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"They're forcing people to have children that they can't afford": A Qualitative
Study of Social Support and Abortion in Georgia

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Study of Social Support and Abortion in Georgia

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University of Georgia
2017

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2020

Abstract

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By Madison S. Dickey

Background: Abortion is a common medical procedure in the United States, yet research has demonstrated that women face significant barriers to accessing abortion care. Prior research indicates that social support and social capital are major facilitators to healthcare, because they work to overcome many barriers to healthcare access. However, limited research has examined social support as a facilitator to abortion access, and no studies have examined social capital within an abortion context.

Objectives: This study explores women's experiences with social networks, social support, and social capital while accessing abortion services in Georgia. It examines how social support and social capital factor into women's decision-making, emotional responses, access to abortion care, and – if unable to access abortion services – their ability to parent.

Methods: We recruited 18 women pre-procedure from an urban abortion clinic in Georgia for in-depth interviews between September 2019 and January 2020. Interviews were conducted over the phone, taking place 1-3 weeks post-procedure. Interview topics included social networks, support, and capital; abortion-seeking experiences and decision making; and barriers to care. We transcribed and analyzed the interviews in MaxQDA using the Sort, Sift, Think, Shift approach for thematic analysis.

Results: Women discussed social support around abortion as mitigating negative emotional, financial, and physical impacts. Women recounted many instances of social support, including advice and emotional support, financial aid, childcare, and accompaniment to the clinic. However, quality and level of support varied by partnership characteristics, depended on resources in the extended network, and was impacted by abortion stigma and community-wide poverty. Women are caught in a double bind, wherein they lack the social support and social capital needed to access abortion care and for childrearing.

Conclusions: Social support and social capital are key facilitators of abortion access and parenting, but patients often experience barriers to social support and capital due to poverty, unstable partnerships, structural inequality, and abortion stigma. Moreover, restricting access to safe and legal abortion services would be of significant detriment to the health and wellbeing of women, their families, and their social networks by perpetuating cycles of poverty and deepening socioeconomic and racial/ethnic disparities.

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Author's Note: Throughout this thesis, I will use the terminology “woman” to describe patients who receive abortions. I acknowledge that not all abortion patients are women, and that trans and non-binary individuals also access abortion care. The majority of evidence draws from samples of women, however, and my data collection was limited to cis-gender women. For these reasons, I will use “woman” throughout.

Chapter I: Introduction

Project Context and Rationale

Abortion is a common – but highly stigmatized – medical procedure in the United States. Though nearly one in four women (23.7%) are estimated to have an abortion by the age of 45 (1), studies suggest that women experience many barriers to safe and legal abortion care. These barriers include – but are not limited to – restrictive abortion policies (2-7), widespread community stigma (8-11), prohibitive cost (12-14), distance to clinics (15, 16), transportation challenges (15), and declining numbers of abortion providers (9, 11). Additionally, abortion stigma and restrictive abortion policies are contributing to and magnifying barriers to care. Abortion stigma is defined by Kumar et al. (10) as “negative attributes ascribed to women who seek to terminate a pregnancy that marks them, internally and externally, as inferior to ideals of womanhood.” Abortion stigma is perpetuated through a mutually reinforcing cycle referred to as the “prevalence paradox (10);” although abortion is a common occurrence, the invisibility of the procedure and stigma surrounding it leads to underreporting of abortion behavior, which creates and perpetuates the social norm that abortion is deviant. Women who have abortions then face discrimination due to their perceived “deviance,” thus creating fear of being stigmatized for engaging in abortion behavior. This results in underreporting and misclassification of abortion behavior within social networks, starting the cycle again (10).

The effects of abortion stigma are visible in United States policy. In the decades since the U.S. 1973 *Roe v. Wade* ruling that the fundamental constitutional right to privacy included abortion care (17), a proliferation of state-level policies has increasingly restricted access to abortion services. Since 2011 and especially in 2019 (the year leading up to this project), an

exceptional number of restrictive abortion policies were created or enacted, predominantly in the Southeast and Midwest (18). Many lawmakers instituted these policies with the ultimate goal of challenging and overturning *Roe v. Wade* in the Supreme Court (19). In Georgia, HB 481 (the “Heartbeat¹ Bill”) was signed into law in May 2019, prior the start of this project. The law bans abortion once a fetal “heartbeat” is detected, which restricts abortion to about six weeks gestation, before most women realize they are pregnant (20). It was scheduled to take effect on January 1, 2020. However, the American Civil Liberties Union of Georgia, in coordination with other reproductive rights organizations, filed a lawsuit challenging the constitutionality of the law and were granted a preliminary injunction, blocking the law until the case goes through the court (20). The injunction was granted on October 1, 2019 – during the data collection phase of this project – with the presiding judge stating that plaintiffs had shown that they and their patients “would suffer irreparable harm” without the injunction (21).

A critical fact about abortion in the United States is that there are significant disparities between socioeconomic, racial, and ethnic groups, with low-income women and women of color more likely to need abortion services due to racialized and institutionalized poverty, lower access to contraception, and other factors (22-24). In 2014, White patients accounted for the largest number of abortions (39%) but the lowest abortion rate (10.0 per 1,000 women) among all racial and ethnic groups. In comparison, Black patients accounted for 28% of abortions but at a significantly higher rate of 27.1 abortions per 1,000 women. Additionally, approximately 75% of women who received abortions in 2014 were classified as low-income (25). Women with income less than 100% of the federal poverty level had abortions at a rate of 36.6 per 1,000 women, the highest rate of all groups examined (26). These key populations also experience greater barriers

¹ Heartbeat is an intentionally misleading term, because the fetus does not have cardiac activity early in pregnancy. Rather, electrical activity can be heard on ultrasound that some misclassify as a “heartbeat.”

to abortion access. For example, research by Roberts et al. (27) found that in a population where one-third of patients reported income at or below 100% of the federal poverty level, 56% reported the total out-of-pocket costs of their abortions to be greater than one-third of their monthly income. This suggests that the women who are least able to manage the cost of abortion are also more likely to need abortion services because they are living in poverty.

Prior research on social support within abortion contexts has shown that social support can be vital in accessing abortion services. Social support is defined as “aid and assistance exchanged through social relationships and interpersonal transactions” (28), and is most often given and received through social networks, defined as “the web of social relations that surrounds individuals” (28). Social capital, another form of social network support, is “the resources- emotional, material, practical, financial, intellectual, or professional- that are available to each individual through their personal social networks” (29). Examples of social support facilitating abortion access include assistance in paying for the procedure (14), providing transportation or accompaniment to the clinic (30), and emotional support (31-33). However, research has also shown that low-income communities have less access to social support because of institutionalized poverty (34). To date, there is not enough evidence to fully understand the interplay between poverty, stigma, and social support within the context of abortion, and particularly within the context of restrictive abortion access.

Problem Statement

There is a dearth of research examining the role of social support and social capital in accessing abortion services in the United States. Prior research has demonstrated that social support and social capital can moderate the health effects of socioeconomic inequality, can facilitate improved health outcomes, and assist in overcoming barriers to medical care (28, 35-

37). The few existing studies on social support and abortion have not adequately explored the roles of partners, family, and friends in women's abortion seeking experiences, including navigating abortion decision-making, identifying how to obtain abortion care, paying for and accessing that care, and dealing with emotional responses. Scant research exists on social capital within abortion-related contexts.

Purpose Statement

In this study, we explore women's abortion-seeking experiences and their use of social networks, social support, and social capital to access abortion services. We collect detailed information regarding women's unique experiences with unintended pregnancy and abortion access, and give voice to women's stories, thoughts, and concerns.

Research Objectives

The objective of this study is to examine the use of social support and social capital among low-income women in the context of abortion access through qualitative methods. This study has three aims:

Aim 1: To explore the economic and other burdens potentially experienced by women seeking abortion services in Georgia

Aim 2: To describe the ways in which social support and social capital may be utilized to overcome such burdens

Aim 3: To explore how abortion policies and restrictions contextualize women's burdens in seeking abortion services

Significance Statement

The findings of this study will provide new information about social support and social capital within the context of abortion care. Exploring women's abortion experiences in a

narrative and contextual domain will enable us to further identify similarities and differences in how women utilize social capital to meet their needs; provide deeper insights and detailed descriptions of the burdens placed on women seeking abortions; describe the dynamics of abortion politics and the impacts policies have on women; and, lastly, provide recommendations on how to better assist women who are seeking abortion services.

Definition of Terms

- Abortion: induced termination of pregnancy, usually through surgical or pharmaceutical methods (38).
- Abortion stigma: “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood” (10).
- Emotional support: a category of social support, constituting “expressions of empathy, love, trust, and caring” (28).
- Informational support: a category of social support, constituting “advice, suggestions, and information” (28).
- Instrumental support: a category of social support, constituting “tangible aid and services” (28).
- Social capital: “the resources- emotional, material, practical, financial, intellectual, or professional- that are available to each individual through their personal social networks” (29).
- Social network: “the web of social relations that surrounds individuals” (28).
- Social support: “aid and assistance exchanged through social relationships and interpersonal transactions” (28).
- Stigma: “an attribute that is deeply discrediting” which transforms the bearer “from a whole and usual person to a discounted one” (39).

Chapter II: Literature Review

Introduction

Abortion is a common health procedure in the United States, yet it is highly stigmatized and often difficult to access; in the current political climate, access to abortion services is becoming increasingly limited. Additional research is needed to understand the role of social support and social capital in facilitating access to safe, legal abortion services. The purpose of this narrative literature review is to synthesize, analyze, and critique existing literature on access to abortion services, as well as social support and social capital within an abortion context in the United States.

This review will first describe the characteristics of abortion in the United States, including incidence and reasons for abortion. Second, this review will discuss the literature on abortion stigma, a major contextual factor in understanding access to abortion, as well as access to social support and capital surrounding abortion. Third, the review will synthesize the existing evidence on abortion policy, and the effects of women being denied abortions – for example, due to gestational age limits as documented in the Turnaway study out of California (40). Fourth, this review will critique the literature on barriers to abortion care, which has not adequately explored the role of social support and capital in abortion access. Finally, this review will highlight evidence on social capital and support from other areas of healthcare and public health. Ultimately, this literature review serves to emphasize gaps in the existing literature and identify opportunities for future research on abortion and social support and capital.

Characteristics of Induced Abortion in the United States

Abortion Incidence and Statistics

Abortion is a common procedure in the United States, with nearly one in four women (23.7%) estimated to have an abortion by the age of 45. In 2017, according to research conducted by the Guttmacher Institute, approximately 862,320 abortions were performed in the United States, at a rate of 13.5 abortions per 1,000 women aged 15-44. Excluding miscarriages, approximately 18% of pregnancies ended in abortion; of these abortion procedures, an estimated 61% were surgical, and 39% were induced through medication (1). Of the women who obtained abortions in 2017, 60% had already given birth at least once (41). The majority of women seeking abortions were in their 20s (60%), with 25% in their 30s (25). In Georgia, specifically, 36,330 abortions were performed in 2017, representing 4.2% of all abortion in the United States (42).

Research has shown that there are significant disparities in the rates of abortion within various racial, ethnic, and socioeconomic groups in the United States (23). Among racial and ethnic groups, White women accounted for 39% of abortions - the largest number of abortions - but had the lowest abortion rate at 10.0 per 1000 women. Although Black patients accounted for 28% of abortion procedures, they were over-represented and had the highest abortion rate, at 27.1 per 1,000 women (26). Hispanic patients made up 25% of abortion patients, Asian or Pacific Islander constituted 6%, and the remaining 3% were other races and ethnicities (25).

In examining economic status, Jones. et al. (26) determined that abortion rates had an inverse relationship with income level: as income levels increased, abortion rates decreased. In 2014, approximately 75% of women who received abortions were classified as low-income individuals, with 49% living at less than the federal poverty level, and 26% living at 100-199%

of the poverty level (25). Additionally, women with income less than 100% of the federal poverty level had abortions at a rate of 36.6 per 1,000 women, the highest rate of all groups examined (26). A qualitative study by Roberts et al. (27) found that in a population where one-third of participants reported income at or below 100% of the federal poverty level, 56% of participants reported the total out-of-pocket costs of their abortions to be equivalent to more than one-third of their monthly income.

Clinically provided abortion-related complications are rare; a retrospective observational study, using 2009-2013 data from the Nationwide Emergency Department Sample, found that of the 189,480,685 weighed emergency department visits among women aged 15-49, 0.01% of these visits were due to abortion-related reasons. Out of these visits, 1.4% of visits were due to attempted self-induced abortion, with the highest rate of visits occurring in the South (43). Additionally, in 2017, 18% of nonhospital facilities reported seeing patients for self-induced missed or failed abortions, with reports of self-induced abortions highest in the South (25%) (1). A 2017 probability-based survey of 7,022 women concluded that of all abortions reported by women in the United States, 10% of those abortions represent a self-induction attempt. Of those attempts, an estimated 28% are successful (44). Multivariate analysis demonstrated that non-Hispanic Black and Hispanic individuals, individuals below 100% of the federal poverty level, or individuals who reported a barrier accessing reproductive health services in the past three years had higher odds of reporting self-induction (44).

Reasons for Seeking an Abortion

In 2004, a mixed-methodology study was conducted at 11 large abortion providers in the United States, consisting of a structured survey of 1,209 abortion patients, and 38 in-depth interviews examining patients' reasons for seeking abortions. Findings showed that the reasons

for seeking an abortion were multifaceted and tended to be multifactorial. Of the 1,160 patients who gave at least one reason for their decision, 89% provided at least two reasons, and 72% gave at least three reasons. The median number of reasons given was four. The four most frequently cited reasons for seeking an abortion were: 74% of women felt that having a child would interfere with their education, work, or ability to care for dependents; 73% of women said they could not afford to have a baby currently; 48% said they did not want to be a single mother or were having relationship problems; 40% stated they had completed their childbearing. Additional reasons provided were not being ready to have a child (33%), possible health problems affecting the fetus (13%), and concerns about their own health (12%) (45).

Biggs et al. (46) examined women's motivations for seeking abortions by utilizing qualitative and quantitative baseline data from the Turnaway Study, a prospective longitudinal study examining the effects of unintended pregnancy on women's lives. The sample included data collected from 2008 to the end of 2010, with 954 women from 30 abortion facilities across the United States. Women's reasons for seeking an abortion were classified into 11 broad themes, with the predominant themes being not feeling financially prepared (40%), mistiming (36%), and partner-related reasons (31%). Further reasons included needed to focus on other children (29%); interference with future opportunities (20%); emotional or mental unpreparedness (19%); health-related concerns (12%); and wanting a better life for the baby than they could provide (12%). Most respondents (64%) reported multiple reasons for an abortion, crossing over several themes. Mixed-effects multivariate logistic regression analyses demonstrated that women seek abortion for reasons related to their circumstances, including socioeconomic status, age, health, parity, and marital status. For example, women who cited financial reasons were more likely to have a higher level of education, more likely to be

single/never married, and less likely to have enough money to meet basic needs. Women who cited partner-related reasons were significantly more likely to be African American, and to have higher parity. Women who cited “interference with future plans” were more likely to be younger, to have more than high school education, and low scores on pregnancy intendedness (46).

Abortion Stigma

Though nearly one-fourth of women in the United States will have an abortion during their reproductive years (1), many experience and encounter social stigma due to their decision, as substantial proportions of the general public have negative attitudes about induced abortion (8). Stigma is conceptualized in a variety of forms, but the most established definition of stigma in social sciences is that of Erving Goffman (39), who described stigma as “an attribute that is deeply discrediting” which transforms the bearer “from a whole and usual person to a discounted one.” These attributes or stigmatizing behaviors do not have to be visible in order to be stigmatized, as Goffman describes the term being applied “more to the disgrace itself than to the bodily evidence of it” (39). Link and Phelan (47) expanded Goffman’s definition to consider that stigma is a co-occurrence of social processes within a power structure, including labeling, stereotyping, separation, status loss, and discrimination. They emphasized that stigma is relational, always including a stigmatizer, and is dependent on social, economic, and political power to be reproduced (47).

Abortion, in particular, is a behavior that is highly stigmatized in the United States for complex moral and political reasons (9). Kumar et al. (10) define abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood.” Women seeking abortions challenge local constructs and norms of the nature of womanhood, violate social expectations, transgress

archetypal constructs of femininity, and challenge moral order. Abortion stigma is not universal, but rather is highly contextual to social norms, constructed and reproduced locally through multilevel pathways, and is perpetuated by power differentials. Kumar et al. (10) describe abortion stigma as manifesting on five levels: individual, community, organizational/institutional, governmental/structural, and framing discourses and mass culture. Abortion stigma is also considered a “concealable” stigma in that it is unknown to others unless disclosed (48). According to Kumar et al. (10), abortion stigma can be perpetuated through a mutually reinforcing cycle of silence and concealability referred to as the “prevalence paradox;” although abortion is a common occurrence, the invisibility of the procedure and stigma surrounding it leads to underreporting of abortion behavior; this underreporting leads to the perception of abortion being uncommon, which in turn creates and perpetuates the social norm that abortion is deviant; women who have abortions face discrimination due to their perceived “deviant” behavior, which creates fear of being stigmatized for engaging in abortion behavior, and results in underreporting and misclassification of abortion behavior, starting the cycle again (9, 10).

A major component of abortion stigma is the stigmatizing attitudes the general public holds regarding abortion. Survey findings from the Pew Research Center in 2019 demonstrated that views on abortion can be nuanced and complex. The majority of the US general public view abortion legality in non-absolutist terms, with 60% of the population believing that abortion should be legal in all or most cases. Further investigation revealed differences on an individual basis as to what cases and circumstances abortion was viewed as permissible or not permissible (49). There is also a distinction between perspectives of legality and morality; a 2017 Pew Research Center survey found that 48% of the US general population believed abortion to be

morally wrong (50). There is a partisan divide on the legality and morality of abortion, with 82% of Democrats and Democratic-leaning independents believing that abortion should be legal in all or most cases, compared to 36% of Republican and Republican-leaning independents that feel abortion should be legal in all or most cases (51).

Research has shown there are significant divides in views on abortion on the basis of religious affiliation, education, and age. The majority (60%) of White mainline Protestants and 64% of Black Protestants believe abortion should be legal in all or most cases. In contrast, 77% of White evangelical Protestants feel abortion should be illegal in all or most cases. Among Catholics, 56% say abortion should be legal in all or most cases. Of individuals not affiliated with a religion, 83% feel abortion should be legal in most or all cases (51). Among all adults, individuals with higher levels of education tended to be most supportive of abortion legality (49). Younger adults are also more likely to support abortion legality, as 70% of adults under 30 are in support of abortion, and 64% of adults in their 30s and 40s (49). In Georgia, specifically, a sample of 968 Georgia residents revealed that 49% felt abortion should be illegal in all/most cases, as opposed to 48% who felt it should be legal in all/most cases (52).

Stigma within Abortion-Seeking Experiences

The stigmatized nature and context of abortion can make women's experiences particularly sensitive, influencing how they perceive their care and evaluate their experiences (53). Some research has been conducted on the experiences of women seeking abortions in the United States. A study comparing positive birth experiences and abortion experiences found three main differences in the needs and preferences of women undergoing each experience: women "appreciated being affirmed as moral decision-makers by providers, having a choice

about their degree of presence during an abortion, and receiving care in a discreet manner to avoid judgment from others for obtaining an abortion” (53).

A cross-sectional survey of 9493 abortion patients from 95 participating facilities in the US examined the perceived and internalized stigma among abortion patients. The study included five items to measure perceived and internalized stigma. It was determined that 66% of women agreed or strongly agreed that other people would look down on them if they knew about the abortion, and 58% reported needing to keep the abortion secret from close friends and family. When specifically discussing friends and family, 40% of women stated they believed their friends and family would think less of them if they knew they had undergone an induced abortion. Each racial and ethnic group had its own set of associations for perceived and internalized stigma, but the groups shared a number of predictors. Characteristics that consistently predicted stigma across the groups were: region of residence, number of previous abortions, not having made a decision to proceed at the time of making the appointment, and not informing the man involved with the pregnancy about the termination. Results showed that regardless of race or ethnicity, abortion stigma was an issue for a large portion of women who seek to terminate a pregnancy. Women living in the southern, western, and midwestern United States were more likely to perceive stigma than women living in the northeast. Additionally, abortion access is often limited in the southern and midwestern regions, and antiabortion activities such as antiabortion billboards, picketing of clinics, and harassment of women entering clinics tend to be more common (54).

Research has repeatedly shown negative impacts on the lives, health, and wellbeing of stigmatized individuals and groups (47, 55, 56). Negative impacts of abortion stigma, in particular, have been demonstrated to manifest in a variety of ways. Harris et al. (9) describes

how stigma can decrease the number of abortion providers, which in turn reduces access to care. Harris discusses that abortion providers risk adverse psychosocial consequences to perform a job that many view to be dirty and morally wrong. In addition to status loss, disclosure difficulties, and other psychosocial consequences, abortion providers also experience hateful rhetoric and threats of violence. An estimated half of all trained providers ultimately chose not to provide abortions, citing concerns that reflect pervasive abortion stigma, such as institutional barriers, strained relationships with colleagues, and personal wellbeing (9). Additionally, stigma makes it more difficult for individual patients to access abortion care for numerous reasons, including internalized stigma, anticipating interpersonal conflict with partners and families, experiencing stigma from other healthcare workers when trying to access abortion, and reduced access due to stigmatizing abortion policies (8-11).

Abortion Policy

The effects of abortion stigma and negative attitudes and perceptions of abortion can also be seen at a policy level in the United States. In 1973, the United States Supreme Court ruled in the *Roe v. Wade* case that the decision to terminate a pregnancy was a fundamental constitutional right, to be made solely by a woman and her doctor; state laws that banned abortions were ruled to be unconstitutional (17). In the decades since *Roe v. Wade*, however, abortion has become increasingly restricted in the United States due to a proliferation of state-level abortion laws, including Targeted Restrictions on Abortion Providers (TRAP laws). The number of abortion restrictions and stigmatizing discourse has continued to grow in recent years and, following the appointment of Brett Kavanaugh to the Supreme Court in 2018, magnified. In 2019, an unprecedented number of restrictive abortion policies were created or enacted in the United States, with 25 new abortion bans signed into law and 58 abortion restrictions enacted within 17

states. These restrictions are most prevalent in the Southeast and Midwestern regions of the United States (18), with the Southeast particularly affected by a surge of state-level restrictions on abortion: “heartbeat bills” or 6-week gestational limit policies have been passed in Georgia, Louisiana, South Carolina, Mississippi, Kentucky, and Tennessee (and attempted in Florida). In Alabama, abortion has been made a felony offense (19). Implementing a ban on performing abortions beyond six weeks gestation essentially bans all abortions; many of these policies have been instituted with the express purpose of taking a lawsuit to the Supreme Court, with the ultimate goal of overturning *Roe v. Wade* (19).

Effects of Being Denied an Abortion

Socioeconomic

As has previously been stated, the majority of women seeking abortion services in the United States are classified as low-income and face economic hardship. Multiple qualitative and quantitative studies have demonstrated that when women are denied abortion services, economic hardships tend to be exacerbated. Foster et al. (57) examined the socioeconomic consequences of receiving or being denied an abortion by following 813 women for five years and conducting semiannual telephone interviews. The participants were women who present for abortion just before or after the gestational age limit of 30 abortion facilities across the United States; socioeconomic outcomes were evaluated based on the receipt or denial of abortion care. The majority of participants were living in poverty at baseline, and results showed that women who were denied an abortion were more likely to experience economic hardship lasting for years, compared to those who received an abortion. Carrying an unwanted pregnancy to term resulted in a nearly 4-fold increase in the odds of having household income below the federal poverty level. Six months after denial, participants who were denied abortions had 3.77 times the odds of poverty,

0.37 times the odds of being employed full-time, and 6.26 times the odds of receiving public assistance compared to women who received an abortion (57).

Mental and Physical Health

Research on health outcomes among women who were denied abortions has demonstrated that women who are denied wanted abortions are more likely to have detrimental health outcomes compared to those who receive abortions, particularly in the days directly after the denial or receipt of the procedure. A five-year longitudinal cohort study followed 956 women who received or were denied an abortion and conducted interviews semi-annually to examine mental health and wellbeing. Results showed that at one week after the receipt or denial of abortion, women who were denied an abortion exhibited significantly higher anxiety symptoms and significantly lower self-esteem and life satisfaction, compared to women who received an abortion. Both groups exhibited similar levels of depression. The study also found that outcomes improved or stayed the same over time, but did not decline (58). A second study conducted within the same cohort found that women who were denied an abortion but did not give birth (either miscarried or sought abortion elsewhere) were more likely to have a self-diagnosed anxiety condition, compared to both women who received an abortion and women who gave birth. However, there was no difference between the groups in terms of professionally diagnosed anxiety or depression. Among women who received abortions, women who were near the gestational age limit when they received an abortion had higher perceived stress following their procedure, compared to those who received abortions in the first trimester; researchers hypothesized that the increased stress was due in part to overcoming barriers that delayed their obtainment of the wanted procedure, such as cost and travel (59).

In addition to mental health outcomes, research has also demonstrated that being denied an abortion has impacts on women's physical health. Compared to women who have abortions, women who give birth experience a 14-fold higher risk of death, and experience significantly more morbidity of gestational-related health disorders, such as hypertensive disorders, infections, and hemorrhage (60, 61). When comparing the physical health of women who received abortions (n= 328 in the first trimester, 383 in the second trimester) to women who were denied and gave birth (n= 163), Ralph et al. (62) found that self-reported physical health was worse among women who gave birth, with a negative health trajectory and increased odds of experiencing chronic headaches, migraines, and joint pain. By the end of the study period, 27% of women who gave birth reported fair or poor health, compared to 20% of those who had an abortion; 23% who gave birth reported chronic headaches or migraines, compared to 18% of those who had a first-trimester abortion, and 17% who had a second-trimester abortion; of the women who gave birth, 12% reported chronic joint pain, compared with 12% and 8% of women who had first or second trimester abortions, respectively (62). Recent studies have also suggested that increased restrictions and barriers to abortion are resulting in an increase in self-managed abortions, which have the potential to be more dangerous to women's health (63, 64).

Children

Being denied an abortion also had an impact on women's existing children. A study of the existing children of mothers who sought abortions found that from 6 months to 4.5 years after women were denied an abortion, their existing children had lower mean child development scores compared to the children of women who received an abortion, and were less likely to achieve self-help milestones. Compared to the children of women who received abortions, existing children of women who were denied an abortion had three times the odds of living in a household that received

public assistance and were more likely to live in a household in which the mother reported not having enough money to pay for essential needs (41, 65).

Barriers to Abortion Access

Targeted Restriction on Abortion Providers

Targeted Restrictions against Abortion Providers (TRAP laws) are state-level laws that impose restrictions on clinics and individuals who provide abortion services, implemented under the stated purpose of protecting the health and safety of women (7). However, TRAP laws are more severe than is necessary to ensure patient safety, and are more stringent than regulations for providers of similar, less stigmatized procedures; their primary purpose is to restrict access to abortion (3). TRAP laws usually require medically unnecessary changes to facilities, staffing, and credentialing of abortion providers, which, in order to be met, require excessive time, cost, and resource burdens that are not always feasible for the providers (7). Due to the difficulty for providers to meet the imposed regulations, and having to close clinics if the new restrictions are not met, TRAP laws frequently result in reduced access to abortion services (3, 7).

According to the Guttmacher Institute, as of January 1, 2020, 24 states have laws that regulate abortion providers, and go beyond what is medically necessary to ensure patient's safety; 18 states have specific requirements for procedure rooms and corridor widths, and require facilities to be close to and have relationships with hospitals – these regulations frequently require costly renovations to obtain; 17 states have arduous licensing standards for facilities and providers, comparable to licensing standards for ambulatory surgical centers; 11 states have policies that place medically unnecessary requirements on clinicians that perform abortions (4). Numerous abortion clinics have closed as a result of the significant institutional barriers created by TRAP laws. According to Mercier et al. (7), restrictions on abortion providers and facilities

have translated into increased patient costs and travel time, delays in accessing care, and decreased availability of second-trimester services. Additionally, many of these barriers disproportionately impacted women of color and lower socioeconomic status (7).

Other TRAP laws include mandatory counseling before an abortion and mandatory waiting periods before receiving an abortion (usually between 24 and 72 hours after counseling, 18 hours in Indiana). Fourteen states require the counseling sessions in-person, effectively necessitating women make two trips to the clinic to obtain an abortion. Within counseling sessions, states have various requirements for what information is provided, sometimes requiring the portrayal of inaccurate or medically incorrect information. Thirty-two states require women to be informed of the gestational age of the fetus, and 28 include information on fetal development throughout the pregnancy. Five states require informing women that personhood begins at conception (5).

Cost

The costs of abortion procedures are high in the United States, and the majority of abortion patients are classified as low income; as such, the cost of an abortion is considered prohibitive to key populations. The most common provider of health insurance for low-income women is Medicaid, a federal and state-funded program designed to help people with limited income and resources access medical care (66). Since the implementation of the Hyde Amendment in 1977, however, Medicaid has been forbidden from using federal funds for abortions except in the case of rape, incest, or life endangerment, thus restricting women's ability to access abortions (6). Policies exist in 17 states that permit using state-only Medicaid funds to pay for abortions in circumstances beyond the limitations of the Hyde Amendment, but as of January 2020 only 16 states appear to do so in practice (67).

A survey-based study in 2013 of 639 abortion patients at six geographically diverse abortion facilities found that despite only 36% of the study population lacking health insurance (Medicaid or private), 69% of patients were paying out of their own pocket for their abortion care. The most common reasons cited for not using insurance were because the procedure was not covered (46%), or not knowing whether the procedure was covered (29%). Of the women who did not use insurance, 52% had difficulties finding the funds to pay for the procedure. Half of the patients relied on other individuals (usually the man involved in the pregnancy) to help cover costs. In addition to the cost of the procedure itself, most women also incurred ancillary costs during the acquisition of their abortion, including transportation (mean of \$44), loss of wages (mean of \$198), childcare expenses (mean of \$57), and other costs related to travel (mean of \$140). Women also reported having to delay or not pay bills such as utilities and other bills (30%), food (16%), or rent (14%) to pay for their procedure (14).

In an analysis of public funding of abortion for poor women, Boonstra (12) found that women classified as poor often have to postpone their abortion, and take up to three weeks longer than other women to obtain their abortion. The author found that economically disadvantaged women tend to be delayed at two stages: first, they tend to take longer than more affluent women to confirm a suspected pregnancy, possibly due to the cost of a pregnancy test or difficulty getting to a doctor; second, they tend to have a longer time period between choosing to have an abortion and actually obtaining one. After controlling for other personal characteristics, research demonstrated that poor women were twice as likely as affluent women to report having difficulties arranging for an abortion, typically due to the time needed to come up with the money. The cost of an abortion procedure increases with gestational age; therefore, the longer women delayed obtaining their abortion, the tougher it was for them to afford it (12).

A mixed-methods study by Finer et al. (13) had similar findings. Based on results from a survey of 1209 abortion patients from 11 larger providers, and 38 in-depth interviews with abortion patients from four sites, poor women were more likely to say they would have preferred to have had their abortion earlier than when they obtained it (67%, compared to 50% of women who were above 200% of poverty). Of the survey respondents, 58% reported they would have preferred an abortion earlier than when they obtained them, with a significant difference between first and second trimesters: 91% of women in their second trimester stated they would have preferred earlier, compared to 52% of first-trimester patients. Probing during in-depth interviews revealed that the majority (60%) of women who were dissatisfied with the timing of their abortion had to delay obtaining the procedure in order to make arrangements and raise enough money; multiple women discussed having to cancel earlier appointments due to insufficient funds. Additionally, 36% mentioned having a delay in knowing they were pregnant, or not knowing how far along they actually were (13).

Distance

Like all health services, travel distance is an important determinant of access to abortion care. In 2017, there were 808 facilities in the United States that provided abortions, with 89% of counties without a known clinic, and 38% of women of reproductive age living in a county without a clinic (1). Fuentes and Jerman (15) utilized data from the 2014 Abortion Patient Survey and Abortion Provider Census to examine abortion patient's one-way travel distance. The average one-way distance patients traveled to their abortion facility was 34 miles. Two-thirds of abortion patients traveled less than 25 miles, 17% traveled between 25 and 49 miles, 10% traveled 50 to 100 miles, and 8% traveled more than 100 miles. Nearly one-fourth (24%) of patients lived in a state with a two-visit waiting period and were twice as likely to have traveled

more than 100 miles one-way to obtain their abortion, compared to women who lived in a state with no waiting period. There were differences in the travel distance based on various sociodemographic characteristics. Women who were White, college-educated, and born in the United States were more likely to travel further for an abortion; researchers hypothesize that this might be reflective of the resources available to the women who traveled further, and that those who did not have the resources to travel might not have been represented in the study sample if they were unable to overcome barriers (15).

Gerdt et al. (2) examined the impact of clinic closures on women seeking abortion services in Texas, following the implementation of restrictive abortion laws in 2014. Researchers surveyed 298 women who sought abortions at ten facilities in Texas in 2014, stratified by whether or not the nearest clinic to them in 2013 remained open in 2014. Findings demonstrated that the average distance to the nearest abortion facility increased by 20 miles between April 2013 and July 2014. Among all participants, the mean one-way distance traveled to the clinic where they obtained their abortion was 46 miles. The mean distance traveled for women whose nearest clinic closed was 85 miles, compared to the average of 22 miles traveled by women whose nearest clinic had not closed. Between the two groups, women whose nearest clinic closed were significantly more likely to stay overnight and incur out-of-pocket expenses greater than \$100, compared to women whose nearest clinic remained open. Additionally, 24% of women whose nearest clinic closed reported experiencing three or more hardships, compared to 4% of women whose nearest clinic remained open (2).

Social Support and Capital in Accessing Healthcare Services

Public health and social science research often point to social support and social capital as major facilitators of health care access because they work to overcome many of the barriers

listed above. Recently, research has been done looking at the use of social support and social capital to overcome medical barriers and moderate the effects of socioeconomic inequality on health outcomes. Social support has been defined and described in numerous forms and fields, all of which are best summed up by Heaney and Israel (28), who defined social support as “aid and assistance exchanged through social and interpersonal relationships.” The authors draw on the work of House (68) to categorize social support into three broad types: emotional, instrumental, and informational support. Emotional support is provided through empathy, love, trust, and caring. Instrumental support is provided through tangible aid and services, such as financial assistance, childcare, transportation, etc. Informational support is provided through advice, suggestions, and information (68). Seminal research by Cohen (35) and others has demonstrated that there are direct health benefits to social support, as well as buffering effects, which increase the probability that stressors will be coped with in a manner that reduces short-term and long-term health consequences (28, 35). These benefits are not exclusive to enacted social support, either; perceived social support has been found to be largely responsible for the buffering effects, in that individuals who have a strong sense of support are better able to overcome adversity – and are less likely to require enacted support and resources in doing so – compared to those who do not perceive themselves as having strong support (36).

Social support has been explored within abortion literature, but not extensively. Major et al. (32) examined women’s perceived social support, self-efficacy, and adjustment to abortion. The researchers surveyed 283 women who underwent first-trimester vacuum aspiration abortions through the administration of a pre-procedure questionnaire, and a post-procedure questionnaire approximately 30 minutes after their abortion. The pre-procedure questionnaire assessed perceived self-efficacy regarding abortion coping behaviors, and post-procedure assessed

physical complaints, mood, anticipation of future negative consequences from the abortion, and depression. The results demonstrated that perceived social support increased women's perceived self-efficacy for coping with abortion, and therefore enhanced psychological adjustment to abortion and their well-being (32).

Veiga et al. (33) also examined social support and abortion recovery with pre and postoperative questionnaires, specifically examining the effect and perception of women being accompanied by a support person in the post-operative recovery room. Researchers recruited 51 unaccompanied patients and 63 pairs of patients and support people. Results showed that though there were no significant differences in pre-procedure anxiety between the two groups, accompanied women experienced significantly lower anxiety post-procedure compared to women who were unaccompanied. Additionally, the perception of accompaniment was strongly positive among patients and support persons, indicating high satisfaction with the presence of a support person during recovery (33).

Another aspect of social network support is that of social capital, which is defined by The Organisation for Economic Co-operation and Development as “the resources- emotional, material, practical, financial, intellectual, or professional- that are available to each individual through their personal social networks” (29). Scant research on social capital has been done within abortion literature. Zeina Fathallah (69) examined the use of social capital and social networks to access abortions in Lebanon – a country where abortion is banned except to save a pregnant woman's life – and explores the intersectional effects of criminalization on women's access to safe abortion services. Fathallah conducted qualitative research over the course of six years in five Lebanese provinces, administering semi-structured face-to-face interviews with 84 women who had abortions, and 35 physicians who offer abortion services. Study results

demonstrated that in the restrictive Lebanese context, access to abortion services is contingent on a women's social capital, networks, and ability to negotiate access with partners, allies, and physicians. The results also demonstrated that single women from lower socioeconomic backgrounds were at the greatest disadvantage in accessing safe abortion services.

Social capital has been examined in greater detail in other healthcare fields, including pregnancy and obstetrics. RezaeiNiaraki et al. (70) conducted a cross-sectional, questionnaire-based study of 240 pregnant women in Iran, examining social capital, quality of life, demographic, and obstetric characteristics. Participants were all married, pregnant women receiving prenatal care at 37 urban health centers in Qazvin, Iran; random sampling methods were utilized to select participants. Linear regression models were utilized to determine the links between social capital and the physical and mental health dimensions of quality of life. Social capital scales that were measured included "community connection," "social agency," "trust/safety," "neighborhood connection," "family & friends connections," "tolerance of diversity," and "value of life." Analysis showed that, with the exception of "family & friends connections" and "tolerance for diversity," all dimensions of social capital had positive, significant association with the physical and mental health dimensions of quality of life among pregnant women; increasing social capital during pregnancy can increase the physical health dimension of quality of life by 0.40, and mental health dimension by 0.44. These findings remained true after adjusting for demographic and obstetric characteristics (70).

Tofani et al. (71) examined neighborhood and individual social capital among pregnant women in Brazil, looking specifically at the association between social capital and health-compromising behaviors (smoking, alcohol consumption, and inadequate diet). Researchers recruited 1046 participants from antenatal clinics, grouped from 46 neighborhoods within two

cities in the state of Rio de Janeiro. Neighborhood social capital was defined as the relationship between social groups and their neighborhood, and included four dimensions: social trust, social control, neighborhood security, and political efficacy. Individual social capital was specific to individuals, and was assessed by scales measuring social support and social networks. Baseline behavior and social capital were assessed during an antenatal visit in the first trimester, and follow-up assessments were performed 30 days postpartum. Multilevel multivariate regression analysis found that low individual social capital significantly predicted simultaneous health-compromising behaviors, while higher individual social capital increased the likelihood of smoking cessation during pregnancy, and improving diet. Low neighborhood social capital was also associated with an inadequate diet, but did not significantly influence the other two health behaviors. Results demonstrated that pregnant women's personal social resources and social capital were more important for health behaviors than where they lived (71).

Agampodi et al. (72) conducted a qualitative study to explore the ways in which social capital might affect the health of rural, pregnant Sri Lankan women. Investigators asked 41 pregnant women from 8 rural Sri Lanka communities to document their social lives every day for two weeks. Within two weeks of completing the diary, participants were interviewed about the contents of the diary and asked to reflect on and agree or disagree with the types of social capital observed in their diaries. Diary and interview data were analyzed using the framework approach, using classifications of major dimensions of social capital. Based on the results, researchers identified four pathways by which social capital could influence health in pregnancy: micro-level cognitive social capital promoted mental wellbeing; micro-level structural social capital reduced minor ailments in pregnancy; micro-level social support promoting physical and mental wellbeing through psychosocial resources, and health systems at each social capital level

providing focused maternal care. Agmapodi et al. concluded that in rural Sri Lanka, social capital can influence health during pregnancy, mainly due to neighborhood social capital and social cohesion in micro communities (72).

Conclusion

The existing evidence demonstrates that patients experience numerous barriers to abortion care in the United States. Simultaneously, research from public health and social sciences shows that informational, emotional, and instrumental support from social networks can improve health and access to vital healthcare services. To date, there has been inadequate attention to the role of social support and social capital in abortion. The few existing studies on social support and abortion have generally found that social support can increase self-efficacy, enhance adjustment to abortion experiences, moderate negative effects, and improve well-being after abortion.

However, they have not adequately explored the roles of partners, family, and friends in navigating abortion decision-making, identifying how to obtain abortion care, paying for and accessing that care, and dealing with the emotional experiences of unintended pregnancy and abortion. Scant research has explored the use of social capital within abortion contexts. Future studies must examine these factors to better understand social support and social capital during abortion, and to identify potential interventions to improve patient's experiences of abortion with support from their social networks. Qualitative and quantitative studies are both needed to address these gaps in the existing literature. Qualitative research, in particular, could explore these new areas of research and identify sources of social support and capital from the perspectives of patients actually navigating the abortion experience. Open-ended questions and

in-depth interviews with abortion patients could identify novel areas for intervention that standardized surveys might miss.

Chapter III: Manuscript

"They're forcing people to have children that they can't afford": A Qualitative Study of Social Support and Abortion in Georgia

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The work herein is the product of primary data analysis collected and performed by the student (MD). The student (MD) developed the recruitment protocol and in-depth interview guide, recruited and interviewed participants, and conducted data analysis. Advisement through this process was provided by members of the student's thesis committee.

Abstract

Objectives: To explore women's experiences with social networks, social support, and social capital while accessing abortion services in Georgia. It examines how social support and social capital factor into women's decision-making, emotional responses, access to abortion care, and – if unable to access abortion services – their ability to parent.

Methods: We recruited 18 women pre-procedure from an urban abortion clinic in Georgia for in-depth interviews between September 2019 and January 2020. Interviews were conducted over the phone, taking place 1-3 weeks post-procedure. Interview topics included social networks, support, and capital; abortion-seeking experiences and decision making; and barriers to care. We transcribed and analyzed the interviews in MaxQDA using the Sort, Sift, Think, Shift approach for thematic analysis.

Results: Women discussed social support around abortion as mitigating negative emotional, financial, and physical impacts. Women recounted many instances of social support, including advice and emotional support, financial aid, childcare, and accompaniment to the clinic. However, quality and level of support varied by partnership characteristics, depended on resources in the extended network, and was impacted by abortion stigma and community-wide poverty. Women were caught in a double bind, wherein they lacked the social support and social capital needed to access abortion care and for childrearing.

Conclusions: Social support and social capital are key facilitators of abortion access and parenting, but patients often experience barriers to social support and capital due to poverty, unstable partnerships, structural inequality, and abortion stigma. Moreover, restricting access to safe and legal abortion services would be of significant detriment to the health and wellbeing of women, their families, and their social networks by perpetuating cycles of poverty and deepening socioeconomic and racial/ethnic disparities.

(Word count: 273)

Introduction

Abortion is a common – but highly stigmatized – procedure in the United States, and access to social support and social capital greatly influences women’s experiences with and access to abortion services (32, 33, 69). Social support is defined as “aid and assistance exchanged through social and interpersonal relationships,” (28) and can be broken into three broad categories: emotional, instrumental, and informational support. Emotional support is provided through empathy, love, trust, and caring. Instrumental support is given through tangible aid and services, such as financial assistance, childcare, providing transportation, etc. Informational support is provided through advice, suggestions, and information (28, 68). Another aspect of social network support is that of social capital, which is defined by The Organisation for Economic Co-operation and Development as “the resources- emotional, material, practical, financial, intellectual, or professional- that are available to each individual through their personal social networks” (29). Social support and capital are critical for helping patients access abortion services, but little is known about social support in the context of abortion.

Though nearly one in four women (23.7%) in the United States are estimated to have an abortion by the age of 45 (1), studies suggest that women experience many barriers to safe and legal abortion care. These barriers include restrictive abortion policies (2-7), widespread community stigma (8-11), prohibitive cost (6, 12-14), distance to clinics (1, 2, 15, 16), transportation challenges (15), and declining numbers of abortion providers (9, 11). Additionally, abortion stigma and restrictive policies magnify other barriers. Abortion stigma is defined by Kumar et al. (10) as “negative attributes ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood.” Abortion stigma is perpetuated through a mutually reinforcing cycle referred to as the “prevalence paradox:”

although abortion is a common occurrence, the invisibility of the procedure and stigma surrounding it leads to underreporting of abortion behavior, which creates and perpetuates the social norm that abortion is deviant; women who have abortions face discrimination due to their perceived “deviance,” thus creating fear of being stigmatized for engaging in abortion behavior, and results in underreporting and misclassification of abortion behavior (10). The effects of abortion stigma are visible at a policy level in the United States. In the decades since the 1973 *Roe v. Wade* ruling that abortion was a fundamental constitutional right in the United States (17), a proliferation of state-level abortion laws has increasingly restricted access to abortion services. In 2019, an exceptional number of restrictive abortion policies were created or enacted, most prevalent in the Southeastern and Midwestern regions of the United States (18). For example, in 2019 Georgia passed HB 481, a bill that outlaws abortion once a fetal heartbeat is detected and restricts abortion to before most women know they are pregnant (73). Many lawmakers instituted these policies with the ultimate goal of challenging and overturning *Roe v. Wade* in the Supreme Court (19).

A critical fact about abortion in the United States is that there are significant disparities in abortion rates within racial, ethnic, and socioeconomic groups, with low-income women and women of color more likely to need abortion services due to racialized and institutionalized poverty and other factors (22-24). In 2014, White patients accounted for the largest number of abortions (39%) but the lowest abortion rate (10.0 per 1,000 women) among all racial and ethnic groups, compared to Black patients who accounted for 28% of abortions, but at a significantly higher rate of 27.1 abortions per 1,000 women. Additionally, approximately 75% of women who received abortions in 2014 were classified as low-income (25). Women with income less than 100% of the federal poverty level had abortions at a rate of 36.6 per 1,000 women, the highest

rate of all groups examined (26). These key populations also experience greater barriers to abortion access. For example, research by Roberts et al. (2014) found that in a population where one-third of patients reported income at or below 100% of the federal poverty level, 56% reported the total out-of-pocket costs of their abortions to be greater than one-third of their monthly income, indicating that the women who are least able to manage the cost of abortion are most significantly impacted by them (27).

Previous research suggests that social support can improve access to health services and decrease barriers to care (28, 35, 36, 68). However, it is unclear if social support operates in the same way for abortion, because it has not been extensively explored within abortion literature. The limited research conducted on social support within abortion contexts indicates that social support can improve women's abortion experiences. Major et al. (32) examined the perceived social support, self-efficacy, and adjustment to abortion of 283 women who underwent first-trimester surgical abortions. The results demonstrated that perceived social support increased women's perceived self-efficacy for coping with abortion, therefore enhancing their psychological adjustment to abortion as well as their well-being. Veiga et al. (33) examined the effects and perception of women accompanied by a support person in the post-abortion recovery room. The researchers administered pre-procedure and post-procedure questionnaires, surveying 51 unaccompanied women and 63 pairs of women accompanied by a support person. The researchers found that though there were no significant differences in pre-procedure anxiety between the two groups, accompanied women experienced significantly lower anxiety post-procedure compared to women who were unaccompanied. Additionally, the perception of accompaniment was strongly positive among patients and support persons, indicating high satisfaction with the presence of a support person during recovery (33).

Recent research has also shown that social capital can facilitate access to health services and improve health and wellbeing (29, 74, 75). To date, sparse research has examined social capital within abortion literature, but has been examined in a variety of other healthcare fields, including pregnancy and obstetrics (69, 76-78). A 2019 study of pregnant Iranian women found that nearly all dimensions of social capital had significant positive associations with the physical and mental health dimensions of quality of life among pregnant women, and that increasing social capital during pregnancy can increase physical and mental health (70). A study of health behavior among pregnant women in Brazil found that higher social capital increased the likelihood of smoking cessation and improved diet during pregnancy, whilst low social capital significantly predicted health-compromising behaviors; researchers also found that pregnant women's social resources and capital were more important for health behaviors than where they lived (71).

These studies demonstrate that social support and social capital are very important for abortion access. To date, however, the limited research on social support and abortion has not extensively described these concepts, nor adequately included the voices of low-income women and women of color (79, 80). Scant research has included social capital and abortion. In order to better facilitate abortion access and improve women's abortion experiences, it is essential to include these voices and explore the gaps in the literature. This qualitative study explores women's abortion-seeking experiences, with the goal of describing the roles of partners, family, and friends in navigating abortion decision-making, identifying how to obtain abortion care, paying for and accessing that care, and dealing with the emotional experiences of unintended pregnancy and abortion.

Materials and Methods

Participant Recruitment

18 semi-structured, in-depth interviews were conducted with women who obtained an abortion at an urban abortion clinic in Georgia. The clinic provides abortions up to 21 weeks and 6 days gestational age, offers medication and surgical abortion procedures. The clinic sees an approximate volume of 400 patients per month. The study site was selected due to patient volume, the availability of several procedures, and the provision of financial assistance. Patients were eligible to participate in the study if they obtained an abortion, were 18 years or older, spoke English, and had a working telephone number and email address. This study was approved by the IRB at Emory University as an amendment to a larger quantitative parent study (AM5_IRB00108685).

Participants were recruited in-person at the clinic on the day of their procedure. Patients were approached privately in the nurses' offices prior to the start of their pre-procedure history and physical assessment; by this stage, patients had already paid for their procedure and received counseling. If interested in participating, patients were given a short self-conducted survey to determine eligibility. Eligible patients were verbally consented then provided researchers with their preferred contact information and availability for scheduling. Interview participants were contacted within a week of their enrollment to schedule their in-depth interview, using IRB-approved scripts. If reached for scheduling, interview participants were contacted at four points over the duration of their participation: 1) telephone call to schedule the interview; 2) text-message reminder of the upcoming appointment (only if consented to text reminders); 3) telephone call to conduct the in-depth interview; and 4) email the electronic gift-card incentive, post-interview. If at any point the researcher could not reach a participant via telephone, a

voicemail was left, and the participant was called at a different time. After three unsuccessful contact attempts, the participant was considered loss-to-follow-up and no further attempts were made.

Data Collection

Data were collected between September 2019 and January 2020 using a semi-structured in-depth interview guide. The interview guide included questions on participants' social network, help and assistance between their social network, comparative social capital related to general medical issues and abortion, potential challenges in obtaining an abortion, and consequences of keeping the pregnancy. Some of the questions included, *"Imagine that you are sick and cannot get out of bed, and need someone to care for you for a full day; who would you ask for help?"* *"Does it feel different asking for support getting an abortion, versus another health condition?"* *"How would you have been affected if you couldn't get your abortion?"* Interviewers probed for barriers and facilitators to accessing abortion services, strength of social support networks, abortion-related stigma, and perspectives regarding abortion-seeking experiences. The interview guide was pilot-tested with two participants. Throughout the data collection period iterative changes were made to the interview guide and recruitment process to explore new topics, and increase participant retention.

Interviews were conducted by one interviewer (MD) trained on qualitative research methods, the study protocol, and research ethics. Interviews were administered over the telephone through Google Voice, conducted exclusively in the private office of the interviewer, and digitally audio-recorded. Participants were asked to find a location they felt comfortable in, and verbally confirm they felt safe discussing their abortion experience. Interviews lasted between 18 and 59 minutes. Each participant received a \$20 eGift Card for their participation.

Data Analysis

Interviews were audio-recorded and transcribed using a professional transcription company and de-identified by the interviewer. Interview data were managed and analyzed using MAXQDA 2020 (81), demographic data were managed and analyzed using Epi Info (82). Transcripts were analyzed using the Sort, Sift, Think, Shift protocol (83), which utilizes a combination of approaches from traditional qualitative methods, including grounded theory, narrative analysis, and phenomenology. Vertical analysis was conducted with each transcript, during which the researcher wrote an interview memo, notated topics to monitor, and identified powerful quotes. The topics to monitor, generated across all transcripts, were consolidated to develop the preliminary codebook and used to horizontally code across all interviews. Second-round horizontal coding was conducted to include emerging themes, and codes not previously covered. Analytic memos and diagramming were utilized to develop themes.

Results

Participant Characteristics

We recruited 64 women from one abortion clinic in Atlanta, Georgia. Of the women recruited, we were able to interview 18 participants. The demographics of the interview group and loss-to-follow-up group can be seen in Table 1. The demographics between groups was similar, with the exception of health insurance and federal poverty level. In the loss-to-follow-up group, 78% of women reported having health insurance, and of the 40 women who reported income and household count, 23.9% were above the federal poverty level. Comparatively, of the 18 women we interviewed only half (50%) reported having health insurance, and all of the women who reported income and household count were below the federal poverty level. Of the 18 interviews, the majority of women identified as Black/African American (77.8%), were

Georgia residents (83.3%), were accompanied to their appointment (83.3%), were employed (77.8%), and had already given birth at least once (61.1%). Based on these interviews, we have identified five themes described below.

General Social Support: “I know they’ll take care of me”

When it came to general life situations, participants described many instances of social support within their networks, particularly emotional support. In this regard, most women did not discuss specific instances of when they needed “advice and emotional support,” instead focusing on general situations, mentioning that when they are “going through hard times” their friends and family will provide emotional support by “just kind of be there for them” and “just help each other out.” Multiple participants discussed the elements of trust and lack of judgment involved in being able to confide in individuals within their network.

Women also received support from their social networks in the form of instrumental support. For example, when asked about whom they would go to if they were ill and needed physical help recovering, most women mentioned they knew someone that could care for them and cited prior experience with being sick and needing help. One participant mentioned that her grandmother “has been there at times when I really couldn't get out of the bed, so I'll always call her first.” For most women, they mentioned they would go to their chosen person because “I know they'll take care of me.” Other forms of instrumental support included financial help and assistance with children. Another participant discussed how her parents have “been very supportive of different things [financially],” such as financial assistance when she got in a car wreck. A few participants discussed how friends or the grandparents of their children “help with the kids.”

Limitations on General Social Support: “I don’t like to ask people for things”

Though instances of social support were common, women also talked about difficulties in accessing the level of social support they needed, due in part to feeling the need to be independent, particularly because their community is affected by poverty. Numerous women discussed their reluctance to ask for help or support, regardless of whether they feel they have someone to go to “if I really need them.” As one participant explains it, “I know I could ask them for help, but I mean, I don’t.” Some women did not elaborate on the reasons for their reluctance to reach out for support, simply leaving it as one participant explained, “it’s very hard for me to ask people for things. Just because I don’t like to ask people for things.” If women did elaborate on their reasons for not wanting to ask for help, most mentioned the desire to remain independent. For example, one woman explained “I’m more independent, so then I’ll try to get it myself before I look for anyone to help me.” Some participants explained the reason for their desire to remain independent stemming from three main reasons: because they wanted to avoid being judged - “they kinda throw it in your face”; feeling they owed someone - “they just make it seem like you owe them or something”; and expectations of reciprocity - “You hear about what you asked for or they’re always asking when you’re going to be able to get it back to them...I’d rather struggle than ask somebody for help.”

Community-wide poverty also limited women’s ability to ask for social support. Some women address this factor directly. According to one participant, “oh, nobody would have no money for no medical expenses. I wouldn’t ask nobody.” Another woman explained that “the people that want to help the most are the ones that doesn’t have the money for it.” Other women expressed their reluctance to place additional burdens on their community. One participant described how she is unable to ask her social network for assistance because “the people that I

hold dear to me, they're not much better off than I am now, which is not great. We're all trying to survive and make it." Additional references to community poverty were not directly mentioned, but rather implied. Several women discussed knowing that some people in their network would provide support if they had the means to do so, implying that having the financial capability is not a given. For example, one participant explained that she and her sister "never had issues lending each other money *when we have it*," and if she went to her children's grandparents, "I know *if they could* help, they will."

Abortion-related Social Support: "Whatever I decided to do, [they] would be there"

Most women described receiving some form of social support during their experience seeking and accessing abortion care, which improved not only their access to care, but also their experience. Many women discussed receiving emotional support from their partners or fathers of the pregnancy, friends, and family members in the form of "emotional and mental support" and advice. Some women described receiving support during their decision-making and prior to receiving the abortion, such as one participant whose friends "were helping me in my decision actually to have an abortion," and another participant whose best friend gave her "emotional support with my decision." One participant discussed how her partner talked with her "just to make things better. He was really my big support through it all." Several women also discussed receiving informational support from their social network, including sharing their own experiences with abortion, like a participant who sought advice from her aunt "and that's when she told me she had [an abortion]." One woman knew where to get an abortion because "my [escort] had been there. I had actually took her to that clinic when she needed to go."

Other women discussed how members of their social network supported them after the abortion procedure. One participant described how she needed "hugs, kind words" and the

support she felt from her mother. Some women received comfort and support because “everybody called after just to make sure I was okay.” A significant factor in the emotional support women received during the process of abortion was the knowledge that members of their social group “had their back” and that they were supported in their decision. Numerous women discussed feeling relief at hearing from friends or family that “whatever I decided to do, [they] would be there.”

Several women also discussed giving and receiving emotional support from their fellow patients in the clinic waiting room, feeling a sense of solidarity and “camaraderie.” One participant described how “you kind of quietly become bonded to the women you sit amongst. We all know why we're there, we all know what's going on and we're just like this quiet camaraderie amongst the women in the office waiting their turn.” Another participant, who had two prior abortions, described how she talks to other patients to “just try to make the newer girls or the younger girls feel a little comfortable about the situation.” A participant with no prior abortion experience mentioned she was comforted in the waiting room because “some of the patients they'll talk to you if you're nervous or if you look nervous. That they've already been through that.”

Most women also received instrumental support from their social network, by way of being escorted to the clinic, having financial assistance, and help with childcare and domestic work. The majority of the women interviewed had someone accompany them to their appointment, partially because “[they] was going to be put to sleep, so [they] needed somebody to drive [them] home.” Other women explained that their escorts “wanted to be there for [them].” Women reported being accompanied by the father of the pregnancy, friends, or family members. Other women also discussed how their social network took care of their children. One

participant, a single mother, mentioned that she was able to come to the clinic because “my sister and my nieces were home, so they were able to take my children.” Another participant in a long-term relationship had a friend who not only watched the kids, but also “did a lot of [household] work for me” while her boyfriend accompanied her to the clinic.

Women also received financial help from either the father of the pregnancy or their family members to access abortion services, though none mentioned receiving financial assistance from friends. Financial help came in varying degrees: a few participants had a member of their network who “paid for the whole procedure;” many women had some portion of their procedure paid for by the father of the pregnancy – or a family member – “and then I paid the rest.” One woman from out-of-state described how her boyfriend, in addition to driving her and helping pay for the procedure, also “paid for a hotel just so we could stay the night” when she told him she wanted to lie down after the procedure.

Limitations on Abortion Social Support: “[It’s] more taboo than any other health condition”

But, again, support during abortion was affected by community poverty, as well as stigma and partnership characteristics. While numerous women discussed their reluctance to ask for general social support from their network due to community poverty, several mentioned how community poverty reduced social support specifically related to their abortion access. One participant discussed her difficulty in accessing abortion services, stating “not having transportation is really a problem when you have abortions. And nobody can take you, cause a lot of people who you would probably be around, work, and you can’t expect them to take off because of you.” Another participant explained how she had to take an Uber to the clinic alone because both her and her best friend’s cars did not work, so “she wanted to be there for me, but she physically just couldn’t.” One woman described struggling to pay for the procedure but was

unable to receive financial support from her social network – despite them supporting her decision – because “they don’t have that financial stability.”

The majority of women described abortion stigma – and their social network not being “supportive of [my decision]” – as a barrier to social support and access to abortion services. Some women had reduced social support because they were unable to tell individuals in their network, or their entire network, about their abortion due to concerns of stigmatization. As one participant explained, “everybody don’t believe in abortion, so you can’t go to everybody and just ask, ‘can you help me with this?’” One woman described abortion as being “more taboo than any other health condition.” Another participant felt that “of course you’ll be judged [for getting an abortion].” One woman discussed how she had a “good support system” in general, but she “couldn’t even trust them” due their beliefs about abortion, and lamented “I wanted to tell my mom... I wish I could have told my best friends... I wanted that comfort.”

Some women faced stigmatization when they disclosed their intentions to terminate their pregnancy. Though she did get help paying for the abortion, one participant still experienced stigma because her “[older brother] wasn’t willing to help, so [younger brother] stepped in and helped. [Older brother] didn’t agree with my decision, so he didn’t feel comfortable helping.” Another participant described receiving opposition from her sisters “when I told them what I was gonna do, two of them, they didn’t want me to go forward.” Other women withheld information from their social network until after receiving the procedure. For example, one participant “didn’t tell [her] aunt and [her] mom until after the abortion was over” because they viewed it as “taking a life;” when she went to them for emotional support afterwards, “they were sad... [mom] was mad.”

Characteristics of partnership with the father of the pregnancy also influenced women's social support surrounding abortion. Many women described the stability or length of their relationship as a factor in their decision to terminate. One participant explained that "we were not dating long enough to just decide to have a child, let alone, I felt like, old or experienced enough to have a child." Another participant, a single mom, described how she had just "separated from my kids' father, so I really just was like 'okay, I just really don't think this is the right time to be pregnant.'" One woman explained that "[the father of the pregnancy] wanted nothing to do with it.... So I also knew if I was gonna have a child, he wasn't gonna do anything to be there."

Additionally, several women described the stability and longevity of their relationships as reasons why they could not tell the father of the pregnancy about their decision to terminate their pregnancy. For example, one woman explained that "I hate that I feel like I can't tell him and it really sucks" but "I barely know him...I don't know if he's gonna stick around or what type of parent he'd be." Another woman described the father of her pregnancy as a "deadbeat," saying "do I really want to deal with person for 18 years that I can't hardly deal with for 18 minutes? No, hell no... he doesn't try to reach out to me... so as far as he knows, I could still be pregnant." One participant described an unstable relationship with her boyfriend, and knowing that they couldn't have a baby together, but also being unable to tell him about the abortion because "he was going to talk me out of it or that probably would have ended the relationship and all... I wish I could have been able to have support from him."

Double Bind: “I might have to keep it ‘cause I can’t afford [an abortion]. But it was also like...you can’t afford to keep it”

Many women talked about how they were placed in a double bind in which they did not have the support to get an abortion, but they also didn’t have enough support to be able to keep a baby, either. One participant, a single mother of two, described how her second child was born because “I didn’t have any money to get an abortion, I didn’t even have money to go to the [OB/GYN],” and how that experience shaped her decision to terminate her recent pregnancy, despite struggling to pay for it: “I had a moment where I was like, I dunno, I might have to keep it cause I can’t afford [an abortion]. But it was also like ‘you know you can’t afford to keep it... how am I gonna pay for [a baby]?’” Another participant, also a single mother of two, explained that “there really not an alternative” to getting an abortion, because “nobody is going to watch your baby every freaking day... there would have been no support... If we’re not working we’re not eating. So there was never a chance where I could really think about keeping this baby because there is no person other than me making the money.” One woman discussed how “it takes two to have a child,” and that she would have had no support from the father of the pregnancy because he’s had nothing to do with the pregnancy, despite him insisting “‘I’ll help you. I’ll help you. I’ll help you,’ and [she] just knew at the end he wasn’t gonna do anything about it.”

Several women expressed feeling that “if things are just a little bit different I probably would have kept the pregnancy.” For example, a single mom who came to the clinic alone, and had a limited local social network after moving to Georgia, explained “if I was back home in [home state], then I most likely wouldn’t have did it, either, ‘cause I would have support for family.” In addition to lacking social support, she was also struggling financially, explaining “if I

was making a little bit more money, then most likely, I wouldn't have went through with it, but I almost had got cut from work, so I knew I wouldn't be able to continue working and have a second child working 30 hours a week.”

Many women also discussed how their lives would have been negatively affected if they had not been able to get their procedure, and how community poverty would be perpetuated. One participant explained that if she or others could not access abortion services, “it just creates more and more people on government assistance. Therefore, it just creates another trickle down of just a mess that the country has to fix, because now people will need government assistance. And that's more and more people living at the bottom. And it's just all because you want to force people to have children that they can't afford.” Other women echoed this statement, such as one woman who said “it just would have upset our lives a whole lot, because I'm not working. I am currently barely taking care of the two that I have, honestly.” Another woman stated she “would be stuck with a child I couldn't afford. Struggling to try — you know — make things happen though.” One participant explained that for her, the decision to get an abortion “was actually a decision between, you know, me living fairly decent or having a child and being homeless and, you know? So that would have – I don't know, that would have caused a lot of turmoil in my life.” She followed this statement by saying if she couldn't get the abortion legally, “[she's] sure [she] could have found another way, like via the black market.”

Discussion

As has been noted by Angela Davis (79), Kimala Price (80), and other reproductive justice advocates, abortion literature and abortion narratives to-date lack the voices of low-income Black abortion patients: our research uplifts these voices, and highlights the complex interplay between social support and social capital, poverty, and abortion stigma. The underlying message

throughout the stories shared in this study is that women are placed in a double bind wherein women lack the social support needed for both abortion care and for childrearing. Women discussed being impacted by numerous barriers previously described in abortion literature, such as cost (14), transportation (15), distance to and availability of clinics (1, 16), and stigma (8). Due to the barriers and burdens associated with abortion, women need social support and social capital to overcome these barriers and access abortion services, but often do not have the level of support necessary to do so. Simultaneously, one of the reasons women need access to abortion services in the first place is because they do not have sufficient social support or resources that would enable them to have a child. As is explained by Angela Davis (79), “when Black and Latina women resort to abortions in such large numbers, the stories they tell are not so much about the desire to be free of their pregnancy, but rather about the miserable social conditions which dissuade them from bringing new lives into the world.” The women who participated in this study described situations of significant poverty and were already struggling to get by; being unable to access abortion services would significantly and negatively impact their already impoverished lives. These findings are consistent with that of Foster et al. (57), which found that compared to women who received abortions, women who carried an unwanted pregnancy to term were more likely to be living in poverty and requiring public assistance.

Restricted access to legal and safe abortion services would perpetuate cycles of poverty, and deepen socioeconomic and racial/ethnic disparities. These findings situate within the context of racialized poverty and health disparities, as documented by House and Williams (37) among others. They discuss how systematic discrimination can affect the quantity and quality of medical services available and received. Disadvantaged groups often do not have access to the same type and quality of health care – abortion, in this instance – and this further perpetuates

socioeconomic inequity (37). If women are unable to access wanted abortion services and are forced to have children they cannot afford, it stretches their limited resources even further, thus magnifying hardships. Additionally, our findings revealed that if given no alternative, some women would attempt self-induced abortions or seek care from non-licensed providers, which has the potential to be more dangerous to women's health. Our research demonstrates that women absolutely need access to legal and safe abortion services, and that access to abortion services is an important component of reproductive autonomy that can mitigate intergenerational poverty. At the same time, another component of reproductive autonomy is the need to alleviate poverty, so women are not forced to make abortion decisions solely on the basis of economic ability.

Our results also demonstrated that although social support and social capital are critical and can be instrumental in obtaining abortion services, it is impractical for health systems and abortion clinics to expect women to rely on their social network to access abortions. Our research found numerous instances of social support and social capital being utilized to facilitate abortion access, but there were many examples of social support and social capital not being available or accessible. This is particularly true with respect to community poverty and abortion stigma, which constituted significant barriers to support from social networks. Expectations that women can rely on – or even access – social support to obtain abortions are inappropriate, and does not reflect the lived experiences of the women we interviewed. More needs to be done to help women access the care they need. A novel example of an abortion social support intervention is Access Reproductive Care (ARC) Southeast (84), an organization based in Atlanta, Georgia that provides women not only with counseling and financial assistance for obtaining abortions, but also logistical support such as volunteers providing transportation to clinics, childcare, and other

services. Another way to facilitate women getting social support and capital for abortion services would be to reduce stigma within communities. Research by Cockrill and Biggs (85) and Chor et al. (31) has shown that sharing abortion stories and normalizing abortion behavior and experiences is an effective method to reduce abortion stigma, and increase women's ability to communicate with and receive help from their social networks in accessing abortion services. In the absence of social support from within women's own networks, some studies such as Chor et al. (86) suggest that having abortion doulas at clinics can greatly improve women's access to emotional support during their procedure. Additionally, abortion clinics could foster post-abortion social support by leveraging the in-clinic camaraderie and bonding discussed by our participants to create a form of aftercare support services. One example of aftercare support is Exhale Pro-Voice (87), an abortion talkline and textline designed to address post-abortion emotional health and wellbeing.

Lastly, our findings demonstrate a need to strengthen social networks and improve social support for women, both for abortion care and in general. We found many examples of women receiving help from their social network with general life events, such as emotional support, being taken care of when they were sick, or receiving financial help and transportation after a car accident. However, there were also a number of impedances to general social support that resulted from community poverty and structural inequality. As explained by Domínguez and Watkins (34), structural socioeconomic conditions lessen the ability of impoverished individuals to help each other. During our interviews, numerous women mentioned they would not have needed their abortions if they had more support within their networks to raise children. We as public health professionals need to think about policies and practices that improve and foster social support and social cohesion by addressing the root issues such as socioeconomic and racial

inequality. In doing so, it is possible to reduce the likelihood that women would need to have abortions, whilst at the same time improving their ability to access abortions if they choose to do so. One public health strategy to foster social support, cohesion, and capital would be to advocate for increased wages and improve access to living wage jobs, thus increasing the ability of individuals to not only support themselves but also assist those in their social network. As is explained by Reich et al. (88), economic and social policy is health policy - in order to address the fundamental causes of poor health and disparities, there must be fundamental interventions to support basic needs, including jobs, education, and housing.

Limitations and Strengths

There are several limitations to this study. First, we only interviewed women who are able to access abortion services and had the ability to conduct a telephone interview. These interviews may not represent the experiences of women who were unable to access abortion services, or did not have the time or ability to have a phone conversation. Furthermore, our budget only permitted a \$20 per-person incentive, so individuals who experienced the greatest barriers and stigmas may not have been sufficiently incentivized to participate in an interview. Despite these limitations, however, the demographics of the sample we interviewed does reflect the typical profile of abortion patients in the Southeast – majority Black/African-American, low-income, and mothers – with diversity among variables such as age, education level, and escort status. It is also worth noting that as a White, middle-income, highly educated woman who does not have children, the researcher does not share the same social experiences as the women she interviewed. Throughout the study, the researcher practiced reflexivity and considered how her experiences, assumptions, and biases might influence the data collected and how she interpreted them. At the same time, it is possible that the participants felt particularly open or inclined to

speak about their experiences with the researcher, because she is not a member of their social network and is a professional who works closely with family planning providers. Additionally, the length and richness of interviews was limited by being conducted over the phone, which inhibited the interviewers' ability to read emotional responses and prevented the interpretation of facial expressions or body language – thus, probing was limited if questions or responses were perceived as emotionally fraught, in the interest of continuing the conversation. There are strengths to conducting phone interviews, however. First, more participants were accessible for interviews than would be in-person, because participants could meet the researchers on their own terms when they were available, and in the comfort of their own personal spaces. Numerous women talked about how busy they were and how difficult their schedules were – giving them the option of a phone conversation increased access and availability. Second, as has been noted within research among stigmatized populations (89-91), it is possible that participants felt more comfortable discussing their experiences over the phone than they would in-person due to perceived anonymity, increased privacy, and perceived mediation of some power dynamics within the researcher-participant relationship.

Conclusion

This study provides insights into the lived experiences of women who obtained abortions in Georgia, demonstrates the complex and multifaceted burdens and decision-making involved in women's abortion-seeking experiences, and illustrates the critical need to maintain abortion access. Our results provide evidence that social support and social capital can play an instrumental role in accessing abortion services, but that there are also barriers to accessing that support from within social networks, particularly in low-income communities and impoverished communities of color. Future research is needed to better understand these barriers to social

support within the abortion context, in order to craft effective policies and interventions that facilitate social network support. Strengthening social networks and increasing social support among low-income communities would benefit the reproductive health and autonomy of women within these communities.

Chapter IV: Conclusion and Recommendations

The findings of this study contextualize women's experiences seeking abortions in Georgia, provide evidence on the numerous and multifaceted burdens experienced by women who seek abortions, demonstrate the utility of social support and social capital in overcoming barriers to care, and illustrate the possible public health implications of restricting abortion access in the United States. The results presented and discussed in the present study can be summarized in 4 key messages: (1) women experience considerable barriers to accessing abortion services, with low-income women most significantly impacted; (2) though social support and social capital can be utilized to overcome these barriers, such support is not always accessible and cannot be relied on for assistance; (3) women are caught in a double bind, wherein they lack the social support and social capital needed both for abortion care and childrearing; and (4) restricting legal and safe abortion access would likely perpetuate cycles of poverty, and deepen socioeconomic and racial/ethnic disparities. These results point to several potential recommendations for equalizing economic structures, as well as increasing social support and additional support for abortion patients. Our findings also build on existing evidence and point to future opportunities for research within the context of abortion, social support, and social capital.

Recommendations for Future Actions

Above all else, this research demonstrates that it is critical for the health and wellbeing of women in Georgia and the United States to maintain safe and legal abortion access. The women in this study discussed how their lives – and the health and wellbeing of themselves, their children, and loved ones – would be significantly negatively impacted if they could not obtain

their abortions. In light of these findings, more must be done to support women in accessing abortion procedures, and that multilevel interventions are needed to do so.

Economic and Structural

First, financial and structural barriers to abortion need to be addressed. Repealing the Hyde Amendment would be one of the most important and effective changes that could be made on a policy level to increase abortion access. Most abortion patients in the United States are classified as low-income, and the most common provider of health insurance for low-income women is Medicaid (66). However, since the implementation of the Hyde Amendment in 1977, Medicaid has been forbidden from using federal funds for abortions except in cases of rape, incest, or life endangerment, thus creating a serious impediment to women's ability to pay for and access abortion services (6). Repealing the Hyde Amendment and allowing women to utilize their Medicaid insurance to help pay for abortion procedures would be instrumental in increasing abortion access. Prior evidence demonstrates that enabling women to use Medicaid to pay for abortion procedures would reduce structural inequalities, improve equitable access to abortion services, and have public health and socioeconomic benefits for individuals and communities. For one, research has shown that after states banned the use of Medicaid in paying for abortions, the number of live births in those states increased to higher than the national average at that time, with the highest increase among Black women (92, 93). Further evidence is seen when comparing states that do and do not permit the use of state Medicaid funds for abortion procedures beyond what is allowed by the Hyde Amendment. A 1994 study found that states which permitted state Medicaid funding for abortions had higher rates of abortions and lower rates of teen pregnancy, premature births, and births with late or no prenatal care (94). More recent studies have shown that state Medicaid coverage of abortion is associated with reduced

risk of severe maternal morbidity (95), and influenced the timing and accessibility of abortion services, particularly among Black and Hispanic patients (96).

Another method to reduce economic and structural barriers to abortion would be to build and sustain community-based organizations such as ARC Southeast (84), a reproductive justice organization that provides informational, emotional, and instrumental support to abortion patients. ARC Southeast has a call line that provides information about abortions, provides counseling and emotional support throughout the decision-making process, offers funding for abortion services and lodging, and has a network of volunteers who provide transportation to abortion clinics, escort patients to their appointments, and provide childcare services (84).

Other ways to improve the financial and structural barriers to abortion would be to address the structural socioeconomic conditions that force women to make abortion decisions on the basis of economic ability (23, 79). As was mentioned in the results and discussion portion of this study, the majority of women interviewed described poverty and financial strain as being primary reasons for seeking abortion, and feeling that they had no choice but to get an abortion because they could not afford to keep the pregnancy. As Reich et al. (88) explain, economic and social policy are health policies, and in order to address the fundamental causes of health and economic disparities there must be fundamental interventions to support basic needs, including jobs, education, and housing. Economic and social policies to improve access to employment and housing, and increase wages to living wages are a way to address these inequities. Additionally, economic policies such as Universal Basic Income – “an unconditional income granted to each citizen, irrespective of work criteria or a means test” (97) – are theorized to improve individual and population health and wellbeing (97, 98). It is likely that improving low-income women’s

socioeconomic status would reduce the need for abortions, whilst at the same time improving their access to abortion if they freely choose to do so.

Social Support and Social Capital

Another way to enhance support for women seeking abortions is to foster social support, social capital, and social cohesion within communities and social networks. One strategy to achieve this is, again, to address socioeconomic and racial/ethnic inequalities. As is explained by Domínguez and Watkins (34), structural socioeconomic conditions lessen the ability of impoverished individuals and groups to help each other. Those findings were exemplified in this present study, during which women explained that their access to general social support was limited by community-wide poverty and structural inequality. Several women also mentioned they would not have needed their abortions if there had been more support within their network to raise children. Addressing socioeconomic and racial/ethnic inequalities within and between communities could provide women with access to greater social support and capital if they needed to have an abortion, and greater social support and capital that would enable them to raise a child.

Another way to increase social support for women seeking abortion services is to reduce community stigma surrounding abortion. As was demonstrated in this study, abortion stigma was a significant barrier to social support for women during their abortion experience. Many participants felt they could not seek advice, emotional, or financial support from individuals who disapproved of abortion. Because of the invisible nature of abortion and the perception of abortion as “deviant,” one strategy to reduce stigmatizing perceptions of abortion would be to increase community awareness of the prevalence of abortion and motivations for having one, thus humanizing the experience. Research by Cockrill and Biggs (85) and Chor et al. (31) has

shown that sharing stories of women's experiences with abortion and normalizing abortion is an effective method to reduce stigma, as it increases women's ability to communicate with and receive help from their social networks in accessing abortion services. As such, it would be beneficial to fund, support, and circulate grassroots abortion storytelling projects such as *My Abortion. My Life* (99) and *Abortion Out Loud* (100). Organizations such as these not only provide a safe space for women to share their abortion experiences, but also help shift the conversation on abortion within communities by hosting storytelling events, film screenings, podcasts, and other media platforms, in addition to connecting storytellers with policymakers (99, 100).

External Support

It is also important to improve external support on a clinical and organizational level, in order to better assist women who lack support from their social networks, or as a supplement to existing support. One way to facilitate external support would be to increase the presence of abortion doulas during the abortion experience. Doulas are non-clinical health workers trained to physically and emotionally support women during pregnancy and childbirth, and some doulas (including "full spectrum" doulas) work in other reproductive contexts such as abortion (101). Qualitative and quantitative research by Chor et al. (86, 101-103) and Wilson et al. (104) has demonstrated that the presence of doulas pre-procedure, during the abortion procedure, and during the recovery period significantly improved women's experiences with abortion, because it provides women with "a human connection" and emotional and psychosocial support through the abortion process (86, 101-104). Integrating more doulas into abortion clinics would be highly beneficial for the wellbeing of their patients. It has been suggested by Chor et al. (103) that the patient-centered care provided by doulas would improve clinic efficiency, because they enable

clinical staff to focus on more technical roles. Additionally, Wilson et al. (104) suggests that integrating abortion doulas into the aftercare process, such as having post-abortion discussions and counseling, would provide additional emotional support and aid in women's recovery.

Other forms of abortion aftercare are also an important way to support women during their abortion experiences. Phone-in support organizations such as *Exhale Pro-Voice* (87) and *All-Options* (105) provide compassionate and nonjudgmental spaces for women to discuss their experiences with unplanned pregnancy or abortion, and receive counseling and emotional support during the decision-making process and recovery period. *All-Options* also has a specific program to address religious and spiritual concerns, called *Faith Aloud*, with trained clergy and religious counselors from numerous faiths available to discuss pregnancy options and provide abortion aftercare within religious and spiritual contexts (105). By providing additional funding to aftercare organizations such as these, as well increasing advertising to raise awareness about their presence and benefits, we would be able to increase external social support for women during their abortion experience and decrease their experiences of stigma. Another method of abortion aftercare would be for clinics or organizations to leverage the between-patient "camaraderie" and bonding described by participants in this study and create post-abortion care and support groups. One example could be to develop a support group similar to Lisa Harris' "Abortion Provider Share Workshop," only tailored specifically to abortion patients (9).

Further Research

This study strengthens the foundation for future research on social support and social capital within the abortion context. In particular, further research needs to be conducted with women who wanted abortions but were unable to access them. In this study, we were limited by only being able to interview women who came to the clinic and obtained an abortion procedure:

despite experiencing barriers, these women were able to overcome them. It is reasonable to assume there are women who were unable to overcome barriers to abortion access, and though we can extrapolate some of their obstacles and experiences, we do not know them. Furthermore, the results of our study reflect the experiences of cis-gendered women; women are not the only people who access abortion care (106), and it is highly probable that trans and non-binary individuals experience significant and unique barriers to abortions that were not captured in this study. Further research needs to be done in order to understand the experiences of pregnant people who could not obtain wanted abortion services, and learn how best to facilitate them and others in the future.

Finally, this study was part of a larger project that included a quantitative survey of social capital and abortion; qualitative research such as this study provide essential context for quantitative findings, can demonstrate some of the mechanisms at play within quantitative data, and impart greater value to quantitative findings. Moving forward, quantitative researchers could use this qualitative study – and others – to adapt metrics of social support and social capital within the abortion context. These metrics could then be used to screen pregnant people seeking abortion services and identify those who might need additional external support during their experience. Together, qualitative and quantitative studies can help to illuminate the relationships between poverty, social support, stigma, and access to abortion care, and identify potential avenues for health-promoting interventions and improvements.

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Table 1: Interview and Loss-to-Follow-Up Demographics

Variable	Interview Group (n = 18)		Loss-to-Follow-Up Group (n = 46)	
	Count or Mean	% or Variance	Count or Mean	% or Variance
Age (yrs)	28.78	37.01	27.98	33.89
Distance Traveled 1-Way (mi)	67.47*	5505.01*	80.96	19063.42
Escort Status				
Yes	15	83.33%	41	89.13%
No	3	16.67%	5	10.87%
Residency				
In-state	15	83.33%	39	84.78%
Out-of-state	3	16.67%	7	15.22%
Race/Ethnicity				
Black/African American	14	77.78%	4	8.70%
White	2	11.11%	36	78.26%
Hispanic/Latina	0	0%	1	2.17%
Asian	0	0%	0	0%
Asian Indian	0	0%	1	2.17%
Middle Eastern	0	0%	1	2.17%
Multi-Racial	2	11.11%	4	8.70%
Other	0	0%	0	0%
Don't know	0	0%	0	0%
Don't want to answer	0	0%	0	0%
Abortion Method				
MAB	3	16.67%	7	15.22%
1-day surgical	15	83.33%	39	84.78%
2-day surgical	0	0%	0	0%
Education				
8th grade or less	0	0%	0	0%
9th-12th, no degree	0	0%	1	2.17%
High School/GED	5	27.78%	11	23.91%
Technical School	1	5.56%	4	8.70%
Some college, no degree	6	33.33%	14	30.43%
Associate's degree	3	16.67%	3	6.52%
Bachelor's Degree	2	11.11%	10	21.74%
Postgraduate or Professional degree	1	5.56%	3	6.52%
Don't know	0	0%	0	0%
Don't want to answer	0	0%	0	0%
Relationship status				
Not in a relationship	6	33.33%	14	30.43%
In a relationship but not living together	6	33.33%	11	23.91%
In a relationship and living together	4	22.22%	14	30.43%
Married	2	11.11%	5	10.87%
Separated/Divorced	0	0%	2	4.35%
Widowed	0	0%	0	0%
Other	0	0%	0	0%
Don't want to answer	0	0%	0	0%
Prior birth(s)				
Yes	11	61.11%	0	0%
No	7	38.89%	0	0%
Unknown	0	0.00%	46	100%
Prior abortion(s)				
Yes	6	33.33%	0	0%
No	3	16.67%	0	0%
Unknown	9	50.00%	46	100%

*n = 17

Variable	Interview Group (n = 18)		Loss-to-Follow-Up Group (n = 46)	
	Count or Mean	% or Variance	Count or Mean	% or Variance
Income Sources				
My job(s)	14	77.78%	40	86.96%
Social Security	0	0%	0	0%
Child Support	0	0%	5	10.87%
Disability	0	0%	1	2.17%
Family	2	11.11%	4	8.70%
Stipend/ allowance	0	0%	0	0%
Other	1	5.56%	1	2.17%
Don't want to answer	1	5.56%	1	2.17%
Household Count				
1 (just me)	1	5.56%	6	13.04%
2	4	22.22%	9	19.57%
3	4	22.22%	16	34.78%
4	7	38.89%	8	17.39%
5	0	0%	5	10.87%
6 or more	2	11.11%	2	4.35%
Don't know	0	0%	0	0%
Don't want to answer	0	0%	0	0%
Monthly Household Income (before tax)				
\$0-\$999	3	16.67%	6	13.04%
\$1000-\$1999	3	16.67%	15	32.61%
\$2000-\$2999	7	38.89%	6	13.04%
\$3000-\$3999	0	0%	4	8.70%
\$4000-\$4999	0	0%	3	6.52%
\$5000 or more	1	5.56%	6	13.04%
Don't know	3	16.67%	4	8.70%
Don't want to answer	2	11.11%	2	4.35%
Federal Poverty Level				
Above 220%	0	0.00%	11	23.91%
101-220%	9	50.00%	17	36.96%
Below 100%	4	22.22%	12	26.09%
Unknown	5	27.78%	6	13.04%
Health Insurance				
Yes	9	50%	36	78.26%
No	9	50%	9	19.56%
Don't want to answer	0	0%	1	2.17%
Expenses Delayed by Abortion Cost				
Rent	3	16.67%	10	21.74%
Utility Bills	4	22.22%	13	28.26%
Food	1	5.56%	5	10.87%
Childcare	1	5.56%	1	2.17%
Other medical expenses	1	5.56%	0	0.00%
Other bills	3	16.67%	8	17.39%
Other expenses	5	27.78%	7	15.22%
None of the above	7	38.89%	16	34.78%
Don't know	0	0%	3	6.52%
Don't want to answer	0	0%	1	2.17%

Appendix A: In-Depth Interview Guide

Introduction

Hello, and thank you for speaking with me today. My name is [interviewer name], I am a student researcher at the Rollins School of Public Health at Emory University. I am conducting a research project looking at women's experiences obtaining abortions in Atlanta, Georgia. During this interview, I will ask you to share a bit about yourself, your personal relationships, and your experience getting an abortion in Atlanta. Before we get any further, are you in a location where you feel safe and comfortable discussing your abortion experience?

[IF NO: *is there somewhere private you can go at the moment?*]

[IF NO: reschedule interview]

We will be discussing things that may be sensitive, so I would like to remind you that your participation in this interview is completely voluntary; please do not hesitate to let me know if you don't feel comfortable answering a question, or do not want to continue our conversation. If you do want to end the interview early, please let me know so that I can make sure I get you your \$20 Walmart eGift Card. Now, if you don't mind I would like to record our discussion so that I don't miss or forget anything we talked about. Our discussion will remain completely confidential, and all research documents relating to our conversation will not include your name or any personal information. **Do I have your permission to record our conversation?**

Wonderful, thank you very much. Before we begin, do you have any questions?

Warm-Up Questions → START RECORDING NOW

"Before I get any further, I'd like to get to know you a little bit."

1. First, what would you like me to call you?

2. Thank you, [name]; Now, would you please tell me a bit about yourself? (*probe: Where are you from? Are you from there originally? Are you currently working? Are you in a relationship? Do you have children? What do you like to do for fun?*)
 - a. Required probe: are you currently employed?
 - IF YES: what do you do?

 - b. Required probe: are you in a relationship?
 - IF YES: what is your relationship? (*married, long-term relationship, etc.*) (*living together?*)

 - c. Required probe: do you have children?
 - IF YES: how many?

 - d. Required probe: Do you live with anyone?

Social Network

“Thank you for telling me about yourself, it’s nice to get to know you. I am now going to ask you some questions about your personal relationships and social network”

3. How would you describe your social network? (*probes: number of friends, family members, acquaintances; how many people are you close with? How often do you have contact with them?*) (*probe: who do you talk to regularly?*) (*IF THEY WORK: what is your professional network, are you close with your coworkers?*)

4. Who are you closest to?
 - a. For each answer, probe: why are you closest to them?

Social Capital

“Thank you for telling me about your social network. These next questions are about help and assistance between you and your social network”

5. In the past month, have you given unpaid help or support to anyone? (*probes: for example, some participants reported providing domestic work or home maintenance, helping with childcare or babysitting, providing emotional support or advice, running errands or helping with transportation, cooking or providing food to others*)
 - a. IF YES: what did you provide?
 - b. Probe for each response: who did you do that for?
 - c. Probe for each response: why did you provide that support?

6. In the past month, has anyone provided you with unpaid help? (*probes: for example, some participants have reported people helping them with work around the house, running errands or taking them places, helping them with childcare, making or giving them meals, providing emotional support*)
 - a. IF YES: what did they provide?
 - b. Probe for each response: who did that for you?

“Thank you. These next questions are about times when you might need help with health problems, and who you would ask for assistance.”

7. Imagine that you are sick and cannot get out of bed, and need someone to care for you for a full day. Who would you ask for help? (*probe: family member? Partner? Friend? Neighbor? Roommate?*) (*Follow-up probe: is there anyone else you might have asked?*)
 - a. Required probe for each person mentioned: what is your relationship to them?
 - b. Required probe for each person mentioned: why would you ask them for help?

8. How easy or difficult would it be for you to ask them for help? (*probes: why is it easy/difficult? would they expect something in return?*) (*Probe: how would you feel if you had to ask them for help?*)

9. If you were injured and needed to borrow a few hundred dollars for unexpected medical expenses, who would you be willing to ask to borrow some money? (*probes: IF DIFFERENT THAN PREVIOUS ANSWERS: what is your relationship? What makes them different from [previous name]?*)

10. How easy or difficult would it be for you to ask them to lend you money? (*probe: why? What is the difference between them?*)

Abortion-seeking Experience

“Thank you for the information you have provided thus far. We are going to move on now to discussing your experience seeking and obtaining an abortion in Georgia.”

11. How did you feel when you found out you were pregnant? (*probes: what went through your mind? What emotions did you feel? What thoughts or concerns did you have?*)
 - a. Required probe: did you tell anyone about the pregnancy?
 - IF YES: who? (*Probe: what is your relationship?*)

12. What was the decision to get an abortion like for you? (*probe if reluctant or unsure: for example, some participants have reported having financial concerns, not feeling prepared to have a child/another child, not having social support*) (*some participants have reported that the decision was difficult or easy for them*)
 - b. Required probe: Did you discuss pregnancy options with anyone?
 - IF YES: who? (*Probe: what is your relationship?*)

13. Before you came to the clinic, did you try to end your pregnancy on your own, or cause a miscarriage? (*probe: for example, some participants have reported eating or drinking things like vitamin C or castor oil to try and end their pregnancy*)
 - a. Required probe **IF YES**: what did you try to end your pregnancy?
 - b. Probe for each method: where did you hear about this method? (*probe: how did you know to do that? Did someone tell you about it?*)
 - c. Did you receive support from anyone when you tried to cause a miscarriage? (*Probe: can you tell me more about that experience?*)

14. Did you have any challenges when making your appointment? (*probe: for example, some participants have mentioned things such as not knowing where to go for an abortion, deciding whether to have an abortion, conflict with partners, family, or friends*) (*how did you know how to make an appointment/find funding/find transportation?*)
- Required probe for each challenge: what made this a challenge for you?
 - Required probe for each challenge: how did you overcome this challenge?
15. Did you have any challenges getting to the clinic for your appointment? (*probes: for example, some participants have mentioned having to travel to the clinic, distance from the clinic, not getting time off work, finding childcare, finding an escort*) (*how did you get to the appointment?*)
- Required probe for each challenge: what made this a challenge for you?
 - Required probe for each challenge: how did you overcome this challenge?
16. **FOR MAB PATIENTS:** did you have any challenges while having your abortion? (*probe: for example, some participants have mentioned the experience being longer or more painful than they expected, not being able to find a private space, not having support at home*)
- Required probe for each challenge: what made this a challenge for you?
 - Required probe for each challenge: how did you overcome this challenge?

17. Did you have any challenges after getting your abortion? (*probe: some participants mentioned having not being able to get back to work as soon as they'd like, or having bleeding longer than expected, taking longer to recover*)

- a. Required probe for each challenge: what made this a challenge for you?
- b. Required probe for each challenge: how did you overcome this challenge?

18. Did you have trouble paying for your abortion? (*probe: for example, some participants have mentioned they were prevented or delayed from paying rent or other bills, not being able to buy as much food, or having to work extra hours, etc.*) (*did these impacts affect you emotionally?*)

- a. Required probe: How did you pay for your abortion?
- b. Required probe: did you take out a loan, or borrow money from anyone?
 - IF YES: who?
 - Did they ask for anything in return?
- c. Required probe: Did paying for your abortion prevent or delay you from paying other expenses this month?

19. How did those challenges affect you? (*probe: stress, coping mechanisms such as smoking and alcohol, working more hours*)

- a. Required probe: how did those challenges influence the timing of your abortion, if at all? (*if you had not had these challenges, would you have gotten your abortion sooner?*)

Comparative Social Capital

20. Who provided support for you during your experience getting an abortion? (*probes: for example, such as assistance paying for the procedure, help with transportation, covering a shift?*) (*Probe: what did you ask them for?*) (*Probe: did they know you were getting an abortion?*)

- a. Required probe for each person: how did this person support you?

21. Does it feel different asking for support getting an abortion, versus another health condition? (*probe: why is that? What makes it different?*)

Closing

“Thank you for sharing that with me. I have one more question for you, and then we’ll be finished with the interview”

22. How would you have been affected if you couldn’t get your abortion? (*probe: how would not having had an abortion affect your life? Your relationships? Your finances? Your health, mental and emotional?*) (*Probe: how would your life have changed?*) (*what would you have done if you could not have had your abortion?*)

- a. How would you have felt if abortion were illegal in GA?

“We’ve covered a lot of information, thank you so much for sharing your experience with me. Before we finish, is there anything that you would like to add or elaborate on, perhaps something you wanted to say that I did not ask you about?”

“Thank you very much for your time and participation, I really appreciate you being willing to share your insight and perspective with me. **[Stop recording now]**

We’ve got one final step before we’re through, I am going to email you a \$20 Walmart eGift Card as a thank you for your time and effort. What email address would you like me to send it to?”

[confirm email address and send gift card]

“Thank you again for your time, it was lovely talking with you. Goodbye, and take care”