

# Variation in Pregnancy Options Counseling and Referrals, And Reported Proximity to Abortion Services, Among Publicly Funded Family Planning Facilities

**CONTEXT:** As frontline providers, publicly funded family planning clinics represent a critical link in the health system for women seeking information about pregnancy options, yet scant information exists on their provision of relevant services. Understanding their practices is important for gauging how well these facilities serve patients' needs.

**METHODS:** A 2012 survey of 567 publicly funded family planning facilities in 16 states gathered information on referral-making for adoption and abortion services, and perceived proximity to abortion services. Chi-square, multi-variable logistic regression and multinomial logistic regression analyses were performed to assess differences among facilities in referral-making and reported proximity to abortion services.

**RESULTS:** Abortion referrals were provided by a significantly smaller proportion of providers than were adoption referrals (84% vs. 97%). Health departments and community health centers were significantly less likely than comprehensive reproductive health centers to refer for abortion services and to have a list of abortion providers available (odds ratios, 0.1–0.2). Rural facilities were more likely than urban ones to report a distance of more than 100 miles to the closest first-trimester abortion provider (relative risk ratio, 11.4), second-trimester abortion provider (8.7) and medication abortion provider (8.0). Health departments were more likely than comprehensive reproductive health centers not to know the location of the closest first-trimester, second-trimester or medication abortion provider (2.5–3.5).

**CONCLUSION:** A better understanding of disparities in provision of pregnancy options counseling and referrals at publicly funded family planning clinics is needed to ensure that women get timely care.

*Perspectives on Sexual and Reproductive Health, 2016, 48(2):65–71; doi: 10.1363/48e8816*

By Luciana E. Hebert, Camille Fabiyi, Lee A. Hasselbacher, Katherine Starr and Melissa L. Gilliam

Luciana E. Hebert is research specialist 3, Camille Fabiyi is research manager and Lee A. Hasselbacher is policy coordinator, all in the Section of Family Planning and Contraceptive Research, Department of Obstetrics and Gynecology, University of Chicago. Katherine Starr is assistant professor, William Beaumont School of Medicine, Oakland University, Rochester, MI. Melissa L. Gilliam is professor of obstetrics and gynecology and professor of pediatrics; chief of family planning and contraceptive research, Department of Obstetrics and Gynecology; and associate dean of diversity and inclusion, Biological Science Division, University of Chicago.

In 2011, some 53% of reproductive-age women living in the Midwest resided in a county that lacked an abortion provider, a higher proportion than was found in any other region of the United States.<sup>1</sup> Abortion providers are often concentrated in urban areas.<sup>2</sup> Living in a rural area is associated with myriad reproductive health inequities, including reduced access to contraceptive services, obstetrician-gynecologists and abortion services.<sup>3–7</sup>

In recent years, the passage of increasingly restrictive state-level abortion laws has compounded the geographic barriers to reproductive health care and further curtailed the rights of women seeking abortion and the activities of clinics that provide services. Currently, more than half of U.S. women live in states with laws that are “hostile to abortion rights” (i.e., that have at least four types of major abortion restrictions in place).<sup>8</sup> Midwestern states have seen some of the most dramatic changes in abortion laws.<sup>9</sup> Thus, geographic distance, a limited number of providers and restrictive laws combine to limit access to abortion for women living in Midwestern rural areas.

Given the many challenges to reproductive health care for rural women in particular, publicly funded family planning clinics represent a critical link in the rural health care infrastructure for women considering their pregnancy options—abortion, prenatal and adoption services.

Understanding the extent to which options counseling and referrals are provided in publicly funded family planning facilities is important for gauging how these facilities serve their patients' needs. Knowing if and how referrals are made for patients who seek information about their pregnancy options might indicate the quality of care provided. Furthermore, since publicly funded family planning clinics provide pregnancy testing, it is crucial to know how they counsel women who have positive pregnancy tests and who may have time-sensitive health care needs.

## BACKGROUND

Publicly funded family planning services are designed to address unmet reproductive health care needs, particularly for low-income women, by offering education, counseling and medical services. Facilities receiving public funds for family planning services are located throughout the United States and provide care to more than seven million women annually.<sup>10</sup> This network comprises a system of community health centers; state, county and city health departments; comprehensive reproductive health centers; and private providers. Public funds include Medicaid reimbursements, Title X family planning support, federal block grants and dedicated state resources.<sup>11</sup> Publicly funded family planning facilities offering reproductive health services serve not only as frontline providers for their own

on-site services, but also as referral sources for services not offered on-site.

Recently, increased attention has been given to providing comprehensive, high-quality family planning services. The American Association of Pediatrics and the American Congress of Obstetrics and Gynecology have outlined guidance describing the components of high-quality family planning care.<sup>12-14</sup> These guidelines are endorsed and echoed by the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs.<sup>15</sup> According to these proponents, physicians and health care providers should counsel a pregnant client about all of her options, which include pursuing parenting, adoption or abortion. Such counseling includes information and referrals for prenatal care, adoption services and abortion services.

While federal funding cannot be used for abortion care, with some exceptions, options counseling and referrals are within the scope of permissible services for publicly funded family planning providers.<sup>16</sup> In line with the CDC and the Office of Population Affairs' recommendations for quality family planning services,<sup>15</sup> program policy instructs grantees to provide nondirective options counseling and necessary referrals following a positive pregnancy test.<sup>16</sup>

Despite this mandate, little information exists on the practice of options counseling and referrals.<sup>17</sup> Existing research largely focuses on ethical frameworks and best practices for options counseling, particularly among adolescents.<sup>18-21</sup> Even since the "gag rule," which prohibited publicly funded facilities from providing any information about abortion, was lifted in 1993, very little research has evaluated the prevalence of options counseling in these facilities.<sup>22</sup> Similarly, while research has explored the distances patients must travel to access abortion,<sup>6</sup> data capturing geographic information about provider referrals for abortion has been limited. For example, a study using a simulated patient model found that only 46% of calls to facilities resulted in a direct referral to an abortion provider (i.e., provided the name or telephone number of a facility), and 27% of calls resulted in no referral whatsoever.<sup>23</sup> However, distance to providers was not reported; furthermore, data on referrals were not stratified by facility type (e.g., private vs. publicly funded, hospital vs. other). Since nearly one-third of U.S. women receive pregnancy testing services at publicly funded facilities,<sup>24</sup> assuring quality referral-making in these facilities is particularly pressing. Moreover, there is a dearth of research on perceived distance to abortion services from the perspective of those responsible for making referrals.

The current study fills a gap in the literature on abortion access by examining facility-level practices regarding pregnancy options counseling and referral, awareness of distance to providers and characteristics associated with referral practices.

\*The 16 states were Colorado, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Ohio, South Dakota, Utah, Wisconsin and Wyoming.

**TABLE 1. Percentage distribution of publicly funded family planning facilities participating in a study of services related to pregnancy options counseling and referrals, by selected characteristics, 16 Midwestern states, 2012**

Characteristic	% (N=567)
<b>Location</b>	
Urban	35.7
Rural	64.3
<b>Type of facility</b>	
Comprehensive reproductive health center	29.1
Health department	52.0
Community health center	7.2
Other	11.6
<b>Annual no. of female patients</b>	
<500	54.8
≥500	45.2
<b>% of female family planning patients who are aged 11–24</b>	
<50%	44.0
≥50%	56.0
<b>Role of respondent</b>	
Clinic manager/director	62.1
Clinician‡	14.7
Nurse/medical staff	9.0
Administrative	14.2
Total	100.0

‡Physician, physician's assistant, nurse, nurse practitioner or certified nurse-midwife. Notes: Percentages may not add to 100.0 because of rounding. Facilities were in Colorado, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Ohio, South Dakota, Utah, Wisconsin and Wyoming.

## METHODS

### Study Design

Data were drawn from a study on rural-urban differences in publicly funded family planning facilities in 16 states in Health and Human Services Regions V, VII and VIII. \* These regions were selected because they have clinically underserved areas, both urban and rural, that are not frequently studied. From June to September 2012, all 772 family planning clinics receiving federal family planning funds in the 16 states were surveyed using a self-administered paper questionnaire. The survey instrument for the parent study was informed by interviews conducted by telephone with regional program consultants and clinic managers located in both rural and urban service areas across the three regions. Interviews addressed barriers to and facilitators of reproductive health care provision in publicly funded family planning centers and services for adolescent and young adult patients. The final survey included variables assessing clinic characteristics pertaining to access to family planning and patient population characteristics.

Before the survey was sent out, researchers contacted facilities and facility networks to identify the most appropriate person to whom the survey should be addressed. These individuals were typically family planning or clinical coordinators, clinic directors or administrators. In most cases, surveys were sent to specific individuals; for facilities at which a specific individual could not be identified, the survey was addressed to the attention of the clinic manager.

A more detailed description of survey administration can be found elsewhere.<sup>25</sup>

All research activities were approved by the University of Chicago Institutional Review Board.

### Measures

The two main outcome variables of interest were the proportion of facilities that provide counseling on abortion and adoption services and the reported proximity of abortion services to facilities. Counseling and referral for abortion and adoption services were measured through a set of four binary measures asking respondents whether clinic patients were referred to adoption services when requested, whether they were referred to abortion services when requested, whether a list of local adoption agencies was available and whether a list of local abortion providers was available. Questions regarding the availability of lists were intended to measure whether information about services was accessible for patients who needed it. Reported proximity of abortion services to facilities was measured in two ways. First, respondents were asked about the proximity of the nearest abortion provider of any kind; response options were “on-site,” “in same state as clinic” and “in a different state.” Second, they were asked the distance to abortion providers of various types (first-trimester, second-trimester and medication); response options were “on-site,” “20 or fewer miles,” “21–50 miles,” “51–100 miles” and “101 or more miles.” Respondents could answer “don’t know” for questions related to proximity of facilities.

Clinic location by rural-urban status was the main independent variable and was represented dichotomously, on the basis of rural-urban commuting area codes defined by the 2010 census. Additional covariates of interest included clinic type (comprehensive reproductive health center, health department, community health center or other), annual number of unduplicated female family planning patients and proportion of female family planning patients who were aged 11–24. Comprehensive reproductive health centers included Planned Parenthood centers; community health centers included federally qualified health centers. For all analyses, we dichotomized the annual number of female family planning patients (fewer than 500 vs. 500 or more) and the proportion of female family planning patients who were 11–24 years old (less than 50% vs. 50% or more). Cut points for dichotomization were established by inspecting histograms and determining median values.

### Analysis

Descriptive statistics were generated to summarize the characteristics of the facilities surveyed. McNemar’s chi-square test was used to compare the proportion referring for abortion with the proportion referring for adoption. Univariate and bivariate analyses were conducted to explore differences in proportions by rural and urban status using chi-square tests of association. Multivariable logistic regression analyses assessed the association between facility characteristics and the practice of options referrals. Multinomial

**TABLE 2. Percentage of facilities reporting selected pregnancy options counseling practices, and percentage distribution of facilities by perceived proximity to abortion providers, according to urban-rural location**

Measure	Total	Urban	Rural
<b>PERCENTAGES</b>			
<b>Practice</b>			
Facility refers for adoptions*	97.2	95.0	98.4
Facility has list of adoption agencies	93.3	93.5	93.1
Facility refers for abortions	84.3	85.5	83.7
Facility has list of abortion providers†	85.4	89.0	83.4
<b>PERCENTAGE DISTRIBUTIONS</b>			
<b>Location of closest abortion provider***</b>			
On-site	3.8	8.1	1.4
In the same state	79.3	84.3	76.6
In a different state	12.7	6.1	16.4
Don't know	4.2	1.5	5.7
<b>Proximity to closest first-trimester abortion provider***</b>			
On-site	2.0	5.1	0.3
≤20 miles	19.1	49.5	2.5
21–50 miles	15.9	24.8	11.0
51–100 miles	18.5	8.1	24.2
≥101 miles	33.0	7.1	47.1
Don't know	11.6	5.6	14.9
<b>Proximity to closest second-trimester abortion provider***</b>			
On-site	1.1	3.1	0.0
≤20 miles	12.5	33.0	1.4
21–50 miles	11.3	19.8	6.6
51–100 miles	12.0	9.1	13.5
≥101 miles	30.1	12.7	39.5
Don't know	33.1	22.3	39.0
<b>Proximity to closest medication abortion provider***</b>			
On-site	3.6	8.1	1.1
≤20 miles	15.0	38.9	1.9
21–50 miles	11.2	19.2	6.9
51–100 miles	15.0	6.1	19.8
≥101 miles	24.8	7.6	34.2
Don't know	30.5	20.2	36.1
Total	100.0	100.0	100.0

\*p<.05. \*\*\*p<.001. †p<.10. Note: Percentages may not add to 100.0 because of rounding.

logistic regression analyses were conducted to examine the association between facility characteristics and reported proximity to different types of abortion providers; a distance of 100 miles or less was used as baseline.\*All multivariable analyses adjusted for rural-urban status, clinic type, annual number of female family planning patients and the proportion of female family planning patients who were aged 11–24. Analyses were unweighted, and alpha was set at .05. All analyses were performed using Stata statistical software, Version 13.

### RESULTS

After we excluded 39 clinics that were closed or no longer publicly funded at the time of the survey, the response rate was 75%. An additional 12 clinics were excluded from analyses: six whose surveys were completed in aggregate at the network level without unique responses for each clinic; one that did not confirm public funding; and five that lacked complete data about referral services they provide. The final analytic sample comprised 567 facilities (73% of those surveyed), all of which had complete information on

\*Interactions between urban-rural status and facility type were examined, but were excluded from the models because few interaction effects were significant.

**TABLE 3. Percentage of facilities reporting selected pregnancy options counseling practices, by selected characteristics; and odds ratios (and 95% confidence intervals) from logistic regression analyses assessing facility characteristics associated with reporting various practices**

Practice and characteristic	%	Odds ratio
<b>REFERS FOR ADOPTIONS</b>		
<b>Location</b>		
Urban	95.0	ref
Rural	98.4*	1.16 (0.28–4.87)
<b>Facility type</b>		
Comprehensive reproductive health center	100.0	ref
Health department	97.6	2.48 (0.55–11.18)
Community health center	85.4	0.41 (0.08–2.21)
Other	95.3**	‡
<b>Annual no. of female patients</b>		
<500	98.0	ref
≥500	97.2	0.77 (0.20–2.94)
<b>% of female family planning patients who are aged 11–24</b>		
<50%	94.9	ref
≥50%	99.0*	15.94 (2.01–126.55)**
<b>HAS LIST OF ADOPTION AGENCIES</b>		
<b>Location</b>		
Urban	93.5	ref
Rural	93.1	1.25 (0.49–3.18)
<b>Facility type</b>		
Comprehensive reproductive health center	97.6	ref
Health department	91.5	0.29 (0.08–1.04)†
Community health center	90.2	0.31 (0.05–1.98)
Other	92.2†	0.25 (0.06–1.08)†
<b>Annual no. of female patients</b>		
<500	91.7	ref
≥500	96.3*	2.13 (0.82–5.52)
<b>% of female family planning patients who are aged 11–24</b>		
<50%	94.9	ref
≥50%	93.0	0.74 (0.35–1.58)
<b>REFERS FOR ABORTION</b>		
<b>Location</b>		
Urban	85.5	ref
Rural	83.7	1.12 (0.61–2.06)
<b>Facility type</b>		
Comprehensive reproductive health center	95.1	ref
Health department	79.2	0.20 (0.09–0.46)***
Community health center	80.5	0.18 (0.06–0.57)**
Other	82.8***	0.22 (0.08–0.61)**
<b>Annual no. of female patients</b>		
<500	81.4	ref
≥500	88.6*	1.34 (0.75–2.39)
<b>% of female family planning patients who are aged 11–24</b>		
<50%	82.1	ref
≥50%	85.9	1.24 (0.76–2.02)
<b>HAS LIST OF ABORTION PROVIDERS</b>		
<b>Location</b>		
Urban	89.0	ref
Rural	83.4†	0.81 (0.42–1.58)
<b>Facility type</b>		
Comprehensive reproductive health center	98.2	ref
Health department	77.5	0.08 (0.02–0.27)***
Community health center	80.5	0.08 (0.02–0.37)**
Other	92.2***	0.22 (0.05–0.98)*
<b>Annual no. of female patients</b>		
<500	82.1	ref
≥500	90.7**	1.21 (0.65–2.25)
<b>% of female family planning patients who are aged 11–24</b>		
<50%	82.1	ref
≥50%	88.3*	1.65 (0.99–2.76)†

\*p&lt;.05. \*\*p&lt;.01. \*\*\*p&lt;.001. †p&lt;0.10. ‡Statistic was not estimated because of collinearity. Notes: ref=reference group.

our measures of interest. Facilities located in rural areas were significantly more likely to respond than were facilities located in urban areas (78% vs. 70%).

### Descriptive and Bivariate Findings

Nearly two-thirds (64%) of facilities were located in rural areas (Table 1). Fifty-two percent of all facilities were health departments, 29% were comprehensive reproductive health centers and 7% were community health centers. Fewer than half (45%) saw 500 or more female patients for family planning services each year, and 56% reported that half or more of their female patients were between the ages of 11 and 24. Clinic managers or directors completed the majority of surveys (62%).

Nearly all surveyed facilities reported referring patients to adoption services when requested and having a list of adoption service providers to distribute to patients (97% and 93%, respectively—Table 2). Rural facilities were more likely than facilities located in urban areas to provide referrals for adoption services (98% vs. 95%). Overall, referrals for abortion services were significantly less common than referrals for adoption services (84% vs. 97%); the proportion did not differ between rural and urban facilities. Eighty-five percent of facilities had a list of abortion providers to give to patients if requested; facilities located in urban areas were marginally more likely than rural facilities to have such a list (89% vs. 83%).

One percent of rural facilities offered abortion services on-site, compared with 8% of urban facilities. Overall, 79% of facilities reported that the nearest abortion provider was in their state. Rural facilities were more likely than urban ones to report that the nearest provider was in another state (16% vs. 6%).

Whereas 3% of rural facilities reported an off-site first-trimester abortion provider within 20 miles, 50% of urban facilities reported that such a provider was this close. Some 47% of rural facilities reported that the closest first-trimester abortion provider was 101 or more miles away, compared with 7% of urban facilities. Rural facilities were also more likely than urban ones to report that they did not know the proximity of the closest first-trimester abortion provider (15% vs. 6%).

One percent of rural facilities reported a second-trimester abortion provider within 20 miles, compared with 33% of urban facilities. Forty percent of rural facilities reported that the closest second-trimester abortion provider was 101 or more miles away, compared with 13% of urban facilities. Rural facilities were also more likely than urban ones to report that they did not know the proximity of the nearest second-trimester abortion provider (39% vs. 22%).

Two percent of rural facilities reported a medication abortion provider within 20 miles, compared with 39% of urban facilities. Some 34% of rural facilities reported that such providers were 101 or more miles away, compared with 8% of urban facilities. Rural facilities were also more likely than others to report that they did not know the proximity of the closest medication abortion services (36% vs. 20%).

## Multivariable Findings

In analyses that controlled for all facility characteristics, rural-urban status was not associated with the provision of referrals for either abortion or adoption services (Table 3). Facilities at which 50% or more of female family planning patients were aged 11–24 were more likely than others to refer for adoption services (odds ratio, 15.9). Compared with comprehensive reproductive health centers, health departments, community health centers and other types of facilities were significantly less likely to refer for abortion services (0.2 for each). A similar pattern was observed for having a list of abortion providers: Health departments, community health centers and other types of facilities were less likely than comprehensive reproductive health centers to have a list of providers (0.1–0.2).

Being located in a rural area was associated with an elevated risk of reporting that every type of abortion provider was more than 100 miles away (relative risk ratio, 11.4 for first-trimester provider, 8.7 for second-trimester provider and 8.0 for medication abortion provider—Table 4); it also was associated with an elevated risk of not knowing the distance to each type of provider (3.8, 3.0 and 2.4, respectively). Health departments were more likely than comprehensive reproductive health centers to report long distances and lack of knowledge of proximity with respect to both first-trimester abortion providers (2.1 and 2.5, respectively) and second-trimester abortion providers (2.2 and 3.5, respectively), as well as to report no knowledge of the distance to the closest medication abortion provider (3.1). Facilities serving 500 or more female family planning patients annually were less likely than those with fewer such patients to not know the distance to the closest first-trimester abortion provider (0.5), second-trimester abortion provider (0.5) and medication abortion provider (0.4).

## DISCUSSION

In this study, the majority of publicly funded facilities reported referring clients to abortion and adoption services when requested, though referral rates were significantly higher for adoption services than for abortion services. Following the recommendations of the CDC and the Office of Population Affairs,<sup>15</sup> program policies make clear that options counseling is an issue of both quality and necessity.<sup>16</sup>

Our findings suggest that facilities are willing to provide abortion referrals upon request, but may lack quality information about nearby providers, or that in some regions there may be no providers nearby. This echoes findings from previous work that has specifically aimed at strengthening referral networks as a step toward increasing abortion access.<sup>26,27</sup> Future research could explore this question further and consider what factors may inhibit or support the process of compiling broadly accessible referral information. Since publicly funded facilities are front-line providers for women seeking information about their reproductive health options, supporting their capacity to make referrals for services not within the scope of their

**TABLE 4. Relative risk ratios (and 95% confidence intervals) from multinomial logistic regression analyses assessing characteristics associated with reported proximity to nearest provider of different types of abortion services**

Provider type and facility characteristic	>101 miles vs. ≤100 miles	Don't know vs. ≤100 miles
<b>FIRST-TRIMESTER ABORTION</b>		
<b>Location</b>		
Urban	ref	ref
Rural	11.42 (6.01–21.73)***	3.83 (1.74–8.46)**
<b>Facility type</b>		
Comprehensive reproductive health center	ref	ref
Health department	2.05 (1.22–3.44)**	2.49 (1.17–5.30)*
Community health center	1.84 (0.63–5.40)	0.65 (0.08–5.50)
Other	1.61 (0.75–3.48)	1.36 (0.42–4.33)
<b>Annual no. of female patients</b>		
<500	ref	ref
≥500	0.65 (0.40–1.06)†	0.49 (0.24–0.99)*
<b>% of female family planning patients who are aged 11–24</b>		
<50	ref	ref
≥50	0.77 (0.50–1.20)	0.70 (0.39–1.26)
<b>SECOND-TRIMESTER ABORTION</b>		
<b>Location</b>		
Urban	ref	ref
Rural	8.67 (4.73–15.87)***	3.04 (1.78–5.21)***
<b>Facility type</b>		
Comprehensive reproductive health center	ref	ref
Health department	2.16 (1.24–3.75)**	3.46 (1.98–6.04)***
Community health center	1.25 (0.42–3.73)	1.69 (0.63–4.54)
Other	1.42 (0.64–3.13)	1.60 (0.72–3.53)
<b>Annual no. of female patients</b>		
<500	ref	ref
≥500	0.80 (0.47–1.36)	0.46 (0.27–0.77)**
<b>% of female family planning patients who are aged 11–24</b>		
<50	ref	ref
≥50	0.75 (0.46–1.21)	0.94 (0.59–1.50)
<b>MEDICATION ABORTION</b>		
<b>Location</b>		
Urban	ref	ref
Rural	8.01 (4.12–15.56)***	2.35 (1.39–3.97)**
<b>Facility type</b>		
Comprehensive reproductive health center	ref	ref
Health department	1.56 (0.90–2.70)	3.09 (1.77–5.41)***
Community health center	1.33 (0.42–4.26)	2.13 (0.79–5.73)
Other	1.49 (0.66–3.33)	1.98 (0.90–4.38)†
<b>Annual no. of female patients</b>		
<500	ref	ref
≥500	0.58 (0.34–0.98)*	0.40 (0.24–0.66)***
<b>% of female family planning patients who are aged 11–24</b>		
<50	ref	ref
≥50	0.87 (0.54–1.41)	0.73 (0.47–1.15)

\*p<.05. \*\*p<.01. \*\*\*p<.001. †p<.10. Note: ref=reference group.

on-site services could help them comply with the previously described recommendations.

The abortion referral rate of 84% in our study is higher than the rate of 73% reported in previous research.<sup>23</sup> As the present study shows, facility type is consistently associated with abortion referral practices. Compared with comprehensive reproductive health centers, health departments and community health centers were much less likely to

report making abortion referrals or having a list of abortion providers. Health departments were also more likely to report long distances to nearest abortion services and to report not knowing the distance. These findings are similar to those from a national study in which community health centers reported a limited ability to connect patients to abortion services in the community.<sup>28</sup> Results from a literature review examining the quality of family planning services in the United States from 1985 to 2005 similarly showed that service quality varied greatly across facilities and providers, and called for efforts to understand the reasons.<sup>29</sup> Our findings suggest that approaches adopted by comprehensive reproductive health centers might serve as models for other facilities that face similar challenges, and that training in options counseling for staff working in other settings might need to include detailed information on where to refer women when they seek additional care. Additional research on providers in health departments and community health centers could explore their referral practices and resources in order to develop a plan for integrating abortion referrals into existing procedures.

This study demonstrates the challenges potentially faced by women who use rural publicly funded family planning facilities. Respondents from rural facilities reported longer distances to all types of abortion services than did those from urban facilities. These findings likely reflect the documented decrease in the number of abortion providers, particularly in some Midwestern states, and the high concentration of providers in cities and metropolitan areas, which has further implications for rural women's reproductive autonomy and health care.<sup>1,2</sup> Our findings also highlight an opportunity to study the use of telemedicine to improve access to abortion care, considering that they suggest greater distance even to medication abortion services among rural publicly funded family planning facilities. However, a number of Midwestern states have increasingly sought to ban telemedicine abortion care, further reducing access for women who live in areas with few providers.<sup>30</sup> Where possible, referral resources from family planning service facilities could include information about providers offering telemedicine abortion care in rural areas.

In addition, rural facilities were more likely than urban ones to report not knowing the distance to the nearest abortion services. This finding may reflect the lower number of abortion services that are located in nonmetropolitan areas.<sup>2</sup> As rural women may have to travel greater distances to access abortion, timely and accurate referrals are crucial. Timely referrals are also necessary given the growth of other restrictions that contribute to delays in obtaining and financial barriers to abortion, including mandatory waiting periods and restricted public and private insurance coverage.<sup>8</sup> This study also found that second-trimester and medication abortion services were often more than 100 miles away from rural clinics, and respondents from rural clinics were less likely than their urban counterparts to know where these two types of services could be found. As

medication and second-trimester abortion are particularly time-sensitive procedures, these findings are concerning.

### Strengths and Limitations

This study has particular strengths that merit mention. First, though our sample was limited to certain geographic regions, all identified facilities in those regions were contacted, so we had a robust sample. Our response rate allowed us to generate reliable estimates while stratifying by rural and urban status, in order to draw comparisons across regions where major differences are often observed. Second, examining pregnancy options counseling practices and referrals is a novel question with important implications for giving women a full range of pregnancy options.

The limitations of this study must also be noted. First, by design the survey covered only three of the 10 Health and Human Services regions; therefore, it is not possible to generalize these findings to the entire country. Second, our response rate of 75% means that not all clinics in these areas are represented. Relatedly, there is potential for reporting bias resulting in overestimations of pregnancy options counseling practices and referrals. While efforts were made to ensure that individuals completing the survey were the most appropriate respondents, they may not have been responsible for making referrals to abortion services; thus, the reporting of distances to abortion providers may be subject to error. In addition, given that different individuals within facilities make referrals, this study may mask provider-level variation in referral-making. Lastly, we have only respondents' perceptions of proximity to abortion services; no objective measures of facility locations or those of nearby abortion providers were available for this analysis. Without geographic data, we are unable to validate the actual proximity of each type of provider to the family planning facility.

### Conclusion

Timely referrals following a positive pregnancy test are a central component of high-quality family planning care.<sup>15</sup> The findings from this study highlight some of the challenges faced by publicly funded family planning facilities in serving as a comprehensive reproductive health care safety net for women. Additional research is needed to improve understanding of facilitators of and barriers to provision of options counseling and abortion referral-making in publicly funded family planning facilities.

### REFERENCES

1. Jones RK and Jerman J, Abortion incidence and service availability in the United States, 2011, *Perspectives on Sexual and Reproductive Health*, 2014, 46(1):3–14.
2. Jones RK and Kooistra K, Abortion incidence and access to services in the United States, 2008, *Perspectives on Sexual and Reproductive Health*, 2011, 43(1):41–50.
3. Chuang CH and Shank LD, Availability of emergency contraception at rural and urban pharmacies in Pennsylvania, *Contraception*, 2006, 73(4):382–385.

4. Bigbee JL et al., Pharmacy access to emergency contraception in rural and frontier communities, *Journal of Rural Health*, 2007, 23(4):294–298.
5. Rayburn WF et al., Distribution of American Congress of Obstetricians and Gynecologists fellows and junior fellows in practice in the United States, *Obstetrics & Gynecology*, 2012, 119(5):1017–1022.
6. Jones RK and Jerman J, How far did US women travel for abortion services in 2008? *Journal of Women's Health*, 2013, 22(8):706–713.
7. Stulberg DB et al., Abortion provision among practicing obstetrician-gynecologists, *Obstetrics & Gynecology*, 2011, 118(3):609–614.
8. Boonstra HD and Nash E, A surge of state abortion restrictions puts providers—and the women they serve—in the crosshairs, *Guttmacher Policy Review*, 2014, 17(1):1–17.
9. Nash E et al., Laws affecting reproductive health and rights: 2013 state policy review, New York: Guttmacher Institute, 2014, <http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html>.
10. Frost JJ, Henshaw SK and Sonfield A, *Contraceptive Needs and Services, National and State Data, 2008 Update*, New York: Guttmacher Institute, 2010.
11. Sonfield A and Gold RB, *Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2010*, New York: Guttmacher Institute, 2012.
12. American Academy of Pediatrics, Committee on Adolescence, Counseling the adolescent about pregnancy options, *Pediatrics*, 1998, 101(5):938–940.
13. American Academy of Pediatrics, *Guidelines for Perinatal Care*, sixth ed., Washington, DC: American Academy of Pediatrics, 2007.
14. American College of Obstetricians and Gynecologists, *Guidelines for Women's Health Care: A Resource Manual*, third ed., Washington, DC: American College of Obstetricians and Gynecologists, 2007.
15. Gavin L et al., Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs, *Morbidity and Mortality Weekly Report*, 2014, Vol. 63, No. RR-4.
16. 42 CFR 59.5 (a)(5), <https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec59-5.pdf>.
17. O'Reilly M, Careful counsel: management of unintended pregnancy, *Journal of the American Academy of Nurse Practitioners*, 2009, 21(11):596–602.
18. Dobkin LM, Perrucci AC and Dehlendorf C, Pregnancy options counseling for adolescents: overcoming barriers to care and preserving preference, *Current Problems in Pediatric and Adolescent Health Care*, 2013, 43(4):96–102.
19. Dailard C, Family planning and adoption promotion: new proposals, long-standing issues, *Guttmacher Report on Public Policy*, 1999, 2(5):1–3 & 13.
20. Singer J, Options counseling: techniques for caring for women with unintended pregnancies, *Journal of Midwifery & Women's Health*, 2004, 49(3):235–242.
21. Aruda MM et al., Early pregnancy in adolescents: diagnosis, assessment, options counseling, and referral, *Journal of Pediatric Health Care*, 2010, 24(1):4–13.
22. Title X 'gag rule' is formally repealed, *Guttmacher Report on Public Policy*, 2000, 3(4):13.
23. Dodge LE, Haider S and Hacker MR, Using a simulated patient to assess referral for abortion services in the USA, *Journal of Family Planning and Reproductive Health Care*, 2012, 38(4):246–251.
24. Frost JJ, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010*, New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/sources-of-care-2013.pdf>.
25. Martins SL et al., Differences in family planning services by rural-urban geography: survey of Title X–supported clinics in Great Plains and Midwestern states, *Perspectives on Sexual and Reproductive Health*, 2016, 48(1):9–16.
26. Zurek M et al., Referral-making in the current landscape of abortion access, *Contraception*, 2015, 91(1):1–5.
27. French V et al., Influence of clinician referral on Nebraska women's decision-to-abortion time, *Contraception*, 2016, 93(3):236–243.
28. Goldberg DG et al., The organization and delivery of family planning services in community health centers, *Women's Health Issues*, 2015, 25(3):202–208.
29. Becker D et al., The quality of family planning services in the United States: findings from a literature review, *Perspectives on Sexual and Reproductive Health*, 2007, 39(4):206–215.
30. Guttmacher Institute, Medication abortion, *State Policies in Brief (as of December 2015)*, 2015, [http://www.guttmacher.org/statecenter/spibs/spib\\_MA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf).

#### Acknowledgments

The authors thank Summer Martins and Dinah Lewis for assisting with this research. This project was supported by the Society of Family Planning Research Fund.

**Author contact:** [lhebert@bsd.uchicago.edu](mailto:lhebert@bsd.uchicago.edu)