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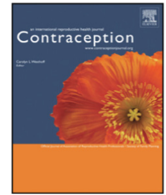

Commentary

Abortion referral-making in the United States: findings and recommendations from the abortion referrals learning community ☆

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ABSTRACT

In recent years, reproductive health researchers and practitioners have increased their focus on abortion referrals as an overlooked component of access. March 2019 proposed changes to the regulation of publicly funded family planning services that severely restrict abortion referrals have heightened public attention. In October 2017, Provide, Inc. convened researchers and practitioners to assess our knowledge of abortion referral and make recommendations for future research. We found that existing literature on abortion referral is limited and may overlook important outcomes as well as variations in patient experiences by age, race, income, and other attributes. Recommendations include more robust attention to patient experiences and research that assesses a broad range of referral-making practices and outcomes, with specific attention to vulnerable populations and to referral quality and the distinction between appropriate and inappropriate referral.

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1. Introduction

On March 4, 2019 the Trump administration issued proposed changes to the regulation of publicly-funded family planning services that include severe restrictions on abortion referrals. Abortion referral-making — generally understood as a process of providing information on treatment options and connecting a patient[1] needing abortion care with a facility that provides services — is an essential component of quality care. The proposed rule has precedent; a "domestic gag rule" was put forth (but never fully implemented) by the Reagan administration in 1988 and state-level restrictions on referral-making have been attempted or passed in a handful of states [1,2]. Leading physician and nursing organizations have long recognized the importance of providing patients with information on and referral for abortion as both an ethical duty and a component of coordinated, patient-centered care [3–6]. Commentaries by researchers, advocates, and practitioners take this one step further, arguing that the need for abortion referral-making is intensified due to the growing scarcity of abortion providers, prohibitions on insurance coverage, and widespread social stigma [7–10]. While the topic of abortion referral-making is enough to warrant attention, the existing literature is both limited and vague as to the precise value of abortion referrals. This gap limits advocates' ability to defend abortion-referral when attacked and to deploy referral-making improvements where these can be of greatest benefit.

In recent years, reproductive health researchers and practitioners have increased their focus on abortion referrals as an overlooked component of access. To support and guide these efforts, Provide, Inc. convened researchers and practitioners in October 2017 to assess our knowledge of abortion referral and to move toward more coordinated efforts.

1.1. Existing literature

Meeting participants reviewed a bibliography of published research relevant to abortion referral-making in the United States. Research was identified with no defined range of dates using the search terms "referral" or "referral-making" and "abortion" or "unintended pregnancy" in PubMed and screened for relevancy in the US context. We consulted with learning-community participants and other experts to crosscheck findings and identify additional relevant research. Research articles fell into two categories: individual healthcare provider perspectives and behaviors (Table 1) and patient experiences (Table 2).

☆ **Disclosure of Potential Conflicts:** Melanie Zurek is Executive Director of Provide, an organization that offers abortion referrals training to health and social service providers. Jenny O'Donnell was, at the time of writing, Deputy Director of Provide. She now serves as Director of Grantmaking and Evaluation at the Society of Family Planning.

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[1] A note on terminology: Cited papers used a variety of terms to describe a person receiving or in need of healthcare: patient, client, pregnant person, etc. In this paper we use patient throughout.

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1.2. Abortion information and referrals: provider practice

Most research that is specifically focused on abortion referral-making examines physicians' self-reported referral-making behaviors and/or willingness to discuss and refer for abortion (Table 1). Responses suggest deficiencies in provider practice, with a third or more of respondents typically reporting that they do not refer for abortion and as many as 1 in 6 reporting active dissuasion. In two nationally representative surveys of primary care physicians and obstetrician-gynecologists (OB-GYNs), one third of respondents said they would not discuss or refer a patient for abortion [11,12]. A study investigating abortion referral-making by primary care and OB-GYN clinicians in Nebraska found similar results; 29% of providers reported they would not refer for abortion and 15% reported providing misleading referrals. [13]. Among health and social service providers of a variety of professional backgrounds 18% would "Refer to a 'crisis pregnancy center' or similar organization that will encourage continuing the pregnancy" and 7% would directly encourage the client to continue the pregnancy [14].

Several studies suggest that deficiencies are also present in dedicated reproductive health settings. In a study of facilities that provide reproductive health services, but not abortion services, 27% gave no referral and 9% referred to a facility that did not provide abortion; referrals were less frequent in states with a greater

Table 1
Summary of seven articles focused on provider perspectives and practices related to abortion referral-making.

Author and year of publication	Title	Key findings	Study approach
White et al. 2018	Counseling and referrals for women with unplanned pregnancies at publicly funded family planning organizations in Texas	In-depth interviews with administrators of publicly funded family planning sites revealed that most organizations report providing a list of agencies offering abortion, though respondents reflect providing more limited support to patients for abortion referrals than other pregnancy options	N=37 Geo = Texas Time Period: November 2014 –February 2015 Sample: researchers captured a sample of 37 family planning organizations who had engaged in providing pregnancy options counseling and referrals, 15 of which had received Title X funding and 22 of which relied on state funding only
Holt et al. 2017	Pregnancy Options Counseling and Abortion Referrals Among US Primary Care Physicians: Results From a National Survey	42.1% reported that they "always/most of the time" discuss abortion with patients with unintended pregnancy; 29.5% said sometimes or rarely; 28.5% said they never discuss abortion. Of 453 who answered about referral information, 61.6% said they provide at least one type of referral always or most of the time (with many fewer providing "facilitative" referrals). Researchers also analyzed data and provided odds ratios for discussing abortion, making referrals, and dissuading from abortion based on type of practice and physician demographics, with 14% of physicians reporting routinely dissuading women seeking abortion	N=572 Geographic Scope: US Time Period: October 2014 – May 2015 Sample: researchers sent out surveys to 3000 primary care physicians across the country, received 755 responses with 572 answering questions about making abortion referrals and 453 answering questions about what information they provide for referrals
Desai et al. 2017	Estimating abortion provision and referrals among US gynecologist-obstetricians in private practice	93% of respondents do not provide abortions; half of those who do not said they would provide referrals, a third said they would not, and 11% said a referral would be dependent upon the circumstances of the pregnancy	N=1961 Geographic Scope: United States Time period: 2015 Sample: researchers polled OB/GYNs across the country to determine whether they provide abortions and/or referrals
Homaifar et al. 2017	"She's on her own": A thematic analysis of clinicians' comments on abortion referral	78/431 (18%) reported giving active assistance in finding a provider, 166/431 (39%) said they would give a passive referral (name and number), 124/431 (29%) do not refer, and 63/431 (15%) provide a deliberately misleading referral	N=431 Geographic Scope: Nebraska Time period: October 2014 to January 2015 Sample: sample recruited from doctors, nurses, and APNs providing ob/gyn care; researchers specifically sought information on referral behavior
French et al. 2016	A Sense of obligation: Attitudes and referral practices for abortion services among women's health providers in a rural US state	52% reported they would refer for abortion, which was significantly less than those who would refer for IVF	N=501 Geographic Scope: Nebraska Time period: October 2014 to January 2015 Sample: sample came from ob/gyn providers in NE; researchers assessed willingness to provide referrals for a range of reproductive health care, including abortion
Hebert et al. 2016	Variation in Pregnancy Options Counseling and Referrals, And Reported Proximity to Abortion Services, Among Publicly Funded Family Planning Facilities	84.3% reported referring for abortion and 85.4% reported they kept a list of clinics. Health departments reported the lowest rate of referrals (79.2%) and list keeping (77.5%)	N=567 Geographic Scope: US Time period: June to September 2012 Sample: researchers surveyed 567 publicly funded family planning clinics in 16 states to assess knowledge of abortion clinics and referrals practices
Dodge et al. 2012	Using a simulated patient to assess referral for abortion services in the USA	45.8% of facilities called gave direct referral, 19% gave indirect, 8.5% gave an inappropriate referral, and 26.8% gave no referral. Facilities in least restrictive states were more likely to provide a referral than most restrictive	N=142 Geographic Scope: US Time period: May 2010–January 2011 Sample; researchers identified five closest health facilities (federally funded family planning clinics, hospitals, private practices) to National Abortion Federation-affiliated abortion clinics across 11 states (six classified as least restrictive, 5 as most restrictive) and randomly chose 1 to call for an abortion referral

Table 2
Summary of eleven articles that address patient perspectives and experiences related to abortion referral-making.

Author and Year of Publication	Title	Key findings	Study Approach
Jerman et al. 2017	Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States	The majority of participants identified "system navigation issues" as barriers to care and approximately half identified lack of information, resources, or referrals as a barrier	N=29 Geographic Scope: Michigan and New Mexico Time period: January – February 2015 Sample: sample recruited from 6 clinics in two states; researchers identified referrals and broader system navigation issues as barriers from the interviews
Provide, Inc., 2017	*(Unpublished)* Impact of Abortion Referrals Training on the Referral Practices of Health Care Providers: A Case Study from a Title X System in a Southeastern US State	Providers discussed abortion in 24% of visits, adoption in 23%, and parenting in 99%. Clients expressed interest in abortion in 5.5% of visits, adoption in 2.2%, and parenting in 98%. When referrals occurred, 7.6% of clients were referred for abortion, 2.8% for adoption, 94% for parenting. 52% were referred for financial support, 8.2% for translation, 23% for more counseling (including CPCs), 4.4% for transportation.	N=466 Geographic Scope: VA Time period: May 2017–September 2017 Sample: sample of patients receiving positive pregnancy tests delivered by federally-funded family planning clinics in 38 health districts, gathered in the 2–3 months prior to referral training offered by Provide; providers completed recorded what the patient requested and what counseling and referrals had occurred for each positive pregnancy test given
White et al. 2016	Accessing abortion care in Alabama among women traveling for services	A small subset of participants received a referral; others describe stigma and discouragement from providers	N=25 Geographic Scope: Alabama Time period: July 2014–September 2014 Sample: sample recruited 20 patients from two abortion clinics; researchers asked about referrals for the 6 who obtained a positive pregnancy test in a clinical setting
French et al. 2016	Influence of clinician referral on Nebraska women's decision-to-abortion time	Majority of participants did not receive an abortion referral, including those who directly asked for one	N=365 Geographic Scope: Nebraska Time period: July 2014–January 2015 Sample: sample recruited from patients receiving abortions at 3 clinics; researchers coded for referral
Margo et al. 2016	Women's Pathways to Abortion Care in South Carolina: A Qualitative Study of Obstacles and Supports	Approximately a third of participants received referral; of those who did not receive a referral, a third wished they had received information; half of those who received a referral reported being treated well during and after referral making	N=20 Geographic Scope: South Carolina Time period: September and October 2014 Sample: sample recruited at abortion clinics in SC; participants were specifically asked about referrals if they confirmed pregnancy with HC provider
Chor et al. 2016	Factors shaping women's pre-abortion communication with their regular gynecologic care providers	Approximately a third of participants who reported having regular care with an OB-GYN discussed abortion with their provider; participants reported reasons for not discussing abortion with their provider, including disruption in relationship and already made a decision about their pregnancy	N=24 Geographic Scope: United States Time period: no time period specified Sample: sample recruited from women obtaining first trimester abortion in a high-volume clinic; researchers asked patients who have regular OB-GYN provider if they discussed abortion with them
Jones et al. 2016	Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients	11.5% of respondents said they chose clinic because it was recommended by a provider; mean number of days from initial call to appointment for patients who chose clinic because of recommendation from provider was 7.0 days	N=7414 Geographic Scope: US Time period: April 2014–June 2015 Sample: sample recruited from clinics participating in Guttmacher's 2014 Abortion Provider Census; survey participants were recruited while visiting clinic for abortion appointment; researchers coded for clinic recommendation by provider
Fuentes et al. 2016	Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas	Approximately a fourth of participants reported they received incorrect information about clinics openings or closures, including being referred to clinics further from them when closer facilities were available	N=23 Geographic Scope: Texas Nov 2013- Nov 2014 Sample: sample recruited from patients seeking abortion at clinics in TX; researchers coded for referrals
Dennis et al. 2015	A qualitative exploration of low-income women's experiences accessing abortion in Massachusetts	Participants expected to receive information they needed on family planning and abortion from their healthcare providers, but the majority did not receive such information around abortion services	N=27 Geographic Scope: Massachusetts Time period: December 2011–March 2012 Sample: sample recruited from patients receiving abortions at a clinic; researchers did not code for referrals, but recorded referral related information

Table 2 (*continued*)

Author and Year of Publication	Title	Key findings	Study Approach
Upadhyay et al. 2014	Denial of abortion because of provider gestational age limits in the United States	19.9% of first trimester patients who obtained abortions and 35.5% of those turned away said they did not know where to go to obtain an abortion	N=683 Geographic Scope: United States Time period: 2008 to 2010 Sample: data from a longitudinal study comparing women who were turned away from abortion services due to gestational limits with women who were able to obtain abortions and the Guttmacher Institute data's on gestational limits
Drey et al. 2006	Risk factors associated with presenting for abortion in the second trimester	Being referred to the wrong provider was cited by both first and second trimester patients as the single most common reason for delay accessing abortion	N=398 Geographic Scope: California Time period: September 2001–March 2002 Sample: samples recruited from a hospital-based clinic; researchers asked women obtaining abortions in the first and second trimesters about difficulty finding a provider and whether patients were referred to an inappropriate provider

number of restrictive abortion laws [15]. Two studies of publicly funded family planning facilities found significantly less support for abortion referral than for other pregnancy options. [16,17]. This disparity is present in other settings as well. A study on medical providers in Catholic health care facilities found that though equally prohibited, referrals for abortion were more constrained than referrals for other family planning services [18].

Two sources examine the effect of an abortion-referrals training on provider practice. In the aforementioned study of health and social service providers, the percentage of providers who reported that they would provide a referral for abortion increased post-training from 50% to 80%. (p<.0001) [14]. An unpublished study of nurse practitioners in family planning clinics in a Southeastern state compared data collected before and after a referrals training among 28 individuals and found that providers who previously were not routinely discussing abortion discussed a referral as an option three times more often after training (35 vs 11%, p=.006) . These sources suggest that training and related interventions hold potential to increase the frequency of abortion referral.

1.3. Receiving abortion information and referrals: patient experiences

Studies that examine patient perspectives on abortion referral typically do so as part of a broader research question (Table 2). These also document moderate rates of referral. In a large study, 16% of women recruited at abortion facilities across the United States reported choosing the facility at the recommendation of a healthcare provider [19]. Two additional studies each found that 30% of women say they had discussed abortion previously with a healthcare provider, but that this did not always result in a "direct referral." [20,21].

Not receiving a referral contradicts patient expectations. In two studies, patients who discussed abortion with their clinician expected to receive a referral [22,23]. Those who received a referral remarked on the positive experience of discussing their pregnancy options with a provider they trusted [22,23]. In contrast, participants who sought information and were not given a referral regarded provider behavior as unprofessional and judgmental [23]. One patient reported that she did not communicate her intent to terminate her pregnancy to avoid the anticipated judgment of the clinician who confirmed her pregnancy [23].

1.4. Receipt and/or quality of abortion referrals: associated outcomes

The existing literature does not yet speak to outcomes in a conclusive or coherent way. Several studies indicate that a lack of information or misinformation about where to locate abortion services are barriers to timely access to care. [24,25]. In a study of California women presenting for abortion services in the first and second trimester, being referred to an inappropriate provider was cited as the most common reason for delay in accessing abortion [26]. However, receipt of a referral (quality undefined) was not associated with timeliness or delays in a convenience sample of Nebraska women obtaining abortion services [20].

1.5. Summary of learning community findings

Based on our review of existing literature on abortion, learning community participants categorized gaps relevant to the field's ability to understand and assess abortion referral and offer recommendations in three broad areas: defining abortion referral, the relationship between referral and pregnancy decision-making, and how a patient's social location may shape the value of an abortion referral.

1.6. Defining referrals

Existing literature defines abortion referrals in multiple ways, in which the details of the interactions vary and are not always captured (Fig. 1). This limits comparability across studies and may lack the nuance to capture important variations in outcomes. The group sought to address these concerns by identifying key considerations in defining abortion referral and by refining a continuum of referral practices for future use.

1.7. Key considerations

The group agreed that a referral definition must be able to describe the quality of the referral. To achieve this, we applied principles of patient-centered care (the referral is responsive to the patient's preferences, needs, and values [27]) and shared decision-making (the provider plays an active role in helping the patient come to the best decision for themselves and refrains from imposing their personal beliefs [28]). An additional consideration in defining referrals- quality is whether or not the discussion is initiated by the provider or the patient. For patients, stigma and fear of judgment or other negative repercussions may make the risk of soliciting an abortion referral greater than the potential benefits. For this reason, a quality abortion referral is one proactively offered by the provider in a manner that is consistent with standards of patient-centered care and shared decision-making.

Secondly, the group identified the need for definitions that describe behaviors that are feasible in the range of service delivery and practice settings — for example a Title X-funded family planning clinic or a private OB-GYN office - in which administrative regulations and requirements as well as provider type (e.g., physi-

Definition of Referrals	
Routine abortion referrals defined as providing at least one type of referral "always" or "most of the time." Referral types were defined as either 1) giving a patient information about an abortion provider, 2) referring to someone else in their own practice who provides abortion, or 3) personally contacting a provider who performs abortions on the patient's behalf. The last two types were defined as "facilitative" referrals. Abortion dissuasion was defined as advising a patient seeking an abortion against terminating her pregnancy.	Holt et al., 2016
Primary referral defined as answering "yes" to whether providers feel professionally obligated to provide a referral for specialized treatment. Active referral defined as 1) giving patient a clinic name/number; 2) sending patient records to facility; 3) contacting clinic or clinician; 4) placing electronic referral to provider; or 5) open ended response by clinician describing how they would give a referral.	French et al., 2016
Direct referral defined as name or number of abortion facility; indirect referrals defined as referral "to Planned Parenthood" without specific facility information; inappropriate referral defined as referral to facilities that do not perform abortions; and no referral defined as advisement to look in phone book or Internet.	Dodge et al., 2012
Direct referral defined as providing name or telephone number of an abortion facility.	Hebert et al, 2016
Referral methods defined as 1) providing name(s) and/or phone number(s); 2) sending patient records to the clinic; 3) contacting clinic or clinician on patient's behalf; 4) making an electronic referral; 5) allowing patient to find provider on their own; or 6) "other" option that asked respondents to write in a referral method not listed.	Homaifar et al., 2017
Direct referral defined as information given about a clinic that provides abortions. Inappropriate referral defined as information given about a facility that does not provide abortions.	French et al., 2016
Referral defined as receiving abortion information from provider.	Margo et al., 2016
Referral understood to encompass information about clinical or financial services surrounding abortion.	Chor et al., 2016
Referral framed as recommendation from health care provider.	Jones et al., 2016
Behaviors along a spectrum of referral behaviors include: 1) provision of information; 2) assistance in scheduling services; 3) assistance in accessing supportive services (transportation, childcare, abortion funding or insurance); 4) follow-up on service utilization and outcomes; 5) assessment of patient satisfaction with referral; and 6) evaluation of referral quality and continual updating and improvement of referral	Provide, Inc., 2012

Fig. 1. Definitions of referrals in literature on abortion referral.

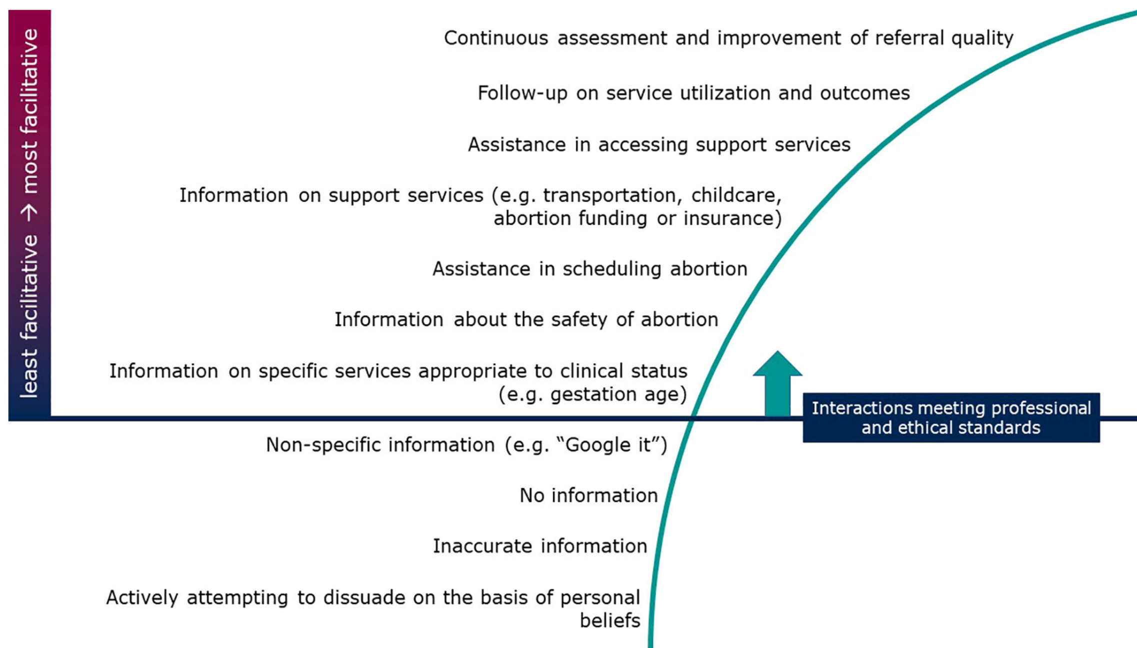

Fig. 2. Continuum of referral-making behaviors.

cian, nurse, social worker) and provider knowledge and time-constraints vary.

Thirdly, while not reviewed, the group acknowledged the variety of positions on abortion referral made by ethicists and others, which distinguish actively facilitating the patient receiving care from providing information alone [29].

1.8. Referral continuum

The group drew on a previously published continuum of referral-making behaviors [7] to generate an adaptive definition of abortion referral that would comply with the identified key considerations. We held as our ethical starting place the professional standards issued by ACOG and others that hold provision of information as always required [6], then expanded and refined the continuum to distinguish behaviors that do and do not meet these standards (Fig. 2).

In this context, **an abortion referral encompasses a range of potential proactive information-giving and facilitative behaviors, the *quality* of which depends on how well the information provided meets the patient's specific needs**. At one end, this continuum describes an ideal interaction that is facilitative and responsive to the patient's needs clinical, navigational, and psychosocial needs. The other end of the continuum describes behaviors that do not meet professional and medical standards. This includes coercive or dissuasive interaction between the provider and the patient.

1.9. Potential outcomes

The existing literature most often considers timely access to abortion care as the outcome of interest; none has explored how receiving an abortion referral relates to a patient's decision-making around an unwanted pregnancy nor to whether the absence of information or provision of inaccurate information may deter or dissuade a patient from seeking abortion care. This limitation is exacerbated by current research that is often limited by the inherent selection bias of recruiting patients at the point of receiving abortion services. Furthermore, existing literature most often compares receipt of an abortion referral to no referral to assess outcomes. Yet this same body of literature points to clear negative outcomes when an inappropriate (inaccurate) referral was made. This suggests that the more meaningful comparison may lie between a quality referral and an inappropriate interaction.

The referrals continuum presented in Fig. 2 offers a framework for comparing a **quality abortion referral** (accurate, specific information about abortion and connection to care) and **an inappropriate interaction** (offering inaccurate information, stigmatizing abortion as a pregnancy outcome, attempting to dissuade). Three sub-scenarios account for impacts on pregnancy decision-making: a quality abortion-referral where the decision to terminate is already made, a quality abortion-referral for a patient who is unsure she is pregnant and/or undecided, and an inappropriate referral.

For a patient who has decided to terminate, positive outcomes may extend beyond the potential facilitation of timely receipt of abortion. Receipt of a quality abortion include may increase patient satisfaction with their providers by demonstrating a patient-centered approach. By providing accurate information and normalizing abortion as a potential pregnancy outcome, a quality abortion referral may reduce patient stress associated with stigma or misinformation.

For a patient who suspects a pregnancy and/or is undecided, receipt of a quality abortion-referral may support informed-decision making by normalizing the need for abortion and correcting misinformation about the medical safety and legality of abortion. For patients lacking such knowledge, information such as specific location of services and sources of financial and logistical support may move terminating the pregnancy from an abstract of unattainable option to a concrete one.

At the other end of the continuum, inaccurate, shaming, and/or dissuasive information (inappropriate referral) may pose greater harm to patients and may have the greatest absolute effect. Negative outcomes associated may include psychosocial outcomes, such as shame, fear, and/or distress; uncorrected misinformation relating to the legality and safety of abortion; inability to identify a facility that provides abortion services or to connect with related services such as financial support; and delay in seeking services because of shame, fear, stress, and/or misinformation.

Finally, the group underscored that abortion referrals are useful as vectors of accurate information about abortion and the facilities that offer them *beyond the immediate term*. This may include infor-

mation to be shared with friends and family, or to be applied to a future pregnancy.

1.10. Social location

Existing research also has yet to explore meaningfully how a patient's social location may shape the value of an abortion referral. While a handful existing studies control for individual attributes such as age, race, income, and rurality [13,20], these studies consider only delays to accessing abortion and do not consistently compare subgroups.

1.11. Recommendations for future research

The learning community recommends that future research apply greater intention and transparency about the selected definition of a referral and why it was chosen, with particular attention to the quality of the referral being given. The proposed spectrum of referral making behaviors notes two key dimensions — specificity and accuracy — as essential to a quality referral. These two dimensions support more substantive exploration of the value of abortion referral in relation to misinformation around abortion and the challenges of identifying services in the current abortion facility landscape.

We further recommend future research that begins with formative explorations of patients' experiences, expectations, and preferences related to abortion referral-making. This scholarship would test the ideas put forth here about the definition and benefits of a quality referral and contribute to the development of a more robust conceptual model that accounts for variation in practice and circumstance, and which further identifies the range of outcomes that may be associated with abortion referrals, including consideration of the impact of abortion referral on pregnancy decision-making.

Subsequent research should transparently describe the hypothesized mechanism between the patient's experiences and the outcome of interest. For example, if the outcome of interest is delay, what are the hypothesized causes? Is shame or stigma a contributing factor? Transparency around these assumptions facilitates a more robust discussion of findings and a more effective exchange between quantitative and qualitative research on referrals.

Finally, future research should seek to avoid the inherent selection bias created by recruiting patients only at abortion facilities and should describe how experiences related to abortion referral-making may differ by personal attributes, with particularly attention to vulnerable populations. Such research recognizes that not all patients may benefit equally from or require an abortion referral and is key to determining if further study of abortion referral-making should focus on the broader population of patients or on specific subgroups.

2. Conclusion

Abortion referral-making once again has become a target for those seeking to restrict access to abortion. However, providing an evidence-based response to how such a prohibition might affect patients cannot be answered by the published literature to date. Failures to protect and deliver patient-centered care place marginalized patients at greatest risk, and inattention to abortion referrals as a component of both access and quality care has the potential to exacerbate disparities in patient outcomes and experiences. The findings of the learning community offer a guide for the work ahead and an invitation for further exploration.

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