Postabortion long-acting reversible contraception desire in women counselled using Bedsider.org versus standard counselling: a randomised trial

Integrating digital media into counselling may be an effective implementation strategy to improve contraceptive uptake in adolescent and young women.1 2 Most women seeking abortion are in their teens or 20s3 and have high uptake of long-acting reversible contraception (LARC) when offered.1 3 We conducted a study to evaluate if the use of the contraception website Bedsider.org along with routine counselling increased postabortion LARC desire in a population of young women seeking first-trimester abortion.

We enrolled women between September 2012 and November 2013 at an academic hospital clinic. The study was registered with ClinicalTrials.gov (NCT02532946). We included English-speaking women, 18–29 years old (the target audience of Bedsider.org), seeking medical abortion less than or equal to 9 weeks and surgical abortion less than or equal to 12 weeks of gestation. To maximise feasibility and acceptability of the implementation strategy, we obtained verbal informed consent and used a quasi-experimental design. Clinical days were randomised in a 1:1 ratio as ‘routine’ counselling days, in which the clinician (physician or nurse practitioner) counselled according to their own non-standardised practice, or ‘Bedsider’ counselling days, in which the clinician supplemented their counselling with guided and structured navigation through the Bedsider website. A statistician not involved in the daily conduct of the study created the randomisation scheme in nQuery Advisor (Statistical Solutions, Boston, Massachusetts, USA).

Participants completed two questionnaires: the first prior to any counselling and the second immediately prior to the surgical abortion procedure, or at the medical abortion follow-up visit. In accordance with clinical practice, participants were offered placement of intrauterine devices (IUDs) or implants at no cost. Intrauterine devices (IUDs) were placed at the time of surgical abortion, or variably at medical abortion initiation or follow-up.

Our primary outcome was the proportion of women who desired LARC (IUD or implant) after their abortion. We planned a sample size of 153 participants per group, to detect a difference of 15% in selecting a LARC method, assuming type 1 alpha error of 5%, 80% power, 25% baseline rate of postabortion LARC desire and loss to follow-up of 15%. We used SAS V9.4 for analysis.

We enrolled 351 women, 171 in the Bedsider counselling group and 180 in the routine counselling group. Demographic information did not differ between the groups. However, baseline desire for postabortion LARC differed between the two groups: 16.4% (95% CI 11.2% to 22.8%; 28/171) in the Bedsider group and 28.3% (95% CI 21.9% to 35.5%; 51/180) in the routine group; (p=0.01), as did the proportion of women undecided regarding contraception: 28.1% (95% CI 21.5% to 34.5%; 48/171) in the Bedsider group and 13.3% (95% CI 8.7% to 19.2%; 24/180) in the routine group (p=0.0009). Thirty-eight women were lost to follow-up, 20 in the Bedsider group and 18 in the routine group, and were assumed not to have chosen a LARC method. LARC desire after abortion was 28.7% (95% CI 22.0% to 36.1%; 49/171; 17% IUD, 11.7% implant) in the Bedsider group and 27.8% (95% CI 21.4% to 34.9%; 50/180; 16.7% IUD, 11.1% implant) in the routine group (p=0.91). The difference between baseline desire

![Initial contraceptive desire](image1)

![Final contraceptive desire](image2)

Figure 1 Number of participants in each group (routine or Bedsider) reporting desire for each class of contraceptive method prior to any contraceptive counselling (above) and immediately prior to surgical abortion or at medical abortion follow-up (below). LARC, long-acting reversible contraception.
and postcounselling LARC desire was non-significant in the routine group (McNemar’s test, \(p=0.85\)) but was significant in the Bedsider group (McNemar’s test, \(p=0.0002\); figure 1).

Strengths of this study include its randomised design with a minimally disruptive implementation strategy. Limitations include data collection from self-report rather than the medical record, lack of data collection on longer-term contraceptive uptake and lack of data collection of implementation outcomes, such as acceptability to providers, and fidelity to the intervention. Increased desire for LARC in Bedsider group suggests that digital media may be a useful adjunct to providers’ standard contraceptive counselling, although additional research is needed to assess this implementation strategy. Although no clear conclusions can be drawn from the results of this study, the high desire for LARC highlights the importance of immediate availability of LARC after abortion.

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