



Sexual & Reproductive Health

Prevalence and Correlates of Having a Regular Physician among Women Presenting for Induced Abortion



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ABSTRACT

Objectives: To determine the prevalence and correlates of having a regular physician among women presenting for induced abortion.

Methods: We conducted a retrospective review of women presenting to an urban, university-based family planning clinic for abortion between January 2008 and September 2011. We conducted bivariate analyses, comparing women with and without a regular physician, and multivariable regression modeling, to identify factors associated with not having a regular physician.

Results: Of 834 women, 521 (62.5%) had a regular physician and 313 (37.5%) did not. Women with a prior pregnancy, live birth, or spontaneous abortion were more likely than women without these experiences to have a regular physician. Women with a prior induced abortion were not more likely than women who had never had a prior induced abortion to have a regular physician. Compared with women younger than 18 years, women aged 18 to 26 years were less likely to have a physician (adjusted odds ratio [aOR], 0.25; 95% confidence interval [CI], 0.10–0.62). Women with a prior live birth had increased odds of having a regular physician compared with women without a prior pregnancy (aOR, 1.89; 95% CI, 1.13–3.16). Women without medical/fetal indications and who had not been victims of sexual assault (self-indicated) were less likely to report having a regular physician compared with women with medical/fetal indications (aOR, 0.55; 95% CI, 0.17–0.82).

Conclusions: The abortion visit is a point of contact with a large number of women without a regular physician and therefore provides an opportunity to integrate women into health care.

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Women presenting for induced abortion may be at an increased risk of lacking a regular health care provider to help address post-abortion reproductive health care needs. Young women, low-income women, and women of color compose a disproportionate share of abortion patients (Jones & Kavanaugh, 2011), and they are less likely to have a regular clinician or to identify a clinic where they obtain routine health care (Salganicoff, Ranji, Beamesderfer, & Jurani, 2014). These populations of women are also less likely to have health insurance, even with expanded coverage options available through the Patient Protection and Affordable Care Act (ACA, 2010; Kaiser Family Foundation, 2015b). Additionally, most women obtain abortions at specialized clinics, rather than with a physician with

whom they have a long-standing relationship (Jones & Jerman, 2014). Although most of these specialized abortion clinics offer immediate post-abortion contraception, many do not offer other follow-up preventive reproductive health care services (O'Connell et al., 2009). Lacking a regular health care provider may have important health implications. Several studies have demonstrated that individuals with a dedicated health care provider have improved health-seeking behaviors and outcomes, including greater use of preventive care, fewer hospitalizations, and fewer emergency room visits (Bindman, Grumbach, Osmond, Vranizan, & Stewart, 1996; Flocke, Stange, & Zyzanski, 1998; Gill & Mainous, 1998; Mainous & Gill, 1998; Saultz & Lochner, 2005).

Low-income women and women of color also face numerous reproductive health disparities, including maternal and infant morbidity and mortality, unmet contraceptive need, and unintended pregnancy (Bryant, Worjloh, Caughey, & Washington, 2010; Cheng, Schwarz, Douglas, & Horon, 2009; Mohllajee,

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Curtis, Morrow, & Marchbanks, 2007; Finer & Zolna, 2014; Frost, Zolna, & Frohwirth, 2014; Jones, Mosher, & Daniels, 2012; Jones & Kavanaugh, 2011). Engaging women in interconception care to optimize positive health behaviors and attend to chronic conditions outside of pregnancy is an innovative public health strategy to address persistent reproductive health disparities and encourage overall reproductive health (Biermann, Dunlop, Brady, Dubin, & Brann, 2006; Floyd et al., 2013; Livingood et al., 2010). Although a substantial amount of attention has been paid to integrating women into care after deliveries (Biermann et al., 2006; Floyd et al., 2013; Livingood et al., 2010), the abortion visit also presents an important opportunity to integrate women into preventive reproductive health care.

In considering the use of reproductive health services, Andersen's Behavioral Model of Health Services Use is a useful framework to help conceptualize the multiple factors that impact health care use and, subsequently, health outcomes (Andersen, 1995). Andersen's model posits that health care use is influenced by 1) predisposing characteristics (e.g., demographics and health beliefs), 2) enabling resources (e.g., income and health insurance status), and 3) perceived need for health care. According to this model, having a regular provider is an important enabling factor that facilitates individuals' use of health care (Andersen, 1995). This model therefore suggests that women presenting for induced abortion who lack a regular provider may be less likely to engage in preventive reproductive health care outside of the abortion visit compared with women with a regular provider.

Information regarding the routine reproductive health care use of women who present for induced abortion is scant, and the research that does exist is outdated. Although a survey conducted in 1995 found that more than 40% of women presenting for abortion lacked a regular physician, more recent data are absent (Westfall & Kallail, 1995). Updated data are important for several reasons. First, new data can reveal whether there are disparities in the characteristics associated with having a regular provider among women currently seeking induced abortion. Second, capturing data gathered before the ACA was fully implemented provides baseline information for future studies exploring whether ACA policies designed to better enable women's use of preventive health care are having an impact among this population. Therefore, we conducted a retrospective chart review with the objective of determining the prevalence and correlates of having a regular physician among women who present for induced abortion. This research will allow a better understanding of the potential need for routine care among this population immediately before the rollout of the ACA. Additionally, such data could be used as a baseline with which to compare potential increases in women's access to primary care attributable to the ACA. Given the demographic characteristics of and persistent reproductive health disparities faced by women seeking abortion care, we hypothesized that a large proportion of women presenting for abortion would not have a regular provider. As such, we anticipated that the abortion visit would remain a critical point of contact with a large proportion of women who may otherwise not engage in routine health care.

Materials and Methods

Sample and Procedures

We conducted a retrospective review of charts for women presenting to an urban, university-based family planning clinic

for abortion between January 2008 and September 2011. This clinic offers outpatient abortion services up to 23 weeks, 6 days' gestational age and provided between 300 and 450 abortions annually during the study period. The clinic serves a primarily low-income population, the majority of whom pay out of pocket for their abortion procedure. In this clinic's state, Medicaid covers abortion when medically necessary and in cases of rape or incest. Women were identified by paper charts and data were collected from clinic intake forms completed by women presenting for abortion. This study received approval from the institution's institutional review board.

A study team member not directly involved in statistical analysis abstracted data from patient charts, including socio-demographic and reproductive health data. We excluded women who did not report whether they had a regular physician, with the plan to analyze excluded women to assess for any potential differences with women with complete information.

Measures

The primary outcome for this analysis was the proportion of women who self-reported having a regular physician in clinic intake forms.

Demographic measures

Age at time of abortion was treated as a categorical measure (<18, 18–26, or ≥27 years). Based on the number of women in each category, race and ethnicity measures were combined into one race/ethnicity variable (non-Hispanic African American, non-Hispanic White, Asian/Biracial/Other, Hispanic). Marital status was dichotomized into married versus single and separated. Highest educational attainment was organized into four categories (less than high school, high school graduate, some college, college graduate). Distance travelled for procedure was treated continuously, using the distance from the patient's mailing address listed on the medical record to the clinic. After using GPS Visualizer (www.gpsvisualizer.com/) to obtain the longitude and latitude of the addresses, the straight-line distance between these coordinates and the medical center was calculated using Microsoft SQL Server 2014. Although individual income was not available in the dataset, median income by resident zip code was obtained from the American Community Survey (U.S. Census Bureau, ND) and used as a proxy measure for socioeconomic status. Median income by zip code was used as a continuous measure. Since chart reviews covered 4 years' worth of data, dummy variables for year, with 2011 as the reference year, were included to adjust for time trends.

Reproductive history

Five reproductive health history measures were assessed. For bivariate analyses, history of prior pregnancy, history of prior live birth, history of spontaneous abortion, and history of prior induced abortion were each treated dichotomously (yes/no). Gestational age at presentation was categorized into 1) less than or equal to 14 weeks, 0 days, 2) 14 weeks, 1 day to 19 weeks, 0 days, and 3) 19 weeks, 1 day to 23 weeks, 6 days. For multivariable regression models, a combined 3-category reproductive health history measure was created with the following categories: no prior pregnancy, no prior live birth (with or without prior abortion or miscarriage), and live birth plus any another outcome (with or without abortion or miscarriage) referred to throughout the remainder of this text and in tables as "prior live birth."

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