Access to health care for induced abortions

Analysis by means of a French national survey

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Background: With an incidence of 15‰, abortion is a common reproductive event in France. The study describes conditions of access to health care for abortions based on women’s reports, taking into account the woman’s background and the influence of the first professional contacted. Methods: A representative sample of 2,863 women, aged 18 to 44, was interviewed by telephone between September 2000 and January 2001. Of these women, 480 had an abortion in the last 10 years. Main results: The choice of first professional depended on women’s background, as we found differences according to age, educational level or past induced abortion. This choice affected subsequent access conditions, in terms of time delay or complexity of patterns of care to access abortion services. Women who first contacted a private gynaecologist, which is the most frequent situation in France, had more direct and shorter patterns of care. Conversely, general practitioners were associated with longer and more indirect patterns of care, especially when women were less well educated. Conclusion: This study reveals the heterogeneous nature of patterns of access to an abortion in France. It also raises questions concerning the training of general practitioners, who seem to be less well prepared to take charge of a request for an abortion than other professionals. Efforts must be made to better inform women and these professionals about the process required for abortions.

Keywords: access to health care, induced abortion
Women who in the last five years had an abortion or whose last pregnancy was unintended in the last five years were all selected (sampling fraction=100%, n=1034), while only a fraction of the other women were randomly selected (sampling fraction=19%, n=1829). Altogether, 2863 women answered the questionnaire, of which 677 had had an induced abortion in their lifetime. To limit a possible memory bias and to limit the effect of progress on access conditions to the health care system, our analysis focused on the 480 women who reported having had an abortion in the last 10 years.

Sampling weight
In order to take the sampling design into account in the analysis, each respondent was given a sampling weight, equal to the product of the number of eligible women in the household multiplied by the coefficient of random selection. The weighted sample was then adjusted to give a sample that was representative of the general population. Data from the last French census (1999) were used as a reference for the distribution of the main socio-demographic characteristics of the French population (age, marital status, occupation status, level of education). The total numbers reported in the tables are gross values, i.e. the number of women actually interviewed. The percentages are weighted percentages taking the sampling design into account.

Social and demographic characteristics
Information was collected concerning the woman’s situation at the time of the abortion (age, professional situation, past pregnancies including abortions, marital and relationship situation, contraceptive profile) and at the time of the survey (level of education, income separated into low, medium and high, on the basis of revenue per person in the household, and gynaecological follow-up in the last year defined as having had at least one appointment with a physician for contraception or other gynaecological reasons in the previous 12 months). Variables describing women’s situation at the time of the abortion were used as proxy variables of the woman’s situation at the time of abortion. This led us to hypothesize that the changes in the woman’s situation between the abortion and the survey did not depend on the conditions to access the health care system for an abortion.

Description of access conditions to health care for an abortion
The following information was collected:

- Professionals contacted before abortion, with particular attention to the first professional contacted. Four categories were considered: hospitals (public and private), social medical centres (family planning, maternal and child health services), general practitioners and private gynaecologists.

- Patterns of care: direct and indirect care. Direct care was considered to be all patterns of care in which there were no intermediary contacts between the first professional contacted and the first abortion service contacted. All other patterns of care were considered to be indirect. For 8% of women, information on the professionals contacted was incomplete and therefore classified as missing data.

- Number of abortion services contacted.

- The elapsed time (in weeks) between the first contact with a professional and the abortion itself.

- The place where the abortion took place (private or public hospital).

- Support from the physician who carried out the abortion and the medical staff. This item was examined by asking the question: ‘Would you say that you felt supported by the physician who carried out the abortion’ (yes very much so, rather yes, not really, not at all).

Statistical analysis
Crude associations between the women’s characteristics and the type of first professional contacted and between this first professional and subsequent access conditions were explored by cross-tabulation and tested with chi² or Anova tests. Multivariate analyses of the associations between social characteristics and the type of first professional contacted, coded in four categories, were performed with polytomous logistic regressions. Variables whose p value in the corresponding univariate analysis was less than 0.25 were included in the multivariate models. As the value of the ORs appeared to be similar in univariate and multivariate analyses, we displayed the results of the univariate analysis as percentages. However, the p values of the multivariate analysis are also provided.

The analyses were performed using STATA software.

RESULTS
Type of first professional contacted and woman’s social and demographic characteristics
The distribution of the type of first professional contacted is shown in figure 1. The group ‘other professionals’ (n=30) was too heterogeneous (e.g. social workers, educators, school nurses) to be taken into account in the following analysis.

This study shows that the gynaecologists as a group were the first professionals chosen by women who seek an abortion, regardless of their age group. However, because of differences of determinants of the choice of the type of first professional contacted, according to the women’s age, the analysis was carried out separately for women aged below and over 30 years.

For women under the age of 30 (table 1), a u-shaped pattern was observed between educational level and hospital as first contact. Women with low and high educational levels were more likely than women with a mid-level education to contact a hospital first. In addition, a negative relationship between education and place of abortion was observed. However, because of differences of determinants of the choice of the type of first professional contacted, according to the women’s age, the analysis was carried out separately for women aged below and over 30 years.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Low education</th>
<th>Mid education</th>
<th>High education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>25%</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Gynaecologist</td>
<td>33%</td>
<td>43%</td>
<td>52%</td>
</tr>
<tr>
<td>General practitioner</td>
<td>32%</td>
<td>40%</td>
<td>47%</td>
</tr>
<tr>
<td>Social medical centres</td>
<td>18%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>11%</td>
<td>12%</td>
</tr>
</tbody>
</table>

The analyses were performed using STATA software.
Women aged 30 years and over were more likely to visit their general practitioner and less likely to contact the hospital than the younger women (table 2). Women who did not report a gynaecologic follow-up in the previous year were more likely to consult a social medical centre. Those who reported at least one appointment with a gynaecologist were more likely to turn to a gynaecologist than others. Unlike in the younger age group, women who consulted a general practitioner at least one time in the previous year preferentially turned to a general practitioner. Women over 30 who reported having already had an abortion, were more likely to turn to a hospital or to a social medical centre than the other women. The same type of pattern was observed for women without children. Income was associated with the choice of first provider; as income increased the percentage of women seeking a social medical centre decreased, and women with the lowest income were less likely than women with higher levels of income to contact a gynaecologist first.

Table 1 First professional contacted according to women’s characteristics for the women under 30 years old (n=263)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–29 years old</td>
<td>n=56</td>
<td>n=45</td>
<td>n=106</td>
<td>n=56</td>
<td>n=263</td>
</tr>
<tr>
<td>&lt;20</td>
<td>29.9</td>
<td>25.1</td>
<td>29.4</td>
<td>15.6</td>
<td>100</td>
</tr>
<tr>
<td>≥20</td>
<td>25.1</td>
<td>18.3</td>
<td>35.7</td>
<td>21.0</td>
<td>100</td>
</tr>
<tr>
<td>≤25</td>
<td>24.1</td>
<td>9.4</td>
<td>45.1</td>
<td>21.4</td>
<td>100</td>
</tr>
</tbody>
</table>

Level of education

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; high school</td>
<td>n=107</td>
<td>23.0</td>
<td>11.5</td>
<td>38.1</td>
<td>27.4</td>
</tr>
<tr>
<td>Graduated from high school</td>
<td>n=59</td>
<td>14.9</td>
<td>21.5</td>
<td>48.4</td>
<td>15.2</td>
</tr>
<tr>
<td>&gt; high school</td>
<td>n=97</td>
<td>34.7</td>
<td>17.9</td>
<td>37.4</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Income

<table>
<thead>
<tr>
<th>Income</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>n=97</td>
<td>25.6</td>
<td>15.9</td>
<td>30.1</td>
<td>28.4</td>
</tr>
<tr>
<td>Medium</td>
<td>n=77</td>
<td>17.0</td>
<td>15.2</td>
<td>49.5</td>
<td>18.3</td>
</tr>
<tr>
<td>High</td>
<td>n=79</td>
<td>28.2</td>
<td>13.1</td>
<td>48.6</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Professional situation

<table>
<thead>
<tr>
<th>Professional situation</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>n=135</td>
<td>25.2</td>
<td>9.7</td>
<td>42.0</td>
<td>23.0</td>
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<tr>
<td>Student</td>
<td>n=67</td>
<td>25.9</td>
<td>24.0</td>
<td>34.1</td>
<td>16.0</td>
</tr>
<tr>
<td>Unemployed</td>
<td>n=28</td>
<td>40.7</td>
<td>17.2</td>
<td>22.4</td>
<td>19.8</td>
</tr>
<tr>
<td>Housewife</td>
<td>n=33</td>
<td>10.5</td>
<td>14.2</td>
<td>54.2</td>
<td>21.0</td>
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</table>

Children at the time of the abortion

<table>
<thead>
<tr>
<th>Children at the time of the abortion</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>n=97</td>
<td>22.3</td>
<td>10.7</td>
<td>43.2</td>
<td>23.8</td>
</tr>
<tr>
<td>No</td>
<td>n=166</td>
<td>27.3</td>
<td>17.9</td>
<td>36.6</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Previous abortions

<table>
<thead>
<tr>
<th>Previous abortions</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>n=39</td>
<td>24.2</td>
<td>29.7</td>
<td>21.6</td>
<td>24.5</td>
</tr>
<tr>
<td>No</td>
<td>n=224</td>
<td>25.3</td>
<td>12.1</td>
<td>42.7</td>
<td>19.9</td>
</tr>
</tbody>
</table>

Use of a contraceptive method at time of conception

<table>
<thead>
<tr>
<th>Use of a contraceptive method at time of conception</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>n=149</td>
<td>23.5</td>
<td>10.5</td>
<td>46.2</td>
<td>19.8</td>
</tr>
<tr>
<td>No</td>
<td>n=101</td>
<td>27.2</td>
<td>20.8</td>
<td>27.8</td>
<td>24.2</td>
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</table>

Gynaecological appointment in the last 12 months

<table>
<thead>
<tr>
<th>Gynaecological appointment in the last 12 months</th>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>n=26</td>
<td>16.9</td>
<td>29.8</td>
<td>26.4</td>
<td>26.8</td>
</tr>
<tr>
<td>By a gynaecologist</td>
<td>n=190</td>
<td>22.6</td>
<td>10.9</td>
<td>47.2</td>
<td>19.2</td>
</tr>
<tr>
<td>By a general practitioner</td>
<td>n=43</td>
<td>40.7</td>
<td>23.0</td>
<td>11.8</td>
<td>24.4</td>
</tr>
</tbody>
</table>

n = number of women actually interviewed in each category. The percentages are weighted percentages, which take into account the probabilities of inclusion and the weighting adjustments.

a: Categories of this variable are exclusive: a woman followed by both a gynaecologist and a general practitioner is included in the ‘gynaecologist’ group.
b: For all variables included in the multivariate model using polytomic regression, the results of the multivariate analysis (p-values) are indicated in addition to the p-values of the univariate analysis.

Access to health care for induced abortions

Access conditions according to the first professional contacted

Patterns of care

Sixty-one per cent of the women had direct care (the first professional directly sent the woman to an abortion service without any other intermediate contacts). Less direct patterns were observed when the general practitioner was first contacted (table 3). One in three of the women who first contacted a general practitioner also consulted a gynaecologist before being referred to an abortion service (data not shown).

Time delay

The mean time between the first contact and the abortion was shortest when a gynaecologist was the first professional contacted (p=0.07). This is partly because, unlike other professionals, gynaecologists tend to refer women to the private sector where the delays are shorter (2.0 weeks between first contact and abortion for gynaecologists versus 3.0 weeks for general practitioners and social medical centres).
the abortion versus 2.6 weeks in the public sector).

Place of abortion and contact with the abortion centres

All types of professional, except gynaecologists, referred more than two women in three to public hospitals. Gynaecologists referred almost 60% of women to private hospitals.

Most of the women (92.8%) only contacted one abortion centre, the one in which they had their abortion; 6.6% contacted two different centres and 1.4% contacted more than two centres (data not shown). On the whole, 46.9% of women felt that the physician who had carried out the abortion had not been supportive and 47.1% thought that the medical staff had not been supportive.

Relationships between the different dimensions of the access conditions

Over two-thirds (70.4%) of the women in the private sector had direct care versus 54.3% in the public sector ($p=0.07$). The weak association between the patterns of care and time delay (2.0 weeks for direct care versus 2.6 weeks for indirect care, $p=0.12$) suggests that the multiplicity and the hierarchy of contacts only slightly increase the time delay.

Interactions between women's characteristics and the effect of the first professional contacted on the access conditions

We examined the effects of the women's characteristics on the relationship between the first professional contacted and the subsequent access conditions one by one (educational level, income, previous abortion, gynaecological follow-up). As general practitioners were associated with more indirect patterns of care in the univariate analysis, we compared the general practitioners and the other professionals involved. The only factor found to be significant was the level of education ($p=0.01$). Women who first contacted their general practitioner and who had not graduated from high school were more likely to have indirect care than those who had graduated from high school (66% indirect care versus 34% indirect care). This difference virtually disappeared when the first professional was not a general practitioner (30% versus 21%).

Table 2 First professional contacted according to women's characteristics for women aged 30 to 44 (n=187)

<table>
<thead>
<tr>
<th>Hospital public/private</th>
<th>Social medical centre</th>
<th>Gynaecologist</th>
<th>General practitioner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>30–44 years old</td>
<td>n=22</td>
<td>n=19</td>
<td>n=94</td>
<td>n=52</td>
</tr>
<tr>
<td>%</td>
<td>11.1%</td>
<td>9.6%</td>
<td>40.7%</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

Age (years) $p=0.41$

30–34 n=99 13.5 12.6 38.1 35.8 100

≥35 n=88 7.8 5.4 44.3 42.4 100

Level of education $p=0.15$ (univariate) $\rightarrow p=0.23$ (multivariate)

< high school n=88 8.4 11.4 36.9 43.3 100

Graduated from high school n=42 2.2 8.8 35.4 26.7 100

> high school n=57 8.5 3.9 60.9 34.1 100

Income $p=0.19$ (univariate) $\rightarrow p=0.04$ (multivariate)

Low n=59 12.4 16.2 30.4 40.9 100

Medium n=43 11.4 5.2 59.6 23.9 100

High n=73 10.7 4.3 44.4 40.6 100

Professional situation $p=0.64$ (univariate)

Employed n=137 10.0 7.2 41.9 40.9 100

Unemployed/housewife n=50 13.4 14.3 38.3 34.1 100

Children at the time of the abortion $p=0.01$ (univariate) $\rightarrow p=0.005$ (multivariate)

Yes n=162 10.5 7.3 40.7 41.4 100

No n=25 15.9 29.0 40.5 14.6 100

Previous abortions $p=0.03$ (univariate) $\rightarrow p=0.001$ (multivariate)

Yes n=58 22.4 16.2 35.9 25.4 100

No n=129 5.9 6.5 42.9 44.7 100

Use of a contraceptive method at the time of conception $p=0.58$ (univariate)

Yes n=111 10.8 8.3 36.0 44.9 100

No n=64 10.8 7.4 49.0 32.7 100

Gynaecological appointment in the last 12 months $p=0.06$ (univariate) $\rightarrow p=0.03$ (multivariate)

No n=19 17.0 18.9 27.2 36.9 100

By a gynaecologist n=145 10.7 9.3 46.3 33.7 100

By a general practitioner n=19 4.6 1.8 19.0 74.6 100

n = number of women actually interviewed in each category. The percentages are weighted percentages, which take into account the probabilities of inclusion and the weighting adjustments.

a: Categories of this variable are exclusive: a woman followed by both a gynaecologist and a general practitioner is included in the 'gynaecologist' group.

b: For all variables included in the multivariate model using polytomic regression, the results of the multivariate analysis ($p$ values) are indicated in addition to the $p$ values of the univariate analysis.
DISCUSSION

The conditions of access to the health care system for abortions have often been studied, particularly in the United States, where health care supply varies considerably according to state legislation. These studies have generally used a socio-economic approach, analysing the effect of health care supply on the structure of public demand. However, they are not adapted to situations in which the terms of legislation, social insurance and health care organization are homogeneous, such as in France. Anderson and Newman’s conceptual framework stated that access to health care results from the interaction between health care supply and health demand. Therefore, it is interesting to note that studies on abortion have mainly focused on supply rather than on demand. This study is one of the few to explore women’s reports of access to abortion services in the general population.

Compared to the French national statistics (the law requests that data on abortions be collected, in the form of a bulletin filled in for each abortion), abortion was underestimated by 40% in our study. The rate reported was similar to those reported in other surveys, which were also underestimated. This underestimation is partly due to our sampling procedure, which did not cover the entire population and excluded women under 18, those with no permanent home, no fixed telephone (5% of French households), or who did not speak French fluently enough. However, the weighting adjustments applied in reference to the national data collected from the French census should have minimized this first possible bias. Beyond sampling bias, this underestimation is also partly related to the difficulty involved in reporting highly personal and sensitive topics. Different factors affect underreporting. These include socio-demographic profile (ethnicity, age, marital status), fertility-related characteristics (method of contraception, number of abortions) and survey methods (directness of the interview).

To estimate the potential effect of underestimation on our results, we compared the characteristics of the women included in our sample with those of the women included in the national statistics. We found that only single women and women with no professional activity were underrepresented in our sample. As these two characteristics were not associated with the type of first professional contacted, our results should not have been affected greatly.

Our results are consistent with the hypothesis that the women’s social and demographic profile affects the choice of first professional contacted. The role of social background on patterns of care is well documented and illustrates the general issue of social inequalities in health. However, as public information on abortion services was forbidden until July 2001 in France, and as social discussions on abortion remain difficult, more specific determinants may be involved, which this study has helped to identify.

The gynaecologists were found to be the first group contacted, regardless of women’s age. This situation is to be analysed as a result of the specific setting for gynaecology practice in France, characterized by the presence of a ‘medical gynaecology’ specialty. Medical gynaecologists have often taken over women’s gynaecological follow-up from the general practitioner, which explains their ‘leadership’ over reproductive health issues.

A number of factors associated with the first professional contacted differed according to whether the women were aged above or below 30 years. This age separation coincides with the mean age for having a child. Women under 30 years who reported an appointment with a general practitioner for gynaecological reasons in the last year chose to refer directly to a hospital and not to their regular doctor, whereas older women first turned to a general practitioner before contacting the abortion service. This may be because young women, who are usually in good health, rarely need medical counselling and therefore have not developed a highly personalized relationship with their general practitioner, whereas older women, who have already founded a family, consult their general practitioner more frequently for their children or for themselves, have a much more personal relationship with their doctor. The u-shaped curve according to the level of education for the younger women who chose to contact a hospital was also noteworthy. This observation may be due to two different patterns of logic concerning medical consumption. For less educated women, direct access to the hospital without first referring to a private physician is a common mode of consultation. On the contrary, for highly educated women, this mode of access is infrequent, and may be explained by the fact that they have probably better integrated the idea of abortion being their prerogative. Thus, turning directly to a hospital may reflect a higher level of autonomy in women who seek efficacy.

Other specific factors were also found to affect the choice of the first professional contacted. For example, women who had had an abortion in the past were more likely to contact a medical structure (hospital or social medical centre) first, rather than a
private doctor (gynaecologist or generalist). Women, who have already had an abortion and therefore know the procedures, probably directly contact the hospital to accelerate the process. Alternatively these women may fear their own doctor’s reaction, which they may assume would be moralistic, and prefer to have impersonal contact with a medical centre. Finally, women may refer to their usual doctor for the happy events of their reproductive life and turn to other structures when it comes to dealing with abortion.24

Our results also confirm the hypothesis that the first professional contacted affects subsequent access conditions. This was also described in a qualitative study on the same subject.24 Women who first contacted a private gynaecologist had more direct and shorter patterns of care. The shorter time delay may partly be explained by the fact that these specialists refer women to private abortion services that have shorter waiting lists than those in the public sector. Furthermore, some gynaecologists practice abortions in private clinics and may thus help women to get appointments more rapidly. Conversely, women who first contacted a general practitioner had longer and more indirect patterns of care. This raises questions concerning the different networks of medical specialists and general practitioners, and concerning the role of general practitioners who are less involved in managing reproductive health issues and seem to be insufficiently informed on the procedures to be followed in the case of abortion. This last point seems particularly important in the present context of the new law on abortion (2001) that should soon allow private physicians to practice ambulatory medical abortions, on the condition of a signed convention between the private physician and an abortion service.

Surprisingly, we found only a weak association between patterns of care and time delay, which suggests that the complexity of access does not significantly affect the waiting time, and therefore does not increase the risk for women to go beyond the legal time for an abortion. However, time delay and complexity of the process represent stressful issues that impact on women’s perception of the quality of health care.24

Finally, we found that the women’s characteristics affected the role of the first professional contacted on subsequent access conditions. Indeed, women with a lower educational level received more indirect care than those with a higher educational level. This difference was much greater when the women first contacted a general practitioner than when they first contacted any other type of professional. This type of interaction was also found by a qualitative study, which showed that when the first professional was not adequately prepared to respond to a request for an abortion, women received more indirect care if they did not have the knowledge or resources to compensate for the professional’s lack of experience.24

CONCLUSION
This study describes the user’s perspective on access conditions to abortion in France. It reveals the heterogeneous nature of patterns of access to the abortion services, associated with differences in access conditions. Our results also raise questions concerning the training of general practitioners, who seem to be less well prepared to respond to a request for an abortion than other professionals. This last point seems critical at a time where expanding options for medical abortion are being implemented in France, the new law (July 2001) allowing private physicians to perform medical abortions outside of an identified abortion clinic. Thus, it potentially could increase the number, type and geographic distribution of abortion providers and facilitate the procedure for women seeking to terminate an early pregnancy. In this context, efforts must be made to better inform health professionals and the general population about the process required for an abortion. These new developments of the health care supply need to be evaluated in the near future. Also, more research is needed to better assess women’s satisfaction and expectations to improve the quality of health care.

The COCON study was carried out with the financial support of the French Institute of Health and Medical Research (INSERM), the National Institute of Demography (INED), the National Health Insurance Agency (CNAMTS). Funding for Data collection was provided by grants from Wyeth Lederle.

We would like to thank all women who answered our questionnaire.

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Received 18 July 2002, accepted 1 July 2003.