that providers seemed to prefer LARC methods or were "pushing" a specific method. Several participants perceived pressure to choose any method due to providers' preference to prevent repeat abortions. Conversely, participants who were offered a range of methods through the use of decision aids and who were given time to deliberate demonstrated more reproductive autonomy.
Conclusions: Almost half of participants perceived a form of coercion around their contraceptive counseling. Coercion manifested in perceived provider preference for specific methods or immediate initiation of a method. Participant narratives involving decision aids to offer a range of methods and time for deliberation demonstrated greater reproductive autonomy and less coercion. Abortion stigma may mediate potentially coercive interactions between patients and providers.
Implications: This qualitative study explored contraceptive coercion at the time of abortion. Findings highlighted provider pressure to initiate contraception, LARC preference, and abortion stigma. Offering many methods and opportunity for deliberation supported autonomy and satisfaction. Findings inform ongoing efforts to improve contraceptive counseling and promote reproductive autonomy, while addressing unintended pregnancies.
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Keywords: Coercion; Contraception; Abortion; Qualitative; Counseling; Shared-decision making

1. Introduction

Reproductive autonomy is defined as one's ability to make strategic decisions about whether or not to become pregnant [1]. Current literature on reproductive autonomy provides a framework for understanding contributing factors such as self-efficacy, decision-making power, communication, and an individual's management of coercion [1]. Contraceptive coercion is one form of reproductive coercion, and refers to any behavior that interferes with contraception use in an attempt to either promote or discourage pregnancy [1,2]. Contraceptive coercion is associated with unintended pregnancy, sexually transmitted infections and intimate partner violence [2,3]. Unintended pregnancies resulting from contraceptive coercion are associated with depression and low birth weight [4].

Professional guidance for reproductive health providers iterates the importance of identifying methods concordant with patient preferences [5–7] while also emphasizing high efficacy of specific LARC methods [6–8]. Novel frameworks for contraceptive counseling emphasize patient-centered care, shared decision making, and informed consent to improve women's autonomy and minimize coercion while still addressing unintended pregnancy [9].

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In surveys of women seeking abortion services, only half desire to receive contraceptive services at that time and some women report pressure from providers to choose a birth control method during their abortion [10,11]. Limited research exists regarding how providers may contribute to contraceptive coercion in health care interactions. We conducted a qualitative study to explore women's perceptions of contraceptive coercion by providers at the time of abortion.

2. Material and methods

2.1. Research design and recruitment

We approached all women undergoing abortion at an academic medical center from June 2016 – March 2017. Eligible women were age 18 years and older, spoke English, and were undergoing medical or surgical abortion. We excluded women with early pregnancy failure or fetal demise and those receiving care from the primary investigator (KB). In our setting, abortion is covered by Medicaid and the gestational age limit for abortion is 23 weeks and 6 days of gestation. Patients are typically seen for two visits: preoperative and operative for surgical abortion, and medication initiation and follow up for medical abortion, and may interact with obstetricians/gynecologists, family medicine providers, nurse practitioners, nurses, students and residents during these visits. These providers initiate postabortion contraception counseling during the pre-abortion visit, and continue counseling or confirm choices as needed on the day of the procedure or at the time of follow up after medication abortion follow. While there is no standardized, universal counseling tool used in our setting, most providers use a tiered effectiveness framework for contraceptive counseling [12].

A trained research assistant approached eligible women to discuss the study after the women had signed clinical consents for surgical abortion or after Mifepristone administration for medication abortion patients. The research staff scheduled interested patients for a study visit for consent and the interview on a separate date after completing abortion care. Participants provided informed consent verbally using a standardized script prior to the one-hour study interview. All participants received compensation for time and travel. This Boston Medical Center Institutional Review Board approved the study.

2.2. Structured interview guide and data collection

We conducted semi-structured interviews with participants in a private, non-clinical setting. We used the Integrated Behavioral Model and the Reproductive Autonomy Scale to develop our interview guide [1,13]. The Reproductive Autonomy Scale is a validated scale used previously to measure factors and correlation with reproductive autonomy [1]. The Integrated Behavioral Model seeks to describe elements to why a person chooses to perform a given behavior [13].

We piloted the interview guide with four participants and adjusted the guide using an iterative process throughout data collection. We anticipated that we would need approximately 30–50 interviews to achieve thematic saturation. We used purposive sampling to sample as diverse a participant sample as feasible and based on ongoing coding during study enrollment, achieved thematic saturation after 31 interviews were conducted and analyzed [14].

All interviews were conducted by one female clinical researcher (KB) trained in qualitative research methodology, digitally recorded, and transcribed by a professional transcription service unaware of research goals. We collected field notes during the interview process. Participants were not contacted after the research interview to protect privacy. We imported de-identified transcripts into qualitative data analysis software for analysis (QSR International's NVivo 11.0) [15]. We recorded demographic information into the Research Electronic Data Capture (REDcap) system [16].

2.3. Data analysis

We performed qualitative analysis of transcripts using modified grounded theory. An initial code dictionary was developed, informed our theoretical models. Two researchers (KB, PM) coded half of the interviews and discrepancies in coding were arbitrated with a high level of inter-reader reliability (K=0.81). The remaining interviews were coded by a single researcher (KB). We identified recurrent themes and representative participant quotations for each theme. Given that the purpose of qualitative inquiry is to generate hypotheses rather than make claims about the prevalence of specific findings, attention was paid to the identification of distinct themes rather than the numeric prevalence of these themes.

3. Results

We screened 664 patients during the study period: 348 were ineligible, mostly for lack of English fluency (n=220). Of the remaining 316 eligible women, 109 declined participation and 176 did not return for the scheduled study interview. A total of 31 women were enrolled and completed interviews. Participants generally completed their scheduled interview about 2 weeks after their medical or surgical abortion, ranging from a day prior to two months after. Gestational age at the time of abortion ranged from 5 weeks 1 day to 12 weeks 3 days. Participant baseline characteristics are summarized in Table 1.

An experience of coercion was coded as such if the participant expressed negative interactions with their provider around their contraceptive choice, if the language used around the experience with the provider was a synonym for the word "coercion" (ex: pressured, forced, encouraged), or if the participant experienced conflict with the provider around their contraceptive goals.

Most participants (n=18, 58%) did not specifically endorse experience of pressure or coercion. Themes most relevant to experiences of coercion and autonomy are presented below and summarized with representative quotes in Table 2.

Table 1
Characteristics of study participants having a first trimester abortion, 2017 (N=31).

Characteristics	n (%) or mean +/− standard deviation
Age, years	27± 5
Race	
Black	16 (52%)
White	6 (19%)
Asian/Pacific Islander	1 (3%)
Other	8 (26%)
Hispanic/Latina ethnicity	7 (23%)
Highest education level	
<High school	2 (6%)
High school graduate/equivalent	12 (39%)
Some college/trade school	9 (29%)
College graduate	8 (26%)
Marital status	
Single	21 (68%)
Married	7 (23%)
Separated/divorced/widowed	3 (9%)
Insurance	
Medicaid	21 (68%)
Private	4 (13%)
Uninsured/self-pay/other	6 (19%)
Gestational age parity	55 days±14 days
1	10 (33%)
2–3	6 (19%)
4+	15 (48%)
Prior abortions	
0	17 (54%)
1	7 (23%)
2+	7 (23%)

3.1. Perceived provider pressure to choose a contraceptive method during abortion care

Some participants (42%) referenced some pressure to choose a form of birth control. Participants describing experiences of such pressure used words such as "encouraged," "persuaded," or "pressured" to describe their interactions. Some participants perceived that providers had an agenda to promote contraception. For example, one participant stated: "each single person that I met, they were like 'what are you gonna use now for birth control.'" Participants reflected on these observations without necessarily changing contraceptive plans: "I probably knew I was going with the [IUD] whether she decided to change my mind or not."

Other participants endorsed repetitiveness in counseling, which was perceived as coercive: "it's kind of like before I leave here, they're not going to stop bringing up birth control until I say yes, so let me say yes." This persistence manifested as either being asked about contraception many times by different providers or being encouraged multiple times to choose a method in one interaction: "I felt like I had to decide on the spot… I almost felt like I needed to choose something." Participants experienced pressure from medical providers as well as nurses and support staff. One women reflected that she was asked about contraception by "every single nurse and every single doctor" that she encountered.

A few participants therefore interpreted contraception as a "mandatory requirement" that every patient must choose. Three participants used metaphors to equate their counseling to providers "selling" contraception, and therefore not being thorough: "if you're advertising something, you're not going to want to tell them the bad stuff."

Five participants felt that pressure manifested as insufficient time to deliberate over a preferred contraceptive method. A few women expressed this through narratives of feeling overwhelmed by the additional decision to choose contraception while also opting for abortion. One participant expressed that this was not the right time for her to decide because she wanted to focus on her abortion, the "one thing that should be tackled first." Others simply wanted to receive information, have more time to research online, or talk to trusted contacts before choosing a method.

3.2. Perceived pressure from providers to use LARC methods

Eight participants (26%) perceived pressure to use specific methods post-abortion. The majority of these women expressed feeling pressure to use an intrauterine device (IUD). Some expressed that they felt the provider emphasized a method because they thought it "worked the best." Participants often externalized this observation in that clinicians were noted to be encouraging LARC for everyone, not themselves alone. However, others assumed the provider had a preference because other methods were not offered: "[she] barely had mentioned any other method but that one."

Participants managed this pressure to use a specific method in different ways. Again externalizing difficult subject matter, one explained that this type of counseling could lead other women to choose this method because they felt they had no other choice available to them: "I feel like [other women] will be more likely to be like, 'Whatever. I will just do that.'" Some who picked an option quickly in order to end the conversation about contraception verbalized not using the option later. Others stated that additional pressure to select a method made them less likely to choose that option.

A few women reflected that their providers thought there was a right and wrong choice. Some women did not say outright what the ideal choice was while others specifically mentioned LARC in this context.

3.3. Contraceptive counseling impacted by provider motivation to prevent repeat abortion

A subset of participants perceived that the provider's motivation to encourage contraception at the time of abortion was to prevent repeat abortion, extending previously described narratives around provider pressure and coercion around contraceptive method selection. Several participants explicitly stated that they felt clinicians counseled persistently because providers were trying to prevent "another abortion from happening." Others expressed that they felt providers did not want women "coming back" for similar care. A few participants shared that providers may treat "people that come often" differently in terms of contraceptive counseling.

A few participants themselves spontaneously discussed beliefs that abortion should be prevented and were encouraged

Table 2
Selected quotes relating to contraceptive counseling in women who had a first trimester abortion, 2017.

Theme	Sample quotation
Perceived provider pressure to choose a contraceptive method during abortion care	
Pressure from variety of providers and staff	*"Each single person that I met, they were like 'what are you gonna use now for birth control' and every single encounter I have with every single nurse and every single doctor, that's the question"*
Part of provider's job is to encourage contraceptive uptake	*"It's their job not to really talk about [negative side effects] – because if you're advertising something, you're not going to want to tell them the bad stuff"*
Pressure to make decision that day	*"It's kind of like before I leave here, they're not going to stop bringing up birth control until I say yes, so let me say yes"*
Not having enough time to deliberate	*"I told her I needed some time to think about it. She seemed like it really wasn't normal for someone to tell her to think about it... that usually people say 'no' or 'yes'"*
Perceived pressure from providers to use LARC methods	
Provider focused on LARC in counseling	*"They were kind of pushing the IUD idea more... They barely had mentioned any other method but that one."*
Feeling deterred vs. feeling compelled to use provider preferred method	*"[I felt] kind of like pressured to get it. Which made me not want to get it. Because if I feel pressured in doing something I'm just not going to do it".*
Perception that provider thought there was a right and wrong choice	*"It was like they felt relieved, like, "Okay, at least she chose one… even though we probably didn't persuade her for the one that we want her to be on".*
Contraceptive counseling impacted by provider motivation to prevent repeat abortion	
Providers want to decrease repeat abortions	*"The goal [was] to pretty much get everyone to have a birth control thought of when they leave so that way you don't have to come back [for another abortion]."*
Providers encouraged contraception in people with prior abortions	*"[Providers] actually encourage you to go on birth control so that you are not always coming back. They encourage more [the] people that come often".*
Providers are not supportive of abortion	*"[Providers try] to prevent another abortion... it's their jobs, but I feel like some people have their own beliefs that [abortion] is not something that should be done."*
Pressure to choose actually as judgement about abortion decision	*"I just feel like they're putting too much pressure on me at that time because I'm getting rid of a child right now… and you're putting birth control on my mind, and that's the least I'm thinking about. I feel depressed and sad because I'm doing this already, and then for you to just throw birth control methods in my mind… I feel like you're judging me because it's like you should have been on birth control, and this would have never happened."*
Participant *should* have been preventing an unintended pregnancy	*"I know to prevent this situation from happening, you should have been on birth control... that's what I don't like neither… when some nurses would judge you and be like, 'Well, you should have been on birth control'."* *"It was kind of contradicting, like I didn't want a child but I didn't want birth control, like I didn't want to prevent [an unintended pregnancy] from happening".*
Autonomy improved with systematic provider review of multiple methods	
Participants felt more coercion when less options were presented	*"My provider could have talked about the other types of birth control… it could have been better if they were like, 'Okay. Well, you are considering a pill [but] these are other options you might want to consider.'"*
Participants felt more self-efficacy when all options were presented	*"I felt better equipped... regardless if they're not all something I can use, I felt better because I had more information about myself and how the products work".*
Visual aids helped improve self-efficacy	*"They had like a chart that showed me my different options and actually before I even saw the doctor, they showed me the chart. They were like, 'just to let you know this is the chart of the different methods. You can check this out while you wait to see your doctor'. Which was a cool way to like kind of start the conversation. This way, when I [saw] the doctor I kind of like already knew."*

that the providers were aligned with this mission, justifying the emphasis on contraception during their care. Others endorsed the view that, despite their profession, their providers and staff were not supportive of abortion. One woman said "it's their jobs, but I feel like some people have their own beliefs that [abortion is] not something that should be done."

Still others felt personalized pressure to choose contraception at the time of abortion. One woman described feeling "judged" for her abortion. She perceived that the clinician's view that she should have been on birth control in the first place so that "this would have never happened." Other participants felt unheard or misunderstood; one stated that when she declined method initiation, her provider was uncomfortable with offering time to decide, resulting in her feeling judged. These women shared stories of guilt about their abortion decision and wanted more time to reflect on contraception after the abortion was completed.

3.4. Autonomy improved with systematic provider review of multiple methods

Several approaches to clinical care were perceived by participants as less coercive. Participants who heard a range of options from providers, with relevant pros and cons presented, demonstrated language showing more control over their decisions. After comprehensive contraceptive counseling, one person said that she "felt better equipped" to make her contraceptive decision. Another participant shared that by getting all of the information she felt her provider was impartial: "She gave me all the positives and negatives of each one… she was very informative and didn't sway me in any direction. Just gave me all the facts." Providing a range of options was associated with language reflecting self-efficacy and autonomy and perceptions of unbiased care.

Visual decision aids were considered especially helpful in this process. Several participants mentioned having charts of different contraceptives in the room to look at while waiting was helpful to start the process of deliberation and showed lack of provider bias.

Conversely, women who were offered limited contraceptive options expressed less control over their ability to make an informed decision. This was true for participants even if they knew which method they would choose prior to their visit. For example, one participant expressed of her desire to use oral contraceptive pills "my provider could have talked about the other types of birth control." Another participant reflected that her provider thought that "she already researched everything and she decided on her decision" and did not offer further options because "they don't want to be confrontational by offering other suggestions."

4. Discussion

Our study found that there are patients who experience contraceptive coercion by providers at the time of abortion, and are called upon to manage this pressure as part of their decision-making process. Perceptions of coercion manifested as not being offered a range of options, not being given enough time to deliberate over contraceptive choice, being pressured to choose any method in order to avoid future abortions, and pressure to choose LARC specifically, at times impacting participant behavior and trust.

The Reproductive Autonomy Framework was an effective tool to contextualize participants' narratives around autonomy and coercion. In this report, we describe the challenges our participants faced in managing coercion around their provider encounters. When coercion was appreciated, participants felt limited ability to exercise self-efficacy and make an autonomous decision. Conversely, providing full-spectrum contraceptive options and allowing time to decide helped improve self-efficacy and led to less conflict around making autonomous decisions. While this framework was used to focus on coercion and its negative effects on autonomy in this study, our findings call for future work exploring ways to improve self-efficacy, communication, and shared decision-making to facilitate reproductive autonomy in critical health care moments.

The fact that women perceived coercion around contraceptive counseling can be framed in existing literature surrounding patient's preferences for discussing contraception options at the time of abortion. Matulich and colleagues [11] found that almost half of women did not want to discuss contraception at the time of abortion. Kavanaugh et al. [10] found similar findings as well as 11% of participants surveyed felt pressure to pick a contraceptive method. Our findings create a narrative around these survey results which suggests that focus on postabortion contraception from providers particularly around LARC and stigma around their abortion decision play a role in participants not wanting to receive counseling in addition to the perception of coercion when they receive unwanted counseling.

Our findings reinforce existing literature suggesting that abortion stigma plays a significant role in some women's abortion experiences. Abortion stigma is defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" [17]. Abortion stigma has been described in the context of the general population and for abortion providers [18–21]. Women may be aware of stigma but may not have the opportunity to grapple with it outside episodic experiences with abortion [19]. As seen in our participants' experiences, women may experience contraceptive counseling at the time of abortion as feeling judged by providers.

Notions of coercion and stigma are particularly important given challenges to abortion access, and recent public health efforts to decrease unintended pregnancy rates using contraception [22–24], with programs focusing on LARC uptake as a key strategy [6,7,22,25]. Providers as well as patients may be impacted by current narratives around contraception (particularly LARC) as a strategy to decrease unintended pregnancy and abortion rates. Participants' internalization of abortion stigma may also color how they interpreted their interaction with their provider. In turn, providers' internalization of abortion stigma may shape unconscious bias in counseling. Our participants spontaneously voiced the concept that unintended pregnancy is perceived as a failure to use contraception effectively, of which abortion is a symbol [18].

Limitations of our work include potential social desirability bias, as participants may not have wanted to share negative hospital-based experiences with a hospital-based study team.

We tried to mitigate this by performing interviews in a non-clinical space with an interviewer not directly involved in participants' care. Our study was conducted with a diverse urban population where contraceptives are available for same-day utilization postabortion, and as such our findings may not be generalizable to other settings. Our study may also be limited by selection bias in that only 10% of eligible participants enrolled and participants who chose to return for the study interview may have had unmeasured differences compared to those that did not return. Despite limiting to a maximum of 2-month between the abortion and interview, it is also possible that our participant's recollection of their counseling could be affected by recall bias.

Another important source of potential bias is that the principal investigator (KB) conducted and analyzed the interviews. We attempted to limit this source of bias by having a qualitative expert (PM) conduct serial reviews on the interview transcripts to confirm interview quality, by having a second interviewer (PM) code half of the interviews, and by excluding patients who were under the clinical care of the interviewer. We also used a semi-structured interview guide to make the interview more uniform (Appendix A).

There is a potential role between abortion stigma and gestational age at the time of abortion. A final limitation of our study is that we did not capture the experiences of women in the second trimester at the time of abortion and our findings do not elucidate how perceptions of coercion may vary by gestational age at the time of abortion care.

Hypotheses generated from this qualitative study provide insight into mechanisms of reproductive coercion by providers and can be used to facilitate future quantitative studies to determine prevalence of our findings and impact on outcomes such as contraceptive uptake and use. Our participants' perspectives call for future interventions and provider values clarification to decrease coercion, improve shared decision-making, and optimize quality of contraceptive counseling while ensuring universal access to reproductive health services.

Supplementary data to this article can be found online at https://doi.org/10.1016/j.contraception.2017.12.009.

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References

[1] Upadhyay UD, Dworkin SL, Weitz TA, Foster DG. Development and validation of a reproductive autonomy scale. Stud Fam Plan 2014;45:19–41.
[2] ACOG Committee opinion no 554: reproductive and sexual coercionObstet Gynecol 2013;121:411–5.
[3] Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception 2010;81:316–22.
[4] Logan C, Holcombe E, Manlove J, Ryan S. The consequences of unintended childbearing. , 28Washington, DC: Child Trends and National Campaign to Prevent Teen Pregnancy; 2007. p. 142–51.
[5] Hatcher RA, Trussell J, Nelson AL, Cates W, Steward FH, Kowal D. Contraceptive Technology. 20th ed. New York: Ardent Media; 2007.
[6] reversible contraception: implants and intrauterine devicesObstet Gynecol 2011;118:184–96.
[7] reversible contraception: implants and intrauterine devicesObstet Gynecol 2012;120:983–8.
[8] Randal A. Guidelines for the use of long-acting reversible contraceptives. Am Fam Physician 2012;85:403–4.
[9] Holt K, Dehlendorf C, Langer A. Defining quality in contraceptive counseling to improve measurement of individuals' experiences and enable service delivery improvement. Contraception 2017;96:133–7.
[10] Kavanaugh ML, Carlin EE, Jones RK. Patients' attitudes and experiences related to receiving contraception during abortion care. Contraception 2011;84:585–93.
[11] Matulich M, Cansino C, Culwell K, Creinin M. Understanding women's desires for contraceptive counseling at the time of first-trimester surgical abortion. Contraception 2014;89:36–41.
[12] World Health Organization. Family Planning: A Global Handbook for Providers. Evidence-based Guidance Developed Through Worldwide Collaboration: Johns Hopkins Ccp-Info; 2007.
[13] Montano DE, Kasprzyk D. Theory of reasoned action, theory of planned behavior, and the integrated behavioral model. Health behavior: Theory, research and practice; 2015.
[14] Patton MQ. Qualitative research and evaluation methods. 4th ed. SAGE Publications, Inc.; 2015
[15] NVivo qualitative data analysis Software. QSR International Pty Ltd; 2015 [Version 11].
[16] Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. J Biomed Inform 2009;42:377–81.
[17] Kumar A, Hessini L, Mitchell EM. Conceptualising abortion stigma. Cult Health Sex 2009;11:625–39.
[18] Norris A, Bessett D, Steinberg JR, Kavanaugh ML, De Zordo S, Becker D. Abortion stigma: a reconceptualization of constituents, causes, and consequences. Womens Health Issues 2011;21:S49–54.
[19] Cockrill K, Nack A. "I'm not that type of person": managing the stigma of having an abortion. Deviant Behav 2013;34:973–90.
[20] Harris LH. Stigma and abortion complications in the United States. Obstet Gynecol 2012;120:1472–4.
[21] Martin LA, Debbink M, Hassinger J, Youatt E, Harris LH. Abortion providers, stigma and professional quality of life. Contraception 2014;90:581–7.
[22] Birgisson NE, Qiuhong Q, Secura GM, Madden T, Peipert JF. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review. J Women's Health 2015;24:349–53.
[23] Madden T, Mullersman J, Omvig K, Secura G, Peipert JF. Structured contraceptive counseling provided by the Contraceptive CHOICE Project. Contraception 2013;88:243–9.
[24] Finer LB, Zolna MR. Declines in Unintended Pregnancy in the United States, 2008–2011. Med 2016;374:843–52.
[25] Gomez AM, Fuentes L, Allina A. Women or LARC First? Reproductive Autonomy And the Promotion of Long-Acting Reversible Contraceptive Methods. Perspect Sex Reprod Health 2014;46:1–5.