Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

04/11/2023

_____ _____

Parie Bhandari

"We just need to create as many avenues for access as we possibly can": A Qualitative Analysis of Sexual and Reproductive Health Provider and Administrator Attitudes Toward the Importance and Priority of Telehealth Medication Abortion Services in the U.S. South

By

Parie Bhandari
MPH

Hubert Department of Global Health

_____
Anna Newton-Levinson
Committee Chair

_____
Subasri Narasimhan
Committee Co-Chair

"We just need to create as many avenues for access as we possibly can": A Qualitative Analysis of Sexual and Reproductive Health Provider and Administrator Attitudes Toward the Importance and Priority of Telehealth Medication Abortion Services in the U.S. South

By

Parie Bhandari
Bachelor of Arts
The George Washington University
2021

Thesis Committee Chair: Anna Newton-Levinson, PhD, MPH
Thesis Committee Co-Chair: Subasri Narasimhan, PhD, MPH

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 Global Health
2023

Abstract

"We just need to create as many avenues for access as we possibly can": A Qualitative Analysis of Sexual and Reproductive Health Provider and Administrator Attitudes Toward the Importance and Priority of Telehealth Medication Abortion Services in the U.S. South

By Parie Bhandari

Introduction

A lack of access to abortion services has severe implications for the health and well-being of pregnant individuals and their families. Given the hostile abortion policy climate, a shortage of abortion clinics, and issues with provider recruitment and retention, abortion seekers in the U.S. South are at a disproportionately high risk of facing barriers to abortion access. Telehealth medication abortion (TMAB) services have the potential to mitigate these barriers and greatly expand access to care. Research on sexual and reproductive health (SRH) provider and administrator attitudes toward and motivations for implementing these services is necessary to understand the TMAB implementation climate in this challenging context.

Methods

This study conducts a secondary analysis of data from the Provider Readiness for Virtual Implementation and Delivery of Medication Abortion Services (PROVIDA) study. Qualitative data regarding perspectives of providers and administrators toward the importance and priority of TMAB was collected during a series of in-depth interviews that took place from June 2021-2022. Data was later analyzed using MAXQDA and results were interpreted.

Results

Four main themes were identified: TMAB is important for patient benefit in mitigating physical, administrative, financial, and privacy-related barriers, TMAB is important for clinic benefit in improving clinic flow and sustainability, the political climate affects participant prioritization of TMAB, and staff hesitance affects clinic prioritization of TMAB. Though provider and administrator attitudes toward the importance of TMAB influenced feelings of prioritization in some cases and vice versa, the two concepts were largely discussed separately and thus priority was not necessarily tied to view of importance.

Discussion

TMAB was found to be particularly important in mitigating physical access barriers for patients and in helping with clinic sustainability. The political climate was found to be the most notable factor influencing participant prioritization of TMAB, and participant perception of staff hesitation to implement TMAB was found to be the most notable factor affecting clinic prioritization. Findings from this study fill a current gap in literature and have both policy and advocacy implications. Future research should use these findings to inform further studies examining the implementation climate of TMAB in the South.

"We just need to create as many avenues for access as we possibly can": A Qualitative Analysis of Sexual and Reproductive Health Provider and Administrator Attitudes Toward the Importance and Priority of Telehealth Medication Abortion Services in the U.S. South

By

Parie Bhandari
Bachelor of Arts
The George Washington University
2021

Thesis Committee Chair: Anna Newton-Levinson, PhD, MPH
Thesis Committee Co-Chair: Subasri Narasimhan, PhD, MPH

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 Global Health
2023

Acknowledgements

First and foremost, I would like to express my sincere thanks to my thesis committee chair, Dr. Anna Newton-Levinson, for her thoughtful advice and continual mentorship without which this work would not have been possible.

I could not have undertaken this journey without the companionship of my fellow MPH peers that I am lucky to call friends. I would like to express my deepest appreciation to my fellow MPH student, Emma Halper, for her constant support, guidance, and friendship that encouraged and motivated me throughout this process.

Finally, I would like to express my deepest gratitude to my parents, Punam Bhandari and Ashok Bhandari, and my brothers, Ashim Bhandari and Abhit Bhandari, for their continual love, encouragement, and unwavering support.

Table of Contents

Chapter 1: Introduction

Background

Access to abortion services is a fundamental human right crucial to the health and well-being of individuals with the ability to become pregnant (WHO, 2021). This right is currently under attack in the U.S. given the recent ruling of the case *Dobbs v. Jackson Women's Health Organization*. In June 2022, this decision overturned the landmark ruling *Roe v. Wade*, effectively eliminating a federal standard for abortion care and allowing each U.S. state the power to decide what protections or restrictions to uphold (KFF, 2022). This decision has dire implications for abortion access in the nation, ultimately violating the safety, privacy, and human rights of individuals in the U.S. with the ability to become pregnant.

The Southern region has been particularly subject to an increase in abortion restrictions over the last 20 years (Guttmacher Institute, 2023d). In comparison to the rest of the nation, abortion seekers in the South face urgent and extreme barriers to access (Schroeder et al., 2022). Disparities in the existence of brick-and-mortar abortion facilities alone are notable – as of 2021, a study recorded only one abortion facility per 158,000 women of reproductive age in the South in comparison to one facility per 56,000 in the Northeast (Schroeder et al., 2022). In addition to physical and financial barriers to access, abortion seekers in the South face a disproportionately high rate of strict, medically unnecessary requirements surrounding waiting periods, counseling, ultrasounds, and Targeted Regulations of Abortion Providers (TRAP) legislation (Guttmacher Institute, 2020b; Guttmacher Institute, 2023a; Guttmacher Institute, 2023b; Guttmacher Institute, 2023c).

Problem Statement

Lack of access to abortion services has strong implications for the health and well-being of pregnant individuals and their families (*The Turnaway Study*, n.d.). Denial of abortion services resulting in pregnant people being forced to carry unwanted pregnancies to term has been linked to worsened economic outcomes for women including higher odds of experiencing poverty, unemployment, and long-term financial distress (Foster et al., 2018a; Miller et al., 2020). Additional implications for pregnant people denied abortion services include a higher risk of experiencing violence from the male involved in the pregnancy, a lower likelihood of having aspirational life plans or a positive future outlook, and a lower intended pregnancy rate later on in life (Roberts et al., 2014; Upadhyay et al., 2015; Upadhyay et al., 2019). Restrictive abortion policies in the U.S. have also been found to be linked to an increase in the risk of total maternal mortality (Vilda et al., 2021). Children born as a result of denial of abortion services are more likely to experience poor maternal bonding, live in low-income households, and reside in households without the financial resources to pay for basic living expenses (Foster et al., 2018b). In addition, implications have been found for existing children at the time of denial of services including lower mean child development scores and a higher likelihood of living below the Federal Poverty Level (Foster et al., 2019). The implications of non-access to abortion services are notably exacerbated among vulnerable, marginalized, and disadvantaged communities, placing these populations at a disproportionately high risk of adverse health outcomes (Sedgh et al., 2022).

Purpose

Though procedural abortion (previously called surgical abortion) has remained the most common form of abortion throughout history, medication abortion usage has been trending upward over the past two decades (Jones et al., 2022). Medication abortion, or the combination of pharmaceutical drugs misoprostol and mifepristone, can occur both in-clinic and out-of-clinic and is approved for up to 10 weeks of gestation (Jones et al., 2022). These pills can either be provided by the clinic or directly sent to the patient, allowing for increased access and privacy for the patient (Jones et al., 2022). TMAB, or telehealth medication abortion, refers to the provision of medication abortion following a virtual provider-patient interaction. TMAB has been shown to greatly expand access to abortion services in certain settings (Seymour et al., 2022). Given the rise in medication abortion preference in the U.S., the role of telehealth in expanding access to healthcare, and a growing demand for TMAB in states with restrictive abortion policies, TMAB has the potential to provide a safe, effective method of terminating a pregnancy while also allowing patients to privately and discreetly complete appointments in the comfort of their homes (Aiken et al., 2020; Grindlay et al., 2013). TMAB has been found to be particularly beneficial in mitigating physical access barriers, abortion stigma and privacy-related barriers, and even financial barriers to care (Grindlay et al., 2013). Given that TMAB has the potential to expand access to care, this study will fill a gap in perspectives of providers and administrators in the South toward these services, ultimately addressing specific motivations and priorities related to implementation, feasibility, and considerations for exploring further implementation in the region.

An increase in restrictive policies surrounding waiting periods, informed consent, ultrasound requirements, and TRAP legislation has left abortion seekers in the South to face

extensive barriers to care. Providers themselves are faced with a unique set of challenges practicing in the South including considerations related to restrictive legislation, the institutional separation of abortion from other medical services, safety concerns, training unavailability, and marginalization within their profession (Chowdhary et al., 2022). Issues with provider recruitment and retention in the South contribute to provider shortages, exacerbated by a recent decrease in the number of abortion providers and facilities in the South (Allsworth, 2022; Chowdhary et al., 2022). As facility-based care in the South becomes continually more strained, TMAB services could become more of an important option for maintaining access than ever before (Grossman, 2022).

Significance

There is currently a gap in literature on the perspectives of sexual and reproductive health (SRH) providers and administrators in the South toward TMAB services. Few studies to date include information on the implementation and benefits of TMAB services specifically in Southern contexts. Furthermore, there is no current literature examining provider perspectives of feasibility and readiness to implement these services. Exploring these perspectives through research is critical to understanding provider and administrator attitudes toward the importance and priority of TMAB to contribute to the development of a richer understanding of the TMAB landscape in the South.

This thesis seeks to answer the following research questions:

What are the attitudes of SRH providers and administrators in the South regarding importance and priority of TMAB service provision?

Sub-question 1: How do population considerations influence Southern SRH provider and administrator attitudes regarding importance and priority of TMAB service provision?

Sub-question 2: How do policy considerations influence Southern SRH provider and administrator attitudes regarding importance and priority of TMAB service provision?

This thesis seeks to fill a current gap in knowledge surrounding provider and administrator perspectives toward providing TMAB services in the South, including policy-based and population-based considerations. Given a rapidly changing abortion policy landscape in the South and the likelihood of continually decreasing access to services, this research is critical to understanding what the motivations of providers and administrators are related to implementing TMAB, a service with the potential to greatly increase access to care.

Chapter 2: Literature Review

Importance of Abortion Services

Abortion as a Human Right

Access to abortion services is a fundamental human right critical to the health and well-being of pregnant people everywhere (World Health Organization [WHO], 2021). According to the World Health Organization, a lack of access to quality abortion care violates the right to life, the right to the highest attainable standard of physical and mental health, the right to benefit from scientific progress and its realization, the right to decide freely and responsibly on the number, spacing, and timing of children, and the right to be free from torture, cruel, inhuman and degrading treatment and punishment (WHO, 2021).

The need for abortion services, whether for medical, physical health, mental health, or practical reasons, will always exist; strict regulations surrounding abortion only increase maternal injuries and deaths (Amnesty International, n.d.). The United Nations (U.N.) human rights chief has condemned the U.S.'s recent overturning of *Roe v. Wade*, a landmark judgment from 1973 that guarantees abortion access, as "a huge blow to women's human rights and gender equality" (United Nations, 2022). The U.N. has urged the U.S. to adhere to the Convention on the Elimination of All Forms of Discrimination Against Women, a legal instrument to protect women signed by the U.S. in 1980 but not yet ratified (United Nations, 2022). The U.N. has repeatedly acknowledged that denying access to safe legal abortion is "a severe restriction on women's ability to exercise their reproductive freedom, and that forcing women to carry a pregnancy to full term involves mental and physical suffering amounting to gender-based violence against women" (United Nations, 2022).

Abortion Procedures

The American College of Obstetricians and Gynecologists (ACOG) defines induced abortion, either procedural or medication, as an intervention to terminate a pregnancy and not result in a live birth (ACOG, n.d.). Procedural abortion, also known as surgical abortion, involves either uterine aspiration or dilation and evacuation methods depending on the gestational stage (Kapp & Lohr, 2020).

Medication abortion usually involves a combination of the pharmaceutical drugs misoprostol and mifepristone and can occur in clinical settings as well as outside of a medical setting (Jones et al., 2022). Patients first take mifepristone followed by misoprostol one to two days later depending on the provider or manufacturer (Jones et al., 2022). This abortion method is approved for use up to 10 weeks of gestation, despite research showing its safety and effectiveness beyond this marker (Jones et al., 2022). A major benefit of medication abortion as opposed to procedural abortion is that it can either be provided by the clinic or directly sent to the patient, bridging gaps in access as a result of an inability to travel or lack of access to transportation (Jones et al., 2022). It has been found to have a very low rate of serious complications and to overall be a safe, effective method of terminating a pregnancy (Jones et al., 2022).

Prevalence of Abortion

Accurate measurement of abortion prevalence is often difficult to achieve given issues with data reporting, particularly in countries where pregnant individuals are forced to seek illegal services due to strict abortion regulations. The Centers for Disease Control and Prevention (CDC) and the Guttmacher Institute both attempt to measure abortion prevalence in the U.S. but utilize different methods to do so; the CDC relies on data voluntarily reported by the central

health agencies of most U.S. states while the Guttmacher Institute relies on contacting every known abortion provider in all U.S. states, using health department data, and creating estimates for providers who do not respond (Diamant & Mohamed, 2023). The most recently available data from the CDC is from 2019, in which the organization estimated 629,898 abortions, while the most recently available data from the Guttmacher Institute is from 2020, in which 930,160 abortions were estimated (Diamant & Mohamed, 2023). Though abortion rates have been steadily declining since the early 1990s, the Guttmacher Institute reported an 8% increase from 2017 to 2020 (Diamant & Mohamed, 2023). These numbers only take into account legal procedural abortions and the distribution of medication abortion pills from certified facilities, leaving notable gaps in data for undocumented abortions (Diamant & Mohamed, 2023).

Though procedural abortion has largely remained the most common form of abortion throughout clinical history, medication abortion usage has been trending upward over the past two decades (Jones et al., 2022). In fact, according to the Guttmacher Institute, medication abortion now accounts for 54% of all U.S. abortions as of 2022 (Jones et al., 2022). Data shows that medication abortion usage jumped 15% from 2017 to 2022, crossing the threshold to become the majority of all U.S. abortions in 2020 (Jones et al., 2022). This increase is likely due to the COVID-19 pandemic and subsequent increased importance of telehealth services as well as an increase in evidence-based policies allowing non-physician medical professionals to provide the service (Jones et al., 2022).

Implications of Non-Access to Abortion

Non-access to abortion services has strong implications for the health and well-being of pregnant individuals and their families (*The Turnaway Study*, n.d.). Denial of abortion services has been found to be linked to outcomes such as higher odds of experiencing poverty,

unemployment, long-term financial distress, violence from the male involved in the pregnancy, a lower likelihood of having aspirational life plans, and a lower intended pregnancy rate later in life. (Foster et al., 2018a; Miller et al., 2020; Roberts et al., 2014; Upadhyay et al., 2015; Upadhyay et al., 2019). Implications for the children born as a result of pregnant individuals being forced to carry unwanted pregnancies to term include higher likelihood of experiencing poor maternal bonding and living in low-income households without the financial resources to pay for basic living expenses (Foster et al., 2018b).

Additionally, restrictive abortion policies in the U.S. have been found to be linked to an increased risk of total maternal mortality (Vilda et al., 2021). A common factor contributing to this association is that strict abortion regulations lead pregnant individuals to seek unsafe, unregulated abortion services that have been shown to contribute to maternal mortality (Vilda et al., 2021). Additionally, health complications often arise or are exacerbated during pregnancy, resulting in maternal deaths for pregnant individuals who are unable to access abortion care and are forced to carry an unwanted pregnancy despite danger to their health (Vilda et al., 2021). Legal restrictions have proven to be ineffective at decreasing abortion rates; estimates have repeatedly shown that abortion incidence remains the same but is more likely to occur under unsafe conditions (Sedgh et al., 2022). Studies have shown that rates of maternal mortality are lower in countries with less strict abortion regulations; fewer pregnant individuals seek unsafe services under these conditions and are less likely to be forced to carry an unwanted pregnancy to term, increasing the risk of dangerous health complications (Bosurgi et al., 2022). As a result, in addition to its already high rates of maternal mortality, the U.S. faces a likely increase in maternal deaths in the wake of the recent overturning of *Roe v. Wade* (Bosurgi et al., 2022).

According to the World Health Organization, common physical complications of unsafe abortions include incomplete abortion (failure to remove all pregnancy tissue from the uterus), hemorrhage (heavy bleeding), infection, uterine perforation, and genital tract/internal organ damage as a result of dangerous objects being inserted into the vagina (WHO, 2021). Additionally, it has been found that abortion regulations have implications on women's education and ability to participate in the labor market, and children's educational outcomes as well as their potential to earn in the labor market later on in life (WHO, 2021).

As is often the case, it is crucial to recognize that all implications of non-access to abortion services are exacerbated among disadvantaged and vulnerable communities. Pregnant people who face a lack of access to information and resources to overcome legal barriers to abortion are at the highest risk of adverse health consequences (Lara et al., 2015).

Abortion Landscape in the U.S.

History of Abortion Policy in the U.S.

Once a commonly accepted practice, abortion has not always been a topic of controversy in U.S. history. In fact, the criminalization of abortion can be traced back to British influence during the early 19th century – British outlawing of abortion prompted U.S. doctors to conclude that midwives, nurses, and pregnant individuals themselves who managed abortions were direct threats to their profession (Baker, 2022). Eventually, in 1847, the American Medical Association (AMA) was formed, consisting primarily of white male doctors (Baker, 2022). As the AMA grew, so did anti-midwife rhetoric; physicians felt threatened and labeled midwives as unsanitary and unethical in an attempt to gain complete control of women's healthcare at the time (Baker, 2022). Despite the fact that physicians in the AMA lacked the crucial training, skills, and knowledge that midwives possessed to provide safe and effective healthcare to women, including

abortion services for pregnant individuals, they chose to ridicule and phase out these essential healthcare workers (Baker, 2022). This way of thought prompted an abortion criminalization campaign that set in motion legal restrictions on abortion all throughout the U.S. (Baker, 2022).

This period of time, also known as the "century of criminalization," began in 1880 and saw restrictive regulations surrounding abortion in all U.S. states (Joffe et al., 2004). By 1910, abortion became completely illegal in every U.S. state with exceptions in few cases in which an abortion would save the pregnant person's life (Planned Parenthood, 2021). Those in power to make these life-or-death decisions were the same primarily white, male physicians. As is often the case with restrictive abortion regulations, this period brought about thousands of preventable injuries and deaths from illegal, unsafe abortions pregnant individuals were forced to resort to (Joffe et al., 2004). In 1930 alone, unsafe abortions caused the deaths of 2,700 pregnant people, making up 18% of maternal deaths that year (Gold, 2004). The late 1960s and early 1970s saw attempts at abortion reform, sparked by concerns of fetal abnormalities, with many states enacting reforms that allowed for more exceptions and some repealing the ban altogether (Joffe et al., 2004). In 1973, the Supreme Court ruled in favor of *Roe v. Wade*, the case that argued that a person's right to terminate their pregnancy is included in the constitutional right to privacy (Guttmacher Institute, 2022). *Roe v. Wade* made abortion services across the nation more accessible, safe, and most importantly, legal (Joffe et al., 2004).

Despite the passing of *Roe v. Wade*, issues with access for marginalized communities continued to persist, exacerbated by the passing of the Hyde Amendment in 1976 which barred the use of Medicaid funds from being used toward abortion services (Joffe et al., 2004). The implications of the Hyde Amendment include adverse health effects as a result of a lack of access to abortion services, disproportionately affecting low-income communities that primarily

utilize Medicaid and already face systemic barriers to healthcare (Guttmacher Institute, 2021a). The Hyde Amendment has also continued to uphold and promote systemic racism and disparities in access to abortion care as women of color are at disproportionate risk of relying on Medicaid (Guttmacher Institute, 2021a). Congress has regularly included this discriminatory policy in annual spending bills since its passing – however, the Biden-Harris administration made history in 2021 by excluding the Hyde Amendment from its presidential budget, becoming the first administration to do so in decades (Guttmacher Institute, 2021a).

In 1984, the Global Gag Rule was introduced (Guttmacher Institute, 2021b). This rule was created to prevent international organizations that utilize U.S. health aid from providing information on abortions, providing referrals for abortions, or advocating for abortion access (Guttmacher Institute, 2021b). This restrictive rule is repeatedly rescinded and reinstated based on the administration that holds office.

The U.S. is at a critical point in its history regarding its abortion policy and access landscape. In 2021, an alarming law known as S.B. 8 was passed in Texas that bans abortion after six weeks (Jones et al., 2021). The law has created perilous conditions for all pregnant individuals of reproductive age in the state; most pregnant individuals aren't aware of pregnancy until far after this marker (Jones et al., 2021). In June 2022, *Roe v. Wade* was overturned by the case *Dobbs v. Jackson Women's Health Organization*, eliminating a federal standard for abortion care and allowing each state the power to decide what restrictions or protections to uphold (KFF, 2022). This decision affects the safety, privacy, and human rights of every person with the ability to become pregnant in the country but will undoubtedly most severely affect low-income pregnant people and pregnant people of color in states with newly restrictive policies.

Recent Increase in State Abortion Restrictions

U.S. states have been attempting to pass legislation to restrict abortion access ever since the Supreme Court ruled in favor of *Roe v. Wade* in 1973; an average of 38 new abortion restrictions were created per year in the decade afterward alone (Guttmacher Institute, 2016). From 1983 to 2010, states adopted an average of 14 new abortion restrictions per year, and from 2011 to 2015 this number drastically increased to an average of 57 per year (Guttmacher Institute, 2016). In 2021, a historical 106 abortion restrictions were enacted by U.S. states in addition to S.B. 8, the ban on abortion past six weeks in Texas (Guttmacher Institute, 2021c). Many U.S. states, particularly Southern ones, were prepared for the overturning of *Roe v. Wade* in June of 2022 with pre-*Roe* laws or trigger bans that were quickly enacted after the decision (Nash & Ephross, 2022). Common abortion restrictions enacted include mandatory waiting periods, forced ultrasounds, state-mandated counseling requirements, insurance coverage policy limits, limits on medication abortion, gestational age limits, and Targeted Regulations of Abortion Providers (TRAP) laws (Guttmacher Institute, 2016).

Waiting Periods

Medically unnecessary waiting periods are measures taken by many states to make the process of getting an abortion more difficult and inconvenient for patients in an attempt to discourage them from going through with the process (Guttmacher Institute, 2020a). As of January 1st, 2023, 27 states require that patients wait a specific amount of time between counseling and an actual abortion procedure (Guttmacher Institute, 2023a). These restrictions usually require that patients seeking an abortion wait for a period of time, ranging from 18 hours to three or more days, between abortion counseling and the actual abortion itself (Guttmacher Institute, 2020a). Additionally, 15 states currently require that the initial abortion counseling take

place in person, meaning that patients must make time to attend two separate appointments just days apart (Guttmacher Institute, 2023a). This introduces a notable hurdle for patients who may not be able to take time off of work, live in rural areas or areas hours away from the nearest abortion clinic, or may not have access to consistent transportation, among other disparities (Guttmacher Institute, 2020a).

Informed Consent

In addition to requiring abortion counseling appointments, many states require informed consent that includes often misleading or irrelevant language intending to discourage patients from obtaining an abortion, be read (Guttmacher Institute, 2023a). As of 2023, 32 states require abortion counseling before a procedure, with nearly all of them requiring that counseling include information about fetal development in relation to the abortion procedure (Guttmacher Institute, 2023a). For example, providers are required to tell patients the gestational age of the fetus in 30 of these states, information surrounding fetal development during pregnancy in 26, information on the ability of a fetus to feel pain in 12, and that personhood begins at conception in 5 states (Guttmacher Institute, 2023a). Additionally, medically inaccurate information about the risks of abortion is often included in required counseling; this includes false statements surrounding the process of medication abortion, the effect of abortion on future fertility, an association between abortion and an increased risk of breast cancer, and negative emotional responses to abortion (Guttmacher Institute, 2023a).

Ultrasound Laws

Another hurdle many women face when seeking abortion services is state ultrasound laws (Guttmacher Institute, 2023b). Though routine ultrasounds are considered medically unnecessary

for first-trimester abortions, many states require them as yet another form of discouraging patients from completing an abortion by humanizing the fetus (Guttmacher Institute, 2023b). As of January 1st, 2023, 27 states regulate ultrasound provision in some form (Guttmacher Institute, 2023b). Of these states, 6 require that providers display and describe the ultrasound image to the patient, 10 require that the provider perform an ultrasound on each abortion patient, 8 mandate that the patient must be provided with the opportunity to view the ultrasound if the provider performs one as part of the procedure, and 6 mandate that the patient be provided the opportunity to view the ultrasound image regardless of whether or not the provider performs one as part of the procedure (Guttmacher Institute, 2023b). Likely an additional effort to discourage patients from obtaining an abortion, ultrasound requirements can significantly add to the overall cost of the procedure for patients (Guttmacher Institute, 2023b).

TRAP Legislation

In addition to strict evidence-based regulations required of all providers to maintain patient safety, almost half of all U.S. states have additional unnecessary regulations specifically for abortion providers with the intention of limiting abortion access called TRAP laws (Guttmacher Institute, 2020b). These laws impede the ability of abortion providers to practice by applying state standards for ambulatory surgical centers to abortion clinics, unnecessarily complicating the conditions under which abortion providers may practice (Guttmacher Institute, 2020b). In some cases, these laws extend to aspects of abortion clinics that have nothing to do with patient or procedural safety; for example, regulations surrounding the layout of physician offices are sometimes enforced (Guttmacher Institute, 2020b). As of January 1st, 2023, 23 states have TRAP laws in place, 17 of which require licensing standards for abortion clinics comparable to those of ambulatory surgical centers, 18 of which have particular requirements for

the physical layout of procedure rooms and corridors, and 12 of which have unnecessarily complicated restrictions for clinicians at abortion clinics, such as requiring them to have some affiliation with a local hospital or have admitting privileges (Guttmacher Institute, 2023c). These burdensome regulations further complicate abortion provision at clinics in states that enforce them (Guttmacher Institute, 2023c).

Medication Abortion Policy at the Federal and State Level

It is important to note that medication abortion comes with its own set of legislative barriers separate from those experienced with procedural abortions. Despite previous FDA approval and the overwhelming evidence of the safety of mifepristone and misoprostol, the FDA implemented the Mifepristone Risk Evaluation and Mitigation Strategy (REMS) Program in 2011, adding unnecessarily complicated and burdensome restrictions to the provision of medication abortion (ACOG, 2023). Restrictions included the requirement that mifepristone be dispensed under certified clinician supervision in a clinic, medical office, or hospital, affecting the ability of patients to receive mifepristone from pharmacies or via mail services (ACOG, 2023). Much like restrictions on procedural abortion, these requirements do not make the process of medication abortion safer but rather create barriers to safe abortion care that disproportionately affect populations who already face systemic healthcare barriers such as patients of color or patients who experience travel-related barriers (ACOG, 2023). During the COVID-19 pandemic, the FDA halted the in-person dispensing requirement of mifepristone, a change that was found to improve patient access and reduce the burden on the healthcare delivery system (ACOG, 2023). As of January 3, 2023, the FDA has permanently removed the burdensome in-person dispensing requirement but added a pharmacy certification process that requires pharmacies to meet certain qualifications in order to dispense prescribed mifepristone to

patients (ACOG, 2023). However, all other previous REMS restrictions remain in place, including requirements of prescriber certification and the completion of prescriber-patient agreement forms (ACOG, 2023). The way in which these restrictions affect clinic practice varies, as access to medication abortion is continually limited by state-level bans and restrictions (ACOG, 2023). Common state-level restrictions include the outright outlawing of TMAB, regulations that require in-person dispensing of mifepristone despite the new FDA regulations surrounding this, and general policies surrounding the legality of dispensing medication via mail (ACOG, 2023). Additionally, many states employ medication abortion "reversal" laws which mandate that patients receive dangerous, medically inaccurate information from their provider regarding the possibility of reversing a medication abortion (Redd et al., 2023). These rapidly-changing restrictions in states with hostile abortion policy landscapes further the extent of the burden placed on both clinics and abortion-seeking patients.

Implications of Abortion Policy for the U.S. South

It is crucial to note that the majority of recent abortion restriction increases have taken place in Southern states that are known to be conservative (Guttmacher Institute, 2023d). Currently, the states with the most restrictive policies are Texas, Oklahoma, Arkansas, Louisiana, Missouri, Mississippi, Alabama, Tennessee, Kentucky, West Virginia, South Dakota, and Idaho (Guttmacher Institute, 2023d). Particularly post-*Dobbs*, the Southern region of the U.S. faces a stark increase in abortion restrictions in comparison to the rest of the country, highlighting the urgency of the situation that abortion seekers in this region are faced with. Though the country as a whole faces an unacceptably low rate of abortion-providing facilities in relation to the population of reproductive-age women, it is critical to look at the geographical distribution of these statistics (Schroeder et al., 2022). As of 2021, in the Northeast U.S., there was one abortion

facility for every 56,000 women of reproductive age; in the same year in the Southern U.S. there was one abortion facility for every 158,000 women of reproductive age (Schroeder et al., 2022). The East South Central U.S., comprised of Alabama, Kentucky, Mississippi, and Tennessee, contains the fewest abortion facilities of any other region of the country as of 2021, at a startling 15 clinics (Schroeder et al., 2022).

Overall, strict regulations surrounding waiting periods, counseling requirements, ultrasound requirements, and TRAP legislation are all notably more prevalent in the South (Guttmacher Institute, 2023d). Additionally, recent restrictions include a reduction in insurance acceptance in many Southern states; as of 2021, only 53% of abortion facilities in the region accept insurance (Schroeder et al., 2022). This has the potential to create notable disparities for economically disadvantaged patients who may not be able to afford out-of-pocket abortion costs (Dehlendorf & Weitz, 2011). The hostile and rapidly changing local state abortion policy landscape in the region makes abortion provision unnecessarily complicated, challenging, and confusing to both providers and patients. Providers in the South are faced with a unique set of challenges that contribute to issues in provider recruitment and retention and therefore provider shortages (Chowdhary et al., 2022). There is no doubt that the recent *Dobbs v. Jackson Women's Health Organization* ruling will ultimately exacerbate the already stark differences in abortion coverage in the South compared to the rest of the nation and subsequently the disparities that vulnerable populations face, placing even more burden and pressure on the scarce abortion facilities that exist in the region and threatening the wellbeing of abortion-seeking patients.

Vulnerable Populations and Disparities in Abortion Access

The need for abortion services does not decrease as strict state policies regulating it increase; rather, the gap between who can access such services versus who cannot grows larger

(Lynch et al., 2022). Though abortion restrictions affect every patient seeking these services, it is important to note the disparities in access that specific vulnerable populations face, particularly low-income pregnant individuals and pregnant individuals of color (Lara et al., 2015). This population makes up the majority of abortion-seekers, likely explained and exacerbated by the multitude of healthcare disparities and barriers to abortion access that they face in comparison to other populations (Anderson et al., 2022; Lara et al., 2015). Continuing an undesired pregnancy, which patients who lack access to abortion services may be forced to do, has its own set of potential health consequences as pregnant individuals in this position are known to be less likely to seek prenatal care and have poorer health outcomes (Dehlendorf & Weitz, 2011). Additionally, a study aimed at assessing racial disparities in pregnancy counseling in the U.S. South found that Black patients were more likely than non-Black patients to want an abortion referral and not receive one, to not receive an abortion referral when they intended to end their pregnancy, and to not receive access to resources like transportation, childcare, or financial support when they expressed a need for them (Nobel et al., 2023). Several structural factors create significant barriers to access for vulnerable populations, including financial, travel-related, and stigma-related barriers.

Financial Barriers

A lack of means to finance an abortion is a particularly notable barrier that affects low-income patients (Dehlendorf & Weitz, 2011). As previously mentioned, the Hyde Amendment prohibits the use of Medicaid funds toward abortion services, negatively impacting the low-income populations that primarily utilize the service (Dehlendorf & Weitz, 2011). Even if a patient has access to private insurance, restrictions regarding coverage policies for abortion services often result in patients having to pay for these expensive services out-of-pocket

(Dehlendorf & Weitz, 2011). Low-income patients in this situation are often unable to pay for the abortion procedure, resulting in delays in obtaining an abortion or the pregnant individual being forced to carry an unwanted pregnancy to term (Boonstra, 2016). In a study that examined the roles of social support and social capital in the abortion process in Georgia, it was found that Black Georgians often cited the lack of alternative options; many participants could not afford an abortion and simultaneously could not afford to continue with the pregnancy (Dickey et al., 2022). Participants cited the ability to reach out to social networks for financial aid in this situation but noted that they often felt guilty doing so given that their community was also affected by poverty (Dickey et al., 2022). The study ultimately stressed the need for social support and capital given the increase in abortion restrictions in a post-*Dobbs* decision policy landscape (Dickey et al., 2022). In addition to financial barriers, a lack of knowledge about abortion laws and services hinders access for low-income patients (Lara et al., 2015). Further exacerbating these barriers is the fact that abortion services become more expensive as the gestational age increases, creating a vicious cycle for economically disadvantaged patients (Dehlendorf & Weitz, 2011).

Travel Barriers

Travel is another significant barrier to abortion access for vulnerable populations, particularly for low-income patients who may live in rural areas or areas far away from the already scarce abortion clinics that exist in the South. In a study examining the distance traveled to obtain an abortion in the U.S., it was found that patients traveled a mean distance of 34 miles each way to reach an abortion facility, highlighting just how burdensome this journey can be. (Fuentes & Jerman, 2019). The South was found to have the highest distribution of patients, with 59.3% traveling less than 25 miles to reach an abortion facility, 19% traveling between 25-49

miles, 12.7% traveling between 50-100 miles, and 9% traveling over 100 miles (Fuentes & Jerman, 2019). Another study predicted that the *Dobbs* decision would increase this distance to an average of 113.5 miles each way, particularly for pregnant individuals seeking abortion services in the South (Kelly & Brewer, 2022). For low-income patients who are forced to cross state lines to obtain an abortion, the travel experience can be incredibly distressing and further stigmatize abortion for the patient (Jerman et al., 2017). Overall, it has been reported that having to travel far distances to reach an abortion clinic makes the experience more negative for patients (Jerman et al., 2017). Travel-related barriers include factors other than distance, however, such as inclement weather, lack of access to safe and reliable transportation, and having to use multiple modes of transportation to reach an abortion clinic (Jerman et al., 2017). A qualitative study examining barriers to abortion access for low-income patients found that participants most frequently reported the largest barrier to be travel-related arrangements, the consequences of which included obtaining abortions at later gestations than desired, experiencing negative mental health outcomes, and considering terminating the pregnancy on their own (Jerman et al., 2017). Additionally, travel-related barriers further complicate the unnecessary burden of waiting periods and ultrasound law restrictions that often require patients in the South to make multiple separate trips to clinics.

Abortion Stigma

Patients who seek abortions often report experiencing abortion stigma (Cockrill et al., 2013). Individual-level abortion stigma has been found to include worries about judgment, isolation, self-judgment, and community condemnation (Cockrill et al., 2013). Abortion stigma leads to feelings of stress, shame, and guilt in patients and has the potential to result in reduced self-efficacy surrounding decision-making, increased likelihood of psychological distress, and

decreased perceptions of social support (Redd et al., 2023). It has been theorized that abortion stigma relies on disparities and inequalities to exist, making the experience more notable for vulnerable populations (Kumar et al., 2009). It has been suggested that it exists due to the fact that it transgresses the "feminine" ideals of fecundity, motherhood, and nurturing (Kumar et al., 2009). Additional causes of abortion stigma may include the humanization of the fetus, legal restrictions, the notion that abortion is "dirty," and that stigma is helpful in making the case for anti-abortion efforts (Kumar et al., 2009). Patients who experience other barriers to access may be likely to experience abortion stigma in conjunction; a study that examined the association between abortion stigma and the distance a patient must travel to obtain one found that traveling 50 or more miles each way was associated with individual-level abortion stigma scores (Dahl et al., 2023). This finding highlights that disparities in abortion access do not stand alone for vulnerable populations but rather often compound.

Telehealth Medication Abortion Services

Benefits of Telehealth

Telehealth, commonly referred to as telemedicine, bridges gaps in healthcare access by allowing patients to virtually talk to their providers, send and receive messages, and utilize remote monitoring services ("What is telehealth?," n.d.). Though the concept of telehealth has existed since the early twentieth century, the COVID-19 pandemic has drastically increased the extent to which patients and providers have relied on this method of healthcare delivery (Mahtta et al., 2021). While this increase was originally largely due to the physical distancing measures necessitated by the COVID-19 pandemic, the impact of telehealth on healthcare outcomes has been found to be largely beneficial (Mahtta et al., 2021). In fact, telehealth services have overall improved healthcare outcomes, served as a cost-effective mode of healthcare delivery, improved

access to and timeliness of care, reduced provider-patient supply-demand mismatch, and are anticipated to be useful in emergency preparedness protocols (Mahtta et al., 2021).

TMAB

As previously mentioned, medication abortion prevalence has risen in recent years, taking the lead as the most popular method as of 2020 (Jones et al., 2022). Telehealth medication abortion, or TMAB, refers to the provision of medication abortion after a virtual provider-patient interaction. The process of TMAB can occur in a variety of ways, largely dependent on state and clinic regulations (Guttmacher Institute, 2023d). Similar processes to in-clinic distribution of medication abortion are followed, with the exception of TMAB dismissing the need for ultrasounds and other routine testing in some cases (Grossman, 2022). If ultrasounds and other forms of routine testing are required as a component of TMAB, it is sometimes an option for the patient to complete these procedures at sites near them rather than having to travel to the abortion clinic (Grindlay et al., 2013). Screening, counseling, and education can also occur remotely via TMAB (Grindlay et al., 2013). Additionally, the medications can be sent to patients via pharmacy, can be available for pickup to patients at clinics closer to them, and even be mailed to them (Grindlay et al., 2013). Differences in screening, counseling, education, ultrasound and routine testing requirements, and medication distribution protocols exist due to variations in state-level policies surrounding TMAB (Grossman, 2022). For example, in some cases, providers may legally complete all of these steps virtually, while in other cases this process can only partially legally occur or not legally occur at all (Grossman, 2022). Despite countless regulations surrounding TMAB in the U.S., studies examining the safety and effectiveness of TMAB have found that almost all patients were able to successfully end their pregnancy without surgical intervention (Aiken et al., 2022).

TMAB and COVID-19

The COVID-19 pandemic has greatly affected the role of telehealth and specifically TMAB in the U.S. In a study examining the impact of the pandemic on U.S. abortion provider attitudes and practice toward medication abortion, it was found that many clinics significantly altered their TMAB protocols in response to the pandemic (Karlin et al., 2021). Provider attitudes were overall found to be more supportive of TMAB, given changing clinic protocols that altered physician perspectives toward risk assessment of the process in the context of COVID-19 (Karlin et al., 2021). The implementation of new TMAB protocols was found to be more efficient when supplemented with evidence-based support, but with the exception of states with hostile abortion policy climates (Karlin et al., 2021). Providers in these states, classified as hostile based on policy data from the Guttmacher Institute in 2020, noted a lack of flexibility of clinics to adapt to changes in TMAB provision (Karlin et al., 2021).

Demand for TMAB

In a study exploring attitudes surrounding the legality of medication abortion, it was found that the majority of participants who resided in a state with at least one law that could be used to prosecute an individual for usage of medication abortion believed that this method of abortion should not be against the law (Raifman et al., 2022). It was also found that factors associated with this belief included prior experience with abortion, higher educational levels, and higher income (Raifman et al., 2022). Trends show that the demand for TMAB is higher in states with more restrictive abortion policies. For example, a study examining the desire for self-managed abortion through an online telemedicine service in the U.S. found significant and prevalent demand; among the thousands of U.S. residents who requested this service, an overwhelming 76% resided in states with a hostile abortion policy landscape (Aiken et al., 2020).

Another study investigating TMAB interest among young populations in Texas and California found substantial interest overall, but notably higher interest levels in Texas than in California (Harper et al., 2022). In the wake of S.B. 8 and other restrictive abortion policies, patients in Texas face great barriers to access in comparison to those in California, further highlighting the need for TMAB services in Southern states with hostile abortion policy climates (Harper et al., 2022).

Following the *Dobbs* decision, it was found that requests for TMAB services increased (Redd et al., 2023). The largest increase in requests occurred in states with total bans, though increases were noted in other states as well with confusion about state laws cited as motivation (Redd et al., 2023). Given the current standing of abortion policy in the country, TMAB services are critical to preserving and expanding access to abortion services (Allsworth, 2022).

Advantages of TMAB

It has been found that expansion and ban removal of TMAB services greatly expand abortion access, particularly for patients who live in rural areas of the country (Seymour et al., 2022). Numerous advantages of TMAB have been cited by both providers and patients including decreased travel, greater options regarding location and timing of appointments, and the experience of a more private, secure, and comfortable experience than an in-person appointment (Grindlay et al., 2013). Patients have reported feeling supported, safe, autonomous, and empowered in their care (Kerestes et al., 2022). On the other hand, it was noted that when participants had to navigate the abortion process outside of TMAB, they often experienced abortion stigma and therefore avoided traditional care (Kerestes et al., 2022).

A study that explored support for and interest in alternative methods of medication abortion found that participants saw advantages to advanced provision of the medication from a

doctor, over-the-counter access to the pills, and online access to the pills without a prescription (Biggs et al., 2019). The advantages of these methods included the ability to maintain privacy, convenience, and being able to end the pregnancy earlier (Biggs et al., 2019). The results of this study further highlight the ways in which medication abortion is useful in overcoming barriers to access in the U.S. Additionally, an article examining the rise of medication abortion usage noted that virtual abortion clinics cost much less than in-clinic medication abortion appointments, helping to bridge financial gaps in access for low-income populations (Baker, 2023). Overall, TMAB patients have noted that these virtual services decrease access barriers while meeting all of their important needs and expressed gratitude for their existence (Madera et al., 2022).

TMAB Landscape in the U.S. South

Current literature suggests that TMAB shows great promise in mitigating access barriers, but it is crucial to note that this only remains true in states where TMAB is permitted in the first place. For example, a study examining abortion providers' views on self-managed medication abortion across the U.S. found that providers in states with a more permissive abortion policy landscape were more likely to believe that they should be able to mail or provide a prescription for medication abortion after a telehealth appointment than providers in states with more hostile landscapes (Kerestes et al., 2019). There is a notable gap in literature surrounding the current TMAB landscape in the South, especially in regards to provider perspectives specifically in this region, likely due to the fact that TMAB is severely restricted in many of these states.

Additionally, abortion providers in the South face a unique set of barriers. Recruitment and retention of abortion providers are certainly challenged by conservative contexts given the constant addition of new and rapidly-changing regulations that affect abortion provision and the burnout that overworked staff often experience (Chowhardy et al., 2022). The consequence of

post-*Dobbs* state-level bans is a dramatic decrease in the number of abortion providers in the U.S., an issue that Southern states are at high risk of facing (Allsworth, 2022). TMAB services are becoming increasingly more important as facility-based care becomes continually more strained in these regions (Grossman, 2022).

Gap in Literature

Given the nonpermissive TMAB policy landscape in the South, the strain and pressure that already sparse abortion clinics are currently under, and the subsequent inability of abortion providers in many Southern states to offer TMAB as an option for patients who prefer it or would benefit from it, there is a gap in literature surrounding the perspectives of sexual and reproductive health providers and administrators in the region toward TMAB. Learning more about these perspectives is critical to understanding how much of a priority TMAB is for providers and administrators in the South; this will aid in developing a richer understanding of the TMAB landscape in the region, both currently and in the future. Additionally, having these perspectives will help to better understand whether or not clinics would implement TMAB, if they do not already do so, given permissive local state laws. This thesis seeks to fill this gap in literature by exploring sexual and reproductive healthcare provider and administrator attitudes in the South toward the importance and priority of TMAB given the uniquely hostile abortion policy climate in the region.

Chapter 3: Methods

Study Design

This thesis conducts a secondary analysis of the Provider Readiness for Virtual Implementation and Delivery of Medication Abortion Services (PROVIDA) study. The study employed qualitative methods, specifically a series of in-depth interviews, to assess the readiness for and experiences with administering TMAB from the perspectives of SRH clinicians and administrators. A quantitative questionnaire was also administered to participants to assess demographics, clinic resources, and service provision considerations.

Study data were collected prior to the *Dobbs v. Jackson Women's Health Organization* ruling that overturned *Roe v. Wade*, from June 2021-2022, with collection ending a few weeks prior to the ruling. Despite this landmark ruling that has since greatly affected abortion legislation and access in the U.S., this data is still significant and critical to understanding provider and administrator attitudes toward TMAB services, especially as TMAB services expand in other states or opportunities to expand TMAB potentially become available in restrictive contexts as the landscape shifts.

Population and Recruitment

The study focused on two populations: 1) clinical care providers, including physicians and nurse practitioners, and 2) clinic administrative staff. Clinical care providers were considered eligible to participate if they were a physician or advanced practice nurse and if they were engaged in providing medication abortion or family planning services at an abortion facility, specialized family planning center, or obstetrics and gynecology practice. Both providers who were

providing medication abortion services without telemedicine and those who were providing TMAB were considered eligible to participate. Clinic administrative staff were considered eligible if they were employed at an abortion clinic, a specialized family planning center, or a private Ob/Gyn practice and if they were engaged in overseeing practice workflows. Participants were recruited through the professional networks of the research team, professional listservs, and snowball sampling methods. A total of 21 participants were recruited: 7 administrators, 1 educator, and 13 providers. Participants were from Southern U.S. states including Georgia, Virginia, Tennessee, Texas, Alabama, Mississippi, Florida, South Carolina, and North Carolina in no particular order. Participants attended interviews via Zoom that ranged from 60-90 minutes and were compensated with a $50 gift card in recognition of their time.

Data Collection Tools

The conducted interviews aimed to assess participant attitudes about and willingness to provide TMAB services as well as the specific needs related to being able to implement such services. Interview guides were informed by the Consolidated Framework for Implementation Research (CFIR) to get a sense of the implementation climate for TMAB at participants' respective clinics (Damschroder et al., 2009). Questions about importance and priority of TMAB were included as they are important in assessing implementation climates. The guides were semi-structured and were created after the research team conducted a review of relevant literature. Separate semi-structured in-depth interview guides were developed for providers and administrators with specific questions relevant to either the provider or administrator scope of work, though there were some overlapping questions as well. General topics that were the same in all interviews included questions about importance, needs, and priority related to TMAB as well as questions about capacity, implementation, decision-making, and resource considerations. Additionally, all

participants were asked to describe their considerations specifically for underserved populations. Interviews for providers included a focus on counseling provision, medication prescription, training needs, and potential workflow challenges while those conducted with administrators included a focus on logistical, workflow, and scheduling considerations. Data collection tools also included a sample protocol for providing TMAB that was used to solicit detailed information about readiness of participants who already did or could implement these services.

During initial contact with the participant, eligibility to participate in the study was determined and a time was set for the interview. Interviews began with the administration of an informed consent form and the study continued after obtaining participant consent. A short demographic questionnaire was then administered to collect demographic information, information about the participant's professional role, and geographic information. The semi-structured interview was then conducted, ranging from 60-90 minutes, and was audio recorded for later transcription. Audio recordings were uploaded into a password-protected One-Drive folder.

All materials were submitted to the Institutional Review Board of Emory University in the United States for ethical review and IRB exemption was received prior to data collection. The study was determined to be exempt from IRB review by Emory IRB (STUDY00003095).

Analysis

Data for this thesis specifically analyzed perspectives of clinicians and administrators in this region toward the importance and priority of implementing TMAB.

Interviews were audio recorded and transcripts were professionally transcribed. The verbatim transcripts were then uploaded into MAXQDA for coding and analysis. The research team coded transcripts to identify both deductive themes from the interview guide and inductive themes from the discussions. The team developed a codebook based on the transcripts, refined coding, and reached a consensus on intercoder agreement. Codes were organized under 6 umbrella codes: organization context, policy codes, TMAB steps, implementation codes, barriers and facilitators, patients and community, and other codes. Within "implementation codes," themes were further split into perceived readiness, intervention characteristics, inner setting, outer setting, individual characteristics, and implementation process. Within "inner setting" included the codes structural characteristics, culture, implementation climate, readiness for implementation, and networks and communications. Team members reached intercoder agreement before beginning coding.

For the purpose of this thesis, the deductive implementation code "Relative Priority" was examined to answer the specific research question of attitudes toward the importance and priority of TMAB. CFIR defines this construct as "individuals' shared perception of the importance of the implementation within the organization"; this was adapted to the study's context and defined by the research team as "individuals' shared perception of the importance of implementing TMAB services within the organization" (Lewis et al., 2018). This code was used for statements regarding the need for and importance of TMAB for meeting patient needs in response to questions about its importance. The code was included within the larger "Implementation Climate" code category. The "Relative Priority" code was assigned to all segments of interviews that fit the description and these segments were further analyzed to identify subthemes and answer the research question. A thematic analysis method was employed to analyze and interpret

data. Segments coded under “Relative Priority” were reviewed and refined to develop subthemes and richness of subthemes assessed.

Chapter 4: Results

Four main themes were identified during data analysis: TMAB is important for patient benefit, TMAB is important for clinic benefit, political climate affects participant prioritization of TMAB, and staff hesitance affects clinic prioritization of TMAB. Though importance influenced feelings toward and prioritization of TMAB for some participants, the two concepts were largely discussed separately and therefore split into two major themes for each. Each of the four themes was further split into sub-themes as necessary.

Importance of TMAB for Patient Benefit

Overall, the majority of participants noted the importance of TMAB in expanding access from a patient-centered healthcare perspective. Participants noted the importance of TMAB for patient benefit, specifically in mitigating physical access barriers, long wait times, and administrative barriers, decreasing cost of services, increasing privacy, and creating as many access points as possible for patients.

TMAB Mitigates Physical Access Barriers

The importance of implementing TMAB for addressing access barriers to abortion care for patients was cited by almost every participant. Among these barriers, the mitigation of physical access barriers to abortion care was particularly notable. Participants noted that patient physical access barriers included living in a rural area and/or hours away from the nearest abortion clinic, having to cross state lines to receive care due to state restrictions and bans, the burdens of finding childcare, a lack of access to transportation services, and the inability to take time off of work for the necessary appointments. Participants cited that TMAB was critical to expanding access by

reducing the need for patients to physically be present at clinics in order to receive abortion services.

"It's really just access. It really helps access for people who have difficulty, for whatever reason, getting to the clinic. It allows people from all over the state to take advantage and to not have to travel, it's really a travel component." – Administrator, Virginia, providing TMAB

Furthermore, it was commonly mentioned by the majority of participants that vulnerable and marginalized populations were at a disproportionately high risk of facing physical barriers to abortion care and would thus especially benefit from TMAB. The importance of TMAB in achieving health equity was noted by some participants.

"I think that when you think about equity across marginalized populations, that again, somebody it's in a rural area of Bullitt County in South Georgia, are they going to be able to drive somewhere to get the care they need… or if they have childcare issues, or they can't get off work." – Administrator, Georgia/Virginia/Tennessee, providing TMAB

Overall, participants were enthusiastic about the importance of TMAB in mitigating physical access barriers for patients and expressed urgency in the desire to implement TMAB due to its critical role in expanding access.

TMAB Mitigates Long Wait Times and Other Administrative Barriers

Some participants specifically cited the importance of TMAB in mitigating long wait times for care and other administrative barriers that patients may face. Long wait times on the day of the patient's appointment were noted as an inconvenience and barrier to care for patients as well as an overall drain on the patient's time. In addition to long wait times during the appointment, participants also identified lengthy wait times for scheduling appointments. The importance of TMAB in alleviating these time-related barriers by increasing efficiency and convenience was commonly discussed by participants.

"I have worked in several abortion clinics and they all take forever and it is a significant drain on patients' time, their time away from work, the time they're having to pay for child care… And the actual care that's provided takes, I mean, 45 minutes, I guess, start to finish, and yet they're with us for hours sometimes… telehealth could really help with that… Let's do everything and then you walk in and we hand you the Mife, you can go about your day" – Provider, Georgia, partially providing TMAB

Additionally, the ability of TMAB to mitigate other regulation-specific administrative barriers associated with abortion consultations, such as ultrasound and bloodwork requirements, within the time constraints of the virtual appointment was noted by participants. Participants did note the small exception of the inability to physically hand the patient mifepristone, which is required in some states. These administrative barriers often make appointments longer and more burdensome for patients, especially if they are traveling long distances.

TMAB Decreases Cost of Services for Patient

The ability of TMAB to decrease the cost of services for patients was cited by some participants, including both those already providing TMAB and those not. Participants commonly noted that TMAB services, especially if they eliminate the need for ultrasounds or bloodwork, have the potential to exponentially decrease the amount that patients are required to pay for appointments. This in turn works toward mitigating financial barriers that patients face to care and ultimately increases access for economically disadvantaged patients.

"I think also in terms of potential costs to patients, it would definitely be a lot cheaper to administer or to do an online appointment versus the costs that are associated with coming in, doing an ultrasound, having blood drawn, speaking to a patient educator, all of those extra steps that are more so involved with coming into the clinic, all of those costs would essentially be not there anymore. So I think, yeah, in terms of benefits to the patient, they would also see those potential savings." – Administrator, Tennessee, not providing TMAB

TMAB Increases Privacy for Patients

Many participants noted the importance of TMAB in increasing privacy for patients and ultimately allowing them to avoid abortion stigma commonly experienced in person. Participants mentioned the importance of TMAB specifically in allowing patients to have a safe, confidential, discreet manner of completing an abortion. The importance of this privacy in avoiding abortion stigma was notably cited in the context of protestors that are commonly stationed outside of abortion clinics in the South; participants cited avoiding protestors and the shame they place on patients as a major benefit of TMAB.

"No… unsurprisingly, Texas is a fairly conservative state. And so you do always have the issue of protesters outside of places that are known to provide terminations. And so being able to order something to your front door and take a medication in the privacy of your own home and not have to go in and pass everyone who is outside picketing is a huge benefit." – Provider, Texas, not providing TMAB

Abortion stigma was also discussed in the context of patients' social circles, as some participants mentioned that in addition to fearing judgment from providers, many patients do not feel safe or comfortable asking friends or family for support during the abortion process. Participants noted that TMAB has the ability to partially, or even fully, eliminate this fear by allowing patients a more discreet and private experience.

"And so, it really seems like having this safe, confidential, discreet way to provide abortions is in my opinion, it really is like the future." – Educator, Florida, providing TMAB

Importance of TMAB for Clinic Benefit

The importance of TMAB for clinic benefit was discussed by many participants. Participants described elements of TMAB that could benefit clinic staffing issues, workflows, the ability to see more patients, and overall financial benefit. Additionally, some participants expressed urgency in prioritizing TMAB due to its potential ability to benefit clinics in these ways.

TMAB Helps with Staffing Issues and Clinic Flow

Many participants, including both those already implementing TMAB and those not, cited the importance of TMAB in potentially helping with staffing issues and overall clinic flow. This was discussed in a variety of contexts, including eliminating the need for physicians to physically be at appointments. For example, some participants noted that having a physician present on-site is particularly challenging, especially when they have to travel to smaller clinics for in-person appointments. A few participants also cited that, particularly in the South, clinics are often short-staffed and it can be challenging to find a physician that wants to work on a regular basis; it was mentioned that providers often choose to moonlight and thus are only available one day a week or sometimes even one to two days a month. The ability of TMAB to alleviate this burden and allow for more consistent staffing was cited both by participants already providing TMAB at their clinics and those not.

"It would mean less of the physicians having to move around to get to some of the smaller clinics and make sure they got out there. It would be great from a system's point and from a patient access point. I think there would be a lot of support for it administratively." – Provider, North Carolina, not providing TMAB

Many participants also emphasized the potential for TMAB to improve clinic flow, citing benefits from both systems and administrative perspectives. More specifically, participants described how TMAB could allow for a more streamlined flow and increased staff efficiency; it was noted that if TMAB services waived the need for ultrasounds, that would reduce a notable bottleneck in clinic flow.

"It would hopefully allow for a more streamlined flow. Currently [Specialized FP Center 2] has a requirement that affiliates provide ultrasounds before abortions are performed, but you can apply for a waiver, especially if we want to do teleMAB. So we would apply for that waiver. That's a huge bottleneck in the flow, having to do ultrasounds. So just in general, getting that would reduce the time of the visit." - Administrator, Georgia/Alabama, not providing TMAB

Some participants noted that these benefits positively influenced their prioritization of TMAB at their clinics as well.

TMAB Helps with Clinic Volume and Sustainability

The majority of participants who noted the importance of TMAB for clinic benefit did so in the context of sustainability. This included mentions of being able to see more patients, reducing expenses of flying physicians out to clinics, and avoiding the overhead costs of having an in-person clinic.

"Our fees are about half of what they are in a clinic setting, and part of that is because we don't have to have the overhead of an office. We operate with many less, that we only have four staff members, and saw 1,000 patients last year. So the ability to see a large number of patients, and so those savings are translated to the patient paying less." – Administrator, Texas, providing TMAB

Many participants, both those who have already implemented TMAB at their clinics and those who have not, cited the benefits of having a purely virtual clinic, particularly in the context of avoiding the costs of maintaining a brick-and-mortar clinic. The ability of TMAB to allow clinics to see more patients was translated to both an increase in revenue for the clinic and a decrease in the amount patients were required to pay for appointments, ultimately increasing clinic sustainability and patient affordability.

Political Climate Affects Participant Prioritization of TMAB

The majority of participants discussed political climate as the most important factor influencing their personal prioritization of TMAB at their clinic. Most of these participants considered legislative restrictions, fear of litigation, and feeling overwhelmed due to the policy climate in their reasoning for TMAB being a low priority, while many conversely felt that the urgency of the political climate made their prioritization of TMAB higher. This does not necessarily reflect the legal feasibility of implementing TMAB, but rather participant opinions of TMAB prioritization.

Legislative Restrictions Make TMAB Less of a Priority

Most participants who noted that the political climate negatively affects TMAB priority discussed this in the context of legislative restrictions in their state. These participants felt enthusiasm toward TMAB, many of whom mentioned that they wished they could implement it, but were held back by legal restrictions. These deterring factors noted by participants ranged from outright being unable to legally provide TMAB in their state, to feeling confused with the rapidly changing policy landscape and not knowing the current legal status of TMAB, to not wanting to risk implementing it for fear of it becoming illegal in the near future.

"I would say it's at the bottom of the priority list just because it is not feasible for us… if we didn't have that law or if there was any notion that that law was going to go away, then I think we would have definitely hopped on the tele-MAB train." – Administrator, Tennessee, not providing TMAB

A few participants also noted that if they were to implement TMAB, the nature of other abortion-related restrictions in their state would negate its benefits as it would not be a low-touch model in practice.

Fear of Litigation Makes TMAB Less of a Priority

In relation to the hostile abortion policy climate in their state, many participants also noted that fear of litigation kept them from prioritizing TMAB. For example, some noted fear of litigation as a result of unclear legislation that could be interpreted to criminalize the provision of TMAB. Many of these participants noted that their main priorities were continuing to provide already existing services for patients and avoiding anything that could jeopardize their ability to do so. Participants mentioned that doing something new or innovative, like TMAB, could bring unwanted attention from anti-abortion activists and in turn jeopardize their ability to provide in-person services.

"Doing innovative types of things like these, I feel like sometimes puts an even larger target on your back, if that makes sense. Particularly when you start thinking outside the box and thinking about loopholes and that sort of thing. When the state has organized private citizens to come after you about providing abortions, is it something you should be undertaking to try to skirt

around the restrictions that are already in place? If that makes sense." – Provider, Alabama, not providing TMAB

Overall, these participants ultimately saw the risks of TMAB as outweighing the benefits due to the hostile abortion policy landscape in their state.

Providers are Overwhelmed due to Policy Climate so TMAB is Less of a Priority

In addition to legal hesitations, many participants also mentioned feeling so overwhelmed by the challenges that their current state-policy climate posed that they did not consider TMAB to be a high priority. Some of these participants mentioned their fear that abortion might not even be legal in their state soon and that they were so overwhelmed in trying to keep their clinic doors open in the first place and providing on-the-ground services that TMAB was not something they even considered to be a feasible option. Most of these participants cited that their main goal was to make sure that patients still had access to abortion services in whatever form possible.

"My priority right now is just to make sure that we are providing the most safe and professional abortion services possible in person to our patients" – Provider, North Carolina, not providing TMAB

Overall, these participants noted that the hostile abortion policy landscape in their state was so overwhelming, both mentally and in trying to stay afloat given staffing and resource considerations, and such a barrier to providing services to patients that they were ultimately just

trying to maintain the bare minimum to ensure that their patients had access to care in some capacity at all.

Political Climate Makes TMAB More of a Priority

While most of the participants cited political climate as the main factor influencing their lack of prioritization of TMAB, some of these participants cited the urgency that their political context brought about as the factor making TMAB a higher priority. The majority of participants who suggested this were not already providing TMAB at their clinic.

"If anything, I think it's made it more urgent that we launch this as soon as possible. We are seeing patients traveling from further. We've had some patients from Texas. We've had patients reach out to us after using some of the online providers, like ordering self-managed abortions. We have seen an uptick of that so it seems like demand is growing for this. So despite what may come in the future, we want to do everything we can to increase access while we can." – Administrator, Georgia/Alabama, not providing TMAB

This included participant mentions of wanting to launch TMAB as soon as possible to increase availability of services for populations losing access as a result of newly restrictive policy environments. Many of these participants cited that TMAB was more important to implement at the time they were interviewed than ever before as policies had become more restrictive and patient barriers to access had increased.

"I think with all of these policies bubbling up and really feeling ... we've always known that there's been risk of rights being taken away at any moment, but actually feeling like it's maybe

imminent. Right? I feel like now more than ever, I think it's crucial that we do learn how to provide tele medication abortion services. And that we are prepared to provide those things… Whether that's from being in a different state and helping to provide that care to folks or working with organizations who already are providing that within certain states. I think it's really necessary for us to be ready to do." – Provider, information not provided

Though these participants cited that TMAB had become a higher priority for them, it is important to note that these thoughts did not necessarily translate to their views on the feasibility of implementing these services given the policy context both federally and in their states.

Staff Hesitance Affects Clinic Prioritization of TMAB

The most commonly mentioned factor affecting clinic prioritization of TMAB was participant perception of other staff members' hesitance and lack of prioritization. "Staff" in this context includes both clinicians and non-clinicians. Many participants cited that, though they were in favor of TMAB, they perceived that staff at their clinics were more nervous and hesitant to implement these services which in turn affects overall clinic prioritization of TMAB. This hesitance was mostly described in the context of staff not wanting to change the ways in which they've done things at the clinic as well as staff being nervous to switch to a virtual format given fear of complications and not having an ultrasound. Similar to political climate factors that affect participant prioritization of TMAB, staff prioritization did not translate to feasibility of implementing such services.

A few participants noted that the staff at their clinics were likely to be hesitant to make new changes, in turn affecting the prioritization of TMAB at their clinics as a whole. Participants

mentioned that the staff at their clinics were unwilling to shift their views and practices surrounding abortion care and that this would get in the way of potential implementation, despite participants' advocacy for TMAB. Some of these participants even mentioned that staff at their clinics did not want to be associated with abortion at all due to personal beliefs.

"How do you get providers to change how they've done something for a long time? Y'all figure that out, it's really applicable across the healthcare field. I think some providers are... it's just a non-starter, right?" – Administrator, Tennessee, not providing TMAB

Additionally, the majority of participants who noted staff hesitance as a barrier to prioritization of TMAB noted that staff were nervous to implement these services due to outdated beliefs on ultrasounds and fear of complications. Participants noted that staff were nervous about not having ultrasounds to confirm gestational age despite literature suggesting that ultrasounds are usually unnecessary for TMAB. Some participants also cited that staff were nervous about potential complications that could arise from TMAB and would not feel confident about it until educated on current literature and shown proof that complications were not common.

"I think it makes a lot of people nervous to not necessarily have an ultrasound and to not... Especially the follow-up. I think it makes people very concerned, just about folks being out there still pregnant and not knowing necessarily… people would definitely be nervous about it… We see all of the unicorns, so its sometimes hard not to think of the unicorns. Everybody is like, "Well what if they have an ectopic," which is fair, but also not as common as people think necessarily." – Provider, Alabama, not providing TMAB

Overall, staff considerations were found to be a major factor affecting participant perspectives toward clinic prioritization of TMAB provision.

Chapter 5: Discussion

Summary and Current Literature

This study is one of few that explores attitudes of SRH providers and administrators specifically in the South toward the importance and priority of implementing TMAB services at their clinics. Key findings include: TMAB is important for patient benefit, TMAB is important for clinic benefit, the political climate affects participant prioritization of TMAB, and staff hesitance affects participant perception of clinic prioritization of TMAB. TMAB was found to be important for patient benefit in mitigating physical access barriers, long wait times, and administrative barriers, decreasing cost of services, increasing privacy, and creating as many avenues of access as possible for patients. As far as clinic benefit, TMAB was found to be important in helping with staffing issues, clinic flow, clinic volume, and sustainability. The political climate was found to be the most notable factor influencing participant prioritization of TMAB at their clinic. Participant perception of staff hesitance was cited by many participants as a factor that affected clinic prioritization of TMAB; participants mentioned that many of their fellow staff members were hesitant to try new methods of provision as well as nervous about not requiring an ultrasound, fearing complications despite literature strongly suggesting that TMAB is a safe method of pregnancy termination. Overall, the findings of this study contribute to a more robust understanding of the TMAB implementation landscape in the South as well as the unique considerations that SRH professionals in this region face.

Findings regarding the importance of TMAB for patient benefit complement those of previous studies, both from provider and patient perspectives. Participants in our study most commonly cited benefits of TMAB for patients in mitigating physical access barriers, particularly for patients who have to travel inconveniently long distances to reach an abortion

clinic. Multiple studies have cited the importance of TMAB in mitigating physical access barriers with emphasis for rural patients (Seymour et al., 2022; Grindlay et al., 2013). Physical access barriers are particularly important to consider for patients in the South; studies have predicted that the *Dobbs* decision would increase the average amount of miles abortion seekers in the South must travel to reach an abortion facility to 113.5 miles each way (Kelly & Brewer, 2022). Few studies have examined the role of TMAB in mitigating financial barriers to access, but one study found that virtual abortion clinics in general cost much less than in-person clinics, ultimately lowering appointment costs and helping to bridge financial gaps for low-income populations (Baker, 2023). This study adds to current literature by complementing existing findings but with the specific lens of benefit to populations in the South. Findings from this study complement existing literature surrounding the importance of TMAB in increasing privacy as well, placing emphasis on the ability of TMAB to help patients have a secure experience while avoiding abortion stigma (Grindlay et al., 2013; Kerestes et al., 2022). Finally, this study adds emphasis to prior literature that has noted the importance of TMAB in creating as many avenues of access as possible for patients, allowing them a convenient way to end a pregnancy earlier (Biggs et al., 2019). Overall, this study adds to what is known about the importance of TMAB for patient benefit by specifically focusing on the South.

In regards to clinic benefit, TMAB was described as important in removing the need for physicians to physically be at appointments, therefore addressing the major issue of abortion clinics in the South being short-staffed. Additionally, a major benefit of TMAB discussed by participants was its flexibility, allowing more patients to be seen while avoiding the overhead costs of having a clinic in-person, and avoiding locum tenens physicians who would need to be transported into clinics from other states. There are few studies to date that cite the importance of

TMAB for clinic benefit, as most examine data through the lens of patient benefit. One study interviewed leaders of telemedicine and telehealth organizations in the U.S. and found that the majority named telemedicine as a general solution to healthcare provider shortages and cited TMAB for patient benefit, but did not elaborate on the importance of TMAB specifically for clinic benefit (Fix et al., 2018). On the other hand, findings of this thesis complement a study that examined factors associated with successful TMAB implementation and found that participants noted the importance of TMAB in reducing staff time inputs by reducing the need for resources as it does not require a physical clinical facility (Godfrey et al., 2021). However, it is important to note that data from this study is collected only from participants that live in states classified as having a "supportive" abortion policy climate by the Guttmacher Institute; the findings of this thesis add to current literature by providing SRH professional attitudes toward the importance of TMAB for clinic benefit specifically in the hostile abortion policy context of the South (Godfrey et al., 2021). The noted benefits of TMAB for clinics by participants are important to consider in the geographical context as well, as abortion clinics in this region of the nation are under extreme strain in keeping their doors open, being able to meet patient demand, and maintaining regular staffing given high risk of staff burnout and turnover (Allsworth, 2022; Chowdhary et al., 2022).

Findings from this study surrounding the effect of the political climate on prioritization of TMAB include the mention of legislative restrictions, fear of litigation, and feeling overwhelmed due to the policy climate as reasons why providers and administrators did not consider TMAB to be high on their priority list. On the other hand, some participants felt that the political climate made TMAB more of a priority. Existing literature and data sources expand on the specific restrictions and regulations that abortion providers in the South face, including information on

the legal ability of clinics to provide TMAB services (ACOG, 2023; Guttmacher Institute, 2023d). However, few studies to date examine qualitative data of provider and administrator considerations of political climate influence on prioritization of TMAB. This could largely be attributed to existing literature surrounding provider perspectives on TMAB only representing states with "supportive" abortion policy climates. For example, a study looking at provider and administrator perspectives on TMAB only interviewed providers who were already implementing these services, who were unsurprisingly not from any states in the South (Ruggiero et al., 2022). Findings from this thesis suggesting political considerations as a major influencing factor in prioritization of TMAB will add to a more robust understanding of the implementation landscape in more hostile states, offering a perspective unique to Southern states under more political strain than the rest of the nation and filling a current gap in literature. Findings also suggest that the political environment of the South may prevent many providers and administrators from prioritizing the implementation of TMAB services in the first place. Other findings within this theme also include the mention of political climate as a factor influencing high prioritization of TMAB; little literature to date examines this relationship. Overall, data collected in this theme will help inform a richer understanding of the role of political climate in prioritization of TMAB services for SRH professionals in the South. More specifically, given newly restrictive policies emerging at a rapid rate, providers and administrators may be even more hesitant in the current post-*Roe* climate to do anything unique that would draw attention to their clinics.

Little existing literature examines the role of staff hesitance in clinic prioritization of TMAB services. This study found that many participants perceived feelings of nervousness or unwillingness to adopt new practices from fellow staff at their clinic as a factor strongly

impacting prioritization of TMAB at their clinic. A study examining staff-reported barriers to implementation of new practices in hospital settings in general found that barriers such as staff workload, lack of time for implementation, and issues in workflows were influential in successful implementation of new practices and were compounded by staff shortages and high staff turnover (Geerligs et al., 2018). Additional barriers were found to be staff commitment to and motivation for implementing the intervention, compounded by a lack of belief in the intervention and the belief that they are already equipped to handle the issue that the intervention targets (Geerligs et al., 2018). These findings strongly complement the findings of this thesis which suggest that staff hesitance to implement new practices and nervousness about the safety of TMAB impacts clinic prioritization of these services and the potential for successful implementation. Given existing challenges with staff shortages and high staff turnover and its implications in abortion and family planning contexts in the South, careful attention should be paid to addressing staff concerns and involving them in implementation planning. (Chowdhary et al., 2022; Newton-Levinson et al., 2022). Overall, data collected in this theme contributes to a greater understanding of the role of clinic staff perspectives in prioritization of TMAB and has implications for staff training, education, and involvement surrounding TMAB to facilitate implementation.

Policy and Practice Recommendations

The importance of TMAB, both for patient benefit and clinic benefit, has strong advocacy implications. Evidence of the myriad of barriers for patients and providers in the South that TMAB has the potential to mitigate should be used to back advocacy-based efforts aimed at influencing policymaker decisions surrounding TMAB legality in the South. Findings suggesting that the political climate is the strongest factor influencing prioritization of TMAB have policy

implications and should be used to back recommendations for state legislature in the South in efforts to increase access to TMAB. Restrictive policy environments create a general sense of anxiety for SRH professionals; specific state restrictions surrounding issues like waiting periods, ultrasound requirements, TRAP legislation, and informed consent further restrict attitudes toward the ability to implement TMAB. Advocates should work toward addressing these large general restrictions to abortion access as well as the more specific restrictions that make implementation of TMAB less feasible. Findings about staff hesitance as a factor influencing clinic prioritization of TMAB have implications for recommendations for staff training on and education about TMAB and its evidence-backed safety and effectiveness as well as encouraging involvement of staff in the implementation process. Providers and administrators in the South who are able to and considering implementing TMAB should use evidence from this study as motivation to increase access for patients and better clinic workflows. Professionals should also consider staff training and education initiatives surrounding TMAB prior to implementation to address any hesitance, given literature suggesting these methods as effective means of getting staff on board with intervention implementation (Geerligs et al., 2018).

Strengths and Limitations

A major strength of this research is its incorporation of multiple states across the U.S. South, all of which have restrictive policy climates for abortion care. Further, this study extended the research on telemedicine to both those interested in and those who had provided the service, thus covering a wide variety of opinions and ideas around implementation. Additionally, the study is one of the first to apply an implementation science framework to the concept of TMAB; this lens has the distinct advantage of allowing research to be translated into effective practice. A major limitation of this research is that data were collected prior to the *Dobbs v. Jackson*

Women's Health Organization decision that reversed *Roe v. Wade*, therefore the landscape for abortion access, and specifically hopes of expanding TMAB services in the Southern region, has decreased. In some states represented in the sample, abortion is completely outlawed. However, data can and should still be used to inform both policymakers and SRH professionals in the South on the benefits of TMAB and considerations for future implementation as policy climates shift.

Conclusions and Recommendations

This study examines provider and administrator perspectives in the South toward the importance and priority of TMAB services. Four major themes were identified: TMAB is important for patient benefit, TMAB is important for clinic benefit, the political climate affects participant prioritization of TMAB, and staff hesitance affects clinic prioritization of TMAB. The importance of TMAB in mitigating physical access barriers for patients was most commonly noted by participants. TMAB was described by participants to be important for clinic benefit in terms of resources, workflow, and workforce benefits. State and federal policy was found to influence the prioritization of TMAB services both positively and negatively, and many participants had perceptions that other staff at their clinic had more negative attitudes toward implementation of TMAB services than they did. These findings point to the potential for TMAB to greatly increase access to abortion services for underserved and vulnerable populations who face access barriers in the South, as well as to help with clinic burdens. Additionally, findings suggest that training will be needed to engage staff at all levels of clinics if implementation is undertaken.

Future research should utilize findings from this study to further investigate the potential to implement TMAB in the South and how best to engage providers and staff in this process.

This data can be used to inform policymakers on the vast benefits of TMAB and its legality. It can also be used to inform SRH professionals considering implementing TMAB on its benefits and make recommendations accordingly. SRH professionals' perspectives on importance and priority of TMAB can help researchers to gain a better understanding of the current TMAB implementation landscape in the South as well as perceived barriers to prioritization.

Citations

Aiken, A. R. A., Starling, J. E., van der Wal, A., van der Vliet, S., Broussard, K., Johnson, D. M., Padron, E., Gomperts, R., & Scott, J. G. (2020). Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States. *American Journal of Public Health*, *110*(1), 90–97. https://doi.org/10.2105/AJPH.2019.305369

Aiken, A. R. A., Romanova, E. P., Morber, J. R., & Gomperts, R. (2022). Safety and effectiveness of self-managed medication abortion provided using online telemedicine in the United States: A population based study. *The Lancet Regional Health - Americas*, *10*, 100200. https://doi.org/10.1016/j.lana.2022.100200

Allsworth, J. E. (2022). Telemedicine, Medication Abortion, and Access After Roe v. Wade. *American Journal of Public Health*, *112*(8), 1086–1088. https://doi.org/10.2105/AJPH.2022.306948

Amnesty International. (n.d.). *Abortion is a human right.* Retrieved November 14, 2022, from https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/abortion-facts/

Anderson, E. M., Cowan, S. K., Higgins, J. A., Schmuhl, N. B., & Wautlet, C. K. (2022). Willing but unable: Physicians' referral knowledge as barriers to abortion care. *SSM - Population Health*, *17*, 101002. https://doi.org/10.1016/j.ssmph.2021.101002

Baker, Brendon. (2022). *The history of abortion access in the U.S*. Penn Today. Retrieved November 14, 2022, from https://penntoday.upenn.edu/news/penn-profs-weigh-history-abortion-access-us

Baker, C. N. (2023). History and Politics of Medication Abortion in the United States and the Rise of Telemedicine and Self-Managed Abortion. *Journal of Health Politics, Policy and Law*, 10449941. https://doi.org/10.1215/03616878-10449941

Biggs, M. A., Ralph, L., Raifman, S., Foster, D. G., & Grossman, D. (2019). Support for and interest in alternative models of medication abortion provision among a national probability sample of U.S. women. *Contraception*, *99*(2), 118–124. https://doi.org/10.1016/j.contraception.2018.10.007

Boonstra, H. (2016, July 12). *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*. Guttmacher Institute. https://doi.org/10.1363/2016.27451

Bosurgi, R., Davidson, C., Dodd, P., Gaynor-Brook, L., Moyer, C., Odeny, B., & Turner, R. (2022). Why restricting access to abortion damages women's health. *PLOS Medicine*, *19*(7), e1004075. https://doi.org/10.1371/journal.pmed.1004075

Chowdhary, P., Newton-Levinson, A., & Rochat, R. (2022). "No One Does This for the Money or Lifestyle": Abortion Providers' Perspectives on Factors Affecting Workforce

Recruitment and Retention in the Southern United States. *Maternal and Child Health Journal*, *26*(6), 1350–1357. https://doi.org/10.1007/s10995-021-03338-6

Cockrill, K., Upadhyay, U. D., Turan, J., & Greene Foster, D. (2013). The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma. *Perspectives on Sexual and Reproductive Health*, *45*(2), 79–88. https://doi.org/10.1363/4507913

Dahl, C., Turner, A., Premkumar, A., Bales, C., Cheu, L., Singh, A., McCloskey, L., Cowett, A., & Debbink, M. P. (2023). Association between distance travelled for abortion care and abortion stigma. *American Journal of Obstetrics & Gynecology*, *228*(1), S614–S615. https://doi.org/10.1016/j.ajog.2022.11.1043

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, *4*(1), 50. https://doi.org/10.1186/1748-5908-4-50

Dehlendorf, C., & Weitz, T. (2011). *Access to Abortion Services: A Neglected Health - ProQuest*. Retrieved February 3, 2023, from https://www.proquest.com/docview/868333759

Diamant, J., & Mohamed, B. (2023, January 11). What the data says about abortion in the U.S. *Pew Research Center*. Retrieved February 3, 2023, from

https://www.pewresearch.org/fact-tank/2023/01/11/what-the-data-says-about-abortion-in-the-u-s-2/

Dickey, M. S., Mosley, E. A., Clark, E. A., Cordes, S., Lathrop, E., & Haddad, L. B. (2022). "They're forcing people to have children that they can't afford": A qualitative study of social support and capital among individuals receiving an abortion in Georgia. *Social Science & Medicine*, *315*, 115547. https://doi.org/10.1016/j.socscimed.2022.115547

Fix, L., Gindlay, K., Seymour, J.W., Burns, B., Reiger, S.T., & Grossman, D. (2018, November 13). *Telehealth leaders' attitudes toward telemedicine provision of medication abortion: A qualitative study*. Ibis Reproductive Health. https://www.ibisreproductivehealth.org/publications/telehealth-leaders-attitudes-toward-elemedicine-provision-medication-abortion

Foster, D. G., Biggs, M. A., Ralph, L., Gerdts, C., Roberts, S., & Glymour, M. M. (2018). Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. *American Journal of Public Health*, *108*(3), 407–413. https://doi.org/10.2105/AJPH.2017.304247

Foster, D. G., Biggs, M. A., Raifman, S., Gipson, J., Kimport, K., & Rocca, C. H. (2018). Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion. *JAMA Pediatrics*, *172*(11), 1053–1060. https://doi.org/10.1001/jamapediatrics.2018.1785

Foster, D. G., Raifman, S. E., Gipson, J. D., Rocca, C. H., & Biggs, M. A. (2019). Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children. *The Journal of Pediatrics*, *205*, 183-189.e1. https://doi.org/10.1016/j.jpeds.2018.09.026

Fuentes, L., & Jerman, J. (2019). Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice. *Journal of Women's Health (2002)*, *28*(12), 1623–1631. https://doi.org/10.1089/jwh.2018.7496

Geerligs, L., Rankin, N. M., Shepherd, H. L., & Butow, P. (2018). Hospital-based interventions: A systematic review of staff-reported barriers and facilitators to implementation processes. *Implementation Science*, *13*(1), 36. https://doi.org/10.1186/s13012-018-0726-9

Godfrey, E. M., Fiastro, A. E., Jacob-Files, E. A., Coeytaux, F. M., Wells, E. S., Ruben, M. R., Sanan, S. S., & Bennett, I. M. (2021). Factors associated with successful implementation of telehealth abortion in 4 United States clinical practice settings. *Contraception*, *104*(1), 82–91. https://doi.org/10.1016/j.contraception.2021.04.021

Gold, R. (2004, September 22). *Lessons from Before Roe: Will Past be Prologue?* Guttmacher Institute. https://doi.org/10.1363/2003.13045

Grindlay, K., Lane, K., & Grossman, D. (2013). Women's and providers' experiences with medical abortion provided through telemedicine: A qualitative study. *Women's Health*

Issues: Official Publication of the Jacobs Institute of Women's Health, *23*(2), e117-122. https://doi.org/10.1016/j.whi.2012.12.002

Grossman, D. (2022). Telemedicine Provision of Medication Abortion. *American Journal of Public Health*, *112*(9), 1282–1283. https://doi.org/10.2105/AJPH.2022.306995

Guttmacher Institute. (2016, March 18). *Last Five Years Account for More Than One-quarter of All Abortion Restrictions Enacted Since Roe*. https://doi.org/10.1363/2016.26353

Guttmacher Institute. (2020, January 22). *Waiting Periods For Abortion*. https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion

Guttmacher Institute. (2020, January 22). *Targeted Regulation of Abortion Providers (TRAP) Laws*. https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-provider-trap-laws

Guttmacher Institute. (2021, April 23). *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*. https://www.guttmacher.org/fact-sheet/hyde-amendment

Guttmacher Institute. (2021, April 27). *The Global Gag Rule and the Helms Amendment: Dual Policies, Deadly Impact*. https://www.guttmacher.org/fact-sheet/ggr-helms-amendment

Guttmacher Institute. *For the First Time Ever, U.S. States Enacted More Than 100 Abortion Restrictions in a Single Year*. (2021, September 30). https://doi.org/10.1363/2021.33193

Guttmacher Institute. (2022, April 25). *Roe v. Wade Overturned: Our Latest Resources*. https://www.guttmacher.org/abortion-rights-supreme-court

Guttmacher Institute. (2023). *Counseling and Waiting Periods for Abortion*. https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortin

Guttmacher Institute. (2023, February 1). *Requirements for Ultrasound*. https://www.guttmacher.org/state-policy/explore/requirements-ultrasound

Guttmacher Institute. (2023, February 1). *Targeted Regulation of Abortion Providers*. https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers

Guttmacher Institute. *Interactive Map: US Abortion Policies and Access After Roe*. Retrieved February 3, 2023, from https://states.guttmacher.org/policies/

Harper, C., Elmes, S., Yarger, J., Brandi, K., Hopkins, K., Rossetto, I., White, K., Van Liefde, D., Marquez, L., & Upadhyay, U. (2022). Medication abortion via telemedicine: Interest among young people in texas and california. *Contraception*, *116*, 86. https://doi.org/10.1016/j.contraception.2022.09.078

Jerman, J., Frohwirth, L. F., Kavanaugh, M. L., & Blades, N. (2017). Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States. *Perspectives on Sexual and Reproductive Health*, *49*, 95–102. https://doi.org/10.1363/2017.28266

Joffe CE, Weitz TA, Stacey CL. (2004). Uneasy allies: pro-choice physicians, feminist health activists and the struggle for abortion rights. Sociol Health Illn. 26(6):775-96. Doi: 10.1111/j.0141-9889.2004.00418.x. PMID: 15383041.

Jones, R. K., Philbin, J., Kirstein, M., & Nash, E. (2021, November 2). *New Evidence: Texas Residents Have Obtained Abortions in at Least 12 States That Do Not Border Texas*. Guttmacher Institute. https://doi.org/10.1363/2021.33275

Jones, R. K., Nash, E., Cross, L., Philbin, J., & Kirstein, M. (2022, February 22). *Medication Abortion Now Accounts for More Than Half of All US Abortions*. Guttmacher Institute. https://doi.org/10.1363/2022.33429

Kapp, N., & Lohr, P. A. (2020). Modern methods to induce abortion: Safety, efficacy and choice. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *63*, 37–44. https://doi.org/10.1016/j.bpobgyn.2019.11.008

Karlin, J., Sarnaik, S., Holt, K., Dehlendorf, C., Joffe, C., & Steinauer, J. (2021). Greasing the

wheels: The impact of COVID-19 on US physician attitudes and practices regarding medication abortion. *Contraception*, *104*(3), 289–295. https://doi.org/10.1016/j.contraception.2021.04.022

Kelly, B. C., & Brewer, S. C. (2022). *Disparities in Distance to Abortion Care Under Reversal of Roe v. Wade: A Spatial Analysis* (SSRN Scholarly Paper No. 4039919). https://doi.org/10.2139/ssrn.4039919

Kerestes, C. A., Stockdale, C. K., Zimmerman, M. B., & Hardy-Fairbanks, A. J. (2019). Abortion providers' experiences and views on self-managed medication abortion: An exploratory study. *Contraception*, *100*(2), 160–164. https://doi.org/10.1016/j.contraception.2019.04.006

Kerestes, C., Delafield, R., Elia, J., Shochet, T., Kaneshiro, B., & Soon, R. (2022). Person-centered, high-quality care from a distance: A qualitative study of patient experiences of TelAbortion, a model for direct-to-patient medication abortion by mail in the United States. *Perspectives on Sexual and Reproductive Health*, *54*(4), 177–187. https://doi.org/10.1363/psrh.12210

KFF. (2022, Jul 15). *What are the Implications of the Overturning of Roe v. Wade for Racial Disparities?* Retrieved November 14, 2022, from https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/

Kumar, A., Hessini, L., & Mitchell, E. M. H. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, *11*(6), 625–639. https://doi.org/10.1080/13691050902842741

Lara, D., Holt, K., Peña, M., & Grossman, D. (2015). Knowledge of Abortion Laws and Services Among Low-Income Women in Three United States Cities. *Journal of Immigrant and Minority Health*, *17*(6), 1811–1818. https://doi.org/10.1007/s10903-014-0147-z

Lewis, C. C., Mettert, K. D., Dorsey, C. N., Martinez, R. G., Weiner, B. J., Nolen, E., Stanick, C., Halko, H., & Powell, B. J. (2018). An updated protocol for a systematic review of implementation-related measures. *Systematic Reviews*, *7*(1), 66. https://doi.org/10.1186/s13643-018-0728-3

Lynch, B., Mallow, M., Bodde, K. E. S., Castaldi-Micca, D., Yanow, S., & Nádas, M. (2022). Addressing a Crisis in Abortion Access. *Obstetrics and Gynecology*, *140*(1), 110–114. https://doi.org/10.1097/AOG.0000000000004839

Madera, M., Johnson, D. M., Broussard, K., Tello-Pérez, L. A., Ze-Noah, C.-A., Baldwin, A., Gomperts, R., & Aiken, A. R. A. (2022). Experiences seeking, sourcing, and using abortion pills at home in the United States through an online telemedicine service. *SSM - Qualitative Research in Health*, *2*, 100075. https://doi.org/10.1016/j.ssmqr.2022.100075

Mahtta, D., Daher, M., Lee, M. T., Sayani, S., Shishehbor, M., & Virani, S. S. (2021). Promise

and Perils of Telehealth in the Current Era. *Current Cardiology Reports*, *23*(9), 115. https://doi.org/10.1007/s11886-021-01544-w

Miller, S., Wherry, L. R., & Foster, D. G. (2020). *The Economic Consequences of Being Denied an Abortion* (Working Paper No. 26662). National Bureau of Economic Research. https://doi.org/10.3386/w26662

Nash, E., & Ephross, P. (2022, December 14). *State Policy Trends 2022: In a Devastating Year, US Supreme Court's Decision to Overturn Roe Leads to Bans, Confusion and Chaos*. Guttmacher Institute. https://doi.org/10.1363/2022.300251

National Academies Press. (2018). *The Safety and Quality of Abortion Care in the United States*. https://doi.org/10.17226/24950

Newton-Levinson, A., Higdon, M., & Rochat, R. (2022). Supporting Staff in Southern Family Planning Clinics: Challenges and Opportunities. *Maternal and Child Health Journal*, *26*(2), 319–327. https://doi.org/10.1007/s10995-021-03339-5

Nobel, K., Luke, A. A., & Rice, W. S. (2023). Racial disparities in pregnancy options counseling and referral in the US South. *Health Services Research*, *58*(1), 9–18. https://doi.org/10.1111/1475-6773.14049

Planned Parenthood. (2021). *Historical Abortion Law Timeline: 1850 to Today*. Retrieved

November 14, 2022, from https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/historical-abortion-law-timeline-1850-today

Raifman, S., Biggs, M. A., Ralph, L., Ehrenreich, K., & Grossman, D. (2022). Exploring Attitudes About the Legality of Self-Managed Abortion in the US: Results from a Nationally Representative Survey. *Sexuality Research and Social Policy*, *19*(2), 574–587. https://doi.org/10.1007/s13178-021-00572-z

Redd, S. K., AbiSamra, R., Blake, S. C., Komro, K. A., Neal, R., Rice, W. S., & Hall, K. S. (2023). Medication Abortion "Reversal" Laws: How Unsound Science Paved the Way for Dangerous Abortion Policy. *American Journal of Public Health*, *113*(2), 202–212. https://doi.org/10.2105/AJPH.2022.307140

Roberts, S. C., Biggs, M. A., Chibber, K. S., Gould, H., Rocca, C. H., & Foster, D. G. (2014). Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Medicine*, *12*(1), 144. https://doi.org/10.1186/s12916-014-0144-z

Ruggiero, S. P., Seymour, J. W., Thompson, T.-A., Kohn, J. E., Snow, J. L., Grossman, D., & Fix, L. (2022). Patient and provider experiences using a site-to-site telehealth model for medication abortion. *MHealth*, *8*, 32. https://doi.org/10.21037/mhealth-22-12

Schroeder, R., Muñoz, I., Kaller, S., Berglas, N., Stewart, C., & Upadhyay, U. (2022). *Trends in Abortion Care in the United States 2017-2021, University of California San Francisco*. https://www.ansirh.org/sites/default/files/2022-06/Trends%20in%20Abortion%20Care%20in%20the%20United%20States%2C%202017-2021.pdf

Sedgh, G., Mason, N., & Singh, S. (2022, August 16). *Undoing of Roe v. Wade Leaves US as Global Outlier on Abortion*. Guttmacher Institute. https://doi.org/10.1363/2022.33643

Seymour, J. W., Thompson, T.-A., Milechin, D., Wise, L. A., & Rudolph, A. E. (2022). Potential Impact of Telemedicine for Medication Abortion Policy and Programming Changes on Abortion Accessibility in the United States. *American Journal of Public Health*, *112*(8), 1202–1211. https://doi.org/10.2105/AJPH.2022.306876

The American College of Obstetricians and Gynecologists. (n.d.). *Abortion Care*. Retrieved February 3, 2023, from https://www.acog.org/womens-health/faqs/induced-abortion

The American College of Obstetricians and Gynecologists. (2023). *Updated Mifepristone REMS Requirements*. Retrieved February 3, 2023, from https://www.acog.org/en/clinical/clinical-guidance/practice-advisory/articles/2023/01/updated-mifepristone-rems-requirements

The Turnaway Study. (n.d.). ANSIRH. Retrieved April 5, 2023, from https://www.ansirh.org/research/ongoing/turnaway-study

United Nations. (2022, July 1). *US abortion debate: Rights experts urge lawmakers to adhere to women's convention | UN News*. https://news.un.org/en/story/2022/07/1121862

Upadhyay, U. D., Biggs, M. A., & Foster, D. G. (2015). The effect of abortion on having and achieving aspirational one-year plans. *BMC Women's Health*, *15*(1), 102. https://doi.org/10.1186/s12905-015-0259-1

Upadhyay, U. D., Aztlan-James, E. A., Rocca, C. H., & Foster, D. G. (2019). Intended pregnancy after receiving vs. Being denied a wanted abortion. *Contraception*, *99*(1), 42–47. https://doi.org/10.1016/j.contraception.2018.09.002

Vilda, D., Wallace, M. E., Daniel, C., Evans, M. G., Stoecker, C., & Theall, K. P. (2021). State Abortion Policies and Maternal Death in the United States, 2015–2018. *American Journal of Public Health*, *111*(9), 1696–1704. https://doi.org/10.2105/AJPH.2021.306396

What is telehealth? | Telehealth.HHS.gov. (n.d.). Retrieved February 3, 2023, from https://telehealth.hhs.gov/patients/understanding-telehealth/

World Health Organization. (2021, November 25). *Abortion*. https://www.who.int/news-room/fact-sheets/detail/abortion