

ARHP Commentary — Thinking (Re)Productively

Referral-making in the current landscape of abortion access

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1. Introduction

2014 has brought a number of abortion facility closures in the United States, often as a result of targeted legislation aimed at limiting the provision of abortion. As these closures decrease the availability of already limited services, women will require greater assistance locating and accessing abortion care. In this context, abortion referral-making—defined here as a process of connecting a woman in need of abortion care with a facility that provides services—may be a critical, yet for many years overlooked, component of access.

2. Accessing abortion care in United States

In the United States, the majority (94%) of abortions are performed in 839 specialized abortion facilities and other reproductive health clinics located throughout country [1]. There are significant regional differences in the number of facilities providing abortion care. For example, 93% of counties, home to 49% of women of reproductive age, in Southeastern states had no abortion provider, and 94% of counties (53% of women of reproductive age) in Midwestern

states had no abortion provider. Compare this to the Northeast region where 65% of counties, home to 24% of women of reproductive age, had no abortion provider [1]. Political hostility towards abortion in the United States also varies by region. Among the 205 abortion restrictions enacted in 30 states from 2011 to 2013, the overwhelming majority were in Southeastern and Midwestern states [2].

Limited services in combination with laws aimed directly at women—including bans on insurance coverage, waiting periods and parental consent laws—influence women's ability to access abortion care. Once a woman has identified that she is pregnant and made the decision to consider or have an abortion, her experience locating and accessing services will vary—from the seamless to the very challenging—depending on her existing knowledge of abortion providers, circumstances and the resources that are known and available to her. It is critical that attention is paid to women's varied experiences and needs. Delays in accessing abortion care are disproportionately experienced by women of color, young women and women with lower educational attainment [3,4].

At its most seamless, some women will learn (or confirm) that they are pregnant after having been given a pregnancy test by a doctor who performs abortion as part of his or her practice. In these cases, the woman can have the abortion at this same medical office as a continuous aspect of her overall care. Given the small percentage of abortions that are

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performed in private physician offices (1%) [1], this is likely the experience of only a very small number of women.

A second category of women is comprised of those who are aware of clinics that provide abortion and who know how to reach them. In these cases, a woman would learn of her pregnancy either at a medical office or through a home pregnancy test and would be able to look up the telephone number for the known abortion clinic in the phonebook or online, make the call and receive an appointment. If payment is a concern, the clinic may be able to counsel women about and access financial resources (for example, a private abortion fund) or assist the woman with payment directly. While we do not know how many women populate this group, the absence of an abortion provider in 89% of US counties suggests that many women also fall outside of this category.

Finally, a third category comprises women who are not aware of an abortion provider (or who, potentially, are not even aware that abortion services are legally available) and will need to investigate and locate one. These women may have an idea about a provider (for example, a Planned Parenthood clinic; not all Planned Parenthood locations provide abortion care) or about how to find one (for example, via an Internet search for “abortion”), but her success in locating care and the time and effort this will take will depend on several factors. These factors can include the number, public visibility and proximity of abortion providers, as well as the number and visibility of Crisis Pregnancy Centers, some of which falsely present as abortion providers in order to deliberately delay or deter women from accessing abortion care. A woman’s individual resources (such as access to the internet) and capacity to perform an effective search and screen the results in order to locate an actual abortion provider can vary widely.

To understand the challenges women may face, consider the following women: a young woman who has relied on a parent to help navigate her previous health care needs but is unable to do so for abortion; an uninsured woman, who interacts with health care services infrequently and often finds specialized services out of reach due to out-of-pocket cost; and a woman who does not have Internet access in her home and is dependent on family members for transportation, making the trip to the local library to search for a provider a challenging step. Each of these women may confront considerations such as a need to shield her search from unsupportive friends and family or, in the case of minors, her ability to involve her parents; the distance she will need to travel and her ability to take time off from school, work or arrange childcare; and her ability to pay the cost of the abortion. Gestational age can further complicate matters, as abortion services at later gestations can be even more difficult to locate and logistics (e.g., scheduling, time commitment costs) more challenging. Prevailing stigma relating to abortion and the subsequent reluctance of women and others to discuss it, stigma-related fears about abortion (e.g., that it is illegal, that it will damage the woman’s health or even be life threatening), and intersecting health and life circumstances such as homelessness, domestic violence, substance use,

mental illness and overall health status can further complicate a woman’s attempt to access care.

In attempting to locate abortion care, these women may seek assistance from others including their partners, friends and family, clergy, and health and social service providers. Among these, some may provide useful help, while others cannot (due to their own lack of knowledge and resources) or will not assist; some may intentionally subvert the woman because of their objection to her decision or to abortion generally.

This third category of women — those who must identify a previously unknown provider — is varied and is likely to comprise the largest of the three groups. For these women, the availability of someone who can assist may be the critical link to care. This may be especially true for those living within complex circumstances, or where stigma attached to abortion is high and where abortion providers are few. Until recently, little attention has been paid to the role of referrals in ensuring abortion access. As a result, abortion referral behavior is often inadequate. For example, a recent report by Dodge et al. [5] found that even after prompting staff members for a referral, less than half (48.5%) of calls resulted in a direct referral (the name or telephone number of a facility that provided abortion services).

The inadequate preparation and support of health and social service providers to offer abortion referrals are also shown in training evaluation data collected by *Provide*, in our work to train health and social service providers in abortion referral-making. Pretraining surveys collected from 429 participants in three Southeastern US states indicated that half of these professionals felt that they lacked the skills and information needed to refer a woman for abortion if requested; one third believed abortion to be medically unsafe, curtailing providers’ ability to serve as trusted sources of health information. Notes one provider during a posttraining evaluation interview, “A lot of places don’t talk about it, so you have to say ‘I don’t know, I don’t have that information,’ then there are no resources to fall back on” (unpublished data). Another echoes this condition, stating “I shied away from the topic and felt I wasn’t qualified to provide them with that info because I didn’t have accurate info or enough.”

3. Potential for intervention

Drawing on several years of foundational work with provider groups in the US South and Midwest, in 2013, *Provide* launched a program to train health and social service providers to offer abortion referrals. Currently being implemented by state-based training teams in five states (Kentucky, North Carolina, Oklahoma, South Carolina, West Virginia), we have seen early evidence that health and social service providers in a broad range of settings want evidence-based information about abortion and skills in referral-making, and that providing this reduces misconceptions about abortion and improves confidence in referral-making behavior, among other shifts in knowledge, attitudes and behaviors [6]. The conceptual model we developed for abortion referral making and the competencies

we identified as the foundation of our program are presented here for use by clinicians and others wishing to reflect upon and/or build their own referral-making practices, as well as for educators and researchers who may wish to address abortion referral-making in their work.

4. Referral-making best practices

To identify best practices, *Provide* sought guidance from sources that included field experience, peer-reviewed research and professional norm-settings entities in abortion and other areas of health care. We conducted two internal, unpublished reviews of these sources (available upon request). In 2011, we reviewed the literature on referral practices within three specific fields: abortion, HIV and human services with particular attention to intimate partner violence. We examined best practices in referrals for abortion in the United States and the United Kingdom, as a potentially instructive counterexample to the US context. Based on this internal review, we developed a conceptual model of barriers and facilitators to referral-making behavior. Our second review in 2013 expanded on this model, examining additional examples from published literature on abortion counseling and pregnancy options counseling, and programmatic materials from various organizations including *Provide*, Cardea Services, International Planned Parenthood Federation/Western Hemisphere Region, Ipas, National Abortion Federation, Planned Parenthood Federation of America, Abortion Care Network and Hope Clinic for Women. We

also looked at guidelines drawn from professional associations for nurses and physicians and from individual authors published in books or peer-reviewed literature (unpublished literature review, sources available upon request).

While there is ample literature describing the competencies for pregnancy options counseling, these internal reviews found a gap around abortion referrals in published research and resources. This gap, coupled with some evidence that abortion referral behavior among health care professionals is often inadequate [5], suggests that a conceptual model for abortion referral-making that can be implemented and evaluated can help. At *Provide*, we are using this model as the basis for training and related interventions to promote referral-making among health and social service professionals.

5. A conceptual model for abortion referral-making

Our model (Fig. 1) proposes that referral behavior functions on a spectrum ranging from a passive to an active, caring role. The provision of information is its most basic component (for example, a list of area abortion providers). Building towards its most active, referral-making may include assistance scheduling an appointment; assistance in accessing supportive services such as transportation, childcare, and abortion funding or insurance; follow-up on service utilization and outcomes; and assessment of patient satisfaction with the referral and with the care received.

To put this model into practice, *Provide* also developed a set of core competencies for referral-making (Fig. 2). For training purposes, this spectrum was further distilled into the

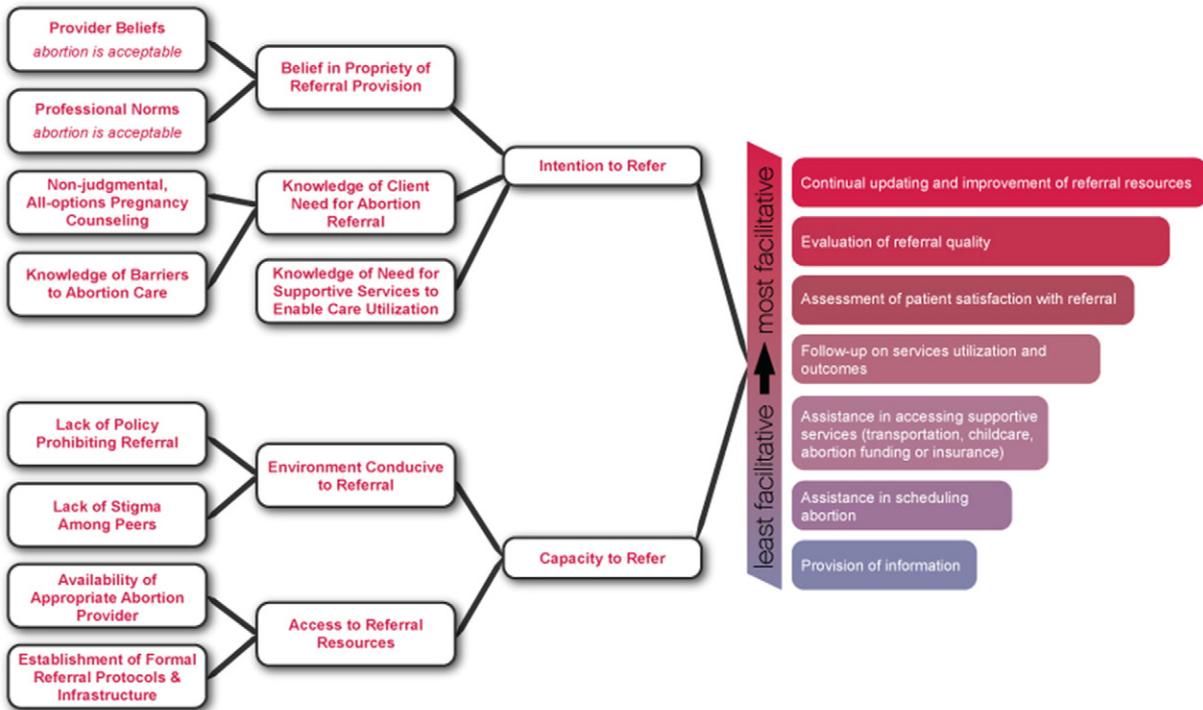


Fig. 1. A conceptual model of factors influencing abortion referral behavior.

Competencies required for referral-making are organized around the factors that influence referral-making identified in the conceptual model, and are located in the cognitive, affective, and skill-based domains. They include competencies for general referral-making as well as referrals specifically for abortion, a sampling of which includes:

Cognitive Competencies (accurate up-to-date knowledge of abortion):

- How poverty and marginalization affect access to information and services
- Local agencies providing financial assistance, including for the costs of abortion
- Information about medical and surgical abortion options, and about abortion safety
- The presence and practices of anti-abortion centers (CPCs) that may manipulate clients and provide misinformation

Affective Competencies (attitudes):

- Empathy for women facing unintended pregnancy
- Respect for clients' autonomy
- Awareness of one's own values and beliefs and the need to avoid having these influence client interactions
- Respect for clients whose beliefs, identity, and/or sexual practices vary from one's own

Skill-based Competencies:

- General referral procedures
- How to ask if a client wants additional information and counseling
- Use of non-judgmental counseling techniques

Fig. 2. Competencies for abortion referral-making.

S.T.A.R. model for referral-making, which describes four elements: Supportive, Thorough, Active, Referral Quality (Fig. 3). Developed for abortion referral-making specifically, the behavior-focused S.T.A.R. model may also be applicable to other stigmatized health needs, such as substance-abuse treatment, mental-health services and specialized care for sexually transmitted infections and diseases.

6. Everyone has a role

Competent referral providers play a critical role in directing women to safe, appropriate care responding to a range of health needs. For abortion specifically, we have seen in our early training results that competent referral providers can also help clear up common misperceptions and/or deliberate misinformation about the legality and safety of abortion, and can assist women with multiple or

complex social and/or medical circumstances they face when accessing abortion care. Furthermore, by looking beyond only current abortion providers and activating the broader existing support systems around her, those providing care to women can bring support to women where they are already accessing care and bring abortion into larger discussions on coordination of care. This is needed especially in settings where women are likely to encounter stigma and misinformation and where abortion is difficult to access.

Professionals working across the health care team and in multiple disciplines and settings are encouraged to assess their current referral-making practices and be able to competently refer their patients and clients for abortion. This includes the ability of abortion providers to refer women who exceed gestational limits within their facility or who have unique health or other needs that require care to be obtained elsewhere. Educators are encouraged to incorporate information and skills development regarding abortion referrals into their curricula and

Supportive

"I know my role in the face of my client/patient's need."

"Supporting my client/patient's decision about her pregnancy is best way I can do my job helping her."

Thorough

"I have the correct information about the service she needs."

"I am knowledgeable about the care she is seeking."

Active

"I actively help my client/patient locate and schedule the care she needs."

"I actively assess her needs for, and help connect my client/patient to, supportive services such as childcare or transportation—to help her to utilize the referral she is seeking."

Referral Quality

"I follow up, asking about her experience accessing this provider and if there is anything else she needs."

"I use her experience to better help the next client or patient seeking a referral."

Fig. 3. A model of supportive, thorough and active referrals.

training programs. Opportunities also exist for researchers to deepen our understanding of women’s pathways to abortion care and to evaluate effective referral-making and the impact of referrals on women’s access to abortion. We urge all professionals who provide care to women to seek the knowledge and skills to do so and make a commitment to play their role in ensuring access to care.

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