Determinants of Late Presentation for Induced Abortion Care

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Abstract

Objective: To determine whether demographic or patient factors contribute to later presentation (10 to 12 weeks' gestational age) for induced abortion in a Canadian abortion clinic.

Methods: Women attending a hospital-based abortion clinic between April and September 2012 were asked to complete a survey. The characteristics of women who presented early (EPs; gestational age < 10 weeks) were compared with those of late presenters (LPs; gestational age ≥ 10 weeks) using *t* tests for means and Fisher exact tests for rates.

Results: Among women referred to the clinic by a primary care provider, LPs were more likely than EPs to report "a delay in obtaining a referral" (20.8% vs. 6.1%; *P* = 0.007). While there was no significant difference between the groups in reporting that "someone tried to discourage [them] from having an abortion" (26.45% for EPs, 32.4% for LPs; *P* = 0.421), LPs were more likely to report that discouragement "caused a delay in making arrangements" (45.5% vs. 16.7%; *P* = 0.019). Of women who had access to a primary care provider, it was more common for the primary care provider to be aware of the pregnancy among LPs than among EPs (80.6% vs. 63.1%; *P* = 0.015).

Conclusion: Some women delay presenting for abortion because of discouragement from friends and family. It is unclear whether there are educational or policy interventions that can have an impact on this delay, and this warrants further study. There may be ways of addressing the delay in referral by primary care providers. Further study into the causes for delay in referral for abortion is warranted.

Key Words: Abortion, delayed presentation, gestational age

Competing Interests: None declared.

Received on June 30, 2014

Accepted on September 10, 2014

Résumé

Objectif : Déterminer si des facteurs démographiques ou liés à la patiente contribuent au fait de se présenter tardivement (âge gestationnel : 10-12 semaines) dans une clinique d'avortement canadienne pour l'obtention d'un avortement provoqué.

Méthodes : Nous avons demandé aux femmes ayant fréquenté une clinique d'avortement en milieu hospitalier entre avril et septembre 2012 de remplir un questionnaire. Les caractéristiques des femmes s'étant présentées tôt (âge gestationnel < 10 semaines) ont été comparées aux caractéristiques des femmes s'étant présentées tard (âge gestationnel ≥ 10 semaines) au moyen de tests *t* (pour les moyennes) et de tests exacts de Fisher (pour les taux).

Résultats : Chez les femmes orientées vers la clinique par un fournisseur de soins primaires, les femmes s'étant présentées tard étaient plus susceptibles que les femmes s'étant présentées tôt de signaler « un délai quant à l'obtention d'une orientation » (20,8 % vs 6,1 %; P = 0,007). Bien qu'aucune différence significative n'ait été constatée entre les groupes pour ce qui est du fait de signaler que « quelqu'un avait tenté de les convaincre de ne pas subir un avortement » (26,45 % des femmes s'étant présentées tôt, 32,4 % des femmes s'étant présentées tard; P = 0,421), les femmes s'étant présentées tard étaient plus susceptibles de signaler qu'une telle intervention « avait causé un délai pour ce qui est de la prise des mesures nécessaires » (45,5 % vs 16,7 %; P = 0,019). Chez les femmes qui avaient accès à un fournisseur de soins primaires, il était plus fréquent que ce dernier soit au courant de la grossesse dans le cas des femmes s'étant présentées tard que dans celui des femmes s'étant présentées tôt (80,6 % vs 63,1 %; P = 0,015).

Conclusion : Certaines femmes tardent à chercher à obtenir un avortement en raison des efforts qui sont déployés par des amis et des membres de la famille pour chercher à les en dissuader. La question de savoir s'il existe des interventions pédagogiques ou de politique pouvant exercer un effet sur ce délai demeure sans réponse, ce qui justifie la tenue d'autres études. Il pourrait y avoir des façons d'aborder ce délai en matière d'orientation lorsqu'il est lié aux fournisseurs de soins primaires. La tenue d'autres études quant aux causes de délai pour ce qui est de l'orientation vers des services d'avortement s'avère justifiée.

J Obstet Gynaecol Can 2015;37(1):40–45

INTRODUCTION

The morbidity and mortality associated with elective pregnancy termination increases with gestational age. The risks of immediate complications such as uterine perforation or hemorrhage, as well as later complications such as infection, increase in a linear fashion in the first trimester, and then increase exponentially in the second trimester.[1–5]

Challenges to finding or accessing abortion services, particularly those due to clinic location, restrictive legal environments, and financial barriers, may account for delayed presentation for some women. Multiple studies have examined the demographic variables and patient factors that may contribute to later (rather than early) presentation for abortion care.[6–18] To our knowledge, only one study (unpublished) has taken place in a Canadian context.[9]

The results of studies of demographic variables that contribute to late presentation for abortion have been conflicting. A study in Singapore[8,16] determined that adolescents were more likely to present late for abortion care, while a retrospective Canadian study (unpublished)[9] found that older age was associated with later presentation. A study in the United States[7] suggested that adolescents and economically disadvantaged women were more likely to present later for abortion, but that the reasons for doing so were different. Adolescents were more likely to have a delay in recognizing that they were pregnant, while economically disadvantaged women did not appear to have a delay in recognizing their pregnancies but were more likely to have a delay between deciding to obtain an abortion and being able to make the arrangements to have one. Studies performed in the United States[7,10] demonstrate that issues related to obtaining funding for abortion care are associated with delayed presentation. In a publicly funded system, such as in Canada, concerns regarding financial barriers to abortion care should be less prominent. We are not aware of any studies examining whether or not challenges of reciprocal billing between provinces have impeded Canadian women's ability to access abortion care in a timely fashion. Studies in the United States also suggest that restrictive legal environments surrounding access to abortion care can cause delays in presentation.[12] In Ontario, where our study took place, there are few legal restrictions that would prevent or delay women who attempt to access abortion care. In some provinces in Canada, particularly New Brunswick, restrictive policies regarding funding for abortion may play a role in delaying access to care.[9,19]

By determining whether there are demographic or patient factors in Canadian women that are associated with late presentation for abortion, interventions could be developed to target those at risk of late presentation to facilitate access to abortion care earlier in gestation.

METHODS

We designed a survey-based study to assess factors associated with later presentation (defined as ≥ 10 weeks' gestational age) for induced abortion. Women attending the only abortion clinic located in a medium-sized city in Ontario (with a referral population of approximately 1 million) between April 2012 and September 2012 were asked to complete a survey that included questions designed to assess several factors previously identified as being associated with late presentation for abortion care. These factors included patient characteristics such as age, occupation, parity, previous obstetric history, contraception use, rural versus urban place of residence, access to primary care physician, distance travelled to the clinic and associated travel costs, relationship to the father of the pregnancy, and social supports.

The clinic offers medical abortion to women presenting up to seven weeks' gestational age, and surgical abortion services up until 12 weeks' gestational age. Women may self-refer to the clinic or be referred by a health care provider. Once the woman or her health care provider has contacted the clinic, appointments are arranged within seven to 10 days in almost all cases. When women are already beyond 10 weeks' gestational age at the time they contact the clinic, an effort is made to expedite their appointment so that they can have their procedure performed in the clinic; if not, they would need to be referred to another facility for the procedure to be performed after 12 weeks. The two facilities to which women over 12 weeks' gestational age are referred are 200 km and 260 km away, respectively. As the wait time is equal for all women, with the exception of those who make initial contact with the clinic after 9+6 weeks' gestation (who would already be considered "late presenters" in this study), a delay in obtaining an appointment in the clinic once initial contact has been made would be unlikely to have changed the distribution of early and late presenters in the study or impacted the study results.

All women attending the clinic had had at least one ultrasound examination to confirm an intrauterine pregnancy and to accurately assess gestational age. In this study all gestational ages were based on ultrasound. Gestational age on the day of the patient's procedure was correlated with the surveys by having a clinic nurse write the gestational age on the outside of each survey envelope as the surveys were handed in.

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