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Barriers to Abortion Access for Young Southerners: A Qualitative Analysis of Case Notes from ARC-Southeast

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B.S. and B.A., Stetson University 2020

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An abstract of
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ABSTRACT

Barriers to Abortion Access for Young Southerners: A Qualitative Analysis of Case Notes from ARC-Southeast

By Ci'erra Larsen

Restrictive abortion laws in Southeastern U.S. states increasingly obstruct access to abortion for young people. Abortion funds have intervened to ensure young people can access safe, compassionate abortion care. Access Reproductive Care-Southeast (ARC-Southeast) is an abortion fund providing financial and logistical support for abortion services in the Southeast. An estimated 1 in 10 of the organization's cases are people under the age of 22 years. Therefore, analysis of ARC-Southeast's Healthline data offers an opportunity to address a gap in the literature for understanding youth experiences seeking abortion in the Southeast region. We seek to identify barriers and understand youth experiences with abortion fund support for abortion care from ARC-Southeast.

The research team extracted a dataset containing demographic information and case notes managed by ARC-Southeast from cases involving people ages 21 and under who resided in six Southeastern states (Alabama, Florida, Georgia, Mississippi, Tennessee, and South Carolina) and who contacted the Healthline between May 2016 and May 2021 (n=2,278). A qualitative analysis of case notes managed by ARC-Southeast was designed to describe the barriers to access which impede the lives of youth seeking abortion fund support from ARC-Southeast between 2016 and 2021.

The secondary data analysis revealed young Southerners encounter a multitude of barriers to abortion access in the Southeast, within four primary categories: structural barriers, financial barriers, personal barriers, and COVID-19 pandemic. The analysis also exposed common experiences and barriers to abortion access for youth seeking abortion care support which are scarcely documented in abortion access literature, such as the consequences of pre-existing conditions, intimate partner violence, and immigration status. To address these challenges, possible recommendations include engaging young Southerners in a full range of intersectional care and urging legislators in the South to repeal restrictive abortion policy. Study findings inform abortion provision for young people in the U.S. Southeast and serve as a foundation for future research to address barriers to access abortion for young Southerners.

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CHAPTER 1 – INTRODUCTION

Introduction and Rationale

Despite the 1973 Supreme Court decision to uphold *Roe v. Wade*, which affirmed that abortion is a constitutional right and can be obtained before fetal viability, U.S. legislators introduced over a thousand abortion restrictions, among which 44% were introduced in the last decade (Jones et al., 2019; Nash [a], 2021). In 2021, for the first time in U.S. history, over 100 abortion restrictions in a single year were imposed across the nation (Nash [a], 2021). The continuous fight for reproductive justice is a timely issue that is stifled by policymakers who deny individuals equitable access to abortion care based on moral and respectability politics.

Based on these foundations, the abortion debate historically captured two ideologies, pro-choice and pro-life (Ross, 2016). As communities have rallied around abortion with these lenses the realities of access to abortion care have been lost. Legislators have benefited from the polarization around the issue by employing false narratives about choice and life. The dominant ideologies have prefaced performative legislation to increase "choice" and initiatives in pursuit of a prosperous life for children; neither addressing the root causes for inequitable abortion access (Ross, 2016). While these actors argue about an approach to abortion care, legislators have enacted structural violence in communities of color that are not represented in pro-choice and pro-life organizing (Ross, 2016). Legislators shamelessly have implemented restrictions that directly criminalize individuals who have abortions and weaponize health inequities to impede abortion access.

These egregious injustices committed against marginalized communities who access abortion are endorsed and promoted by Southern legislators. Most recently, the notorious Texas S.B. No. 8 prohibits abortion after six weeks and distributes a bounty for those who have

received an abortion (Hughes, et al., n.d.). Following this legislation, Southern states have aimed to imitate these restrictions and amplify aspects of existing regulations that directly harm birthing people in the U.S. Southeast (Nash [a], 2021). The U.S. Supreme Court *Dobbs v. Jackson Women's Health Organization* decision will also be positioned to decide whether to protect birthing people or stand idly by as legislators allow for a nearly complete ban on abortions in the Southern United States (Nash [a], 2021). While these restrictions are at the center of federal and state-level debates, these nonsensical restrictions are not new to the South.

In the U.S. Southeast, abortion funds have operationalized reproductive justice and filled the gap in abortion care. The National Network of Abortion Funds (NNAF) has been in service to people seeking abortions nationally for the last two decades (NNAF, 2022). Abortion funds provide direct service to people who seek abortions by providing logistical and financial support to ensure people receive safe and compassionate abortion care. However, abortion funds have not been provided the financial or organizational capacity to contribute to the process of knowledge production around the barriers to access abortions.

Access Reproductive Care-Southeast (ARC-Southeast) is among the first abortion fund organizations to develop this work. The study found abortion cases maintained between 2016 and 2019 represented caller who were primarily non-Hispanic Black, 18-34 years of age, publicly or uninsured, completed a high school degree or some college, had one or more children, and were Christian (Rice et al., 2021). Rice et al. (2021) also exposed that most cases were in-state and less than half of the callers traveled more than 50 miles out of state for abortion care. The study also highlighted the implications of state-level restrictions on young people. Young people with lower incomes who sought an abortion reported delays in accessing care due to cost, travel, and other barriers (e.g. waiting periods). This research and relevant literature

suggest young people are disproportionately affected by abortion legislation, yet the extent to which youth are marginalized is not captured in their own voices (Kavanagh et al., 2012; Rice et al., 2021; Upadhyay et al., 2014).

Problem Statement

There is limited research on young peoples' experiences of barriers to access abortion in the U.S. Southeast. Abortion literature provides quantitative representations of the demographics of individuals who access abortion and primary risk factors for abortion, although the circumstances which contribute to challenges to access abortion for youth are absent from the literature. Few qualitative studies exist in the literature to provide a voice to the experiences of young people who access abortion funding and support.

Purpose Statement

Data from abortion funds provide insight into the barriers to abortion access that young people encounter when seeking abortion care. A qualitative analysis of the case notes will classify and describe the barriers to abortion access for young people in the U.S. Southeast who sought abortion fund support from ARC-Southeast from August 2016 to May 2021.

Research Objective

To describe the experiences of young Southerners who must navigate hostile abortion policies, it is important to expose the structural, financial, and personal barriers to abortion access. Additionally, it is important to identify the barriers to abortion access for young people in abortion restrictive settings to improve the accessibility of abortion for youth in the U.S. Southeast. The aims of this study are to:

Aim 1: Identify the barriers to abortion access experienced by young people in the U.S. Southeast who sought abortion funding from ARC-Southeast between May 2016 and May 2021.

Aim 2: Describe the context in which young people in the U.S. Southeast received abortion funding from ARC-Southeast between May 2016 and May 2021.

Significance Statement

Abortion research has rarely sought abortion funds to understand the barriers people encounter when accessing abortion despite abortion funds' exclusive knowledge about abortion care navigation. Abortion funds have intervened in restrictive abortion settings to ensure young people can access safe, compassionate abortion care. ARC-Southeast is an abortion fund providing financial and logistical support for abortion services in the Southeast. An estimated 1 in 10 of the organization's cases are people under the age of 22 years (Rice et al., 2021). Therefore, analysis of ARC-Southeast's Healthline data offers an opportunity to address a gap in the literature for understanding youths' experiences navigating abortion care in the Southeast.

Definition of Terms

U.S. Southeast: This research will address access to care for young people in the U.S. Southeast. The U.S. Southeast will refer to Alabama, Georgia, Florida, Tennessee, Mississippi, and South Carolina.

Young people: Unless specified otherwise, young people, youth, and young Southerners will be used interchangeably to describe individuals who are 21 years of age or under.

Minors: Individuals who are under 18 years of age.

Reproductive persons: People who have a uterus and/or can become pregnant.

Mixed-status family: A family containing people with different citizenship or immigration statuses.

CHAPTER 2 – LITERATURE REVIEW

Abortion Policy in the United States

Supreme Court of the United States Decisions

In 1973, the Supreme Court of the Unites States upheld *Roe v. Wade* which affirms that abortion is a constitutional right and can be obtained prior to fetal viability (Jones et al., 2019). *Roe v. Wade* was introduced to the courts by a pregnant single woman who challenged Texas's criminal abortion laws which prohibited abortion with the exception of life-saving circumstances (Blackmun & Supreme Court of the United States, 1972). The landmark case would serve as the foundation for abortion policy in the United States bolstering succeeding cases presented to the Supreme Court. The Supreme Court of the United States would re-affirm abortion as a constitutional right in the decisions, *Planned Parenthood v. Casey* (1992) and *Whole Women's Health v. Hellerstedt* (2016). The *Planned Parenthood v. Casey* decision would endorse the "essential holding" of *Roe v. Wade*, although fail to support abortion in the first trimester by permitting states to adhere to a medical definition of viability which states deemed most suitable (Planned Parenthood of Southeastern Pa. v. Casey, 1992). However, an "undue burden" or a law for which the "purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability" is invalid (Blackmun & Supreme Court of the United States, 1972). *Whole Women's Health v. Hellerstedt* (2016) would expand on the undue burden standard by invalidating Texas laws which imposed unwarranted admitting privileges and surgical-center provisions (Whole Woman's Health v. Hellerstedt, 2016).

U.S. abortion policy over the last decade has experienced many changes and challenges to the constitutional precedent. However, the greatest challenge to the Supreme Court precedent is currently being battled in the courts. The U.S. Supreme Court heard oral arguments on

December 1, 2021, in *Dobbs v. Jackson Women's Health Organization*, which challenges Mississippi's 15-week abortion ban (Dobbs v. Jackson Women's Health Organization, 2021). *Dobbs v. Jackson* is particularly an important decision because Mississippi has called for the overturn of *Roe v. Wade* and the Supreme Court will directly affirm whether a state has the autonomy to ban abortion before viability (Nash [a], 2021). Therefore, the constitutionality of abortion is being contested. The Guttmacher Institute, one of many expert agencies who conduct abortion policy research, have urged the U.S. Supreme Court to uphold the fundamental right to abortion, which *Roe v. Wade* endorses. Abortion policy analysts stipulate the Court's acceptance of a case which challenges the legality of abortion and reluctance to stifle the unconstitutional Senate Bill 8 (S.B. 8)—a six-week abortion ban and authorization of private citizens to report individuals who have abortions in Texas, are indications of an imminent post-Roe society (Nash [a], 2021 & Hughes et al., n.d.). Figure 1 provides a visual of the anticipated aftermath of a *Dobbs v. Jackson Women's Health Organization* decision which overturns *Roe v. Wade* (See Figure 1) (Nash [b], 2021).

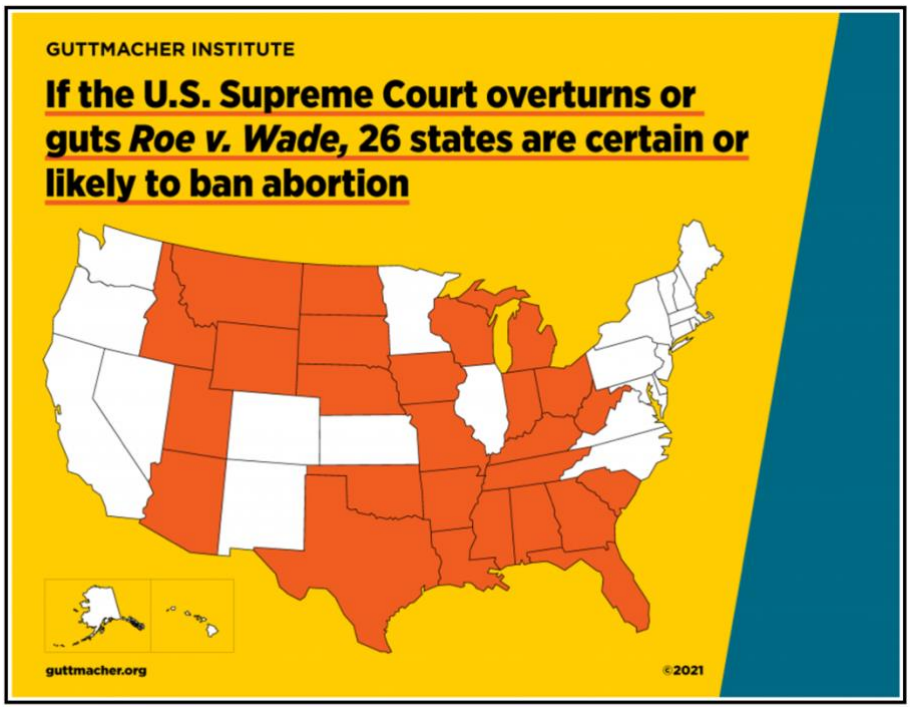


Figure 1. States who are certain or likely to ban abortion if the U.S. Supreme Court overturns *Roe v. Wade* (1973). The U.S. Southeast and Midwest are the most vulnerable to be denied access to abortion.

Despite Supreme Court decisions to date that uphold abortion as a constitutional right, individual states have continued to challenge constitutional precedents. Since Roe, a total of 1,338 abortion restrictions have been enacted, among which, 44% were introduced in the last decade (Nash [b], 2021). In the following sections, infamous targeted regulation of abortion provider laws and trigger laws, the categories of policy used to regulate abortion access at the state level are described in detail.

Targeted Regulation of Abortion Providers Laws

Healthcare providers in the United States, including abortion providers, are all held to standard evidence-based regulations, such as state licensure and association requirements to ensure the overall safety of patients (Guttmacher, 2020). Regardless of these high standards, nearly half of U.S. states have proposed additional strenuous laws for abortion providers to

adhere to called targeted regulation of abortion provider laws, also known as TRAP laws. TRAP laws are designed by policy makers to burden abortion providers with excessive requirements imposed on facilities, equipment, and staff, and have few to no benefits to patients (Guttmacher, 2020). States that impose TRAP laws often regulate abortion facilities equivalent to ambulatory surgical centers (ASCs), which are surgical centers associated with high risk and more invasive procedures relative to abortion clinics (Guttmacher, 2020). These regulations are also utilized to burden physicians' offices where abortions are performed, sites where medication abortion is administered, and clinicians who provide abortions. To restrict abortion providers, TRAP regulations often manifest as minimum room size and hallway widths which impose costs to renovate or relocate clinics. Legislators also mandate clinicians to have admitting privileges at a local hospital. These laws are particularly harmful because hospitals have annual minimum admissions to obtain admitting privileges which are uncommon among abortion providers due to the safety of abortion procedures and rarity of complications which require hospital admission (Guttmacher, 2020).

Consistent with previous U.S. Supreme Court cases related to abortion, the state of Texas has notoriously imposed hostile TRAP laws which dispute and woefully ignore the *Whole Women's Health v. Hellerstedt* standard. Texas introduced two TRAP laws to mandate physicians who provide abortions to have admission privileges at a local hospital and abortion facilities to adhere to ASCs standards in the 2010s (Guttmacher, 2020). As a result, clinics across the state were forced to close and the reported distance a person would travel for an abortion more than tripled between 2013 and 2014 (Guttmacher, 2020). Consequently, more people who sought abortions delayed their procedures, which disproportionately affected individuals with low-incomes, youth, less education, and Black compared to other groups accessing abortion

(Guttmacher, 2020). In 2016, the Supreme Court concluded there was insufficient evidence these laws improved the safety and quality of abortion care provided in the state thus created an undue burden. The 2016 TRAP restriction disputes highlight the vulnerabilities of U.S. abortion providers as *Whole Women's Health v. Hellerstedt* is a pathway to challenge TRAP laws, however it cannot immediately invalidate all TRAP regulations (Guttmacher Institute, 2020).

Trigger Laws

In the United States, *Roe v. Wade* continues to be disputed and its adversaries are prepared to authorize legislation to severely restrict and ban abortion at the state-level automatically or promptly if the precedent is overturned. There are 12 states with a trigger ban already in place which can become effective, contingent on *Roe v. Wade* being overturned. In addition to trigger laws, the Guttmacher Institute has identified many other states who are implementing various types of bans to stifle abortion access in U.S. states (Guttmacher, 2021).

Abortion Access in the U.S. Southeast

Structural Barriers

In the U.S. Southeast, the consequences of *Roe v. Wade* overturned by the U.S. Supreme Court are alarming. In the last decade, Southeastern states have upheld extremely restrictive abortion policies to limit access to abortion and establish the U.S. Southeast as one of the most restrictive regions in the nation (See Figure 2) (Nash, 2019).

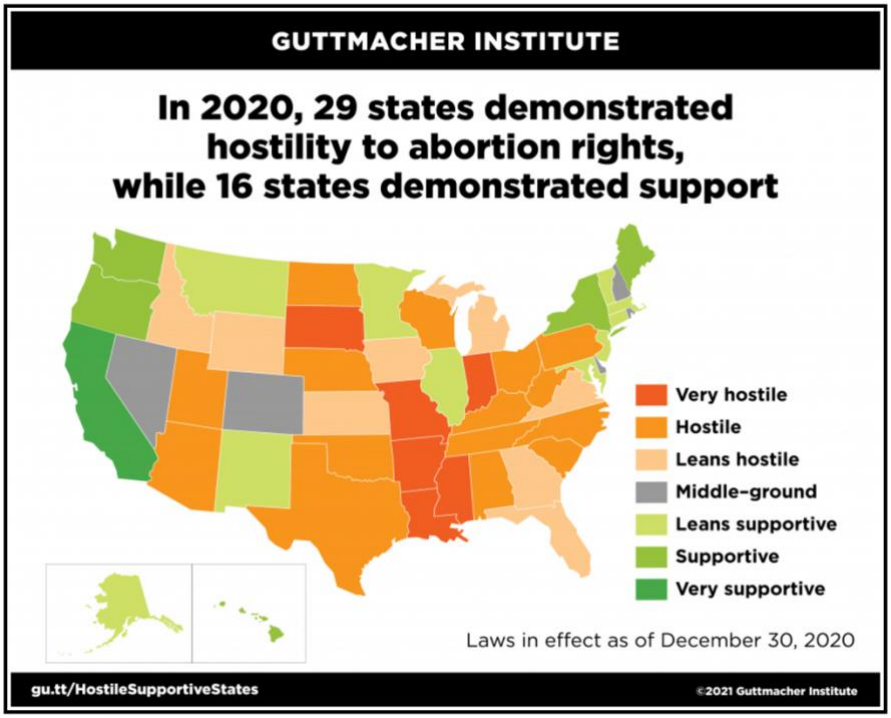


Figure 2. A depiction of U.S. states and their degree of hostility towards abortion rights. The Southeast and Midwest represent the most hostile regions in the nation.

To restrict access to abortion, Southern policy makers institute laws which impose numerous barriers for people accessing abortion (See Table 1). These abortion restrictions are commonly characterized as physician and hospital requirements, gestational limits, partial-birth abortion, public funding, private insurance coverage, refusal, state-mandated counseling, and waiting periods (Guttmacher [a], 2016). The physician and hospital requirements are common across the U.S. to ensure that licensed professionals are the only providers allowed to provide abortions. However, an abortion is a relatively safe procedure and could be performed by nurses and nurse practitioners (Weitz et al., 2013). Additionally, some states require abortions be carried out in a hospital and/or with a second physician past a particular gestational period. Gestational limits are often weaponized against reproductive persons during the abortion process. While the constitutional precedent is "viability," Southeastern states are notorious for arbitrarily

imposing limits on gestational age for an abortion based on legislators' preferences. An extension of the gestational limits is partial-birth abortion restrictions which constrain access to abortion after the first trimester (Guttmacher [b], 2016).

Funding for abortion is a particularly complex issue in the South as all Southern states prohibit private insurance coverage for abortion and only allow public funds in the most medically necessary circumstances to save a patient's life. Almost all U.S. states have granted health care providers the ability to refuse to participate in abortion services. For practitioners who decide to provide these services, state-mandated counseling is prescribed by the state for patients. State-mandated counseling in the South often includes a range of unsupported information about abortion and breast cancer, fetal pain experiences, and/or long-term mental health effects of an abortion. State-mandated counseling is often instituted in conjunction with the infamous waiting periods. These laws require patients to wait a specific period, often between 24 hours to 72 hours, to receive an abortion after receiving counseling (Guttmacher [a], 2016). These restrictions often force individuals to schedule more than one appointment to obtain their abortion, which can become very costly and time consuming.

Southeastern states employ various combinations of these laws to restrict access in the region, which often perpetuates conditions where out-of-state travel may be required to reach the nearest abortion facility, with greater burdens for the most marginalized in society. Additionally, these restrictions facilitate coercive conditions which force birthing people to carry unwanted pregnancies. Law makers who implement these policies fail to validate the reasons individuals desire to terminate their pregnancy, which are often related to socioeconomic circumstances. The Turnaway Study provides compelling evidence that 95 percent of women who received their desired abortion report satisfaction with their decisions five years later (Foster et al., 2018). Yet,

law makers continue to implement restrictive policies which inevitably reinforce worse health outcomes for women who were denied an abortion, as compared to their counterparts who had an abortion (Foster et al., 2018). Turnaway Study evidence suggests that those denied access are more likely to experience a multitude of adverse outcomes, such as poor physical health, short-term anxiety and low self-esteem, and interpersonal violence, after being forced to carry a pregnancy to term (Foster et al., 2018). The various structural barriers imposed on reproductive persons reject individuals' bodily autonomy and dignity to make informed decisions about their reproduction free of coercion.

Table 1. Overview of State Abortion Laws in the U.S. Southeast

State	Must be performed by a licensed physician	Must be performed in a hospital if at:	Second physician must participate if at:	Prohibited except in cases of life or health endangerment if at:	Partial-Birth Abortion Banned	Public Funds Limit to Life Endangerment, Rape, and Incest	Providers may refuse to participate		Mandated Counseling includes information on:			Waiting Period (in hrs.) after counseling
							Individual	Institution	Breast Cancer	Fetal Pain	Negative Psychological Effects	
Alabama	X	Viability	Viability	20 weeks*	▼	X						48
Florida	X	Viability	24 weeks	24 weeks	▼	X	X	X				▼
Georgia	X			20 weeks*	Post viability	X	X	X		X		24
Mississippi	X[Φ]			20 weeks*,[€]	X	X[Ω]	X	X	X			24
South Carolina	X	3rd trimester	3rd trimester	20 weeks*	X	X	X	Private				24
Tennessee	X	Viability	Viability	Viability*	X	X	X	X				▼

*Exception in case of threat to the patient's physical health.

▼ Permanently enjoined, law not in effect.

[Φ] Law limits abortion provision to OB/GYNs.

[€] A court has temporarily blocked enforcement of a Mississippi law that would have banned abortion at 15 weeks of gestation after the patient's last menstrual period.

[Ω] Exception in case of fetal abnormality.

(Guttmacher Institute [a], 2022)

Socio-Cultural Barriers

The majority of Americans (61%) believe abortion should be legal in all (27%) or most (32%) cases, and 70 percent of Americans do not want to overturn *Roe v.* Wade (Pew Research Center [a] et al., 2019). However, the 38 percent of Americans who believe abortion should be illegal in all (12%) or most cases (26%) and 28 percent of individuals who want to overturn the constitutional right to abortion dominate the narrative around abortion in the U.S. Southeast (Pew Research Center [a] et al., 2019). While many Americans (59%) have expressed concern for the increasing limitations on abortion access at the state level, abortion restrictions in the U.S. Southeast remain a topic of contention.

Public opinion on abortion in the U.S. is largely dependent on political affiliation. Republicans in the U.S. have utilized abortion to mobilize evangelicals and the Moral Majority since the late 1970s (McKeegan, 1993). Republican efforts to target religious communities in the abortion debate may indicate the religious community as a primary source of anti-abortion views. However, Southeastern religious communities' views of abortion are more nuanced with various levels of support from religious leaders (Mosley et al., 2021). These varying degrees of support for the legalization in all or most instances are held among 64% of Black Protestants, 63% of White Protestants who are not evangelical, and 55% of Catholics, while the opposition is represented by White evangelical Christians (77%) (Pew Research Center [b] & Inquiries, n.d.). The composition of the religious opposition is reflective of the Republican party which six in 10 Republicans oppose the legalization of abortion (Pew Research Center [b] & Inquiries, n.d.). Conversely, abortion is generally accepted by Democrats in the U.S. Democrats shared a general belief access to legal abortion in all or most cases (80%) (Pew Research Center [b] & Inquiries, n.d.). These trends have remained steady in the last 5 years and show a general divide based on

party affiliation. The bipartisan gap has increased over the years between Democratic and Republican Americans in relation to abortion in all or most cases representing an increasing bipartisanship.

Young Southerners Access to Abortion

Among all age groups nationally, pregnancy rates, birth rates, and abortion rates have been on the decline between 2010 to 2019. The abortion rate decreased the most among adolescents compared to any other group. However, women ages 20–24 account for the highest percentage of abortions (27.6%) and had the highest abortion rates (19.0 per 1,000 women aged 20–24) (Kortsmit, 2021). In the United States, more than half of U.S. abortions are among individuals who are in their 20s (56.9%) (Kortsmit, 2021). Moreover, the abortion ratio was the highest among adolescents under 19 years in 2019 (Kortsmit, 2021). These statistics highlight the trends in abortion among young people in the United States and the importance of ensuring these populations have the autonomy to access abortion without barriers. However, legislation in the United States is often targeted at young people to stifle their utilization of abortion.

Parental Involvement Laws

In the Southeast, all six states have parental involvement laws such as parental notification requirements, parental consent requirements, or both, with an exception for situations when the physician determines that a medical emergency exists that requires an immediate abortion (Salvador, 2020). Parental notification generally requires a medical provider to give written notification to parents 24 to 48 hours before a young person can obtain abortion services. Parental consent entails a minor obtaining consent from one or both parents to have an abortion procedure performed (Adjroud, 2019). Parental involvement laws vary across states and often require various documentation from one or both parents or guardians to obtain an abortion

for a minor 24 or 48 hours before an abortion procedure (See Table 2) (Dennis et al., 2009). Proponents of parental involvement laws suggest these laws are necessary to ensure parents are informed of their children's pregnancy intentions and protect parents' rights to be involved in minors' health decisions to reduce harm. However, those who do not agree with parental involvement laws argue these restrictions have negative health consequences for young people, such family violence, coercion to continue an unwanted pregnancy or terminate a desired pregnancy, and delays in abortion care which could increase complications. Young people are often unaware of parental involvement laws when pregnant and are challenged to navigate different state laws and the varying iterations of parental involvement laws (Dennis et al., 2009).

Table 2. Parental Involvement in Minors' Abortion Decisions

State	Parental Involvement			Other relatives allowed to consent	Parent must provide:		Minor must provide identification
	Consent only	Notification and consent	Notification only		Identification	Proof of parenthood	
Alabama	X				X	X	
Florida		X			X		
Georgia			X		X		
Mississippi	Both parents						
South Carolina	X†			X			
Tennessee	X					X	

†Allows specified health professionals to waive parental involvement in limited circumstances. (Guttmacher Institute [c], 2022)

Judicial Bypass

Belloti v. Baird (1979) ruled states are allowed to permit minors to obtain consent from a parent before terminating a pregnancy (Jerman et al., 2016). The Supreme Court decision allows for minors to terminate a pregnancy without parental involvement if (1) a minor is "mature enough and well enough informed" to make their abortion decision or (2) even if the minor is unable to make their abortion decision "independently" the abortion would be in the person's best interest (Salvador, 2020). Therefore, judicial bypass, which permits a minor to pursue a

court order that warrants them to have an abortion without parental notification or consent, is dictated by a court's perception of maturity and best interests of a minor. If a minor can demonstrate maturity and that they are informed enough to make the decision to have an abortion independently, they are omitted from having to prove their best interests (Salvador, 2020). Thirty-eight U.S. states that require some iteration of parental involvement legislation have a judicial bypass procedure (Salvador, 2020). Judicial bypass is legislated in all six Southern states in compliance with the *Belloti v. Baird* decision (See Table 3).

Table 3. Judicial Bypass Laws in U.S. Southeast

State	Judicial Bypass			Exceptions	
	Available	Specific criteria	"clear convincing evidence" standard	Medical Emergency	Abuse, assault, insect, or neglect
Alabama	X			X	
Florida	X	X	X	X	
Georgia	X			X	
Mississippi	X		X	X	
South Carolina‡	X			X	X
Tennessee	X			X	X

‡Applies to people under age 17
(Guttmacher Institute [c], 2022)

Consequences of Abortion Decision

In the United States, parental involvement laws impose additional barriers to abortion access for minors as compared to adults. Research indicates that while many minors will notify partners (83%) and a parent, particularly mothers (64%), there are still grave consequences for youth who are forced to disclose their abortion decision to an unsupportive parent (Ralph et al., 2014). Mothers often are the primary adult that youth consult in abortion decisions, although disclosure to a mother does not guarantee youth are protected. Compared to adults, adolescents are more likely to report external pressure about their abortion decisions and attribute this pressure to mothers' contributions (Ralph et al., 2014). Pregnant youth who have concealed their

abortion decision from parents often cite a range of consequences from fear of physical violence or homelessness (Kavanagh et al., 2012). To mitigate these consequences, young people have sought mentors, teachers, and friends for support for an abortion (Hasselbacher et al., 2014).

Unfortunately, the anonymity of judicial bypass data has resulted in limited ability to analyze data related to judicial bypass among adolescence (Altindag & Joyce, 2017). However, in-depth interviews with young people exposed that youth view parental involvement laws negatively due to the revocation of a right to choose whether to have an abortion independently and the undue burden of obtaining a judicial bypass (Kavanagh et al., 2012). Young people describe the judicial bypass process as "overwhelming" and "logistically complicated;" which raises concerns about youth seeking extreme options to avoid the process altogether (Kavanagh et al., 2012). The most cited consequence of parental involvement laws are minors traveling out-of-state for an abortion in a state that does not require parental involvement or have less restrictions(Dennis et al., 2009). There are indications from existing research that young Southerners are traveling to other states for care due to this reason (Altindag & Joyce, 2017).

Furthermore, abortion stigma deters young people from disclosing their abortion decisions and imposes potential restraints on their social support for an abortion (Coleman-Minahan et al., 2020). Anticipated abortion stigma informs young people's decisions to conceal their abortions (Coleman-Minahan et al., 2020). Adolescents fear adverse responses from parents and other trusted individuals in their lives, although they also desire emotional and material support for their abortion decision (Coleman-Minahan et al., 2020). There is evidence of youth experiencing enacted stigma in their abortion experience which included shame and emotional abuse (Coleman-Minahan et al., 2020). A combination of young people being less likely to identify a pregnancy early compared to adults combined with anticipated stigma of concealing an

abortion decision contribute to the complexity of young people trying to navigate abortion care alone in the South compared to adults (Altindag & Joyce, 2017).

The Role of Abortion Funds

Volatile and incohesive national abortion policy leave many gaps for funding abortions. In particular, the Hyde Amendment (1975) denies people who are insured under Medicaid from receiving coverage for their abortions (Henshaw et al., 2009). 58% of people of reproductive age enrolled in Medicaid reside in states who have banned Medicaid coverage for abortion with few exceptions (Donovan, 2017). Correspondingly, to add to the disparities in access beyond the state individuals reside in, 51% of these enrollees are people of color (Donovan, 2017). Research indicates when policy makers impose restrictions on Medicaid coverage of abortion, 1 in 4 poor individuals who seek abortion are forced to carry an unintended pregnancy (Henshaw et al., 2009). Consequently, evidence indicates people who seek an abortion and are denied have four times greater odds of living below the federal poverty line than a person who is able to get an abortion (Foster et al., 2018).

These decisions made by legislators amplify disparities experienced by people of color, people with low incomes, young immigrants, and people living in rural communities. The Hyde amendment severely impedes access to abortion among the most marginalized in society and abortion funds have intervened to disrupt and resist the reproductive coercion and injustice experienced by Americans.

National Abortion Federation

The National Abortion Federation (NAF) is a nationally recognized non-profit organization that provides abortion care referrals to quality providers and financial assistance to individuals seeking an abortion (NAF, 2022). NAF recruits individuals, private and nonprofit

clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals in the U.S. and Canada to refer patients for abortion care (NAF, 2022). All ARC-Southeast callers are advised to contact NAF prior to their appointment to be assigned a case manager and receive funding assistance. The federation generally has more funding capacity than most local and regional abortion funds. Therefore, NAF is a primary funder for individuals who contact ARC-Southeast's Healthline for logistical and financial support.

National Network of Abortion Funds

The National Network of Abortion Funds (NNAF) is composed of over 80 member organizations dispersed throughout the nation to provide financial and logistical support for people to access abortion (NNAF, 2022). Services delivered include help to pay for an abortion, transportation, childcare, translation, doula services, and boarding for people who travel for an abortion. The network includes abortion funds who advance NNAF's mission to build power among member organizations and eliminate financial and logistical barrier to access abortion by "centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice"(NNAF, 2022). NNAF mobilizes grassroots organizations and individuals affected by barriers to abortion access to ignite cultural and political change (NNAF, 2022). NNAF organizations are "frontline responders" to individuals who seek abortion care in the nation and have exclusive knowledge about the issues afflicting communities of people who seek to obtain an abortion (NNAF, 2022). Therefore, abortion funds have become an essential partner in mobilizing the reproductive justice movement and building collective power that centers people who have abortions (NNAF, 2022).

Access Reproductive Care – Southeast

Access Reproductive Care – Southeast (ARC-Southeast) is a reproductive justice organization based in Atlanta, Georgia that helps southerners navigate the various pathways to access safe, compassionate, and affordable reproductive care by providing financial and logistical support, including abortion services (ARC-Southeast, 2022). ARC-Southeast is a NNAF member organization which supports people in Alabama, Florida, Georgia, Mississippi, and South Carolina, and Tennessee. The organization primarily functions as a health hotline, referred to as the Healthline, which processes requests for abortion funding and mobilizes a vast network of practical support volunteers who offer practical support for people from the Southeast region of the United States (ARC-Southeast, 2022). Practical support for an abortion at ARC-Southeast can include rides, lodging, childcare, or escorting (NNAF, 2022). ARC-Southeast sustains its values of radical love, Southern synergy, autonomy and self-determination, and collective power to challenge hateful anti-abortion narratives and coercive reproductive health regulations in marginalized communities (ARC-Southeast, 2022). The organization's commitment to education and leadership development has built power in BIPOC communities to "abolish stigma and restore dignity and justice" (ARC-Southeast, 2022).

Reproductive Justice Framework

The Reproductive Justice (RJ) framework was championed by the Women of African Descent for Reproductive Justice in 1994 to address the need for a theoretical framework that challenged white-centered feminism and pro-choice dialogue (SisterSong, 2022). Inspired by the Declaration of Human Rights, the RJ framework demands all individuals are granted "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong, 2022). In recent years, the

RJ framework has gained recognition nationally and globally, although the operationalization of the concept has not been applied evenly. Additionally, RJ as a "buzz word" has been utilized to mobilize communities yet has often failed to completely embrace the grounded theory of Black Feminist Epistemology.

RJ centers Black Feminist Epistemology which is conceptualized through lived experiences as a criterion for meaning, use of dialogue, the ethic of personal accountability, and the ethic of caring (Jackson, 2021). To guarantee the human right to maintain personal autonomy abortion policy and research must integrate this grounded theory. The conceptualization of RJ is comprehensive and robust, although the operationalization by politicians and public health practitioners is an area of contention. Discussions about RJ commonly reference sexual and reproductive health access, yet RJ also calls for a complete analysis of power systems, centering the most marginalized, and embracing intersectionality (SisterSong, 2022). To dismantle the various institutions and social norms which perpetuate the marginalization of reproductive persons globally, RJ demands an acceptance of the intersectionality of one's own lived experience. As described by Audre Lorde, "There is no such thing as a single-issue struggle because we do not live single-issue lives" (SisterSong, 2022).

The RJ Framework is applied to this research at every stage. ARC-Southeast staff and most clinical partners are trained on the RJ Framework and its implication in their work. Additionally, the research approach is entirely influenced by Black Feminist Epistemology using qualitative research to uplift the value of personal experiences with accessing abortion in the Southeast. This research utilizes a RJ lens to call for a critical reflection of the policies that regulate abortion care and delivery of abortion care for young people in the U.S. Southeast.

CHAPTER 3 – METHODOLOGY

To contextualize the experiences of young Southerners who navigate hostile abortion policy in the U.S. Southeast, I conducted qualitative research with case notes from ARC-Southeast. The data collection was completed by ARC-Southeast Healthline staff during intake of people who contacted the organization for abortion funding or "callers" as referred to by the organization. The data was prepared and managed by Katie Labgold, a doctoral student at The Center for Reproductive Health Research in the Southeast (RISE). A qualitative analysis of cases containing at least one case note were included in the analysis followed by categorization of relevant cases that meet inclusion criterion, which were condensed into inductive and deductive themes. The study protocol was approved by the Institutional Review Board at Emory University (IRB 00114890).

ARC-Southeast Data Collection

The data used for this project were originally collected by the ARC-Southeast Healthline staff between May 2016 and May 2021. Though the research applied secondary data analysis, the researchers had access to the primary data collection methods. The ARC-Southeast Healthline provided the intake process for young callers who contacted the Healthline during the study period (See Figure 3). Additionally, to understand the most common reasons to document context specific information about callers the research team surveyed ARC-Southeast Healthline staff in March 2022. Healthline representatives attributed motivations to include context on case notes were to ensure the Healthline staff can establish an informed and compassionate relationship with the caller. Also, staff utilized the case notes to create a comfortable, safe space to seek support and provide additional advocacy for funding and other resources as necessary. Healthline staff revealed there are cases with less contextual information because of time limitations during high call

volumes and when the caller chose not to share detailed information. The ARC-Southeast team acknowledged case notes can tell a story about a callers' lived experiences leading up to the abortion decision. However, Healthline staff were committed to maintaining the callers' autonomy to disclose information as they feel appropriate and guarantee callers understood ARC-Southeast would provide financial and logistical support regardless of their individual circumstances.

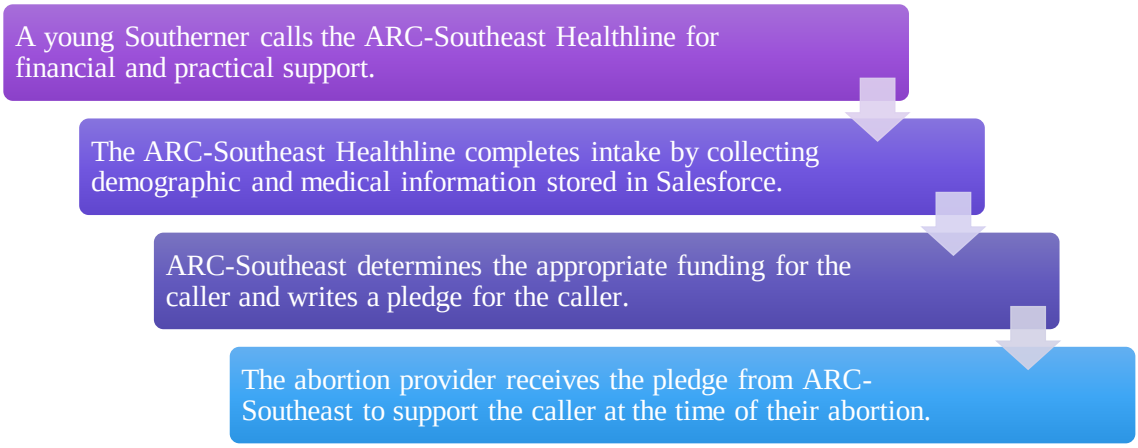


Figure 3. ARC-Southeast caller intake process utilized during the data collection process.

ARC-Southeast Case Notes

The project data originates from ARC-Southeast's case management system, Salesforce. The research team extracted a dataset containing demographic information and case notes managed by ARC-Southeast from people ages 21 and under who resided in six Southeastern states (Alabama, Florida, Georgia, Mississippi, Tennessee, and South Carolina) and who contacted the Healthline between May 2016 and May 2021 (n=2,278). See Table 4 for the characteristics of ARC-Southeast callers included in the study. The case records were securely stored on the Emory RISE Shared Drive as an excel file. Each case was provided a unique, de-identified ID number linked to the ARC-Southeast records, which are protected on a flash drive that requires ARC-Southeast authorization. The case notes were also de-identified by removing specific information

about the caller, such as name or home address. The data includes four variables from Salesforce including: case ID, case year, comment body, and number of comments. Case notes including at least 1 case comment were included in the preliminary qualitative analysis (n=1,879) (see Figure 4).

Table 4. Characteristics of 2016-2021 ARC-Southeast callers ages 10-21 years, residing in Georgia, Mississippi, Tennessee, South Carolina, Alabama, and Florida (n = 2,029)

Caller Characteristic	**Overall (n=2,029)**
Caller Age	
10-14 years	36 (2%)
15 years	41 (2%)
16 years	89 (4%)
17 years	164 (8%)
18 years	239 (12%)
19 years	353 (17%)
20 years	453 (22%)
21 years	654 (32%)
Caller Race/Ethnicity	
Hispanic	62 (3%)
NH Black	1,073 (53%)
NH White	239 (12%)
Other Race/Ethnicity	13 (<1%)
Missing	642 (32%)
Year Case Opened	
2016/2017	161 (7%)
2018	248 (12%)
2019	729 (36%)
2020	538 (27%)
2021	353 (17%)
Caller State of Residence	
Alabama	265 (13%)
Florida	167 (8%)
Georgia	939 (46%)
Mississippi	275 (14%)
South Carolina	103 (5%)
Tennessee	283 (14%)
State of Clinic Attended by Caller	
Alabama	130 (6%)
Florida	184 (9%)
Georgia	1,131 (56%)
Mississippi	199 (10%)
South Carolina	30 (1%)
Tennessee	270 (13%)
Other State	57 (3%)
Missing	28 (1%)
Abortion Type	
Medication	723 (36%)
Surgical	1,247 (61%)
Missing	59 (3%)

Operationalization of Abortion Barriers for Youth

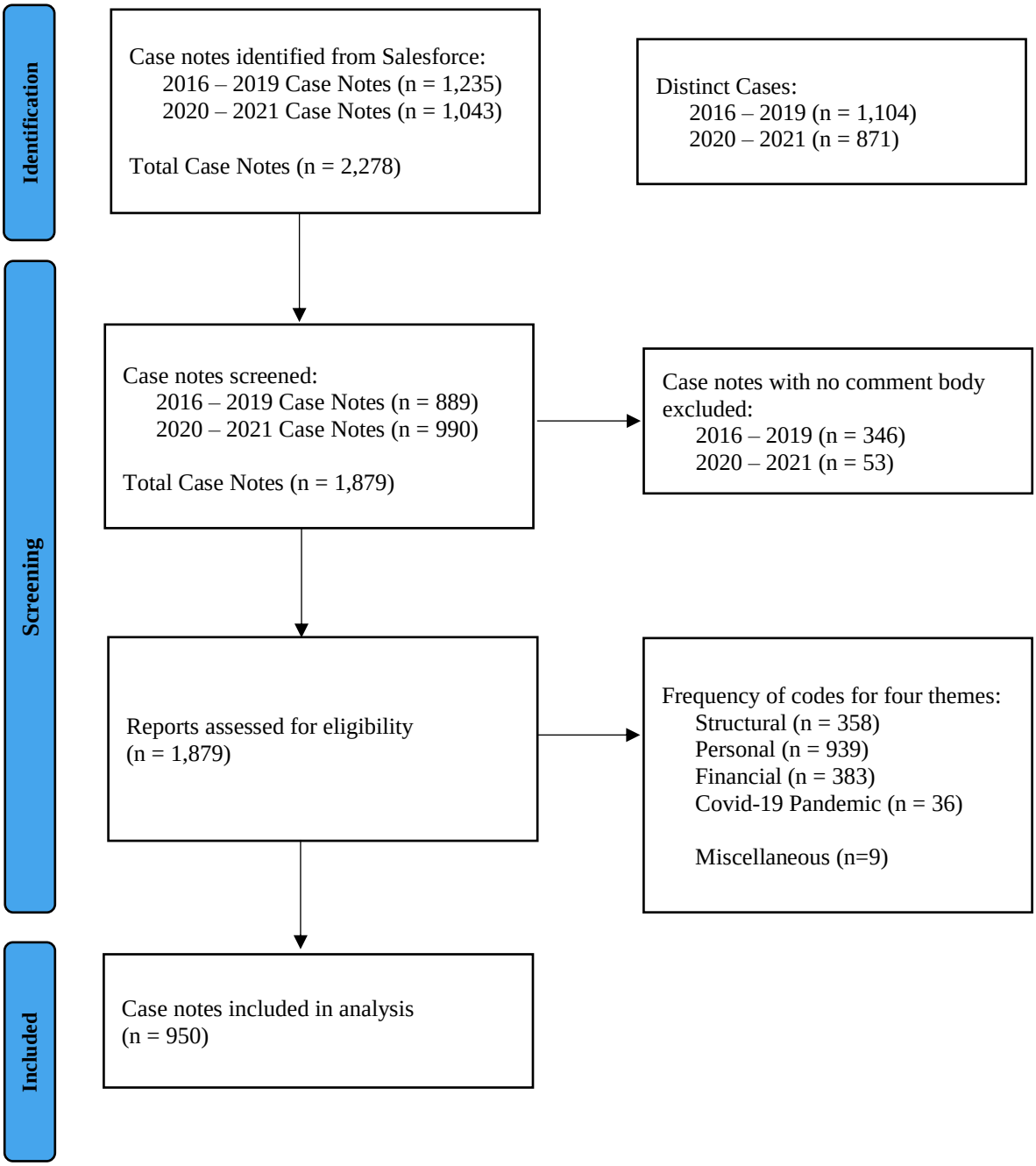
The proposed project will entail a qualitative analysis of the comment body or case notes from Salesforce.[4] The terms "comment body" and "case notes" are used interchangeably to refer to the notes provided by the Healthline staff about the case. The case notes often provide information about the callers' situation, people involved, practical support requests, and funding. To conduct the qualitative analysis, a deductive and inductive codebook and code summaries will be produced from relevant literature and the preliminary analysis of case notes from 2019-2021 (n=1,043) (Appendix I). The deductive and inductive themes will be refined throughout the analysis to categorize the data where applicable.

To conceptualize abortion access for youth in the U.S. Southeast the qualitative analysis will use MAXQDA, a textual analysis software, to identify case notes which reference barriers to abortion access identified in the preliminary analysis. Initial codes associated with access identified during the preliminary analysis of the data and literature on young people's abortion experiences will be used to identify cases with rich information about barriers to access young people encounter (See Figure 4). Braun and Clarke (2012) method for thematic analysis will be deployed to systematically identify and organize themes across the data (Braun & Clarke, 2012). To expose patterns of meaning the thematic analysis will include a thorough read of each case note, coding, memoing, and segmentation of cases notes with relevant text. Themes will be constructed from the coded data and subsequently reviewed to ensure distinctive and coherent themes.

In MAXQDA, properties and dimensions of structural, personal, and financial barriers to access abortion were identified. Segments were used to create pictorial diagrams to portray the various experiences of young Southerners accessing abortion in a region hostile to abortion rights.

Additional diagrams were used to display the intersections of structural, personal, and financial barriers to access among young people in the Southeast who have sought logistical and/or financial support for an abortion. Nine-hundred and fifty information rich case notes were selected for thematic analysis.

Figure 4. Data Management of Case Notes



Methodological Limitations

ARC-Southeast Healthline data were collected by Healthline workers over a 5-year period. Therefore, standards related to the amount of information reported increased over time. The Healthline staff has also changed since 2016, thus individuals entering information have changed. In consideration of this limitation, the research accepts that the amount of detail and motivations for providing contextual information in the case notes may vary for these reasons.

Moreover, this project utilizes secondary data to describe the barriers to access abortion for young Southerners. The data used for analysis were primarily collected for administrative purposes and were not intended for qualitative research. Thus, the data seldom include direct quotes from callers and do not exclusively capture the experiences of young people, but also those who support the caller with Healthline intake. Administrative data collection restricts the research from presenting primary source data, although adequately can describe the experiences of youth who sought abortion care during the study period.

Another methodological limitation of this research is the restraints of a case-based analysis. To protect the identity of callers, callers are not provided unique identifications; yet all case notes related to a particular case managed by the Healthline have a unique study identification. Therefore, we can distinguish multiple case notes documented to resolve an individual case. It is not possible to identify callers who have accessed services from ARC-Southeast more than once during the study period. However, an analysis of ARC-Southeast data matching callers based on identifying characteristics showed 4 percent (332 case records) of all callers between 2016 and 2019 were potential repeat callers, which suggests that nearly all cases in the dataset represent unique individuals who received an abortion once in the study period (Rice et al., 2021).

CHAPTER III – RESULTS

The thematic analysis identified four broad deductive themes representing barriers to access an abortion in the U.S. Southeast during the study period: (1) structural barriers, (2) financial barriers, (3) personal barriers, and (4) the COVID-19 pandemic. Each of these barriers to access abortion were documented in the case notes (n=950) (See Table 5). The author also made additional observations during the analysis, which provided important context for the case notes but were not frequently discussed to be identified as a theme. Nonetheless, these findings provide novel information for discussions to follow related to abortion access among youth in the U.S. Southeast. See Table 5 for emergent codes in the case notes acknowledged as inductive codes assigned to themes in the data.

Table 5. Inductive Codes

Language	Part-time employment
Reschedule	Unexpected expenses
Abortion Type	Violence
Incarceration	Distrust
Pre-existing Conditions	Family Planning
Caregiver	Menstruation

1. Structural Barriers

Structural barriers to access abortion were documented in the case notes related to parental involvement laws, distance traveled, gestational limits, waiting periods, mandatory counseling, insurance coverage, and abortion funding resources. Callers did not explicitly reference restrictive legislation or policies that impeded access to abortion. However, the implications of restrictive federal and state level policies were evident in the case notes.

1.1. Parental Involvement Laws

Parental notification and judicial bypass were mentioned rarely in the case notes. One case note mentioned parental notification as "safer" than parental involvement for a young person who wanted to conceal their pregnancy from their parents. While many minors involved at least one parent in their abortion intake, some youth requested for a judicial bypass to avoid disclosing their decision with their parents. Youth who sought a judicial bypass were adamant about not involving their parents because of fear of the consequences of their pregnancy and abortion decision. The few young people who chose to proceed with a judicial bypass or parental notification were supported by Jane's Due Process, an organization providing legal support for minors who seek abortion in the United States without parental involvement. Abortion funds partnered with Jane's Due Process to coordinate judicial bypass hearings in the city where the young person received abortion care, which resulted in out-of-state travel for judicial bypass proceedings. Due to the complexity of the legal proceedings and document acquisition, most youth avoided the process altogether and delayed care until their 18th birthday, if possible, or attempted to receive a parent's approval despite concerns of retaliation.

1.2. Distance Traveled

The case notes included information about care coordination for callers traveling out of state or more than an hour for abortion care. The case notes revealed the primary reasons for traveling far distances for abortion care were gestational limits, proximity, procedure costs, and funding eligibility of the clinic. Less than one-third of callers who traveled out of state mentioned travel was due to a later gestational age that required the young person receive care in another state. The distance individuals traveled for care was also influenced by a consumer preference for lower cost and closer proximity (in miles). ARC-Southeast also provides funding pledges to a

select number of clinics in Florida and South Carolina; therefore, some callers were traveling greater distances to receive care at partnered clinics.

1.3. Gestational Limits

Gestational limits caused young people to travel to other states for abortions. Young people who misestimated their gestational ages were surprised to learn of the high cost for their abortion procedure and state-level gestational limit. Most young Southerners were able to travel between the six states ARC-Southeast provided funding. More than half of callers who surpassed their state of residence gestational limit would travel to Georgia for abortion care. The case notes did not identify any callers who traveled to South Carolina for abortion care. Callers with a gestation greater than 20 weeks were provided logistical support from multiple abortion funds to access care at a Maryland, New Mexico, or Colorado clinic partnered with ARC-Southeast. In one case note, a caller expressed stress to schedule an abortion procedure before their state gestational limit to avoid coordinating care across state lines. Those who traveled further distances for care most frequently requested support for financing additional costs such as transportation (e.g., gas, flights, bus tickets) and lodging.

1.4. Mandatory Counseling and Waiting Periods

Mandatory counseling and waiting periods appeared in unison in the case notes (n=20). These two structural barriers contributed directly to callers' need to schedule more than one appointment. Mandatory counseling content required during the first appointment were not captured in the case notes, although cost and scheduling challenges to receive counseling were documented. Many people contacting ARC-Southeast lacked funds for the abortion procedure because callers used most or all their funds for the first appointment. Callers most frequently mentioned paying out of pocket for an ultrasound at the first appointment. Moreover, a common

occurrence for young people who obtained an ultrasound at the clinic also discovered their gestational age was higher than the clinics' service limit. In these situations, some clinics offered a refund, although more frequently callers accepted the loss and paid for an ultrasound at another clinic that could provide services.

Waiting periods required callers to wait between 24 and 48 hours to perform an abortion procedure after counseling. The case notes discussed waiting periods predominately in reference to the challenges of scheduling, travel, and lodging to accommodate multiple appointments. Callers who were traveling out of state experienced further barriers to care due to coordination of extended lodging, transportation, requesting time off from work or school, and intricate anecdotes for concealment from parents.

1.5. Insurance Coverage

Most young people were insured by their parents' insurance or Medicaid. However, insurance coverage managed by parents requires an insurance claim and Medicaid does not provide abortion care coverage. Young people who wanted to conceal their abortion from their parents could not use insurance to cover healthcare costs at the first appointment. However, the National Abortion Federation verified the household income and insurance coverage of young people to determine financial assistance. Thus, young people are not afforded the appropriate amount of funding to cover the abortion on their own. Moreover, Medicaid recipients were only eligible for a clinic endorsed discount. To benefit from Medicaid discounts, some callers registered for Medicaid prior to their appointment to reduce the cost of the abortion procedure.

1.6. Abortion Fund Resources

The extent of financial and logistical support ARC-Southeast, other abortion funds, and clinics provided young Southerners were documented. The case notes revealed abortion service

delivery organizations and providers were collectively providing essential services to young people. Many callers learned of abortion funds from clinic staff who referred patients who demonstrated financial need. Abortion funds came together to raise solidarity funding for callers who demonstrated an immediate financial need (e.g., exceeded gestational limit in region). ARC-Southeast, other abortion funds, and clinics also requested solidarity funding when the organizations' finances were depleted. Abortion care organizations across the Southeast and national co-conspirators in other states (e.g., Maryland) would support the coordination of care and costs of transportation, lodging, food, and childcare.

ARC-Southeast case notes also revealed that Healthline services exceed abortion funding. Callers and their families were provided funding advocacy, emotional support, and non-clinical resources. Healthline staff advocated for young people and their families by collaborating with additional abortion funds and clinics to secure solidarity funding and intervened to prevent reproductive coercion. To provide emotional support, Healthline staff actively listened to callers and delivered trauma-informed care. Callers and parents in crisis were guided in breathing and grounding techniques. Moreover, Healthline staff extended their knowledge of state resources to support callers who disclosed instances of domestic violence, homelessness, and food insecurity.

Case notes highlighted expressions of appreciation for abortion funding and logistical support from ARC-Southeast. However, there were a few instances of distrust captured among minors' guardians and mixed-status families—families including people with different citizenship or immigration statuses—accessing abortion funding. Few case notes described guardians who were hesitant to allow Healthline staff to speak directly to minors, disclose demographic information, and discuss the nature of the pregnancy. Additionally, young people managing the intake process alone were adamant about confirmation the funding would be

available at the appointment. Healthline staff were intentional to validate callers concerns and provide in-depth explanations of ARC-Southeast's standard operating procedure.

Many cases included a detailed navigation plan for callers who had not been provided a case manager with NAF. The federation's high caller volume and delayed response was a major barrier for young people. ARC-Southeast intervened, when possible, to accelerate the funding process. In addition, ARC-Southeast would learn of the NAF mandatory reporting policy which requires case managers to report cases involving minors that raise concerns. In one case, the ARC-Southeast's disclosure of a minor's age resulted in inquiry about the nature of the pregnancy and police notification from the NAF without the mother's consent.

1.7. Family Planning Provision

Family planning topics such as sexual behaviors, contraceptive use, and pregnancy intentions were expressed throughout the case notes. Young people's experiences with sexual and reproductive health services were nuanced and no experience was shared between cases. However, experiences with menstruation tracking difficulties, unexpected positive pregnancy results during traditional doctors' visits or emergency room visits due to pregnancy symptoms, and failed birth control methods were shared. In one case, an individual had scheduled an appointment to obtain birth control and found out that she was pregnant at the appointment. In other instances, callers used emergency contraception or supplements which compromised their birth control which resulted in pregnancy. In one case note, an individual who obtained and completed medication abortion pills reported the abortion method failed. These experiences introduced unexpected expenses and required individuals who attempted to prevent and space their births from achieving their family planning desires. Cases which involved mothers of callers seeking abortion services noted parents supporting their child's case intake who were

unaware of their child's sexual decision making and prompted requests for information about birth control methods.

To estimate a young person's gestational age, the Healthline staff requested that individuals provide the date of their last menstrual period. The case notes rarely mentioned callers who did not know the date of their last menstrual period. However, among these case notes, individuals cited irregular periods, spotting, and not knowing the last menstrual period prevented them from providing a date. Inaccurate gestational age estimations led to miscalculations of the cost, change in abortion method, and clinic transfers.

2. Personal Barriers

Documented examples of personal circumstances provided context for the various barriers to access abortion that young Southerners encounter. Personal barriers included: concealment, parenting, social support, confidants, anti-abortion, incarceration, quality of relationship, caregiver, language, and pre-existing health conditions.

2.1. Concealment

Youth explicitly described concealing an abortion decision to avoid retaliation from abusive partners and parents and to maintain privacy. More than half of callers who referenced concealment of their abortion shared safety concerns. Callers who were in abusive relationships or attempting to escape domestic violence were frequently interested in concealing their abortion decision to avoid reproductive coercion of partners. For example, a young person experiencing houselessness and intimate partner violence expressed fear their partner would persuade them to continue an unwanted pregnancy. In addition to partners, callers perceived parents as a threat to obtaining an abortion. These safety concerns were often related to a callers' perceived consequences imposed by parents for becoming pregnant and having an abortion. Young people

described a fear of parents who would “kick them out” of the house if they were to either learn of the pregnancy, continue an unplanned pregnancy, or terminate the pregnancy.

The cost of an abortion impeded young people’s autonomy to decide whether to conceal their abortion decision. For young people, it was challenging to finance their abortion in private without raising “red flags” among parents. Youth were uncomfortable with the possibility of parents asking for an explanation for why they had sought financial support. Moreover, young people were concerned parents who monitor their finances would ultimately be forced to disclose their abortion decision. Young people explicitly asked Healthline staff to at least fund an amount that allowed them to discreetly ask their social network, specifically family members, for funding support.

2.2. Parenting

Many callers and their parents who supported intake reported caring for children. Young callers disclosed that recent pregnancies were the reason to terminate their current pregnancy. About half of parents who requested abortion fund support gave birth within the last year. These callers were concerned about their ability to care for a child as they have experienced challenges with affording to care for their infant or toddler. One case note detailed a young parent who struggled to afford the abortion procedure because they needed diapers and formula for their newborn. Additionally, many young people who reside with multiple siblings struggle to obtain sufficient financial support. Most mothers who supported intake for these young people identified as the head of household and had other children they supported financially, therefore could not distribute funds toward abortion procedures.

2.3. Social Support

Social support varied greatly across case notes. See Table 6 to explore the numerous people callers received financial and logistical support from during the study period. The case notes exposed disclosure of an abortion did not equate to social support. Lack of social support because callers chose to conceal their abortion, had an economically vulnerable social support system, or were denied support due to their choice to terminate the pregnancy was common. Callers with little to no social network were challenged to navigate care differently as compared to callers with support. Young people predominately obtained loans, used academic financial aid, money saved for other expenses (e.g., rent, car payment), increased hours at work or generated income through other informal money generating opportunities (e.g., DoorDash, Uber, selling clothes).

Table 6. People who provided young people support

Parents	Sister-in-law
Guardians	Grandmothers
Partners	Mother-in-law
Friends	Parent of person conceived with
Sisters	Therapist
Roommate	Family Members (e.g. aunt)
People from church	Stepmother

People who supported young callers accessing abortion offered financial and logistical support. Young people with social networks that were accepting of abortion and had the means to support the abortion procedure costs accessed abortion care in a timely manner with fewer barriers. Callers with expansive social networks were able to request money from multiple individuals and identify transportation for the appointment. When social support was afforded, mothers, guardians, and friends were primarily involved with paying for the abortion and providing transportation to the clinic.

2.4. Confidants

Mothers and partners were the most frequently involved individuals during caller intake. Among mothers, the case notes exposed knowledge of the abortion decision and involvement during intake did not equate to funding and logistical support for an abortion. The case notes demonstrated many instances of young people whose parents were involved with the ARC-Southeast Healthline intake, although did not support financially or logistically because (1) parents did not have the funds to support the procedure or (2) parents did not agree with the abortion decision. Tense dialogue between mothers and children was included in the case notes. In a few instances, mothers were described as abrasive and coercive towards their children. Additionally, mothers were the only confidants to express hesitation and skepticism with Healthline staff when staff asked to speak with the person getting an abortion. From the perspective of a caller who did not involve their mother, they described refusing to seek support from their mother because "it's not her problem."

Though these instances were documented, mothers were overwhelmingly the most common person involved in intake, funding, and logistical support. Regardless of the various degrees of support shown to adolescents from their mothers, mothers are the dominant group of individuals responding to young people in the Southeast seeking abortion support. Mothers supported young people during intake to mitigate distress and trauma and protect their children from other family members or abusive partners who threaten their child's physical and psychological safety.

Callers also often sought partners to provide financial and logistical support with the abortion procedure. Case notes uncovered that the degree of support youth received from partners depended on the quality of their relationship. Individuals who referred to the people they

conceived with using terms that imply a relationship, such as husband and boyfriend, prompted more support from a partner during the abortion process. However, a caller who referenced their partner solely as the person they had sex with, the baby's daddy, or father had less support and were more likely to unexpectedly fail to provide financial support.

2.5. Anti-Abortion

Explicit anti-abortion rhetoric from family and peers was scarce in the case notes. The few instances of anti-abortion commentary are pervasive in combination with other codes such as homelessness, intimate partner violence, and concealment. Callers who were exposed to anti-abortion rhetoric from family and partners often anticipated negative consequences such as being kicked out the house, spiritual condemnation, life endangerment, interference with the abortion process, and negative familial perceptions. These narratives around callers fostered fear and concealment among young people seeking abortion.

For a caller who self-identified as anti-abortion, the abortion process ignited anger. The caller was adamant about not rescheduling an abortion procedure due to feelings of having to "kill her baby." This caller's partner refused to support the abortion to protect his desire for the pregnancy to be carried to term. To conceal her abortion decision, she would ask her social support for money for "bills."

2.6. Pre-existing Health Conditions

Young people who seek abortion fund support also have pre-existing conditions and pregnancy experiences which inform their emotional, physical, and mental wellness to continue a pregnancy. An unexpected pregnancy coupled with chronic diseases management complicate the abortion process as blood transfusions cannot be completed, scheduling can be compromised due to flare-ups, and people may have limited or volatile financial resources to afford an abortion

procedure (e.g., disability, unemployed for medical reasons). Youth with various health conditions resulting from injury or chronic illness can negate abortion care as abortion providers express hesitation or discomfort performing more complex procedures. Moreover, the ability status of callers prompted additional support during intake to ensure speech and learning delays do not interrupt compassionate and comprehensive care. Additionally, previous experiences with pregnancy, such as COVID-19 infection, professional opinion, or child loss and personal health history (e.g., cancer) contributed to a caller's current decision about pregnancy termination.

2.7. Caregiver

The Healthline documented a few instances of callers who provided health and financial support to family. Callers provided direct support to families and children who have disabilities during the study period. Youth who provided care to parents, grandparents, and children with complex health issues had limited funding opportunities as they were either not able to work while providing care or disability insurance and other welfare benefits could not cover the cost of an abortion procedure. Youth also intervened to alleviate familial financial struggles by purchasing medications and sending remittances to family during COVID-19, which limited their capacity to afford abortion care.

2.8. Language

Very few callers encountered language barriers to access care. Interpreters were not available every day of the week for languages other than Spanish and English. Therefore, callers who spoke another language had to involve someone trusted who spoke English and contact on a specific day the Healthline could have an interpreter to ensure the person could access care. When English was not a caller's first language there were additional challenges to access care and maintain privacy.

2.9. Immigration Status

Political rhetoric around family separation and the U.S. Immigration and Customs Enforcement (ICE) during the study period interfered with immigrant families seeking abortion care. Immigration status is an important aspect of accessing abortion care for undocumented individuals and mixed-status families. In one case, a parent supporting their child's intake expressed fear abortion funds and clinics would ask for their immigration status and report their information to ICE. The parent disclosed her fear of deportation and separation from her children if ICE were to be notified.

2.10. Abortion Type

There were a few narratives surrounding medication abortion, surgical abortion, and telemedicine in the case notes. The cost, timing, and privacy concerns influenced personal preferences for a particular abortion method. Callers had a predilection for medication abortion to maintain privacy, obtain timely care, or mimic a miscarriage among social networks who disapproved of pregnancy termination. To navigate the reproductive desires of influential individuals in young people's lives, youth constructed strategic plans to replicate natural pregnancy loss. In one case, a young person disclosed their pregnancy to family members who were adamant they continued the pregnancy. To avoid retaliation from family members who do not approve of abortion, she had requested a medication abortion to imitate a miscarriage. Additionally, telemedicine was mentioned for the first time in the case notes in 2021. The emergence of telemedicine during the pandemic increased access to more affordable care and medication abortion pills (e.g., mailed) without compromising their privacy.

Surgical abortions would present pronounced barriers to callers who wanted to conceal their pregnancy and travel more than an hour from home or out of state for a 2-day surgical

procedure. Callers planned a “cover” story which often involved seeking a friend to tell their parents they were at their house. However, for some young people, surgical abortion was the preferred method because of the affordability in their region.

2.11. Violence

Violence against young people seeking abortions in the case notes appeared in multiple different forms. For this research, the violence was categorized by intimate partner violence, domestic violence, and rape and sexual assault (See Appendix I). More than half of sexual assault and rape victims were minors. The rape and sexual assault cases were predominately handled by mothers or another guardian unless the pregnancy threatened the persons safety and concealment was necessary. In the cases of rape and sexual assault, there was a pronounced urgency to receive timely abortion care.

Domestic violence was captured by Healthline staff and used to identify cases of violence between romantic partners. However, for this research, intimate partner violence was defined by violence between romantic partners and domestic violence was restricted to violence occurring in the household between parents. The classification was necessary to delineate experiences of violence underrepresented in the literature. For example, in one case, a domestic violence survivor who recently escaped their husband was challenged to hide her daughter’s pregnancy to prevent retaliation from her husband.

Case notes describing intimate partner violence exposed various violent acts such as emotional and verbal abuse, stealthing (e.g., poking holes in condoms), and forced penetrative acts. One-third of IPV experiences that involved a partner who is incarcerated accounted for all mentions of incarceration documented.

Gun violence was also present in one case of a young person who had been healing from a wound acquired from a gunshot. The wound directly impacted the young person's ability to have a safe pregnancy, which forced them to terminate the pregnancy. Serious injury presented challenges for this young person as select providers are comfortable preforming abortions for individuals with health histories and injuries that they deemed challenging.

Moreover, homelessness was present in young people's experience of sexual violence. In one case, homelessness was the consequence for a young person disclosing a pregnancy that resulted from rape and in another case, a young person's homelessness preceded rape.

3. Financial Barriers

Financial barriers were frequently documented due to ARC-Southeast's funding capacity. Among relevant cases, the Healthline reported student status, employment opportunity, rescheduling, and recurrent and unexpected expenses.

3.1. Student Status

Young people under the age of 22 are pursuing various levels of education including: elementary school, middle school, secondary school, higher education, and GED completion (n=110). However, a shared experience for young people is the potential for missed instruction time and scheduling concerns. Callers in grades 1-12 were difficult for the Healthline to obtain consent due to school hours and coordinate an appointment due to conflicting school schedules and parent's work schedules. Those who were pursuing higher education encountered the pressure of academics, work, and athletics. For example, one case described a young person who had to delay their appointment because they could not have their surgical procedure during midterms week.

Students cannot afford abortion procedures because of limited income. Most students do not have reliable or substantive financial opportunities. To focus on school, young people work part-time and have limited income. Therefore, youth who want to terminate a pregnancy often encounter a dilemma of whether to tell their parents or guardian about the abortion or attempt to reduce the cost to low enough that they can seek financial support without raising suspicion. Funding opportunities can be limited for some youth. For example, NAF—a primary abortion funder— requests young people's household income to determine funding. For youth who would like to conceal their abortions, the higher household income simply makes it more difficult to secure funding. This process does not acknowledge that the household may not be in support of the person seeking an abortion. Therefore, youth utilized school funds such as academic loans and financial aid reimbursements, to afford their abortion procedures.

3.2. Employment Opportunity

Many individuals and families seeking abortion fund support experienced volatile employment opportunities. Part-time employment and unemployment were persistent frequently documented. Many young people relied on part-time jobs to afford the cost of their abortion procedure. However, these jobs were not reliable and provided fluctuating wages. Callers and their families who experienced unemployment could not pay their abortion costs. For those who were working, abortion appointments were sometimes a challenge because if they occurred before pay day, callers would not have money to contribute to their procedure.

3.3. Rescheduling Appointments

A prominent occurrence for young people seeking abortion support was frequent rescheduling due to lack of funds. Young people who did not have the capacity to pay for the total abortion procedure, even after ARC-Southeast funding, were challenged with locating

funding from other sources before their abortion procedure. To afford an abortion procedure, Healthline staff often brainstormed during intake different sources of income people could seek. Young callers most frequently resorted to selling personal items, working extra shifts, asking friends and family for money, or taking out loans. However, if the total could not be covered by the date of the appointment, individuals would continue to move their procedure date. The frequent delay to access abortion care would contribute to growing concerns as callers approached greater gestational ages, faced higher procedure costs, and expiration of ARC-Southeast pledge (expires after 30 days). If callers continued to reschedule appointments, the Healthline would advise callers to attend the appointment to seek emergency funding from the clinic on the day of the appointment.

3.4. Recurrent and Unexpected Expenses

Appointments were also rescheduled because of unexpected occurrences. Unfortunately, unpredictable occurrences such as theft, loss of a family member, car trouble, and housing damage affect young people too. Additionally, recurrent expenses such as bills and rent were competing costs for callers. Callers who were having trouble to afford their abortions referenced having to allocate funding for basic needs to pay for the abortion. These sacrifices prompt young callers and their families to experience food and housing insecurity.

3.5. Homelessness

Houselessness among young people was prevalent in the case notes under two conditions (1) houseless before the pregnancy and (2) refused shelter with parents due to either disclosure of their pregnancy, abortion decision, or both. Callers also mentioned concerns their parents would force them out of the house if they were to continue the pregnancy. The perspicuous consequences of housing insecurity faced by young people caused these individuals to conceal

their abortion decision, which resulted in many barriers to financial support for the procedure as parents were not an option for support.

4. COVID-19 Pandemic

Among young people and their families, unexpected layoffs (n=8), reduction in work hours, isolation periods due to exposure in the workplace (n=4), and persistent unemployment (n=9) further marginalized low-income people seeking abortions in the Southeast. Youth encountered unexpected changes in living situation as universities sent youth home, which directly impacted their access to care and other young people assumed responsibility for providing financial support for family. For example, in one case, a young person cited sending remittances to family abroad who were struggling to support themselves during the COVID-19 pandemic. Many of the financial struggles encountered by young people were unexpected and amplified the existing challenges to access abortion care.

COVID-19 imposed barriers were most often associated with a delay in abortion care. Due to a lack of funding at the time of an appointment or clinic closures due to staff COVID-19 exposure, callers were forced to delay their appointment. Delay in seeking care resulted in care seeking at later gestational ages, which require out-of-state travel for abortion care due to gestational age limits in callers' respective states and challenged callers to decide whether to travel for their appointment by car or plane to reduce COVID-19 exposure.

5. Conceptual Framework: Challenges, Impacts and Opportunities

The barriers to access abortion for young Southerners occurred in the same environmental context, thus while some challenges differed, most were interrelated. To understand the abortion-restrictive environment young people navigate in the U.S. Southeast, a conceptual framework developed by Chowdhary (2022) was adapted to represent the findings of this study. The

conceptual framework summarizes the barriers to access abortion care by young Southerners, their perceived consequences of the identified barriers, and opportunities to mitigate the negative repercussions for youth who seek abortion care in the region. As illustrated in Figure 4, structural barriers to access abortion augment most existing financial and personal circumstances to hinder abortion access. While some of the impacts of barriers to access are restricted to specific challenges, the framework exposed the pervasiveness of constrained bodily autonomy and delayed abortion care. The study identified opportunities for gatekeepers, such as abortion funds, providers. and Southerner legislators, to alleviate various barriers to access in relation to specific challenges these stakeholders have the potential to address.

Conceptual Framework

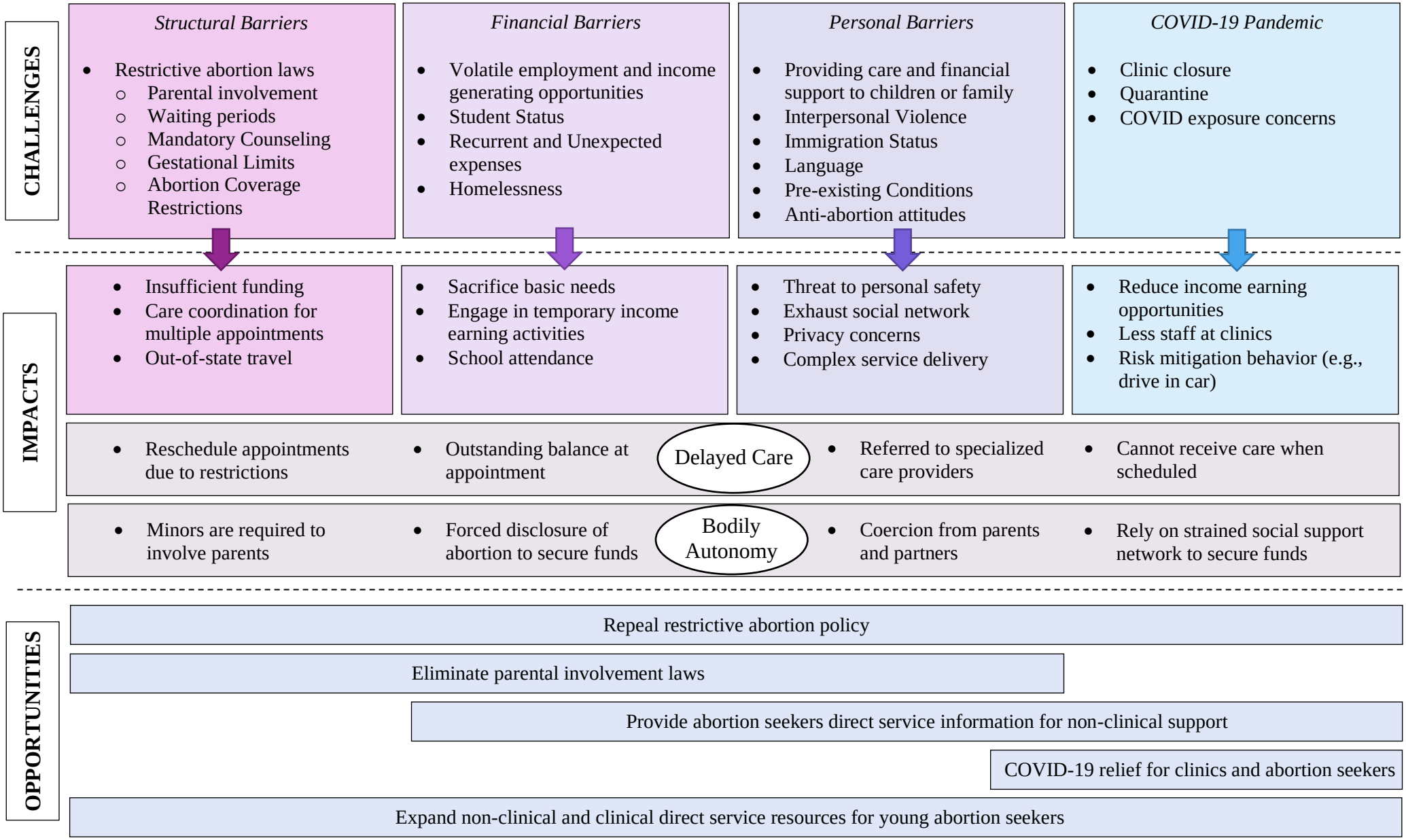


Figure 4. Conceptual framework summarizing the challenges affecting youth who seek abortion support in the U.S. Southeast, the associated impacts, and potential opportunities to mitigate them

CHAPTER 5 – DISCUSSION

In the context of an increasingly hostile abortion environment in the Southern United States, this study provides critical insight to the regional challenges. The study findings expand on literature about characteristics of people who access abortion and abortion barriers in the U.S. Southeast (Jerman et al., 2016; Jones et al., 2019; Rice et al., 2021). The novel focus of this research on young people provided contextual information to improve understanding of barriers to abortion access for this population group. The study also observed disparities in access to abortion for young people based on structural, financial, and personal barriers. This study provides descriptions and examples of the barriers young people encountered to access abortion between 2016 and 2021. Focusing on the disparities in abortion access for young people is important to better provide timely, affordable, compassionate, and safe abortion care.

Study findings provide evidence of the detrimental effects of structural, financial, and personal barriers. In the U.S. Southeast, restrictive structural barriers such as parental involvement laws, gestational limits, and waiting periods, impeded access to abortion care. Parental involvement laws are a form of legislation that disproportionately affects minors who access abortion. Existing literature suggesting that youth often chose to involve a parent and perceived judicial bypass as challenging were consistent with the study findings (Kavanagh et al., 2012). However, the study captured more explicitly the consequences cited in the literature related to a pregnancy or abortion disclosure. These consequences often included homelessness, reproductive coercion, or denial of funding support for an abortion procedure. Young people often discussed their perceived safety in relation to concealment from parents, guardians, and partners. These fears contributed to young people going to great lengths to conceal their abortion

decision, which included delaying care until their 18th birthday and imitating a miscarriage for family members.

In the context of the U.S. Southeast, abortion care navigation remained a challenge throughout the study period. Healthline staff and callers were challenged with scheduling abortion appointments with consideration of various abortion restrictions. Young people across the region had different experiences learning of their pregnancy. Thus, gestational age estimations were not always accurate and sometimes required callers to travel to other clinics in or out of state for care. Gestational limits would dictate which clinics and states young people were eligible to receive care. The state the clinic was in also determined the waiting period for the young person. The presence of these instances contributed to a multifaceted care coordination plan orchestrated by ARC-Southeast, clinics, and other abortion fund partners.

Financial barriers often amplified the direct service barriers imposed by restrictive abortion policies. Young people who accessed abortion care would be challenged to navigate out-of-pocket costs for their abortion. In the U.S. Southeast, there is no insurance coverage for an abortion (Henshaw et al., 2009; Upadhyay et al., 2021). For young people who did have coverage under their parents, they refused to utilize insurance because they did not want to involve their parents. Many young people were challenged to secure funding for their abortion procedure, although exhausted their funds for the first appointment (including the ultrasound and mandatory counseling). ARC-Southeast provided as much support as possible to all callers, although pledges often were not enough and required young people to rely on volatile employment opportunities, request money from their social network, sell personal items, or utilize student loans and financial aid to cover costs. Callers and parents also discussed applying finances allocated to important needs, such as rent and food, to afford the abortion procedure.

Insufficient funding opportunities and inescapable recurrent expenses amplified the dire consequences restrictive abortion coverage. The short-term consequences described by youth in the study reflected cautionary statistics developed in the Turnaway Study (Foster et al., 2018). In addition, callers' reliance on Medicaid discounts allocated by the abortion clinics implicates the sizeable resolution an expansion of Medicaid coverage for Southern recipients could produce (Upadhyay et al., 2021).

The most salient study finding was the evidence suggesting the combined barriers to access abortion in the U.S. Southeast caused a delay in abortion care (Upadhyay et al., 2014). Per the Association of Obstetrics and Gynecology, abortion care is essential and time sensitive (K. Munro et al., 2013). Yet, abortion barriers in every case prolonged the ability of an individual to acquire abortion care. Many callers described rescheduling their abortion appointments many times due to a lack of funds at the time of the appointment. However, the delay in care simply increased the cost of the procedure for the caller. ARC-Southeast would eventually have to either instruct callers to just bring everything they had to their appointment and request support from the clinic or coordinate logistics for the caller to travel out-of-state, as far as Colorado.

Personal barriers to abortion highlighted concerns related to self-determination and autonomy. Young people described experiencing multiple levels of violence. Consistent with existing literature on abortion seekers, intimate partner violence was the most frequently cited violence as partners perpetuate reproductive coercion (Saftlas et al., 2010; Silverman et al., 2010). Parents also demonstrated coercive behaviors such as kicking callers out of the house for either becoming pregnant or having an abortion or intervening in the abortion intake process (Kavanagh et al., 2012). Many young people were conditioned to navigate care with fear of the consequences imposed by parents and partners.

For some callers, ARC-Southeast was a trusted source of support, although the political rhetoric around family separation during the study period invoked mistrust. There is no literature available about abortion provision for undocumented individuals or mixed status families who access abortion support in the U.S. Southeast. Existing literature around prenatal care utilization suggests uninsured undocumented migrant women delayed care later in pregnancy compared to documented insured women (K. Munro et al., 2013). To add to disparities in care, research suggests immigrant and racial-ethnic minority women in a new immigrant destination utilized perinatal care services less frequently (Korinek & Smith, 2011). Delaying care or not accessing abortion care due to immigration status could expose a great disparity in access and care for young people (Gonzalez et al., 2020). Additionally, guidance for undocumented parents of minors or undocumented minors who must navigate parental involvement laws and identification requirements to receive an abortion is not widely available. The study findings also revealed that people who recently migrated to the US and those for whom English is a second language experienced different barriers to access abortion care than native born callers.

The COVID-19 pandemic shifted healthcare delivery tremendously, although among abortion care, the common consequences of COVID-19 in other healthcare settings were simply common occurrences of abortion clinics in the Southeast. Clinic closures, staff shortages, and changing clinic policies are ever-present among abortion facilities in the Southeastern region. However, the amplification of the circumstances of callers during COVID-19 tested the resilience of abortion funds and providers across the region. Callers also demonstrated different abortion care preferences due to the availability of telemedicine amid the COVID-19 pandemic.

Implications and Recommendations

Structural, financial, and personal barriers to abortion access can be mitigated by political leaders, abortion funds, and other abortion care providers. These gatekeepers to abortion care must contribute to the repeal of restrictive abortion policy and employ an intersectional lens to facilitate abortion care for young people in the U.S. Southeast. There is extensive literature on the consequences of the abortion barriers identified in this study, although this study uplifted novel barriers to abortion care navigation for young people (Barr-Walker et al., 2019; Bossick et al., 2021; S. Munro et al., 2021). These barriers to abortion care for young Southerners can inform innovative intersectional approaches to policy and reproductive health care delivery.

Dismantle Restrictive Abortion Policy

The research observed structural barriers, such as restrictive abortion legislation and abortion funding requirements, were pronounced in young peoples' experiences navigating abortion care. Hostile abortion policies including gestational limits, waiting periods, parental involvement laws, and insurance coverage for abortion, had pronounced consequences for timely abortion care for youth. Legislators should ensure timely care for young people who want to terminate a pregnancy by upholding individuals' constitutional right to an abortion before viability. The human right to have to access essential health care, such as an abortion, must be upheld by liberating gestational limits and eliminating waiting periods.

Parental involvement laws also coerce young people to involve parents or guardians in their sexual and reproductive health decisions. These laws violate the reproductive justice principle of bodily autonomy guaranteed to all people, including minors. Many young people chose to involve their parents or guardians during abortion care intake, although this study highlighted the negative consequences of pregnancy or abortion decision disclosure, such as

homelessness, life endangerment, reproductive coercion, and debt. To safeguard minors' bodily autonomy and safety, legislators should repeal parental involvement laws.

This study raised concern about whether disclosure of abortion decision was a "choice" for minors and young people. Financing an abortion procedure for young people was particularly complex and required multiple gatekeepers to abortion care to distribute funding. However, federal and state -level enforced legislation and organizational funding standards inhibit funds being distributed to young people with limited or no support for abortion care. Legislators must repeal the Hyde Amendment to liberate federal and state -level financing of abortion. Jointly, NAF must revise funding procedures that require young people to report a household income, rather than an individual income.

Comprehensive Sexual and Reproductive Health

One of this study's noteworthy findings is the notable gap between pregnancy symptom identification, intentions, and outcomes. To support young birthing people and parents in the U.S. Southeast, comprehensive policy and community-based sexual health education must be centered in discussions related to pregnancy and abortion outcomes. Reproductive justice cannot be maintained in communities that are denied access to a wide range of resources to support sexual and reproductive health and family planning decisions. Legislators should facilitate improved access to sexual and reproductive health knowledge to support young birthing peoples' health decisions (e.g., menstruation tracking tools, guidance to discuss menstruation with providers, pregnancy symptoms education). Providers can also advance care delivery to young birthing people by standardizing patient-centered contraceptive counseling and respectful maternity care for young people postpartum (Green et al., 2021; Yecies & Borrero, 2020). These

interventions are essential to delivering informed, quality reproductive health care to young birthing people.

Intersectional Reproductive Health Care Delivery

The research findings urge reproductive health care gatekeepers to reconcile with the intersectional experiences of young people who seek abortion support in the U.S. Southeast. Young people who seek abortion care in the U.S. Southeast exist in a complex social-ecological system of care. Abortion service delivery organizations represent a single point of entry, although should not be recognized independent of the interrelated social systems which negate safe, compassionate abortion care without bias or barriers. To advance reproductive justice abortion organizations and providers must acknowledge the ecological landscape young Southerners navigate by establishing community partnerships with organizations who can provide direct relief to youth who demonstrate needs within and beyond reproductive health care (e.g., food banks, mutual aid funds, homeless shelters, immigration support services, domestic violence shelters, abortion support groups, judicial bypass support).

Strengths

Several conditions lend strength to the results of this study. The use of a thematic analysis of abortion fund case notes to identify the barriers to access abortion experienced by young people in the U.S. Southeast who sought abortion funding was novel. Case notes documented by Healthline staff allowed for the collection of contextual information relevant to young people who sought abortion funding absent in quantitative caller case management data. This contributed to the production of knowledge about young peoples' experiences navigating a hostile abortion landscape and the explicit consequences of seeking abortion care in anti-abortion environments. Moreover, most cases represented under-insured Black birthing youth in the

Southeast. The representativeness of this demographic is important because the findings can contribute to the knowledge of a population who are disproportionately affected by abortion regulations.

This study also expanded on information related to abortion care delivery resilience between May 2016 and May 2021. The five-year study period allowed for the data to provide insight to the consequences of novel or revised restrictive abortion regulations in the region and of the COVID-19 pandemic. To validate the findings across the time periods, MAXQDA analytical software displayed a consistent occurrence of the deductive and inductive codes among cases over time. While the case codes were not delineated by state, the study could inform the regularity of barriers to access abortion amid abortion policy changes and before and after the COVID-19 pandemic onset.

The use of case notes collected by abortion fund Healthline staff also provides this research insight to the ways abortion funds and other care navigators are supporting young people in the U.S. Southeast. The research provides the first documentation of standard procedures utilized to aid young people navigating restrictive abortion environments in the U.S. Southeast. Healthline staff case notes allow for this study to make recommendations to abortion funds and other abortion care navigators about best practices to relieve and assist young people and their families during abortion care procurement.

Limitations

This study has several limitations readers should consider when interpreting the results. The generalizability of the results in this study is limited due to the population sampled and use of secondary administrative data. The study findings are only applicable to individuals who sought financial and logistical support abortion care in the U.S. Southeast, thus inherently are

biased towards individuals who demonstrate a need for support with accessing care. Convenience sampling also reduces the generalizability of the research findings in the six states represented in the study. ARC-Southeast provided abortion funding to callers who received care at 44 clinics across the U.S. Southeast, Maryland, Colorado, and New Mexico who have signed a memorandum of understanding (MOU). The organization funded all clinics located in Alabama, Georgia, Mississippi, and Tennessee and select clinics beyond the U.S. Southeast during the study period to ensure care for callers who had a gestation greater than 20 weeks. ARC-Southeast chose not to fund Central and South Florida and select South Carolina clinics due to funding limitations and malpractice reports. Therefore, the findings do not represent patients at all abortion clinics in the U.S. Southeast.

Further contributing to a loss of generalizability of the study results is the absence of geographic and demographic information about callers whose case notes were included in the analysis. The thematic analysis included case notes which contributed information about abortion barriers and excluded case notes that did not provide enough context to contribute to the knowledge of abortion barriers. Therefore, the research cannot determine the representativeness of the case notes which have contribute to this analysis. The basic descriptive geographic and demographic statistics indicated that the callers represented are Black (53%) and Georgia residents (46%). An inability to confirm that the case characteristics included in the analysis are systematically different indicate potential bias in the study findings. While this study did not aim to describe differences in abortion barriers between states or describe the underlying population of youth accessing abortion in the U.S. Southeast, external validity and sampling bias must be considered to interpret the study findings.

Directions for Future Research

This study demonstrated increased research on abortion barriers and abortion care navigation practices of young people is necessary to determine interventions to improve access to timely, safe, and compassionate abortion care in the U.S. Southeast. The constraints of this study implicate additional research to incorporate qualitative and quantitative data analysis that observe geographic and demographic characteristics of young people who access abortion support in the U.S. Southeast. To best develop strategies to improve youths' experiences of abortion care navigation and advocate for the liberation of abortion policy, decolonized research methodologies and frameworks developed by Black women and femme should be applied to future research. These methodologies and frameworks have been successful in community due to an emphasis on mutually beneficial, community-based participatory action research which validates lived experience and facilitates community and individual healing.

Abortion funds provide direct service to communities that have been historically oversaturated and harmed by paternalistic, white-led research projects. Therefore, posits the responsibility of future researchers to restore dignity in reproductive health care research in BIPOC communities. An assets-based approach was not feasible with this data, although future research should expand on an in-depth understanding of the facilitators to abortion access and ways young people resist and reject hostile abortion environments in their own voice (e.g., in-depth interviews, focus group discussions). Acknowledgement of the collective power and resources existing in BIPOC communities can foster connections that have historically been fragmented in reproductive health research.

CHAPTER 6 – CONCLUSION

While many Americans await the ruling on the *Dobbs v. Jackson Women's Health Organization* decision, abortion funds continue to defend reproductive health and rights. The imminent denial of abortion as a constitutional right daunts many Americans, although for abortion funds, the ramifications of the Supreme Court decision reflect years of aimless and arbitrary abortion regulations enacted nationally. ARC-Southeast and co-conspirators in the reproductive justice movement in the U.S. Southeast are prepared to mitigate the aftermath of the potential overturn of Roe v. Wade. The study findings suggest amid the most hostile decade for abortion regulations in the United States, ARC-Southeast and partners were in direct service to communities disproportionately affected by these injurious laws. The study provides evidence of how ARC-Southeast used their values of radical love, Southern synergy, autonomy and self-determination, and collective power, to guarantee young Southerners could access abortion services.

The study findings suggest abortion funds serve a vital role in the disruption of structural violence imposed by Southern legislators to deter and delay young birthing people from obtaining abortion care. To dismantle the systems of oppression that deny dignity and respect to young people who seek abortion care in the U.S. Southeast, the best practices employed by abortion funds should be adopted to improve abortion care provision. Abortion fund leaders should also be supported in community-based participatory action research that offers young Southerners an opportunity to define their lived experiences accessing abortion and defy abortion policies in the U.S. Southeast in their own voices. The study findings demand Southern legislators and researchers validate the lived experiences of young Southerners and liberate abortion in the U.S. Southeast.

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Appendix

Appendix I. Deductive and Inductive Codebook

Code	**Simple Description**	**Full Description**	**Detailed Inclusion Criteria**	**Detailed Exclusion Criteria**
		Structural Barriers		
Distance Traveled	The distance callers will travel to access abortion care	Use this code when a caller or person supporting intake describes traveling a far distance or out-of-state for abortion care.	Include mentions of "out-of-state" travel and traveling far distances to access abortion (more than 1 hour for appointment).	Does not include mentions of appointments that are in-state and travel to an appointment less than 1 hour away.
Abortion Fund Resources	The collective financial and logistical support of abortions in the Southeast	Use this code when a caller or Healthline staff discusses their experiences locating and securing funding from an abortion fund in the Southeast.	Includes mentions of solidarity funding efforts, searching for abortion funds, additional support not related to abortion, and difficulty receiving funding.	Does not include mentions from callers who accessed abortion logistical and financial support without issues or difficulty.
Parental Involvement Laws	States have various laws that require parents' involvement in a child's abortion decision	Use this code when a caller discusses obtaining parental consent or notification to have their abortion procedure.	This includes mentions of judicial bypass, asking for parents' consent, or challenges receiving parental consent.	Do not include callers who do not require their parents' consent or notification to have an abortion.
Gestational Limits	States impose limits on when a person can have an abortion based on the gestational age of a pregnancy	Use this code when a caller discusses challenges accessing abortion due to their gestational age.	This includes instances when a callers' gestational age exceeds a state's gestational limit, a caller having to go to another clinic to receive abortion care because their gestational age, or urgency around obtaining an abortion within the gestational limit imposed by a state.	Do not include callers who do not encounter difficulty or urgency accessing their abortion due to their gestational age.
Waiting Periods	States enforced laws that require individuals wait various amounts of time between a counseling appointment and receiving an abortion	Use this code to indicate a caller had to wait more than 24 hours after initial appointment to receive their abortion.	This includes mentions of waiting after first appointment to receive the abortion when there are no health concerns preventing a person from having the abortion at time of appointment.	Do not include callers who did not have to wait to receive abortion or callers who chose to wait for their abortion.
Insurance Coverage	The coverage callers must receive medical care	Use this code when a caller or person supporting caller	Include mentions of insurance such as "private	Does not include mentions of how caller will afford cost of

		indicates having an insurance plan.	insurance," "public insurance," and "Medicaid."	abortion through coverage non-insurance related.
Mandatory Counseling	States require individuals receive counseling of all their pregnancy options before proceeding with an abortion	Use this code when a caller mentions receiving required counseling for abortion procedure.	Includes mentions of being required to receive an ultrasound or counseling before an abortion procedure.	Do not include callers who do not mention receiving mandatory counseling.
Personal Barriers				
Concealment	Individuals who state a preference to conceal their abortion decision	Use this code when a caller mentions they intend to not disclose their abortion decision.	This includes mentions of conceal an abortion decision from parents, partners, family, and/or friends.	Do not include callers who mention disclosing their abortion decisions with all people mentioned during intake.
Parenting	Individuals who are parenting a child	Use this code when a caller or parent completing a caller's intake mentions being the only parent or guardian in the household.	This includes mentions of having a child by the caller or the guardian or parent of the caller being the sole provider who will support abortion.	Do not include mentions of callers who have partners or spouses who provide for a caller's child, caller's parents who are married or cohabitating providing support for caller, or callers who mention more than one parent involved in their life.
Social Support	Social support is defined as individuals present in the callers' life who are willing or not willing to provide funding or logistical support for caller's abortion	Use this code when a caller mentions an individual who will or will not contribute financially or support logistically to the caller accessing an abortion.	This includes mentions of people who will or will not support the caller; individuals who refuse to support caller, individuals who cannot support caller due to financial or other reasons, and people who have no social network to seek for abortion.	Do not include mentions of support which is not preexisting in the callers' support network (ex. abortion funds).
Confidants	Individuals who have intervened in the abortion process for/with a caller and the caller talked about their abortion decision	Use this code to indicate a person who was involved with caller intake, funding support, and/or logistical support for the abortion.	This includes mentions of fathers, boyfriends, husband, mothers, sisters, friends referred to using "she/he," extended family, and other femme roles/friends referenced during intake.	Do not include mentions of people during intake who were not informed of the abortion decision.
Anti-abortion	An individual who does not support abortion	Use this code when a caller explicitly mentions themselves or another person who does not agree with abortion.	This includes explicit discussions of abortion being wrong, conservative values, negative attitude toward abortion, punishments/consequences for people who access abortion, and/or abortion as killing a baby or sinful.	Do not include mentions of abortion with positive emotions, non-explicit discussions of negative emotions about the abortion process, and non-explicit refusal to support abortion decision.

Incarceration	Callers who have been incarcerated or have a partner or reside in a household where a person is incarcerated at the time of pregnancy or abortion appointment	Use this code when a caller or person supporting caller indicates themselves, their intimate partner, or a person in the household is/was incarcerated	This code includes mentions of intimate partner, household member who is in prison or jail, or caller who was previously incarcerated.	Do not include callers or individuals mentioned by the caller who are not incarcerated or have never been incarcerated.
Quality of Relationship	The quality of a relationship the caller has with the person who they conceived with	Use this code when a caller mentions their relationship with the person they conceived with.	This code includes mentions of the intimate partner who the caller conceived with. These include boyfriends, "baby daddy," partner, father, and husband.	Do not include mentions of relationships with people who the individuals did not conceive the current pregnancy with.
Pre-existing Health Conditions	Callers who have existing health issues which conflict with pregnancy and/or inform abortion decision	Use this code when a caller mentions a pre-existing condition which affects their decision whether to terminate a pregnancy.	This includes mentions of a disease, injury, previous pregnancy complications, or disorders which are related to the health and well-being of a caller (e.g., cancer, recovery from injury, previous miscarriage)	Do not include mentions of health conditions which the caller specifies does not relate to decisions to terminate pregnancy or conditions of the person completing intake.
Caregiver	Individuals who are caring for another individuals at time of intake	Use this code when a caller mentions providing financially and physically supporting another person.	This includes discussions of callers who provide money to family member on disability, elderly guardians, family who cannot work, and/or people who have sustained injuries that require assistance from caller.	Do not include mentions of callers who have no responsibilities to other individuals and callers who do not provide for individuals affected by injury, disability, or financial distress.
Language	Individuals whose first language is not English	Use this code to indicate when a caller or person supporting intake would prefer to continue intake in another language other than English.	This includes mentions of difficulty understanding intake questions due to language barriers and requiring interpretation or support from someone who feels more comfortable communicating in English.	Do not include conversations with individuals are comfortable completing their intake in English.
Financial Barriers				
Student	Callers who indicate pursuing primary, secondary, or higher education	Use this code to indicate a caller is pursuing education at the time of the call whether the caller is in elementary, middle, high school, or higher education.	This includes mentions of school, elementary school, middle school, high school, college, GED, or any other indication a caller is taking classes for education purposes.	Do not include callers who are not in school or taking classes to advance education.

Unemployment	Callers who are not employed	Use this code to indicate a caller has no work or employment.	This includes mentions of job loss, layoff, furlough, and other instances that indicate a caller is not working for income.	Do not include callers who mention having a part-time job or consistent employment.
Part-time Employment	A job requiring less than 40 hours/week and no benefits	Use this code to specify whether a caller is working a part-time job, such as a server or schoolwork study.	This includes mentions of low hours at work, no benefits or coverage from work, and difficulty earning more money/hours at work.	Do not include mentions of full-time employment.
Reschedule	Callers who reschedule an abortion appointment due to insufficient funds	Use this code when a caller describes a financial situation that causes a caller to reschedule an appointment.	This is including mentions of changing an appointment because a person could not secure funding from support network or fundraising, gestational age increased cost, or other causes.	Do not include when callers mention attending their appointment on the scheduled date and changing the appointment due to reasons not related to funding.
Unexpected Expenses	An expense callers must pay that could not have been anticipated	Use this code when a caller describes an expense that they did not anticipate which interfered with their ability to afford an abortion.	This includes mentions of accidents, family emergencies, personal health issues, and other unpredictable situations.	Do not include when callers mention fixed occurrences, such as rent or bills, that can be anticipated.
Houseless	Individuals who do not have a consistent residence or house	Use this code to specify whether a caller does not have a permanent residence or place to reside consistently; or a caller who will not have a permanent or consistent place of residence due to pregnancy and/or abortion decision.	This includes mentions of sleeping at multiple individual's homes, temporary housing arrangements, living outside of a house, or living in a shelter.	Do not include callers who mention having a consistent and permanent residence that will NOT be affected due to their pregnancy and/or decision to have an abortion.
		Abortion Type		
Surgical	Abortion procedure or surgery conducted by a physician for individuals who are more than 10 weeks pregnant	Use this code when a caller mentions requiring a surgical abortion procedure to terminate pregnancy.	This includes mentions of surgical abortion as a preferred method of abortion due to price, degree of invasiveness, privacy, and feasibility.	Do not include mentions of non-surgical abortions.
Medication Abortion (MAB)	Abortion pill or medication prescribed to an individual to terminate a	Use this code when a caller indicates having an appointment scheduled for MAB or provides an	This includes mentions of medication abortion or the abortion pill as the preferred method of abortion due to price, degree of	Do not include mentions of abortions not induced with misoprostol or mifepristone.

	pregnancy that is less than 10 weeks	opinion related to receiving MAB.	invasiveness, privacy, and feasibility.	
		Violence		
Rape/Sexual Assault	Sexual assault involving sexual intercourse or sexual penetration by a person who has not obtained consent AND/OR Sexual acts, such as sexual touching, coercion, or physical force applied to an individual without consent	Use this code when a caller states they have been raped, sexually assaulted, or experienced unwanted sexual intercourse or penetration by a person who did not receive consent.	This includes mentions of rape, unwanted and non-consenting sexual intercourse or penetration by a person who did not receive consent. This code also includes mentions of unwanted sexual contact such as sexual touching, coercion, or physical force applied to an individual without consent.	Do not include mentions of sexual intercourse or penetration by a person who received consent AND sexual contact by a person who was provided consent.
Domestic Violence (DV)	Violence occurring among and/or perpetuated by parents or guardians	Use this code when a caller or caller's guardian indicates they have experienced DV.	This code includes mentions of living in a household where DV is present or recently relocating to another household to escape DV.	Do not include discussions of households where DV is not present.
Intimate Partner Violence (IPV)	Violence between partners who are or have been intimate with one another	Use this code when a caller indicates their intimate partner or most recent intimate partner was physically abusive.	This code includes mentions of intimate partners who have been physically abusive to the caller.	Do not include discussions of intimate partners who were not violent with caller.
		Distrust		
Mandatory Reporting	Law requiring professionals to report cases that indicate harm to a minor or oneself to the police/authorities	Use this code when a caller or person supporting caller indicates having to report their case to authorities or police.	This code includes mentions of mandatory reporting, police, opening a case with the police department, or submitting a police report.	Do not include cases when the police or mandatory reporting were not mentioned or involved during intake.
U.S. Immigration and Customs Enforcement (ICE)	U.S. enforcement agency involved in obtaining individuals who reside in the U.S. without U.S. required documentation	Use this code when a caller or person supporting caller indicates concern of ICE involvement.	This code includes mentions of ICE or immigration status reporting.	Do not include cases that do not discuss immigration status or ICE.
ARC-Southeast Healthline	Reproductive justice organization based in Atlanta, GA providing logistical and practical support	Use this code when a caller or person supporting caller are suspicious, hesitant, or distrustful with	This code includes discussions of whether the Healthline will fund the amount discussed, concerns about how the Healthline	Do not include callers and people supporting callers during intake who do not explicitly express various levels of trust with the

	for people in the Southeast through call center	ARC-Southeast Healthline Staff during intake OR instances of establishing trust with caller.	will use personal information, suspicions about why the Healthline needs to speak to the caller alone, or tension between the caller and Healthline staff when asking questions about pregnancy and personal funding institutions OR conversations that explicitly establish trust.	Healthline team during intake.
COVID-19 Pandemic				
Job Loss	Losing employment or reduction of hours because of the COVID-19 pandemic	Use this code when a caller lost a job, been laid off, reduced hours, or furloughed because of COVID-19.	This code includes mentions of job loss, layoffs, reduced hours, or furlough because of COVID-19.	Do not include callers whose work and work hours were not directly affected by COVID-19.
Quarantine	10-14 days isolated due to potential exposure to COVID-19	Use this code when a caller indicates having to quarantine around the time of abortion appointment.	This code includes instances when a caller was exposed to COVID-19 and had to quarantine within days of their abortion procedure or funding capacity affected by quarantine.	Do not include callers who did not quarantine because of COVID-19 exposure and funds were not affected by COVID-19 exposure which resulted in quarantine.
Clinic Closure	COVID-19 guidelines required clinic closures when exposure in the clinic occurred	Use this code when a caller indicates an abortion clinic had to close or short staff due to COVID-19 exposure.	This code includes discussions of changing appointment dates because of a clinic closure and staff availability due to COVID-19 exposure.	Do not include clinic closure or staff shortage that are not a result of COVID-19 exposure among staff.
Sexual and Reproductive Health				
Family Planning	A person's ability to plan and manage their decisions about whether or when to have children	Use this code when a caller discusses pregnancy intentions related to family size desires, sexual behavior, and contraception.	This code includes mentions of family planning, such as family size desires, contraceptive use, and other practices that facilitate planned and unplanned pregnancies.	Do not include discussions that do not mention pregnancy intentions, family size, sexual behaviors, or contraception.
Menstruation	General knowledge about menstruation among reproductive persons	Use this code when a caller is unaware of last missed period or misdiagnosed pregnancy symptoms.	This code includes mentions of not knowing the last missed period, uncertainty about symptoms leading up to pregnancy were due to menstruation, pregnancy, or BC, or difficulty understanding/following cycle.	Do not include callers who can report a last missed period or mention accurately identifying pregnancy symptoms.