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Victoria deMartelly Date

It was hard because I wanted to get this over and get it done: A qualitative study of socioeconomic status and barriers to abortion access in Alabama

By

Victoria deMartelly
MPH

Department of Environmental Health

____
Roger Rochat, MD
Committee Chair

____
Dana Boyd Barr, PhD
Committee Member

____
Paige Tolbert, PhD
Committee Member

____
Kari White, PhD
Committee Member

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By

Victoria deMartelly

BA
University of Illinois at Chicago
2009

Thesis Committee Chair:
Roger Rochat, MD
Kari White, PhD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Environmental Health
2015

Abstract

It was hard because I wanted to get this over and get it done: A qualitative study of socioeconomic status and barriers to abortion access in Alabama

By Victoria deMartelly

Purpose: Alabama has seen a dramatic reduction in the number of abortion clinics available to women in the state, totaling six clinics in 2011 to only three in operation at the time of the study in July 2014. The closing of clinics means that many women must travel further distances in order to receive an elective abortion. Low income and minority women are particularly vulnerable to the barriers presented by the increased distance, as many barriers are related to cost. The purpose of this thesis is to explore the relationship between abortion access in Alabama and socioeconomic status for women driving long distances to arrive at an abortion clinic, focusing on the decision-making process, physically accessing a clinic and covering the procedure-related costs.
Methods: I recruited women traveling a distance greater than 30 miles from two of the highest volume clinics in operation in Alabama between June and August 2014. Eligible women had to be at least 19 and speak fluent English. I conducted in-depth interviews with 25 women. These interviews were digitally recorded and transcribed. These transcripts were then coded for themes. I summarized the interviews under themes about women's experiences seeking care and selected representative quotations for these themes.
Results: Women in the study traveled an average distance of 83 miles. Women living further from clinics more frequently received abortions later in gestation than did the women traveling less than 50 miles among those interviewed. Many arrangements had to be made in order for the women interviewed to be able to reach the clinic for each of their appointments, including rides, child care for the 68% of women who had children, time off work, and to have the procedure.
Conclusions: Women face many barriers when attempting to access abortion, a majority of which are exacerbated by cost. For those who struggle to meet the cost of the procedure itself, the added cost related to further travel distances made necessary by the closing of clinics could prove too burdensome. In order to aid these communities, Alabama needs to repeal its targeted regulation of clinics.

Keywords: abortion; abortion access; socioeconomic status; reproductive justice; environmental justice; barriers; Alabama;

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By

Victoria deMartelly

Bachelor of Arts, Anthropology
University of Illinois at Chicago
2009

Thesis Committee Chair: Prof Roger Rochat, M.D.
Dr. Kari White, PhD

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ACKNOWLEDGEMENTS
I would like to thank my committee chair, Professor Roger Rochat, for his incredible knowledge of and care for the topic of abortion and abortion access, without whose encouragement I could not have written this master thesis. His commitment to supporting students in developing scholarship in the field is an absolute asset to Rollins School of Public Health.

Additional thanks go to Dr. Kari White, who gave me the opportunity to work on the Alabama Women's Access Study. Her insight into qualitative assessment of abortion access and patience in developing my skills in this field are to be admired.

I would like to thank Dr. Julienne Rutherford at the University of Illinois at Chicago for her mentorship throughout the process of my discovery of my passion for considering reproductive health through a public health lens, and the tiny little marmoset placentas with which she trained me to work, ultimately leading me to that fateful meeting with Prof Rochat.

I also cannot express my gratefulness for my supportive family and friends deeply enough.
Finally, much gratitude is also extended to all of the women in the Alabama clinics, who were generous enough to share with me their time, stories and struggles.

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I. INTRODUCTION

Over half of all pregnancies in the United States are unintended, and among these 40% are unwanted ("Unintended Pregnancy in the United States Face Sheet," 2015). The frequency of unplanned and unwanted pregnancies disproportionately affects poor and minority women (Dehlendorf & Weitz, 2011). It is generally assumed that the reproductive rights of women are protected under rulings such as *Roe vs Wade*, but this is not so. Both *Roe vs Wade* and its contemporary, *Doe vs Bolton*, exist to defend a woman's right to elective abortion for the duration of the first trimester, leaving no specific protections of abortion after that point (Powell Jr, 1972). The right to make decisions about family planning uniquely affects women due to the fact that their bodies are implicated directly. While the topic of abortion rights has traditionally been a highly debated one, it is currently facing a wide barrage of threats unseen in recent memory. Policy changes introduced throughout the United States over the last few years have seen extensions in the state-specific required minimum waiting periods following state-mandated counseling that women must undergo prior to receiving an abortion (Boonstra & Nash, 2014; Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009). In some states, legislation directs the content of what an abortion provider is required to say to his/her patients, sometimes including misinformation about a connection between abortion and increased risk for breast cancer (Vanderwalker, 2012).

Targeted Regulation of Abortion Providers, also known as TRAP laws, are those policies that offer strict regulations of abortion facilities and providers that are not deemed necessary for other health care services. Many of these laws direct restrictions on building codes, requiring that they meet the standards of ambulatory surgical centers,

and the alterations required to bring buildings up to the new standards in Alabama have proven to be financially arduous for some
clinics. An abortion clinic in Huntsville serving all of northern Alabama closed in July 2014 due its inability to meet state standards requiring expansive structural changes (Doyle, 2014). In January of 2014, Planned Parenthood in Birmingham temporarily suspended services, making it one of the largest cities in the U.S. not to have abortion services available (Cleek, 2014). The reductions in provider availability have placed an obvious burden on the women seeking abortions in Alabama, as well as the three clinics in the state that had continued offering abortion services at the time of the Alabama Women's Access Study in June through August of 2014. In 2011, Alabama had six abortion clinics in operation, which in total performed 9,550 abortions (Jones & Jerman, 2014). As of July 2014, Alabama only had three clinics providing abortion services, each of which was serving women not only from Alabama but also from the surrounding states, where the number of clinics is limited and extensive regulations are in place.

Low income women experience some of the highest rates of unintended pregnancy and are those most vulnerable to legislation restricting access to pregnancy termination services, as they are often the least able to adapt to these changes. Closing clinics increases the distances many women must travel in order to arrive at a clinic. It is important to understand the barriers faced by these women living far distances from clinics. The purpose of this thesis is to provide contextual knowledge about the experiences of women that travel greater than the national average of 30 miles or 35 minutes to access abortion services in Alabama and the influence socioeconomics has at each stage of the process of deciding on abortion, arriving at a clinic and covering the

cost of the abortion.

I will discuss a few historical landmark cases in the United States which are of particular importance to the discussion of the current legislative climate, followed by a discussion of the current policy in Alabama. I will then outline the current issues influencing access to abortion services in Alabama. I will next outline the methods of the study, the common themes found along the course of interviews conducted with the women involved in the study, and a discussion of what the thematic analysis has revealed. Finally, I will close with concluding remarks and recommendations for improving this public health issue.

II. LITERATURE REVIEW

Abortion Law in the United States

Roe vs Wade (1973): For the purpose of protecting a woman's privacy, a woman has the right to have an abortion prior to fetal viability outside the womb, though the definition of what is meant by viability was not laid out in the document and has been the source of much contestation pertaining to what point in a pregnancy states can create regulations ("Roe vs Wade," 1973).

Doe vs Bolton (1973): Previously, the state of Georgia had required signatures from three separate physicians in order for an abortion to be legally obtained, and an individual had to be a resident of Georgia in order to obtain an abortion there. This ruling struck down both of these statutes (Powell Jr, 1972).

The Hyde Amendment (1976): This ruling, reaffirmed by the Supreme Court in 1980, bans the use of Medicaid and other federal funds for abortion. This item of legislation has the greatest impact on access to abortion among low income women (Cates, 1981).

Planned Parenthood of Southeastern Pennsylvania vs Casey (1992): With the passing of this law, women have the right to opt for abortion before 'viability' without interference from the state. It grants the state power to restrict abortion after viability, except in the case of threat to the women's life or health (Calhoun, 2012). However, this ruling also made it possible for the state to enact legislation that allows for a woman to be exposed to "persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest"(from the original ruling, quoted in (Calhoun, 2012)), which is where the legitimacy of laws regarding required counseling and waiting

periods originates.

Gonzales vs Carhart (2003): Federal Abortion Ban, which makes it legal for states to ban abortion as early as 12 weeks gestation, regardless of whether or not it would protect the health of the mother ("Who decides: the status of women's reproductive rights in the United States," 2015).

In the United States between 1994 to 2014, 835 anti-choice measures were passed, following a trajectory of increasingly limited access to abortion services ("Who decides: the status of women's reproductive rights in the United States," 2015). The majority of these restrictions fall under the category of Targeted Regulations of Abortion Providers, or TRAP laws, which describes policy that is created only to limit access to abortion without actually providing any justifiable health benefit to women seeking induced abortion (Gold & Nash, 2013).

Abortion Policy in Alabama

Throughout its history, Alabama has been a space of hostility and violence for abortion, enacting some of the nation's most restrictive abortion laws, and serving as the setting for the bombings of multiple clinics over the last 20 years, one of which resulted in the death of a police officer (Thompson, 2014). Alabama's first abortion law, enacted in 1840, specified that abortion was legal until 'quickening,' a term used to refer to the moment that movement of the fetus could be detected in the womb (Herring, 2003). Alabama maintains a law enacted in 1852 that deemed providing a woman an induced abortion for reasons other than to protect her health a criminal act, punishable by a fine, which range from $100-$1000, prison time, or hard labor for up to 12 months ("Inducing or attempting to induce abortion, miscarriage or premature delivery of woman," 1852).

According to a report by Ibis Reproductive Health and the Center for Reproductive Rights, Alabama has 12 abortion restrictions, and ranks second—along with Ohio, South Dakota, Texas, Utah and Virginia—among states with the most restrictive abortion regulations (Burns, Dennis, & Douglas-Durham, 2014). This is a particularly interesting set of peers, as South Dakota is in the process of passing legislation banning abortion at seven weeks gestation and giving felony status to physicians who provide services after this point (Greenier & Glenberg, 2014). Texas just passed legislation reducing the number of clinics in operation from 22 in May 2014 to only six in September 2014 ("Rapidly Changing Access to Abortion in Texas," 2015), and increasing the number of reproductive-aged women living in a county 200 miles or greater from an abortion clinic from 10,000 to 250,000 (Burns et al., 2014).

One TRAP law passed in Alabama includes legislation requiring that medical abortion be provided by a physician, who must be in the room with the patient to give her the mifepristone, makes telemedicine impossible, though such methods are used for many other types of healthcare services (Boonstra, 2013).

Alabama's regulation that women must go through counseling separately from the procedure in order to have the abortion, often means that the trip to the clinic must be made twice, increasing travel cost and time demands. It is also possible for women to receive the information provided during the counseling appointment via certified mail, but this option can be expensive, time-consuming and is not available through all clinics in Alabama. This in tandem with the reduction in abortion providers makes greater travel distance necessary for many women and exacerbates costs considerably.

Testimony given by an administrator at the Planned Parenthood in Mobile, Alabama,

claims that 90% of women receiving services at this location in 2013 were living in poverty (Thompson, 2014), making any added costs exceptionally challenging. The population involved in the Alabama Women's Access Study represents those women who were able to make it to the clinic in order to have the procedure; in light of the above presented research it is reasonable to assume that many more women could not meet these costs and continued with unwanted pregnancies.

Alabama requires that minors obtain parental consent or go through the process of judicial bypass in order to have an induced abortion. Though the state is only one among 38 in the US to have this requirement, Alabama is unique in that the state can appoint legal representation on behalf of the fetus. For the purposes of the hearing, the pregnancy and plead for an abortion can be disclosed to anyone within the minor's life in order to have them testify against allowing the minor to have the induced abortion for which she has opted (Rex, 2014).

Disparity in Access to Abortion

In discussing access to abortion services, it is important to consider the implications socioeconomic status has on each stage of the process of obtaining an elective abortion, including the decision-making process, getting to the clinic, and covering the cost of the abortion itself. Barriers limiting access place a higher burden on poor and minority women.

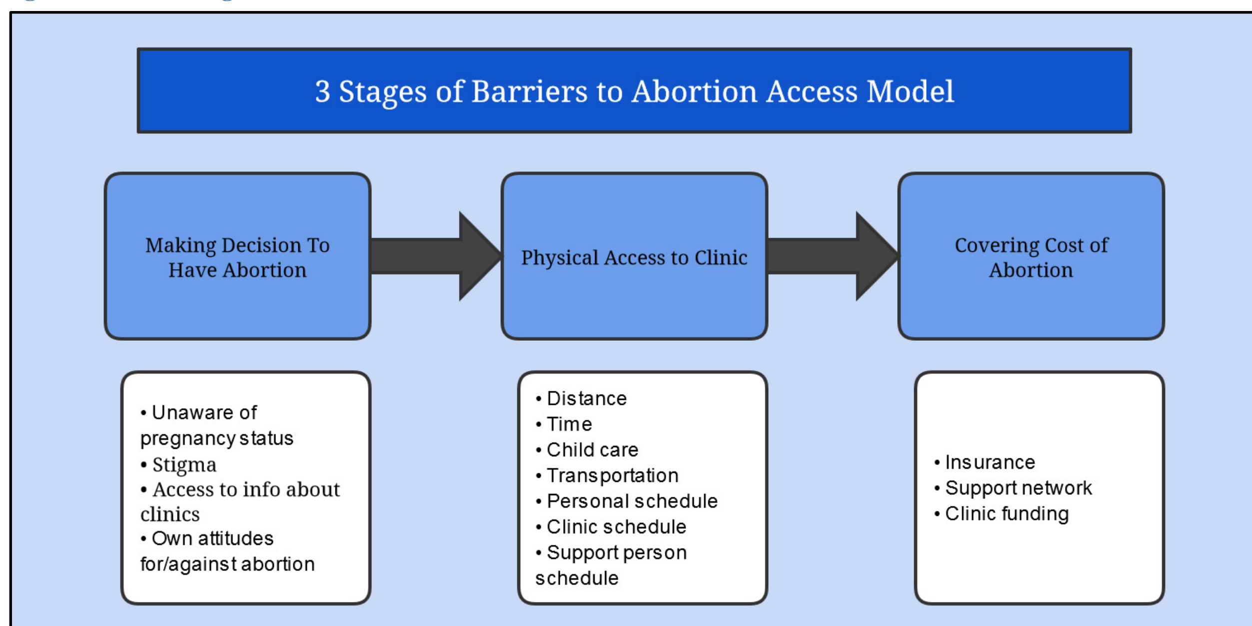
Though no significant differences are seen in fertility rates, unintended or mistimed pregnancy rates among poor women are five times those of women in the highest income category (Finer & Zolna, 2013). As of 2008, 51% of pregnancies in the United States were unintended, while up to 70% of pregnancies among black women were unintended

(Finer & Zolna, 2013). Teen pregnancy among black women was 2.3 times more likely than teen pregnancy among white women and 3.2 times as likely among Hispanic women (Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer, 2010). These pregnancies could be avoided with the usage of effective contraception methods, but the upfront costs of the most highly effective methods can serve as a barrier to use for low income women (Frost & Darroch, 2008), which is reflected by the fact that birthrates are elevated in areas where contraception is more expensive in proportion to average income (Matthews, Ribar, & Wilhelm, 1997).

Stages of Barriers to Access

Based on the 3 Delays Model, which discusses the stages where delays in access to quality health care impact maternal mortality (Thaddeus & Maine, 1994), I have created a model laying out the barriers that can influence a woman's ability to terminate an unwanted pregnancy at three key stages: decision-making, accessing a clinic, and covering the cost of the abortion. Though maternal mortality in the United States is an incredibly rare outcome of abortion at less than 1 death per 100,000 legal abortions between 1988-1997 (Bartlett et al., 2004), risk does increase by 38% with each week of gestational age at the time of abortion, and if barriers prove too burdensome, it can lead to continuing to carry an unwanted pregnancy. Each of these barriers is vulnerable to the effects of SES, as the price of abortion often increases with gestational age.

Figure 1. Three Stages of Barriers to Abortion Access



The causes of these disparities in access stem from many sources. Minority and poor women tend to have more limited access to abortion due to the influence of SES on the resources required to overcome associated barriers. One such barrier is cost. Due to the Hyde Amendment, stipulating that no federal money can go towards funding abortion (Cates, 1981), women on Medicaid, who represent those with the most extremely limited financial resources, are not able to use this resource to cover abortion costs in most circumstances. Cost represents one of the central causes for delayed abortion, and with increased gestational age at the time of abortion comes increased cost of abortion (Bailey, Malkova, & Norling, 2014; Boonstra, 2007). If abortion costs cannot be met, some women no longer are able to have an abortion at all. A study done in North Carolina looking at abortion rates between 1980-1994 when funding rates were fluctuating showed that 33% of the time, poor women who could not access public funding would carry an unwanted pregnancy to term (Cook, Parnell, Moore, & Pagnini, 1999).

Unwanted children suffer. Mistimed and unwanted children have been shown to

underperform on skill development opportunity in comparison to intended peers, have poorer relationships with their mothers, and tend to have lower verbal aptitude scores (Baydar, 1995). Unwanted or mistimed children are additionally at a much higher risk for suffering abuse (Zuravin, 1991). Moreover, women who carry unwanted pregnancies seek prenatal care less often than women carrying planned pregnancies, putting their children at higher health risk of negative health outcomes, a fact especially true among women of lower socioeconomic status (Lia-Hoagberg et al., 1990).

Women who are faced with geographically limited access to abortion services get fewer abortions, which is revelatory of the fact that an undue burden exists among women who live further from clinics after closures (Matthews et al., 1997).

A study done in 1976, shortly after the passage of *Roe vs Wade*, showed that the further a woman lives from a clinic, the less likely she is to obtain an abortion, regardless of whether or not the pregnancy was wanted or unwanted (Shelton, Brann, & Schulz, 1976). In this study, the correlation between distance and elective abortion is even stronger among black women. One cause is that as distance increases, so do associated travel costs, including gas and time.

In a related study, findings showed that an increase of 100 miles from a clinic decreased abortion rates by roughly 22% (Brown & Jewell, 1996; Brown, Jewell, & Rous, 2001). This is due in part to car ownership, which is lower among women living in poverty, either because they do not own cars or they feel their cars are unreliable (Ong, 2002). Without a means to drive herself to a clinic, she must depend on a ride, though disclosing the pregnancy and the desire for an abortion can be met with judgment.

Poverty in Alabama

Alabama currently ranks as the seventh poorest state in the U.S. ("Alabama Poverty Data Sheet," 2014) with 27.6% of children and 900,000 of its 4.85 million residents overall living below the federal poverty line. Research by Bailey et al (2014) has shown that there is a very clear connection between increased access to family planning methods, including abortion, and decreased rates of child poverty, which in turn leads to reduced rates of poverty in adulthood. By further reducing access to family planning services with the closure of several clinics, Alabama abortion regulations work against movement out of poverty.

III. METHODS

The Alabama Women's Access Study took place between July and September 2014. Women who were seeking services for any abortion care appointment (counseling, procedure or follow up) at the two highest volume clinics in Alabama were invited to participate in the study. According to data from the Guttmacher Institute, the average distance reproductive aged women travel to an abortion provider in the United States is 30 miles. In order to be eligible to participate in the study, women had to be at least 19 years of age, have traveled at least 30 miles or 35 minutes in order to arrive at the clinic, and speak fluent English. (Though the eligibility criteria for the study specified that women travel a minimum of 30 miles, one woman revealed during the interview that she had actually only traveled 25 miles but it had taken over 35 minutes.) Because of the limited number of clinics operating in the state at the time of the study, I will refer to the locations involved as Clinic A and Clinic B.

At Clinic B, clinic staff first screened women for eligibility and then directed the women to speak with us about whether or not they were interested in participating. At Clinic A, we approached women in the waiting room. If women were eligible and expressed interest, we further explained the purpose of the study and what to expect of the phone interview. We told women about how the information collected about them will be handled, including the protocol for keeping their information confidential. We offered the women the option of taking a copy of the "Invitation to Participate" with them. At each clinic, we left signs posted with a brief explanation of the study, eligibility criteria and a discrete number they could call if interested. We recruited in-person at each clinic on three separate occasions. Interviewees were mailed a $30 gift card for

completing the phone interview. I also offered the option of inserting a copy of the Invitation to Participate, outlining the purpose of the study, how data collected during interviews would be used, and what would be done with the data to ensure that their identities were protected, with the gift card.

A total of 59 women agreed to be interviewed. I completed semistructured phone interviews with 25 women. I digitally recorded interviews and obtained oral consent at the beginning of each interview before recording began. I emphasized to the participants that they could opt out at any time without any negative repercussions for choosing to do so.

Interview questions focused on general use of health care; suspicion, confirmation and reaction to the pregnancy for which she was visiting the clinic; methods for finding information and a clinic; factors influencing her ability to schedule the mandatory counseling and abortion visits; arrangements needed in order to arrive at the clinic for her appointments; method and degree of challenge in covering the cost of the abortion; overall experience with the abortion; birth control use both before and after the procedure; experiences with or knowledge of methods of self-induction; and any general comments on any aspect of her experience. At the end of each interview, I collected demographic information on age, race/ethnicity, level of education completed, number of children, employment status, number of children, number of previous abortions, as well as whether she had health insurance.

Recordings of completed interviews were then sent to an outside company to be transcribed. I checked transcripts for accuracy against the original recording and any identifying information, including names, clinic, and location more specific than state,

was removed. In order to further protect the identity of the women involved in the study, each woman was only identified based on the order in which she was interviewed.

Transcripts were then assessed via thematic analysis by each of the researchers independently and the codes ascribed were compared for consistency. I summarized the interviews under themes about women's experiences seeking care and selected representative quotations for these themes.

All aspects of the study protocol were approved through the Institutional Review Board at the University of Alabama at Birmingham before the start of the study.

IV. RESULTS

Table 1. Participant Characteristics from White, *et al (In Preparation)*

	n	%
Age, years (n=25)		
19-24	11	44.0
25-29	6	24.0
30-34	4	16.0
≥35	4	16.0
Parity (n=25)		
0 children	8	32.0
1 child	11	44.0
2 children or more	6	24.0
Previous abortion (n=24)		
No	20	83.3
Yes	4	16.7
Race/ethnicity (n=25)		
White	9	36.0
Black	14	56.0
Other/multi-racial	2	8.0
Relationship status (n=25)		
Single, not in a relationship	12	48.0
In a relationship, not married	12	48.0
Married	1	4.0
Health insurance (n=24)		
None	8	33.3
Medicaid	5	20.8
Private	11	45.8
Employment status		
Employed	15	60.0
Unemployed	10	40.0
Procedure type (n=25)		
Medical	11	44.0
Surgical <12 weeks	6	24.0
Surgical 12-16 weeks	8	32.0
State of residence (n=25)		
Alabama	17	68.0
Mississippi	6	24.0
Georgia	1	4.0
Florida	1	4.0
Clinic where obtained services (n=25)		
Clinic A	9	36.0
Clinic B	16	64.0

Socioeconomic Status and Deciding on Abortion

In many cases, the women involved in this study knew before they took a pregnancy test that they would seek an abortion if the test were to be positive. While the circumstances influencing why a woman makes the choice to have an abortion vary, a frequent component of the decision was based on whether or not the woman would be able to support a child financially. Of the women interviewed, 12 stated that they were pursuing elective abortion because they knew they were not able to support a child in this way at this point in their lives.

> *I really did not have a choice because of my situation, my income. I already have a seven-year-old son that I raise on my own. His father walked out of his life and moved away so I am 100% responsible for him and that is pretty much my life.* (white, age 28).

> *I am a single mom as it is with my first daughter; I already struggle to support her. I work full time and she goes to daycare. I buy everything for her. I just know I do not think it would be fair for me to bring another baby into this world with the struggle that I am under right now.* (white, age 20).

Abortion allows for these women to make decisions about reproductive timing; many have children, do not want to have more children, or have plans to have children in the future, but they know this is not the ideal time to do so.

> *I didn't plan on having [any] more kids till my baby turned five.* (black, age 22).

Having the option to choose to abort an unwanted pregnancy allows women to focus their attention on ensuring a high quality of life for the children they already have.

Socioeconomics and Physical Access to a Clinic

DISTANCE

Distance informs travel time, which contributes to cost factors such as the amount of work some women miss or those joining them for support may have to miss in order to have the abortion, how long child care might be needed, the cost of gas, as well as other factors.

Distances traveled by the women ranged from 25 miles to 201 miles with an average distance of 83 miles traveled in one direction to reach the clinic. On average, the black women in this study traveled 92.6 miles, while white women traveled 64.0 miles.

Table 2. Race/Ethnicity and Average Distance

Race/ethnicity	n	Average Distance (mi)
White	9	64.0
Black	14	92.6
Other	2	103.1

Eight of the 25 women were traveling from out of state, including six from Mississippi.

Table 3. Distance and Gestational Age at Time of Abortion

Distance (miles)			Gestational Age >12 weeks	
	n	*%*	*n*	*%*
<50	8	32.0	0	0.0
50-99	10	40.0	3	30.0
≥100	7	28.0	4	57.1

As shown in Table 3, all of the women driving a distance of less than 50 miles were able to have an abortion during the first trimester, while almost 60% of the women

traveling over 100 miles had the procedure done past 12 weeks. Distance was not the only contributing factor to the delay, but it exacerbated the reasons why many had later abortions, including added costs of travel, as expressed by one woman:

I have been almost living pretty much living from paycheck to pay check. So, I didn't have a whole lot of savings. Aside from borrowing, the little bit that I have borrowed; it is just outside of my budget to spend that much in gas, or just to have that much for a medical thing. I did not have that on my hand. Just outside of my budget. (white, age 30).

TRANSPORTATION

Table 4. Source of Ride for Any Visit

Source of ride (n=24)	*n*	*%*
Self	13	54.2
Man involved	4	16.7
Family member	7	29.2
Friend	4	16.7

In order to have the abortion, women needed a means of getting to the clinic. While most had their own cars, others did not, and for those women receiving sedation for a surgical abortion, the clinic required that they have a ride present upon arrival at the clinic. A woman traveling a distance of 113 miles in each direction:

[Getting to the clinic] was difficult, because…I had to do it two weeks. I had two appointments and I was having car trouble at the time, so just did not really trust my car to go the distance. I had to get a friend to take me, I had to ask off work, and I had to be kind of vague about the reason… My friend, the best friend, has a sound vehicle, so he was able to [drive]… He did have to take off work, so he had to work

in the afternoon. (white, age 30).

Some had previously been responsible for making arrangements/giving rides to other women in their lives.

I had to [go through this process] a few months ago with my sister, who was in high school at the time, so I had already researched it with her, the options and everything. (white, age 25).

When asked what one of the women would have done had she not been able to arrange a ride to the clinic for her appointments, she explained:

I feel like I would be stuck with a pregnancy I don't really want. And I feel like that's not fair… [I would want to] be prepared because I believe when you have a child, bring a child in this world, you have to give the best for that child, but if you're not prepared you cannot provide all this stuff. (Hispanic, age 34).

TIME

The amount of time women waited at the clinic, the hours of operation of the clinic and work schedules were the largest sources of time-related impediments for women to obtain their abortions, and all of these same barriers had to be faced twice due to the required counseling and procedure visits.

The range of time that elapsed between calling to make an appointment and actually getting in for counseling was between the same day as the call to two weeks later. None of the nine women recruited from Clinic A were able to return to for their procedure immediately after the required 48-hour wait time had elapsed. Only seven of the 16 from Clinic B returned 48 hours later, four of whom were unemployed and therefore unaffected by work schedules. Due to clinic scheduling issues and trouble acquiring the

funds to cover costs, in one case the delay between the counseling appointment and the procedure date caused her to become ineligible for the medical abortion she preferred.

> *I was 11 weeks [at the time of the counseling appointment]. It was hard because I wanted to get this over and get it done. I wanted to get and take a pill because I was uncomfortable with – it is just, the surgical procedure. Them not being able to give me an early appointment. It was like I did not really have an option.* (black, age 19).

Women often felt the need to be discrete with employers as to why they needed the time off, causing one woman to claim she was being treated for a kidney infection for which she would need an extended lunch break (white, age 35). Not only personal work schedules but also the work schedules of support persons had to be considered in arranging appointments. Friends, partners, and family members offering rides had the same experience of lost wages due to missing work and being cautious about telling employers the reason. Lost wages are particularly burdensome to the women who were already struggling to pay for the procedure itself.

CHILD CARE

Sixty-eight percent of women interviewed in the study have children. Eleven of the 25 women have one child, and six of the women have two or more children.

Twelve of the women mentioned that specific arrangements had to be made in order to ensure their children were cared for during appointments. Caretakers included friends, teachers, family members, their children's fathers, ex-husbands, and daycare services. Making these arrangements often added to the cost of the abortion. One single mother, who traveled 40 miles to the clinic, arranged for her son to stay with a 24 hour daycare at a cost of $25 per day, not a negligible sum for a single mother facing an unexpected

procedure.

Women also felt they did not want to or could not disclose the reason they sought child care. One woman traveling 113 miles each way from out-of-state and has two children explains her experience:

I got my ex-husband to watch them. I don't remember the excuse I made….I figured I had to say something [for the second appointment] because he was going to have to watch the kids, and I was going to be down for the evening. (white, age 30).

This woman knew she would find returning to the clinic for follow up challenging if she were to have had the medical abortion, which is what made her opt for a surgical abortion though she was only five weeks pregnant at the time of her procedure.

Socioeconomics and Covering Cost

Increased driving distance also increases cost of gas. For women driving long distances, the cost is considerable.

I paid about $150 in gas back and forth because my friends car, it's a big Ford. And it drinks a lot of gasoline. It's around $75 for just one trip. And $65.00 to come back on Thursday, plus the food we had to eat on the way and Saturday the gas back and forth in my boyfriend's car. He had to change the oil and he spent like $150 or $90 in gas total. (Hispanic, age 34).

While a few women had no trouble paying for the procedure, more commonly women had to pull funds from many sources in order to cover costs. Out of 24 women for whom there are data on insurance status, 16 had some sort of coverage, including 11 on Medicaid. Among these women, only one was able to have any of her abortion costs covered using her Flex Card benefits.

Of particular note in discussing the process through which the women interviewed made the decision to have the abortion is the fact that two women, one with an extensive list of chronic conditions and the other having had an endometrial oblation, were most strongly influenced by a perceived medical need to end the pregnancy because it posed a threat to the life of the women and the fetus. While one of these women was supported by her healthcare provider in her consideration of terminating the pregnancy, for the other woman, the experience was much different:

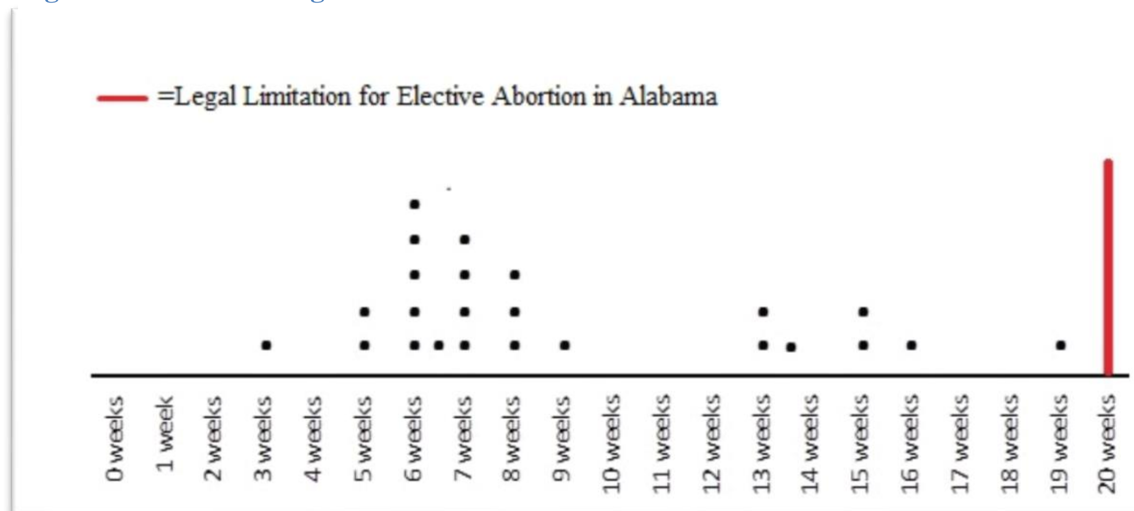
> *I have a heart disease, I have blood pressure, and I am a diabetic. I have degenerative joint disease. I have rheumatoid arthritis, issues with my hip, there's one that's going, and I am going to have to replace it with metal soon. I have metal in my back for disc work, but they are going now. I mean it is just – there are so many complications with my health. And it was like that was all dismissed, it did not matter. And I mean it was hard, it was hard to have that support. It was hard. It was. It was hard.* (white, age 28).

Neither woman had any portion of her abortion covered by Medicaid despite the fact that they perceived the pregnancy as being a threat to their health.

Both of the clinics from which I recruited offer need-based funding for which 11 women were eligible. An additional woman, who had delayed her abortion by a month, received funding from a private organization. Others borrowed money from in-laws, the man involved, parents and work friends to whom they did not disclose the purpose. Seven women were able to cover the costs without help from outside sources, but most of these women indicated that it was challenging for them to do so. These same networks also serve as resources for childcare and ride arrangements. Some of the women

mentioned that they are not sure what they would have done had these networks not been in place.

Figure 2. Gestational Age at Time of Procedure



Twenty weeks is the gestational age limit in the state of Alabama. One of the women interviewed, who was 20 years old, was four days shy of no longer being eligible to have her abortion in state because of a multitude of confounding factors, including the clinic schedule, arranging a ride to travel the 143 mile distance from her house to Clinic B, stigma from her small town reducing her social network and inciting a rift in her relationship with her mother and struggling to cover costs. Each of these barriers aggregated ultimately caused her to delay her surgical procedure seven weeks from the counseling appointment and could have led to the birth of an unwanted child, as opposed to an unwanted pregnancy, something she felt that was too young to do.

For one student, the financial burden of the abortion and related costs ultimately forced her to make the decision not to return to school in the upcoming semester *The money I had to pay for this, I was unable to end up helping for school towards the end.* (white, age 23).

Safe Abortion

Fourteen of the 25 women had heard of methods of terminating a pregnancy on her own. Women involved in the study mentioned methods to self-induce an abortion including mixing various teas, inserting parsley into the vagina, consuming excess amounts of vitamin C, drinking vinegar, and other herbal remedies purchased online. One woman specifically cited the cost of abortion as one reason she tried to end her pregnancy herself.

V. DICUSSION

Delays in Abortion

Women expressed potential sources of delay for abortion at each stage of the process. During the decision-making process, social stigma impacted how easy or difficult it might be for them to carry a child or find financial support in their lives for making the decision to terminate the pregnancy. This fear of judgment caused some women to wait to take a pregnancy test so that they could put off making decisions about what to do. A frequently mentioned force for choosing to have an abortion was a knowledge that they lacked the financial resources for children at this point in their lives and also that the timing would impede professional and educational goals.

Abortion offers these women an opportunity to plan for children when these goals are met; without it, many of these women would be forced to make decisions that exacerbate poverty they already experience.

While attempting to physically access abortion, women were faced with many challenges, including the travel distance, the time it takes to get to the clinic and have the abortion, arranging rides, and arranging for child care for the women who have children. For low income women, the added costs of each of these components can serve as barriers too great to overcome.

Limitations

One major source of limitations within this study is that the sample involved represents those women who were able to make it to the clinic in order to have the procedure; in light of the above presented research it is reasonable to assume that many more women could not meet these costs and continued with unwanted pregnancies.

Additionally, the sample size was limited, as I conducted the in-depth interviews with 25 of the women. While this group of women provided a lot of insight on diverse experiences influencing their experiences accessing the clinics, there are without doubt more factors about which I did not ask or that were experienced by women who did not participate in the study.

Lifetime Earnings and Education

In the case of education, lifetime earnings increase and unemployment rates decrease as level of education increases. In 2013, median weekly earnings for those with a high school diploma averaged $651, and the rate of unemployment held at 7.5% ("Earnings and Unemployment Rates by Educational Attainment," 2014). For those with some college, which describes nine women in this study, the average weekly earnings are $727, and this figure jumps to $1108 with the completion of a bachelor's degree ("Earnings and Unemployment Rates by Educational Attainment," 2014). For those eight women in the study currently enrolled in school, abortion has, in part, made it possible for them to continue to pursue a degree. However, the cost burden proved too high for one of the women, who was not able to return to school. With adequate funding, this could have been avoided.

Poverty belies almost all of the barriers faced by the women in this study. If a woman does not have the money, she cannot cover the cost of travel, child care, work missed, or the procedure itself. If she cannot afford these costs, she surely does not have the financial resources to support a child, and Alabama has been ranked among the most unsupportive of programs which promote women's and children's health ("Who decides: the status of women's reproductive rights in the United States," 2015). Considering

Alabama’s striking level of poverty, and the frequency with which budget cuts to subsidized child care services arise, family planning options, including abortion, need to be available to women with unwanted pregnancies ("Alabama Poverty Data Sheet," 2014).

Reproductive and Environmental Injustice

Disparities in access to abortion services for low income women and minority women is a reproductive justice issue that intersects with issues of environmental justice. With limited numbers of abortion clinics available, women are forced to choose between exercising their reproductive rights or making choices that are supportive of a healthy environment. Though not the focus of this study, almost no genre of research has the privilege of remaining untouched by the impacts of climate change, and research involving access to abortion services is no exception. In the case of abortion access, policies requiring a person what has the potential to be a single visit outpatient health care service drive greater than 100 miles in one direction for at least two visits implies an unnecessary increase in our carbon footprint. With 9,550 abortions performed in Alabama in 2011, this represents an important consideration. In Texas, where 73,200 abortions were performed in the same year, similar legislative changes have forced the closure of most clinics, and only six remain (Fuentes, 2014). As of 2014, 900,000 women of reproductive age live a distance greater than 150 miles from the nearest clinic (Grossman et al., 2014). The carbon footprint associated with access to reproductive health services, in the case abortion, could be argued to be an example of environmental injustice, or more specifically environmental sexism, as this need rests specifically within the bodies of women. Women living in areas experiencing clinic closures lack alternative

options to driving by car to get to clinics, despite its environmental impact. They lack the power to make the legislative decisions that have inspired laws that have led to the closing of clinics and the consumption of gas required to travel these distances.

Further reading on the topic of Environmental Justice, some helpful resources are available on the EPA's website (http://www.epa.gov/environmentaljustice/), and "Justice, nature and the geography of difference" by Harvey, *et* al 1996. An interesting article discussing the intersection of reproductive and environmental justice can be found at (http://www.nwlc.org/resource/if-you-really-care-about-environmental-justice-you-should-care-about-reproductive-justice-1).

VI. CONCLUSIONS AND RECOMMENDATIONS

The limited number of clinics available to women in Alabama and the distances that some women must drive in order to access them has an exaggerated impact on many of the barriers faced by women attempting to access abortion services.

I would suggest the following policy changes in order to reduce the negative economic and health consequences of unintended and unwanted pregnancy:

1) Expand availability for Long Acting Reversible Contraceptive methods, making them more readily available to low income women. With the introduction of more effective methods of contraception, unwanted pregnancy, which can be unsafe due to less frequent use of prenatal care, and the number of unwanted children, who suffer health consequences, will be reduced.

2) Expand geographic access to clinics. The more accessible a clinic is, the sooner a woman is able to obtain an abortion. As gestational age increases, so does risk associated with abortion.

3) Repeal Ambulatory Surgical Center standards for clinics. There is no demonstrated need for these requirements, and these standards only serve to create financial hardships for clinics, contributing to the closures of many throughout the United States.

4) Expand funding for abortion services. Denying funding only affects the low income women who qualify for Medicaid, and as seen in this study, sometimes encourages women to make the dangerous decision to attempt to find other means to terminate an unwanted pregnancy.

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