

Repeat Abortion and Use Of Primary Care Health Services

By John M. Westfall and Ken J. Kallail

One-third (34%) of 2,001 women who sought an abortion in 1991–1992 in Wichita, Kansas, were repeat-abortion patients. Compared with first-time abortion patients, repeat-abortion patients were significantly older, more often black, and younger at their first pregnancy ($p < .001$). The two groups did not vary significantly by income or age at first intercourse. However, repeat-abortion patients were significantly more likely than first-time patients to have been using a contraceptive method at the time of conception (65% compared with 59%) and more likely to say they always or almost always used a method (63% and 53%, respectively). More than 40% of women in each group reported they had no personal physician. Further, 34% of repeat-abortion patients said they had no follow-up examination after their previous abortion, and 28% said they received no contraceptive counseling. Only half of women whose pregnancy was confirmed by their personal physician obtained an abortion referral from that physician. (Family Planning Perspectives, 27:162–165, 1995)

Abortion is one of the most commonly performed surgical procedures in the United States. Currently, approximately 1.5 million abortions are performed each year, and that number has remained fairly constant over the last 10 years.¹ In 1992, nearly 28% of all pregnancies were terminated by abortion.²

In 1990, approximately 40–50% of abortions performed in the United States were obtained by women who had had a previous abortion.³ The repeat abortion rate has risen steadily since the landmark 1973 *Roe v. Wade* decision. Christopher Tietze explained the initial increase in repeat abortion as a consequence of the greatly increasing numbers of women who had ever had a first abortion.⁴ In one model, he projected that repeat abortion would account for more than 55% of all abortions within 30 years of legalization.⁵

Nonetheless, this steady rise in repeat procedures has caused great concern among public policymakers, abortion clinic staff, and the general public on both sides of the abortion debate. In the present climate, where abortion law and practice are hotly contested, repeat abortion is an important public health issue.

Previous studies have described the demographic characteristics of women who obtain abortions.⁶ Several studies conducted during the 1970s compared women

who had an abortion for the first time with those who had had a repeat abortion.⁷ Most have concluded that there are only a few differences between the two groups. Berger, for example, found that in Canada, first-abortion patients were similar to repeat-abortion patients in contraceptive practice, education level, socioeconomic status, religious affiliation and religiosity, and attitudes about sex and contraception; however, compared with women having an abortion for the first time, those obtaining a repeat abortion were older, held more liberal attitudes toward abortion, were more likely to be single, and reported more frequent intercourse.⁸ Shepard and Bracken found that repeat abortion patients were significantly more likely than first-time patients to be on welfare, and were significantly less likely to have been referred by a physician.⁹ Moreover, Steinhoff and colleagues found that women with lower socioeconomic status were more likely than those with higher socioeconomic status to become pregnant again shortly after an initial abortion.¹⁰

The most recent comparison between first- and repeat-abortion patients was published in 1984. Several important changes have occurred in the abortion and reproductive health field since most of these were conducted. First, in August 1977, the Hyde Amendment, which was supported by a 1980 Supreme Court ruling, eliminated federal abortion assistance for low-income women. The amendment's impact on low-income women has been elucidated in great detail,¹¹ and since

it has now been in effect for nearly 15 years, the impact on the current situation should be stable.

Second, cutbacks in health care spending and tighter insurance regulations (including the development of Diagnostic Related Groups, which regulate charges for specific procedures), may have made it more difficult for women to obtain preventive reproductive health care. For example, total federal and state spending on family planning dropped 18% between 1981 and 1982; and while Medicaid funding for contraception increased slightly in 1983 and 1984, 1985 levels of funding were well below 1980 levels.¹² Third, the number of abortions recorded rose steadily for several years after the legalization of the procedure in the United States. However, it has not varied much over the last decade, and the rate has remained fairly steady at 26–29 abortions per 1,000 women of reproductive age.¹³

The impact of these and other changes on recent trends in repeat abortion is unknown. A clear and current assessment of the practice of repeat abortion and its risk factors is important for both policymakers and practicing physicians, who play a major role in the provision of preventive health services. The following study aims to gain a better understanding of the demographic characteristics of women who obtain a first or repeat abortion, and to assess any differences between the two groups, not only in their personal characteristics but in their use of primary and preventive health care.

Methods

A 100-item survey was given to 2,445 consecutive patients who sought an abortion at one of three clinics in Wichita, Kansas, between July 1991 and July 1992. Women were handed the questionnaire before they received treatment, as one of the forms that were part of the clinics' general intake procedures. The survey instrument, which had been pilot tested on 159 women, collected information on the patient's demographic and personal characteristics, access to health care, attitudes toward abortion and its legality, and previous experience with either pregnancy

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or abortion. The use of available health care services was assessed by questions on whether the respondent had a personal physician, how often they visited that physician, how they learned of their pregnancy, and whether their physician referred them to a clinic.

Each survey had a letter attached that described the study and asked for voluntary participation while assuring the participant's anonymity. Both the survey and the letter were reviewed by the University of Kansas Institutional Review Board. Each patient was instructed to read the cover letter, complete the survey and then, as they returned their other paperwork to the receptionist, place the survey in the locked box provided at each clinic, whether or not they had chosen to complete it. Only the research team had possession of the key to the box; no clinic staff had access to the surveys. The team collected the surveys regularly, which allowed for good communication and close follow-up with the staff at each clinic.

We first performed a descriptive analysis of the total sample. Differences between first- and repeat-abortion patients were determined using chi-square calculations for percentages and t-tests for continuous variables. Partially completed surveys were included in the analysis. As the items had varying response rates, the number of respondents to each question was not always equal. A comparative analysis of nonrespondents was not possible.

Results

Of 2,445 surveys that were returned, 2,001 were completed, yielding a response rate of 82%. Table 1 presents the demographic and personal characteristics of women in the sample. Two-thirds of the women were between the ages of 19 and 30, and overall, their average age was 23.6 years. The patients were evenly divided between urban and rural residents; roughly one-third had incomes below \$15,000, one-third had incomes of \$15,000–30,000 and one-third of more than \$30,000. Approximately 80% of the women were white, and only 20% were currently married.

Thirty percent of the women had first had intercourse at age 15 or younger, and 87% had done so before the age of 19, with an average age at first intercourse of 16.5 years. The mean age at first pregnancy was 19.4 years. For 66% of the women, this was their first abortion; 24% had had one previous abortion and 11% had had at least two.

An overwhelming majority of the respondents thought that abortion should be legal in the United States (98.5%, not

Table 1. Percentage distribution of abortion patients by demographic and personal characteristics, Wichita, Kansas, 1991–1992 (N=2,001)

| Characteristic | % |
|---------------------------------|-------|
| Age | |
| ≤15 | 2.4 |
| 16–18 | 16.7 |
| 19–21 | 28.2 |
| 22–30 | 38.0 |
| ≥30 | 14.7 |
| Residence | |
| Rural | 46.2 |
| Urban | 53.8 |
| Household income | |
| <\$15,000 | 36.1 |
| \$15,000–29,999 | 34.2 |
| \$30,000–74,999 | 25.6 |
| ≥\$75,000 | 4.1 |
| Race | |
| White | 79.4 |
| Black | 11.3 |
| Asian | 2.9 |
| Hispanic | 5.1 |
| Other | 1.3 |
| Marital status | |
| Single | 55.5 |
| Married | 19.5 |
| Divorced | 18.2 |
| Widowed | 0.8 |
| Cohabiting | 6.0 |
| Age at first intercourse | |
| ≤15 | 29.9 |
| 16–18 | 57.1 |
| 19–21 | 11.0 |
| 22–30 | 2.1 |
| ≥30 | 0.0 |
| Age at first pregnancy | |
| ≤15 | 8.5 |
| 16–18 | 38.7 |
| 19–21 | 33.9 |
| 22–30 | 17.3 |
| ≥30 | 1.6 |
| Previous abortions | |
| 0 | 65.8 |
| 1 | 23.7 |
| ≥2 | 10.5 |
| Total | 100.0 |

Note: In this and the following table, percentage distributions in some categories may be based on fewer than the total of 2,001, because not all respondents answered all questions.

shown). Nonetheless, a somewhat lower proportion (68%) classified themselves as “pro-choice,” and 4% described themselves as “pro-life;” the remaining 28% did not identify themselves with either viewpoint.

Slightly more than two-fifths of the clinic patients (43%) had no personal physician, and just 21% of the total sample said they learned of their pregnancy from their physician. Twice as many women (41%) diagnosed it themselves with a home test and 9% went to another clinic for a pregnancy test. A sizable proportion (28%) indicated they learned they were pregnant through “other” means; many of these women were probably sure they were pregnant from their physical symptoms and never medically confirmed their pregnancy before arriving at the clinic. Twelve percent reported that they learned of the

clinic from their physician, but only 10% had actually been referred to the clinic by their physician. Just under one-third of the patients (30%) had not seen a physician in more than six months, and 13% reported they not done so in the last year.

Forty-four percent of the patients had had intercourse with more than one partner in the previous year, and nearly 10% with four or more partners. Thirty-nine percent of the abortion patients had used no contraceptive method at the time they conceived. Only 22% reported they “always” used a method. Further, when asked whether they had received contraceptive information from a physician, 27% indicated that they had not.

Table 2 (page 164) compares the characteristics of the first-abortion and repeat-abortion patients. Women seeking a repeat abortion were significantly older than those having an abortion for the first time (25.7 years vs. 22.5 years, $p<.001$). Repeat-abortion patients were also significantly younger at their first pregnancy (18.7 years vs. 19.7 years, $p<.001$). However, age at first intercourse was not significantly different for the two groups (16.4 years and 16.6 years, respectively, $p=.058$).

There were significant differences by race, in that repeat-abortion patients were less likely than first-abortion patients to be white and more likely to be black. They were also significantly less likely than first-abortion patients to be single. No difference existed between first-abortion and repeat-abortion patients in the proportion without a personal physician (42% of first-time patients and 44% of repeat patients, $p=.43$). As the table indicates, women having a first abortion were more likely than repeat-abortion patients to have had their current pregnancy confirmed by a physician (22% and 18%, $p=.017$). The two groups of women did not differ significantly in the proportion who had been referred to the clinic by a physician (not shown, 11% of first-time patients and 8% of repeat patients, $p=.08$). There were also no significant differences between the two groups in the total number of visits to a physician in the past year and in the time elapsed since their last physician visit. Women in either abortion group who had a personal physician were significantly more likely than those who did not to have been referred to the clinic by a physician, to have received contraceptive counseling, and to have used a method consistently (not shown, $p<.01$).

Contraceptive practice varied significantly between first-abortion and repeat-abortion patients. In general, Table 2 indi-

Table 2. Mean age and percentage distribution of abortion clinic patients by demographic and health care characteristics, according to whether visit is for first-time or repeat procedure

| Characteristic | First-time | Repeat |
|---|------------|--------|
| Mean current age** | 22.5 | 25.7 |
| Mean age at first intercourse | 16.6 | 16.4 |
| Mean age at first pregnancy** | 19.7 | 18.7 |
| Race** | | |
| White | 82.8 | 75.3 |
| Black | 8.5 | 16.1 |
| Asian | 2.5 | 2.8 |
| Hispanic | 4.6 | 5.2 |
| Other | 1.6 | 0.7 |
| Residence | | |
| Rural | 46.9 | 43.8 |
| Urban | 53.1 | 56.2 |
| Marital status** | | |
| Single | 61.8 | 43.2 |
| Married | 17.4 | 22.8 |
| Divorced | 15.4 | 24.0 |
| Widowed | 0.5 | 1.1 |
| Cohabiting | 4.9 | 8.9 |
| Household income | | |
| <\$15,000 | 34.8 | 37.6 |
| \$15,000–29,999 | 33.3 | 35.3 |
| \$30,000–74,999 | 27.2 | 23.7 |
| ≥\$75,000 | 4.8 | 3.4 |
| Personal physician | | |
| Yes | 57.9 | 56.0 |
| No | 42.1 | 44.0 |
| How confirmed pregnancy | | |
| Physician* | 22.0 | 18.2 |
| Clinic | 8.4 | 11.3 |
| Home test | 42.5 | 40.3 |
| Other | 27.0 | 30.2 |
| Time since last physician visit | | |
| 7 days | 17.1 | 14.7 |
| 1 month | 22.5 | 19.0 |
| 5 months | 31.1 | 34.8 |
| 1 year | 15.7 | 18.5 |
| >1 year | 13.5 | 13.1 |
| Total visits in previous year | | |
| 0 | 14.2 | 13.5 |
| 1–3 | 59.2 | 63.1 |
| ≥4 | 26.6 | 23.4 |
| Contraceptive use at conception | | |
| None** | 41.4 | 35.0 |
| Pill | 13.7 | 21.9 |
| Other† | 44.9 | 43.1 |
| Consistency of contraceptive use | | |
| Always** | 20.6 | 23.8 |
| Almost always | 32.9 | 39.5 |
| Occasionally | 19.5 | 16.5 |
| Almost never | 10.8 | 10.8 |
| Never | 16.3 | 9.4 |
| Total | 100.0 | 100.0 |

*Difference significant at $p < .05$. **Difference significant at $p < .001$.
 †Diaphragm, IUD, condom, sponge and rhythm.

cates that very few respondents consistently used a contraceptive method, but repeat-abortion patients were more likely than first-abortion patients to have been using a method at the time of conception and to say they used a method always or almost always. Repeat-abortion patients were significantly more likely than first-time patients to say they had received contraceptive information from a physician (not shown,

79% vs. 70%, respectively, $p < .001$). Among women having a repeat abortion, 12% said they had made no follow-up visit after their previous abortion, 34% had not received a follow-up examination, and 28% reported they had not received contraceptive counseling after the procedure.

Discussion

Slightly more than one-third of the women in our Wichita sample—34.2%—had had at least one previous abortion. This rate is lower than the national repeat abortion rates reported by The Alan Guttmacher Institute for 1988 (43%)¹⁴ and by the Centers for Disease Control for 1990 (45%).¹⁵ However, our repeat abortion rate is close to that for Kansas as a whole in 1989; according to the Kansas Department of Health and Environment, 32% of women who obtained an abortion had already had at least one previous procedure.¹⁶ It is unclear why Kansas should have a comparatively low repeat abortion rate; however, the state's general abortion rate is below the national average also, and the finding may simply reflect the generally conservative attitudes of the area.

Some of the previous research has shown that women who have repeat abortions tend to be in lower socioeconomic strata than first-time abortion patients, a finding that may indicate they have less access to primary care, including contraceptive services. In our study, however, there were no significant socioeconomic differences between first- and repeat-abortion patients. The self-reported indicators in our study may not accurately determine socioeconomic status, or access to primary preventive health care may not be directly related to socioeconomic status within this population.

Our data, and the national data, suggest that there is a subset of conscientious contraceptive users among women seeking abortion who report that they always use a contraceptive method. This group of women may represent the irreducible limit of repeat abortion. Our finding that repeat-abortion patients were slightly more likely than first-time patients to be using a method when they conceived is similar to that found in previous studies.¹⁷ However, 35% of repeat-abortion patients and 41% of first-time patients reported using no contraceptive method when they got pregnant, and fewer than one-quarter of women in each group said they always practiced contraception. Tanfer and colleagues found that approximately 13% of single women aged 20–29 exposed to the risk of pregnancy were not using any method of con-

traception.¹⁸ Their statistics and ours indicate that public health dollars could be well spent by making more resources available for reproductive education, contraceptive counseling, and the development and provision of contraceptives.

Several opportunities exist for primary care practitioners to help improve the statistics by becoming more active in discussing sex and contraception with their young patients, female and male. In our sample, a substantial proportion of women had had their first sexual intercourse at a young age, but their contraceptive use was poor. Adolescent women in particular may have poor access to primary care, including contraceptive services, due to social barriers against providing contraceptives to teenagers. However, Lundberg and Plotnick found that better access to family planning services decreased the incidence of unwanted pregnancy among adolescent women.¹⁹ Young people can be counseled to postpone their sexual debut; for those who are sexually active, appropriate contraceptives should be discussed and provided. Likewise, contraceptive education and counseling should be given to adolescent men.

Second, physicians can become involved in identifying women at risk of a repeat abortion. Some women may be reluctant to initiate a discussion of their experiences with abortion or contraception with their personal physician. These patients may need more active counseling from a physician. By becoming involved with these women at the time of their first abortion, physicians who provide follow-up and contraceptive counseling may help decrease repeat abortion rates.

Over 40% of the respondents in the current study stated they had no personal physician. Women who have no physician need primary care for general health maintenance, as well as for regular contraceptive counseling. When such women have an abortion, there is a crucial need for follow-up; according to Hodgson, this follow-up may also serve as "an entry point into a family planning program and even comprehensive health care."²⁰ Some women may only come into contact with the health care system when they seek an abortion. If they are then referred by clinic personnel to primary care services, they may be able to attain better contraceptive and primary care. Conversely, primary care providers may need to make themselves more available for referrals from abortion clinics.

In addition to finding that many abortion patients had no primary physician, we learned that women having a repeat

abortion were significantly less likely than those having a first abortion to confirm their pregnancy through a physician. Furthermore, only half of those who learned of their pregnancy from a physician were referred to the clinic by a physician. These are indicators that physicians may not be giving timely counseling and referral to women facing a problem pregnancy. It is comforting to note that women who had a personal physician were more likely than those who did not to be consistent users of effective contraceptive methods.

Abortion is a serious personal, political and health care issue in the United States, and repeat abortion is even more so. The primary care physician's office may be the best place to intervene. Physicians are in a position to encourage young people to postpone their sexual debut, counsel about appropriate contraceptive use, provide options for a problem pregnancy and give follow-up care to women who obtain an abortion. They can identify women at risk of problem pregnancy, and be more open to discussing sex and contraception with their patients.

As new restrictive laws are enacted and more obstacles hinder women facing a problem pregnancy or seeking abortion, health care providers may need to become more involved. Abortion is a very safe procedure. We would like to do what is necessary to keep it safe—and as with all medical interventions, as little needed as possible.

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