

Reference material on restricted access to abortion: Five studies

NOTE: The following abstracts describe reports on different aspects of restrictions in access to abortion. They represent a small sampling of publications on this topic.

Using a Simulated Patient to Assess Referral for Abortion Services in the USA

Laura E Dodge, Sadia Haider, Michele R Hacker
J Fam Plann Reprod Health Care. 2012;38(4):246-251

Background: Women seeking abortion services need to access services in a timely fashion. Quick and appropriate referrals to abortion providers are critical to this process.

Methods: The objective of this study was to determine the quality and quantity of referrals for abortion services from reproductive health care facilities that do not provide abortion services. USA states were ranked by restrictiveness of abortion, and a simulated patient made calls to the five most and six least restrictive states. Referrals were considered direct if the name or telephone number of a facility that provided abortion services was given; indirect when Planned Parenthood was suggested without additional details; and inappropriate if the referral did not provide abortion services.

Results: Of 142 calls, 77 (52.4%) were made to least restrictive states and 62 (45.8%) were made to most restrictive states. Among all calls, even after prompting staff members for a referral, 45.8% resulted in a direct referral, 19.0% resulted in an indirect referral, 8.5% resulted in an inappropriate referral and 26.8% resulted in no referral. Facilities in least restrictive states were significantly more likely to provide unprompted direct referrals ($p=0.006$) and significantly less likely to provide no referral ($p<0.001$) than facilities in most restrictive states, though these differences disappeared after prompting the staff member to provide a referral.

Conclusions: A simulated patient received a direct referral for abortion services less than half the time, even after prompting a staff member to provide one. All facilities providing women's health care should have appropriate referrals readily available for patients seeking abortion services.

Access to Abortion Services: A Neglected Health Disparity

Christine Dehlendorf, MD, MAS, Tracy Weitz, PhD, MPA
Journal of Health Care for the Poor and Underserved, Volume 22, Number 2, May 2011, pp. 415-421

Abstract: Minority and low SES women have persistently and disproportionately higher rates of abortion than White and higher SES women, yet have limited access to these services. The response of governmental health agencies to these disparities in abortion has focused solely on decreasing the number of abortions, without attention to access to needed health services. This commentary seeks to build an understanding of how access to abortion care is currently impeded for low-income women and women of color and calls for an end to that omission.

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Decision making and referral prior to abortion: A qualitative study of women's experiences

Kumar U, Baraitser P, Morton S, Massil H.

J.Fam Plann Reprod Health Care 004 Jan;30(1):51-4.

Background: Despite abortion being one of the most common gynaecological procedures performed in the UK, significant regional variation exists in access to services.

Objective: This study explores women's experience of referral for abortion in three inner London boroughs to determine if services met their expectations.

Method: In-depth interviews conducted with 21 women of varying ages, gestations and ethnicity, 3-9 weeks after termination of their pregnancy. The data were subjected to qualitative analysis.

Results: Most women had made a decision to proceed with abortion before approaching the health service, and expected non-judgmental support, information and prompt referral. We found variations in the extent to which these expectations were met. Delays in referral occurred when health professionals either required women to have more thinking time, referred them elsewhere for pregnancy testing or avoided discussing abortion. This was further compounded by difficulties in making appointments via the centralised telephone booking service. The brief counselling session offered to most women by the abortion providers, although helpful to some women, was viewed as unnecessary and intrusive by others.

Conclusions: Most women seeking an abortion prefer not to discuss their decision but expect information and prompt referral. Delays in referral cause distress and later abortions and should be avoided. High-quality counselling should be targeted at those in need.

Self-induction of abortion among women in the United States

Daniel Grossman et al

Reproductive Health Matters 2010;18(36):136–146

Abstract: Recent media coverage and case reports have highlighted women's attempts to end their pregnancies by self-inducing abortions in the United States. This study explored women's motivations for attempting self-induction of abortion. We surveyed women in clinic waiting rooms in Boston, San Francisco, New York, and a city in Texas to identify women who had attempted self-induction. We conducted 30 in-depth interviews and inductively analyzed the data. Median age at time of self-induction attempt was 19 years. Between 1979 and 2008, the women used a variety of methods, including medications, malta beverage, herbs, physical manipulation and, increasingly, misoprostol. Reasons to self-induce included a desire to avoid abortion clinics, obstacles to accessing clinical services, especially due to young age and financial barriers, and a preference for self-induction. The methods used were generally readily accessible but mostly ineffective and occasionally unsafe. Of the 23 with confirmed pregnancies, three reported a successful abortion not requiring clinical care. Only one reported medical complications in the United States. Most would not self-induce again and recommended clinic-based services. Efforts should be made to inform women about and improve access to clinic-based abortion services, particularly for medical abortion, which may appeal to women who are drawn to self-induction because it is natural, non-invasive and private.

Denial of abortion care due to gestational age limits

Diana Greene Foster, Loren M. Dobkin, Ushma D. Upadhyay

Contraception 87 (2013) 3–5 [There is no abstract; Please see full commentary on following pages.]

Commentary

Denial of abortion care due to gestational age limits [☆]

Many women are denied wanted abortions in the US. This happens for medical, personal and financial reasons and because women are just too far advanced in pregnancy by the time they present at the abortion facility near them. In the US, each abortion facility sets their own gestational limits, based on physician training, clinician and staff comfort, facility regulations, institutional policy and legal restrictions. Although the phenomenon of women presenting at an abortion facility beyond the gestational limit is not uncommon, it has not been well documented or studied.

The Title X Family Planning Program, the only dedicated source of federal funding for family planning services in the US, requires all subsidized facilities to provide “factual information...on each of the [pregnancy] options, and referral upon request” [1]. While many professional health care associations offer more specific guidance for pregnancy options counseling [2–5], only very rarely do they advise clinicians to assess gestational age prior to making referrals for abortion [6]. For a clinician, the experience of counseling women who are past the gestational limit can be memorable. In her first year of the family nurse practitioner program at the University of California, San Francisco, Loren Dobkin remembers counseling a teenaged woman about her pregnancy options, overlooking the possibility that the woman might be too far along to receive an abortion.

During my first year of training as a primary care provider, I received a lecture about how to counsel women about their options for continuing or terminating an unintended pregnancy. That same week, my last patient, “Rachel,” presented for pregnancy testing. She had tested positive. Rachel was 17 years old, publicly insured through Medi-Cal and had requested and received birth control (a Depo-Provera injection) at her last visit 1 year ago. Rachel appeared to be a typical patient in many ways but one: she also had a serious case of an intestinal disease called Crohn’s, for which she was taking mercaptopurine, a Food and Drug Administration Pregnancy Category D medication thought to cause birth defects.

After I told Rachel that she was pregnant and outlined her options of raising the child, adoption or abortion, I asked how she felt about it. Eyes wide, the first word she offered was “angry.” During the past year, she had been attending another health care facility and insisted that she had not missed any appointments for her birth control. She felt betrayed and wanted to request her medical records to see why it had failed. Then, without any additional prompting, she declared, “I need to get an abortion. My father’s gonna kill me.”

I explained that there were good clinics she could go to nearby and described how to set up the appointment and what to expect when she arrived — glad to be able to offer a solid referral. I thought that the hard part of the counseling was over when I eventually asked her whether she was feeling any pregnancy symptoms. Already overweight, Rachel felt like she was gaining weight faster than usual. She did not think much of it until last week, when she started to feel “zooming in my tummy.” It turned out that she had not had sex in about 4 months. My stomach turned as I realized that I had spoken too soon about the availability of abortion services and recalled the limit for abortion in our state — 24 weeks. I left to report back to my supervising doctor, nervously converting months to weeks in my head as I passed between rooms. Rachel was at least 18 weeks pregnant and possibly much more.

Our clinic did not have ultrasound equipment so the best approximation of gestational age we could offer was to size her uterus by measuring fundal height, which suggested 24 weeks, ± 2 weeks. It was late afternoon on Friday, just a half hour until closing at the only facility that does later abortions. I reached the nurse manager, who offered to keep the clinic open late for her first step — the ultrasound. But Rachel’s father was waiting for her to return home, and the 30-min drive to that clinic was too long to take that night, she said, setting up an appointment for Monday afternoon instead. “Isn’t there anywhere closer she can go?” her older sister pleaded disbelievingly when she came to pick Rachel up. During my prior rotation at that clinic, I had understood and appreciated the great distances women traveled from across the state and from other states to get to that facility. However, I never considered the special barriers that younger and more disadvantaged patients may face in getting to the facility

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and that it might be hard for Rachel to reach it even from a neighboring city.

Rachel returned to the teen clinic the following week. She had been 26 weeks and 2 days when she arrived at the abortion clinic, well past their gestational limit. With the support of the counselors there, she had told her family and decided against adoption. That was the last time I saw her, as we inserted her name into a long waitlist for the only local prenatal care provider who accepted Medi-Cal and could also manage her chronic disease during pregnancy.

1. Why do women present for abortion after the first trimester?

Loren's patient has many characteristics associated with delay in seeking care — youth, obesity, poverty and late recognition of pregnancy. And she experienced common barriers to accessing abortion care — a shortage of providers who accept public funding and a shortage of providers who provide abortions later in pregnancy. Several recent studies have examined risk factors for late presentation for abortion. Women report a number of delaying factors including late detection of pregnancy, difficulty deciding whether to continue the pregnancy, difficulty locating a provider, difficulty getting state insurance, inappropriate or delayed referrals, taking a long time to make arrangements and cost and access barriers [7–9]. The major factors associated with late detection of pregnancy include obesity, abuse of drugs or alcohol, prior second-trimester abortion, being unsure of last menstrual period and emotional factors such as being in denial and fear of abortion [9].

Loren's story is also typical in that the clinician doing pregnancy options counseling usually does not learn what happens to the women or their children. What outcomes can women who are denied an abortion expect for themselves and their families?

2. The Turnaway Study

The Turnaway Study is a longitudinal prospective study of women who receive an abortion and women who are denied an abortion because they present for care after the provider's gestational limit. The study was uniquely designed to follow women like Rachel, investigating the consequences of carrying an unwanted pregnancy to term versus receiving a wanted abortion. The Turnaway Study examines the effects on women's well-being, including short-term physical health, mental health, socioeconomic, substance use and exposure to intimate partner violence.

The Turnaway Study's innovative design involves comparing two groups of women who have had unintended pregnancies: women just over and just under the gestational limit at 30 abortion facilities across the US where no

provider within 150 miles has a later gestational limit. The Turnaway Study follows turnaways ($n=231$) and their abortion-receiving controls ($n=452$) as well as a first-trimester group ($n=273$) via telephone interviews every 6 months for 5 years. We have recently presented preliminary results on the consequences of receiving an abortion compared to having an unwanted birth at the 2012 American Public Health Association meeting, and the publications of our findings are forthcoming.

Our interviews with women in the Turnaway Study demonstrate that a myriad of factors delay seeking of abortion services. Anecdotally, we know that clinicians do not always consider gestational age when counseling patients about their pregnancy options or when referring them to abortion care. Several improvements in pregnancy option screening and referrals may reduce the incidence of women being denied wanted abortions.

3. Recommendations for reducing the incidence of women presenting ineligible for care due to advanced gestational age

- Improve referral procedures. When making referrals, consider gestational age, provider limits, sources of funding and less expensive providers who may be farther away.
- Maintain a current list of abortion providers with contact information and corresponding gestational age limits in your area to which clinicians may refer. Generally, you may obtain contact information online (see www.laterabortion.org#resources).
- Estimate patients' pregnancy gestational age (by history, exam or ultrasound) relative to clinic limits prior to providing referrals to help facilitate access to care. Eliciting sexual and menstrual history before disclosing pregnancy test results may be a part of a patient-centered counseling strategy [10].
- Help patients set up appointments and obtain directions to appropriate clinics.
- Inform patients who desire an abortion that costs usually increase with increasing gestational age. The average cost of abortion in the US is US\$543 for an abortion at 10 weeks compared to US\$1562 for an abortion at 20 weeks and varies widely among clinics [11].
- When providing care for adolescent girls, provide additional support for contraceptive continuity and pregnancy testing as needed. Tailor pregnancy options counseling to their unique circumstances (e.g., legal restrictions, limited transportation and psychosocial developmental stage) [12]. Be familiar with any parental notification or consent laws for minors in your state (see <http://www.plannedparenthood.org/health-topics/parental-consent-notification-laws-25268.htm>).

- If possible, routinely follow up with your patients and make referrals as needed so that they receive care in a timely manner, including prenatal care if abortion was not selected or is no longer an option [2,3,12].

The problem of being denied an abortion due to gestational limits is likely to become worse in the years to come. New laws aim to lower the state legal gestational limit. In recent years, six states have reduced the upper gestational limit to 20 weeks from fertilization and one state to 18 weeks [13]. These laws will make it more challenging for women to obtain a wanted abortion and will likely increase the number of women carrying unwanted pregnancies to term.

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