**WEEK 5: Overcoming Obstacles to Abortion Access**

**QUIZ QUESTIONS**

1. In the United States \_\_\_\_\_\_\_\_ women have the highest rates of abortion.
* White women
* women of high socioeconomic status
* Black and Latina (Hispanic) women
* The rate of abortion is the same for all races and socioeconomic classes
1. Primary or secondary prevention strategies to reduce disparities in abortion include:
* Supporting policies that enable all women, regardless of race or socioeconomic status, to access the contraceptive method of their choice.
* Supporting all women who wish to continue their pregnancy.
* Addressing underlying causes of disparities in unintended pregnancy, such as racism and class discrimination.
* All of the above
1. In the United States, women of color have \_\_\_\_\_\_\_ rates of unintended births and unintended pregnancy compared with White women.
* Higher
* Lower
* The same
* We do not have enough scientific evidence to suggest a comparison.
1. Which of the following contribute to health disparities in family planning?:
* Higher rates of poverty and less education experienced disproportionately by racial minorities.
* The United States’ history of medical abuse targeted at minority populations (i.e. the Tuskegee Syphilis Study)
* Patient mistrust of the medical community
* Providers’ implicit biases toward certain racial and socioeconomic groups
* All of the above
1. Why is it important to integrate abortion training into health professional training programs?
* Learners will be less likely to opt-in to abortion training during residency
* Healthcare providers learn many transferable skills that are applicable to aspects of care other than elective abortion.
* Hospitals can restrict abortion services to an inpatient setting
* All of the above
1. How can provider bias contribute to disparities in family planning?
* Providers who offer differential pressure to control fertility may be perceived as coercive.
* Provider bias elicits resistance from the patient so they are less likely to return for care when they need it
* Provider bias leads to greater tendency to discontinue contraceptive methods and not return to care to start a new method
* All of the above
1. Studies in Family Medicine and Obstetrics and Gynecology have found that starting residency with the intention to provide abortions and \_\_\_\_\_\_\_\_\_\_ are two factors consistently predicting provision of abortion after residency.
* Excluding residents on the family planning rotation who only wish to partially participate in abortion training
* Routine inclusion of abortion in residency
* Structuring abortion training in as an “opt-in” model (meaning that residents don’t receive abortion training unless they request it, or “opt-in”)
* None of the above
1. One benefit to providing abortion care in a primary care setting is:
* Providers have an improved knowledge of the patient’s medical history, which may contribute to increased safety of abortion provision and can integrate abortion services into ongoing care
* Providers are more likely to recommend medical abortion to patients because first trimester uterine aspiration must be conducted in an inpatient setting.
* Most malpractice insurance in primary care policies cover abortion services.
* All of the above.
1. Approximately \_\_\_\_\_\_\_ of counties in the United States have no abortion provider.
* 10%
* 30%
* 50%
* 90%
1. True/False: Based on a recently published review, evidence suggests that Advanced Practice Clinicians (APCs) can be trained to provide first-trimester surgical and medical termination of pregnancy safely.
* True. Evidence suggests that APCs can provide surgical and medical pregnancy termination services in the first trimester as safely and effectively as physicians.
* False. To ensure safe and effective surgical and medical pregnancy termination, a licensed medical physician must provide services.
* There is not enough scientific evidence to make a conclusion regarding the safety and efficacy of pregnancy termination provision by Advanced Practice Clinicians.