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Well-woman Care Barriers and Facilitators of Low-income Women Obtaining Induced Abortion after the Affordable Care Act

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A B S T R A C T

Objectives: This study uses the abortion visit as an opportunity to identify women lacking well-woman care (WWC) and explores factors influencing their ability to obtain WWC after implementation of the Affordable Care Act.
Methods: We conducted semistructured interviews with low-income women presenting for induced abortion who lacked a well-woman visit in more than 12 months or a regular health care provider. Dimensions explored included 1) pre-abortion experiences seeking WWC, 2) postabortion plans for obtaining WWC, and 3) perceived barriers and facilitators to obtaining WWC. Interviews were transcribed and analyzed using ATLAS.ti.
Results: Thirty-four women completed interviews; three-quarters were insured. Women described interacting psychosocial, interpersonal, and structural barriers hindering WWC use. Psychosocial barriers included negative health care experiences, low self-efficacy, and not prioritizing personal health. Women's caregiver roles were the primary interpersonal barrier. Most prominently, structural challenges, including insurance insecurity, disruptions in patient–provider relationships, and logistical issues, were significant barriers. Perceived facilitators included online insurance procurement, care integration, and social support.
Conclusions: Despite most being insured, participants encountered WWC barriers after implementation of the Affordable Care Act. Further work is needed to identify and engage women lacking preventive reproductive health care.

Low-income women and women of color face many reproductive health disparities, including lower rates of cervical cancer screening and mammography. In pregnancy, low-income women and women of color are more likely to initiate late prenatal care, and to experience higher rates of unintended pregnancy, abortion, preterm birth, and maternal morbidity (Ahmed et al., 2017; Bryant, Worjoloh, Caughey, & Washington, 2010; Cheng, Schwarz, Douglas, & Horon, 2009; del Carmen & Avila-Wallace, 2013; Fernandez & Becker, 2017; Finer & Zolna, 2014; Jones & Kavanaugh, 2011; Kost, Landry, & Darroch, 1998; Mohllajee, Curtis, Morrow, & Marchbanks, 2007). Well-woman care (WWC), defined as care that "promotes health over the course of a woman's lifetime through disease prevention and preventive health care," aims to address the reproductive health needs of individuals, thereby improving population-level reproductive health disparities (Conry & Brown, 2015). Prior studies have demonstrated a relationship between use of routine reproductive health care and improved reproductive health behaviors (Hall, Dalton, & Johnson, 2014; Hall, Moreau, & Trussell, 2012).

The Affordable Care Act (ACA) sought to increase access to WWC by expanding insurance coverage and mandating coverage for key reproductive health services, including pap smears and breast examinations. Despite advancements in expanding access to WWC, some women continue to face challenges accessing

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these services. Between 2014 and 2016, 19% of African American women and 24% of Hispanic women had not seen a doctor in the past 12 months owing to cost, compared with 12% of White women (Kaiser Foundation, 2017a). During that same period, 17% of African American women and 32% of Hispanic women did not have a physician/health care provider, compared with 13% of White women (Kaiser Foundation, 2017b).

Women who undergo induced abortion may be more vulnerable to not accessing WWC. Young women, low-income women, and women of color are disproportionately represented among abortion patients (Jones & Kavanaugh, 2011). They are also less likely to have a regular health care provider, identify a clinic where they can obtain health care, or be insured (Salganicoff, Ranji, Beamesderfer, & Kurani, 2014; Kaiser Foundation, 2016). One study before the ACA's major expansions found that 40% of women presenting for induced abortion lacked a regular health care provider (Chor, Bos, Hasselbacher, & Whitaker, 2014). In contrast, a nationally representative survey of 2,907 women in the same period found that 19% of reproductive age women did not have a regular provider (Salganicoff et al., 2014).

Eliciting women's experiences seeking WWC after implementation of the ACA is important to understand the challenges that continue to limit some women's use of WWC. Prior quantitative studies have assessed factors associated with use of preventive reproductive health services since the implementation of the ACA (Arora & Desai, 2016; Hall, Fendrick, Zochowski, & Dalton, 2014; Jones & Sonfield, 2016). However, these studies are limited in their ability to elucidate how women experience these barriers and how individual barriers work together to continue to hinder engagement in WWC. The current study used the abortion visit as a point of contact with low-income women who may otherwise not engage in reproductive health, to qualitatively explore barriers that prevented them from engaging in WWC and consider facilitators that could help marginalized women engage in future care.

Methods

This qualitative study explores barriers and potential facilitators to engaging in WWC among low-income women presenting for induced abortion. Participants were recruited between June 2015 and January 2016 from a clinic that provides first-trimester medical and surgical abortions and second-trimester surgical abortions through 21 weeks and 6 days gestation. The clinic accepts medical insurance and has a self-pay package for women whose insurance does not cover abortion, who choose not to use insurance, or who lack insurance. The Institutional Review Board of the University of Chicago approved study procedures.

A trained research assistant recruited women after they had completed routine abortion counseling and provided informed consent for abortion, before completion of the abortion. Eligibility criteria included age 18 years or older; having had no interaction with a reproductive health care provider in the past 12 months outside of pregnancy, and/or not having a regular health care provider; income at or below 200% of the federal poverty level; ability to understand study procedures; and willingness and ability to sign study consent in English. Exclusion criteria included obtaining abortion for maternal medical or fetal indications. The study aimed to include 25 to 30 participants a priori; however, final sample size was determined by thematic saturation (the point where additional data is unlikely to yield new information). Purposive sampling was used to recruit participants. Factors considered in sampling included participant age, education, race/ethnicity, insurance status, and obstetric history. Women were compensated $25 upon completion of the 30-minute interview.

Study personnel met in person with eligible women to review study procedures and obtain informed consent. Before the interview, participants completed a short survey assessing sociodemographic information, obstetric and contraceptive history, and use of health care services. In-depth interviews followed a semistructured interview guide exploring pre-abortion experiences with WWC care and postabortion plans for WWC. The initial interview guide was modified after review of the first three interviews. Recognizing the complexity of women's lives, the interview guide and subsequent qualitative analysis were informed by Bronfenbrenner's ecological systems theory, which posits that individuals are anchored within interrelated systems that interact to influence and contribute to individuals' health and ability to enact health behaviors (Bronfenbrenner, 1977). Although this model has been used to understand barriers that low-income women face in engaging in other forms of care, such as prenatal care, this model has yet to be used to explore the barriers and facilitators that women face in engaging in WWC (Sword, 1999; Figure 1). Adapting this model for this study, the innermost level consists of psychosocial factors (e.g., self-efficacy), followed by interpersonal factors (e.g., familial responsibilities), and finally broader structural factors that impact individual health behaviors (e.g., insurance).

Interviews were digitally recorded and professionally transcribed, and transcriptions were verified for accuracy and de-identified. Analysis followed a modified template approach, whereby an initial code directory was developed from our review of the literature and the interview guide and was subsequently modified with continued data review (Crabtree & Miller, 1999). Two investigators independently coded the first fifteen transcripts and Cohen's kappa scores were calculated for each code to assess inter-rater reliability (Crabtree & Miller, 1999).

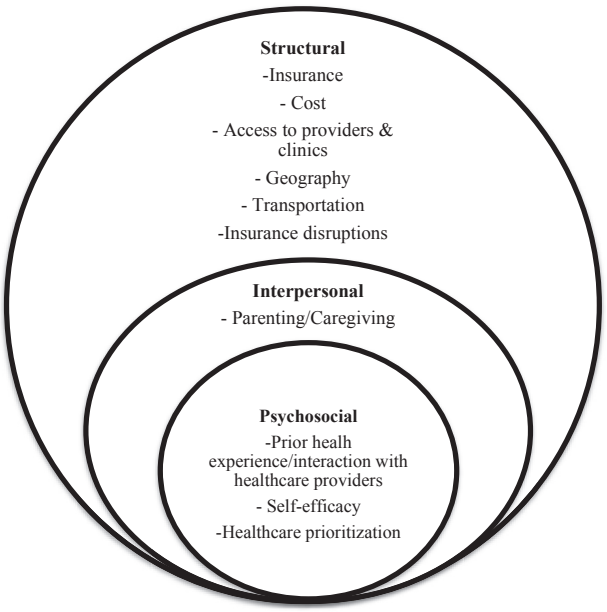

Figure 1. Conceptual model for women's engagement in reproductive health care as adapted from Bronfenbrenner's ecological systems theory model.