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Oregon Women Tell Their Stories

Abstract approved:

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ABSTRACT:

Current estimates indicate that between one-third and one-half of women in the United States have at least one abortion in their lifetime, and that many women encounter socioeconomic, logistical, or social obstacles in the process of seeking care (Jones 2005, Guttmacher 2008). The purpose of this study is to critically examine the experiences of women in western Oregon as they seek abortion care. Specifically, I set out to answer the following research questions:

- 1) What obstacles or barriers, if any, do women face as they seek abortion care in western Oregon?;
- 2) If women do encounter obstacles or barriers to care, how do they negotiate them?;
- 3) What role, if any, does social support play in helping women to obtain abortion services?; and finally
- 4) Given the potential ethnographic relationship between obstacles and social support identified in the first part of this study, how might clinic staff and reproductive rights advocates work together to improve access to care and to reduce disparities for vulnerable populations? Using a mixed-methods approach that combined quantitative data from surveys and demographic data with qualitative data from in-depth interviews and participant-observation, I found that women in western Oregon do in fact encounter substantial obstacles in the process of seeking care. In addition, women report that social support helps them overcome obstacles, and a lack of support is experienced as an obstacle itself. Women of lower socioeconomic status encounter more barriers and have a more difficult time overcoming them. Based on these findings, this study indicates the need for improved advocacy at institutional levels, to reduce obstacles and to improve women's access to social support and other resources.

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The Role of Social Support in Overcoming Obstacles to Abortion Access:
Oregon Women Tell Their Stories

by
Bayla Ostrach

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APPROVED:

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Dean of the Graduate School

I understand my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Bayla Ostrach, Author

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Chapter 1 – Introduction

The Role of Social Support in Overcoming Obstacles to Abortion Access: Oregon Women Tell Their Stories

I took the test, and it said for sure that I was pregnant. I told my boyfriend and he gave me a hug. We had talked about it before. I told him, "No, you know, obviously, we are in no state at the moment to have a child." I'm twenty, he's twenty-four. He doesn't have a job; I don't have a job. We're both students, you know, just barely getting by, so it's obvious. But I did not really know what to do. What is the next step? I had no idea. I knew that I had to tell my mother eventually, but my father has been sick for a while. I had my appointment on the 3rd of September, and I had found out that I was pregnant on the 21st of August. It seemed like a lot longer, there was a lot of stress in between then. Just those couple of days when I didn't really know about the insurance. My boyfriend freaked out a couple times, he was like, "What are we going to do? I'm going to have to sell my car!" but he came with me. He was there the whole time.

Evangeline¹ (20 years old, became pregnant due to a birth control failure)

Approximately half of all pregnancies in the United States are unplanned, and half of these end in abortion (Ellison 2003, National Abortion Federation). Current estimates suggest that between one-third and one-half of all women in the United States will have at least one abortion in their lifetime (Guttmacher 2008). Based on the prevalence of abortion care needs among women of reproductive age, the question of access to abortion is an essential one (Ellison 2003, Dudgeon and Inhorn 2004). A significant body of literature addresses controversies surrounding the legality of

¹All names are pseudonyms

abortion in the United States (Wright 2006, Powell-Griner 1987). However, relatively little research focuses on women's experiences with obstacles encountered while seeking abortion care. Recent studies indicate that many women are forced to navigate obstacles and disparities that are socioeconomic, logistical, or social in nature, or a combination of all three (Guttmacher 2008, Boonstra 2007, Ellison 2003, Powell-Griner 1987). According to current research, social inequality and socioeconomic status significantly influence women's access to abortion care, as well as their perceptions of the process of seeking abortion care (Henshaw 1995, Jones 2005, Boonstra 2007). Abortion as a legal medical procedure is a current reality in the United States (National Abortion Federation, NAF 2010), and therefore, this study examines access to abortion care beginning from the premise that women *do* seek abortion services; it does not address the contentious issue of whether or not they should.

Study Purpose

The purpose of this study was to critically examine the experiences of women in western Oregon as they seek access to abortion care, with a focus on the ways women may overcome any obstacles they encounter, if they do in fact encounter obstacles. I also hoped to elicit women's stories about the role of social support in their experiences of seeking care. Specifically, I set out to investigate:

- 1) What obstacles or barriers, if any, do women face as they seek abortion care in western Oregon?;
- 2) If women do encounter obstacles or barriers to care, how do they negotiate them?;
- 3) What role, if any, does social support play in helping women to obtain abortion services?; and finally
- 4) Given the potential ethnographic relationship between obstacles and social support identified in the first part of this study, how might clinic staff and reproductive rights advocates work together to improve access to care and to reduce disparities for vulnerable populations?

In valuing women who come to the clinic as the ultimate experts on their own experiences, I designed a project to formally analyze women's voices and experiences, triangulating results from open-ended, semi-structured interviews, participant-observation field notes, and surveys, with the initial goal of better understanding what women face as they seek access to abortion services.

Significance

Prior research in this area focuses on documenting which barriers to access women encounter, and on examining women's experiences of the abortion procedure itself (Guttmacher 2008, Henshaw 1995, Dudgeon and Inhorn 2004). This leaves gaps in the literature related to how the experience of encountering obstacles or barriers may affect women's perceptions of the process of seeking abortion care, and of understanding how women overcome any barriers or obstacles they do encounter. This research is designed to fill these gaps. By examining women's experiences, my project brings their voices into the silence that is frequently found between statistics that document socioeconomic, logistical, and social barriers to abortion access, and qualitative accounts of women's lived experiences of seeking care. Furthermore, the applied advocacy piece of my study (see chapter 6) may contribute to reducing structural barriers to abortion access by providing policymakers, providers, and affected women with relevant and compelling information about that obstacles are actually experienced by Oregon women, and what women say about what helps them overcome obstacles.

My quantitative research methods were designed to examine women's perceptions of whether or not they encountered barriers to care, and if they did, which barriers were most challenging for them. Qualitative interviews with women who sought abortion services, and with clinic staff who interact with many patients, documented perceptions of women's experiences with obstacles potentially encountered in the process of seeking care. Mixed-methods research (Bernard 2006), that combines both quantitative and qualitative methods, is particularly well-suited for investigating topics such as abortion that may be contentious or stigmatized (Ellison

2003). The appropriateness of mixed-methods research can be seen in Faye Ginsburg's book (1989), *Contested Lives: The Abortion Debate in an American Community*, which incorporated rich ethnographic data collected in interviews and through participant-observation into a comprehensive examination of a particular community's experiences with the contentious debate about a new abortion clinic that opened in town. A more recent example of compelling mixed-methods research that addresses personal and potentially-controversial issues, Melissa Cheyney's recent ethnography (2010), *Born at Home: The Biological, Cultural and Political Dimensions of Maternity Care in the United States* explores pregnancy and birthing practices: topics that some women may feel more comfortable discussing in an in-depth interview, and about which more nuanced data may be collected by utilizing multiple methods (Bernard 2006). In addition, Elaine Lawless (1991) discussed the hesitation that research participants may feel about sharing intimate or personal experiences with a researcher who they may assume will not understand. In the area of perceptions of and experiences with abortion care, mixed-methods research has the potential to successfully elicit and triangulate information from informants who might feel anxious about discussing a personal and contested topic (Bernard 2006). Finally, Marcia Inhorn (2006) highlighted the importance of ethnographic work in revealing women's emic understandings of, and concerns about, health and healthcare experiences, in an in-depth review of 157 ethnographies on women's health. By articulating recurring patterns in women's stories about health and healthcare, Inhorn drew attention to the power of women's voices to describe their experiences with barriers to care, socioeconomic and political realities that affect health and healthcare, and other themes that speak to the importance of using in-depth interviews and ethnographic material, in addition to quantitative survey data, to reveal nuances and potential patterns in women's experiences with healthcare. As surveys alone may have failed to reflect the impact of barriers to care on women, stories told in interviews become especially valuable for better understanding women's lived experiences of attempting to access abortion care.

Theoretical Approach

Structural Violence

I approach the topic of abortion access, and my research questions, from a critical and gender-sensitive perspective. I attempt to understand reported obstacles to abortion access as forms of structural violence that directly affect women who live with the realities of sexism, classism, and other forms of structural oppression (Galtung 1969). Johan Galtung (1969) described structural violence as the unequal social and political structures that perpetuate racism, class stratification, and other forms of social inequality. Structural violence thus frames an understanding of unequal access to healthcare as the result of social, economic, and political realities that create more barriers to care for those with less money and fewer resources. As sociological literature suggests, women are disproportionately affected by poverty and other forms of social inequality both in the United States and globally, making the lens of structural violence and an analysis of the effects of social inequality crucial to understanding women's experiences with healthcare access (Marger 2008).

In this research, I use Galtung's idea of structural violence as a theoretical concept that helps to explain why some Oregon women may experience more barriers to abortion services. The value of considering barriers to abortion access, or any situation of unequal access to healthcare, as the result of structural violence lies in identifying the systems and power structures that perpetuate inequality, and thus create disparities in care for marginalized populations most affected by social inequality, including low-income pregnant women in Oregon (Marger 2008). Exploring whether or not women in western Oregon encounter obstacles to care that appear to result from structural barriers offers an opportunity to examine how structural violence may affect access to healthcare for marginalized women in this setting.

Critical Medical Anthropology

Medical anthropology, understood as the examination of health and healthcare situations and interactions through the use of anthropological approaches, offers an opportunity to carefully examine the intersections of patients and providers, structures and individuals, and medical care and sociocultural experiences and perceptions (Brown 1998). As a medical anthropology research project, this study focuses on recipients of a form of reproductive healthcare, pregnancy termination, whose experiences may be more affected by social and economic expectations and realities, than by particular biomedical techniques or treatments (Alan Guttmacher Institute, Guttmacher 2008). Articulating a critical sub-discipline within Medical Anthropology, Merrill Singer (1986) brought political-economic perspectives squarely into the arena of anthropology when they argued that capitalist influences on healthcare can be seen in power relationships that exist within medical settings. These power relationships, Singer and others argue, are shaped by poverty, race, ethnicity, gender, use of technology, and access to resources. This theoretical approach, known as Critical Medical Anthropology (CMA), focuses on political and economic determinants of health. In Singer's words, "critical medical anthropology struggles to synthesize macrolevel understandings of the political-economy of health" and engages in a "critical analysis of health and social configurations in the various sectors of the capitalist world system" (Singer 1986:128).

The value of this critical perspective for examining healthcare access lies in its emphasis on tracing the lived experiences of marginalized populations back to the economic and political structures that determine, in this case, why some women may have a harder time than others accessing abortion care. Following Singer's tradition, more recent studies using CMA call for combining critical theory with social action, in order to better address the needs of marginalized communities such as low-income and working-class people, and others in "subordinate" positions (Baer et al. 2003:ix). In this way, CMA offers a framework for examining how social inequality and social

forces affect Oregon women's experiences with abortion access, while also considering the potential for advocacy to improve access to care.

This same call for action inspires some critiques of CMA as a theoretical approach to research (Wiley 1992). As Andrea Wiley (1992) argues in her response to a perceived lack of biocultural analyses in CMA, examining experiences of health and healthcare from a political-economic perspective may lead to an assumption that CMA has activism as a goal. I see this perception of CMA, to the extent that it is true, as a feature that in fact makes it uniquely suited to examining questions of abortion access, rather than experiences with the medical procedure itself. When research indicates that people do in fact encounter barriers to healthcare, analyzing such data from the perspective of power relationships that result from structural and institutionalized forces, and using information shared by research participants to work toward possible improvements, is entirely appropriate.

Wiley (1992) also argues that CMA overlooks biological and biocultural forces that affect access to healthcare, however Singer (1993) and other practitioners of CMA respond to this accusation by reminding us that, "CMA does not condemn the study of biology or... biological aspects... as inherently reductionistic, rather it is critical of the failure to recognize the significant impact of social relationship on human biology, health, and the physical environment, as well as the conditions of their interaction," demonstrating that CMA can be combined with additional frames of analysis, whether they be biocultural, feminist, or others. In addition, recent work on syndemics (Singer 2010), health conditions that result from intersections of biological, cultural, and socioeconomic conditions, explicitly combines a biocultural approach with CMA. By focusing on immediate and indirect causes of illness or disparities in healthcare access, along with larger patterns and situations of exposure to illness and inequality, and the consequences of these overlapping conditions, syndemics offers an important model for combining biocultural and critical approaches, demonstrating the value of CMA for studying "biosocial understanding(s) of disease" and healthcare disparities (Singer 2010:15).

While Wiley (1992) argues that CMA has an overly narrow focus that utilizes a political-economic lens to the exclusion of other diverse strategies, critical medical anthropologists actually strive to encourage debate and discussion within medical anthropology (Singer 1993). Researchers including Margaret Lock (2001, and with Shirley Lindembaum 1993) and Emily Martin (1987), as well as Faye Ginsburg and Rayna Rapp (Ginsburg and Rapp, eds., 1995), have persuasively used concepts from CMA, alongside feminist and other theories, to discuss structured power relationships that affect larger issues of health, healthcare, medicalization of women's bodies, and the impacts of technology usage in biomedicine. For example, Lock's (1993) use of the Foucauldian focus on medical constructions of biological experiences facilitates her argument that dominant cultural discourses, shaped by gender-based expectations of femininity, and age-and-gender-based values about aging, reflect cultural and societal power dynamics that give primacy to the assumed legitimacy of biomedicine, and limit women's agency in responding to health and healthcare concerns. While this approach incorporates feminist and cultural theories, as well as a critique of the dominance of biomedicine, rather than engaging political-economy per se, Lock's analysis of structural and institutionalized values and ideologies that affect women's lived experiences nonetheless engages elements from CMA's focus on power relationships. Furthermore, Lock argued (2001) in a later work that women are not always passive when confronted with the potential or perceived medicalization of their reproductive experiences, even when they are affected by structural violence. In this sense, Lock suggests that women who encounter cultural and social expectations that might constrain their sense of options demonstrate agency in ways that can be seen as challenging a dominant system - an important possibility often considered by researchers who engage in CMA. Similarly, Emily Martin (1987) described how the interplay between biomedicine, sexism, racism, and class stratification in reproductive healthcare can result in women internalizing dominant representations of their biology and choices that shape their sense of options. In addition to highlighting the importance of listening to and learning from women's perceptions, Martin encourages

an awareness of the ways in that cultural assumptions and expectations shape women's lives, thus acknowledging the impact of structural forces that create these expectations.

Due to its emphasis on power relationships and the experiences of marginalized populations affected by structural, theory in Critical Medical Anthropology informed my research as I investigated women's perceptions of barriers to abortion care. This proved to be a particularly relevant approach, given the ways that socioeconomic conditions and social interactions influenced women's perceptions of available resources, social support, power relationships, and overall access to care. I analyzed women's stories in the context of social inequality. I noted examples of class-based and socioeconomic, logistical, and social obstacles that enabled me to identify, as Singer proposes, “the relationship of this medical system to its encompassing political-economic environment” (Singer 1986:129). This project expands the use of CMA beyond its traditional usage by Medical Anthropologists to critique disparities in healthcare systems. I used CMA to examine and understand how women seeking care themselves, as well as healthcare providers and advocates, seek to reduce and overcome obstacles by correcting for failings in existing systems, and/or challenging systems which fail to meet people’s needs.

Healthcare provision does not take place in a vacuum, as structural violence and unequal power relationships create and maintain existing social inequalities by determining *who* has access to healthcare. This is an essential starting point for integrating research on abortion access into a larger political, social, and economic picture of class and social-race based disparities in the United States today (Singer 1986, Farmer 2005). As stories told by women themselves will reveal, access to abortion care seems to be affected by socioeconomic, social, and logistical factors, that may manifest as obstacles or barriers to care. Women perceive varying levels of social support that may influence their ability to overcome obstacles. In the following chapters, women affected by obstacles to abortion, healthcare providers, and women's healthcare advocates offer suggestions of ways to overcome barriers.

Chapter 2 - Methods

“Well the *first* thing I did was...”

Madeleine, age 20

The clinic where I conducted my research serves a diverse population of women from all over Oregon, and across a broad range of gestational ages. I collected demographic data and anonymous, closed-ended surveys and recruited participants for semi-structured, open-ended interviews. Participant-observation also contributes to my research, based on ten years of working in abortion clinics and volunteering with an abortion referral and funding hotline (Bernard 2006). Where appropriate, I integrate my interpretations of women's experiences, based on my direct interactions with more than 4,000 women seeking abortion care. I gathered information and narratives in order to describe the lived experiences of Oregon women navigating barriers as they seek abortion care. Much of the background literature on abortion access uses the term "barriers" to describe challenges that women encounter in the process of attempting to access care, and thus, my survey tool and in-depth interview guide used this term (Guttmacher 2008, Henshaw 1995). However, many women I spoke with perceived "barriers" as a term for factors that would have prevented them from obtaining abortion care, rather than something that could be overcome. The term "barrier" simply did not resonate with some women. Therefore, I use the *en vivo* (Bernard 2006) code "obstacles" to describe the problems and challenges that some women in this study faced, and overcame, to successfully obtain abortion care.

Sampling Technique

In order to authentically convey women's perspectives on the process of seeking abortion care in western Oregon, I used a modified grounded theory approach (Charmaz 2000; Cheyney 2008), guiding in-depth interview conversations with topic suggestions and allowing the interview participants' ideas to emerge organically, rather than strictly following a pre-determined set of questions (Glaser 1978, Glaser &

Strauss 1967). I engaged in opportunistic sampling (Bernard 2006) by working with the clinic to give all women seeking care during the study period the opportunity to complete surveys and to self identify and volunteer for one-on-one, in-depth interviews. I was able to collect demographic information and anonymous survey data from 238 women, and later conducted in-depth interviews with a volunteer sample of eleven women who sought abortion care at the clinic. In addition, I engaged in expert sampling (Bernard 2006) when I conducted interviews with four members of the clinic staff, and collected surveys from eight clinic staff members. Collectively, this combination of approaches allowed for a level of detail and a sense of women's experiences that I argue is missing in other studies on abortion access (see for example Finer 2006, Jones 2009 & 2005, Henshaw 1995).

Positionality

As an insider in the clinic setting, by virtue of my employment as a medical assistant, I had unique opportunities to interact with patients, and to engage in participant-observation with an implicit understanding of the language and culture of the clinic and clinic staff (Lawless 1991). Extending Kirin Narayan's (1993) idea of a native anthropologist as someone who studies a community they come from or have strong ties to, I felt particularly well-equipped to elicit women's stories about their experiences seeking abortion care (or, in the case of clinic staff, asking them about their perceptions of patients' experiences), due to my background in abortion care and advocacy. I began working in abortion clinics more than ten years ago, and have worked with a non-profit abortion funding and referral hotline (Network for Reproductive Options) for nearly seven years, thus ensuring a great deal of familiarity and comfort with the language, style, and typical activities of patients and staff in these settings (Narayan 1993). I believe that this positionality enhanced my ability to establish rapport with interview participants, and to analyze the data I collected with a comprehensive understanding of the context of abortion care settings in western Oregon. As a native in the clinic setting (Narayan 1993), regular one-on-one experiences with women seeking abortion care helped me to establish trust and rapport

with patients, and set the tone for hundreds of informal conversations where women shared stories about their experiences attempting to access care. As Narayan (1993) proposed, the stories told to me and to other clinic staff by women, in their own words, carry as much weight as quantitative numbers that describe patterns and trends without revealing details of the narratives behind the numbers.

Expanding on Narayan's suggestion that someone from a given community who knows the insider language and culture may have more relative success eliciting narratives from people who participate in that community, Lanita Jacobs-Huey (2002) points out that research participants' contributions may be unknowingly influenced by the perceived role or identity of the researcher(s). This makes a strong case for the value of conducting research in arenas where we have enough expertise, or can participate in enough preliminary participant-observation, to ensure that the researcher is familiar with common *en vivo* codes, practices, and scenarios that may be encountered in the research site. Even researchers who are not native to the research community are likely to find it beneficial to be familiar with, and comfortable using, terms and definitions used by the research participants. In the case of this project, my role as a long-time medical assistant and volunteer in abortion care settings facilitated my ability to speak with women who sought abortion care, and to engage in conversations that appeared comfortable for them. My positionality was conducive to eliciting women's narratives. My status as an insider or native in the field of abortion care may have assuaged some women's concerns about possible abortion-related stigma (Ellison 2003), and increased their perceptions that I would understand what they chose to tell me about their experiences (Jacobs-Huey 2002, Narayan 1993).

Data Collection: Mixed Methods Triangulation

During the first phase of data collection, and following Institutional Review Board (IRB) approval for the ethical and non-coercive treatment of research participants, I received copies of anonymous, closed-ended surveys and demographic information from 238 women seeking abortion services at a free-standing clinic in a metropolitan area of western Oregon that has a population of approximately 150,000

people. The optional, anonymous surveys (Appendices A1 & A2), routinely collected by the clinic receptionist from abortion patients, asks women to report information about any logistical, economic, or social obstacles to abortion care they encountered, their perceptions of whether or not they encountered any obstacles, and their judgments about which obstacles, if any, were most challenging for them. The demographic information was provided to me in the form of copies of an anonymous vital statistics forms (Appendix B, items 1-15 only) filled out by clinic staff for each abortion patient, in accordance with state reporting requirements (Bours Health Center,). Participant-observation in the clinic and many years of volunteering with an abortion referral and funding hotline informed the survey tool, and the clinic staff and I worked closely together to refine the tool based on our combined years of experience providing abortion services (Bernard 2006). The survey tool also reflected widely-recognized barriers to access, from the literature (Guttmacher 2008, Henshaw 1996, Boonstra 1997).

Soon after the clinic began soliciting optional anonymous surveys from all patients coming in for abortion care, I began a second phase of data collection, recruiting participants for qualitative, in-depth interviews. Participants were recruited via study announcement and recruitment forms (Appendices C1 & C2) distributed by the clinic receptionist to all abortion patients. Nearly forty women filled out the form indicating they were willing to be contacted about scheduling an interview – of these, a total of eleven women actually participated in in-depth interviews. Interviews were conducted over a period of about six weeks. Of the women who filled out the form, but did not participate in interviews, many of them could not be reached despite at least three phone calls, or were no longer interested in participating once I reached them. Several women scheduled interviews with me, but then canceled at the last minute, or did not return my phone calls attempting to confirm an interview time. Based on background literature describing the socioeconomic and life circumstances that often result in unplanned pregnancies and the decision to seek abortion care, it is possible that the gap between the number of interview volunteers and the number of

women who actually followed through to participate in interviews can be explained by similar factors (Guttmacher 2008, Ellison 2003, NAF, Henshaw 1995, Guttmacher 2002). In addition, many women who initially filled out the form volunteering to be contacted for an interview had traveled from outside of the area to reach the clinic, and once they returned home and resumed their day-to-day lives, they may not have been interested in having a researcher arrive in their community to talk to them about an experience they had, by that point, effectively left behind them. Finally, clinic staff occasionally remark that they feel women arriving at the clinic are nervous about the procedure and may not carefully read all the forms they are asked to fill out, suggesting that some women may have filled out the study recruitment form without realizing that they were potentially volunteering to be interviewed at a separate time (BHC2010).

Following informed consent counseling and after obtaining each interview participant's signature on an IRB-approved consent document (Appendix D1), the interviews took the form of conversations that ranged from half an hour to well over an hour, with participants describing what they went through, thought about, and made arrangements for, from the time they learned of their pregnancies until they arrived at the clinic for their abortion procedures. Many women also discussed their experiences with, and feelings about the abortion itself, as well as describing their thoughts and feelings since the procedure. I asked women to begin by telling me about everything they went through, in any order they wished. I used a checklist of recognized barriers to access (Guttmacher 2008) to mark off any obstacles that women mentioned, and then prompted women to talk about any relevant obstacles they had not already discussed, before the conclusion of each interview (Appendix E1).

Interviews took place at locations chosen by the research participants with most of them choosing to be interviewed at home, and a few asking me to meet them at a public cafe or another neutral location. Each participant chose a pseudonym, that I use when describing these in-depth interviews in greater detail in subsequent chapters. After the first three interviews, I coded and analyzed the transcripts to identify themes

and key ideas that emerged (Charmaz 2000). I then mapped out connections between the main themes in a Grounded Theory schema or concept map (see chapter 5, Figure 1), in order to generate a theoretical construct to explain the apparent relationships between the themes (Charmaz 2000). I then scheduled additional in-depth interviews to generate more information and narratives to further inform the theoretical construct (Charmaz 2000). While each interview participant offered individual stories and perspectives related to the main themes, showing variation in their specific experiences, certain patterns did emerge, that were also suggested by and echoed in hundreds of participant-observation interactions that occurred during the data collection phases (Charmaz 2000, Bernard 2006).

Following completion of data collection from clinic patients, I conducted in-depth interviews with four of the clinic staff members. I recruited participants for clinic staff interviews by individually recruiting participants from among my coworkers, approaching those staff members whose perspectives I most wanted to include based on their levels of experience in the clinic, constituting opportunistic and expert sampling (Bernard 2006). I conducted targeted interviewing at this stage in order to speak with a medical assistant who had previously been to the clinic as a patient, another medical assistant, now the clinic manager, who has worked at the clinic for more than five years, the physician who provides all of the abortion services, and his wife, who ran their practice for many years. I chose to recruit these respondents for interviews because of their unique perspectives on the topic (Bernard 2006). The medical assistant who had previously been a patient had the ability to speak to her own experiences of trying to access care, and how those experiences inform her role as a medical assistant now. The clinic manager has worked with more patients than any of the other medical assistants, making her very much an expert on patients' experiences. Finally, with thirty-four years of experience providing abortion care, the physician and his wife have interacted with literally thousands of women seeking abortion care.

Following informed consent counseling and after obtaining each interview participant's signature on an IRB-approved consent document (Appendix D2), I solicited clinic staff members' perceptions of our patients' experiences with obstacles to access, and sought their suggestions for how clinic staff and other advocates can help women overcome obstacles to access. For these interviews, because I was narrowing the focus of the conversation to address the experiences women seeking care had already described in the earlier round of in-depth interviews, I used a more specific interview guide (Bernard 2006) to direct the clinic staff interviews (Appendix E2). The results of patient surveys and interviews informed the in-depth interviews I conducted with clinic staff, guiding the topics I asked clinic them to address.

As an additional method to triangulate the data I collected from clinic staff interviews, I solicited short anonymous surveys (Appendix F) from current and former clinic staff, and received a total of eight surveys. These short surveys asked clinic staff to share their perceptions of the main obstacles they believe our patients encounter, their ideas about how women overcome these obstacles, and suggestions for how clinic staff and other advocates could assist women to overcome obstacles encountered in the process of seeking abortion care. The clinic staff surveys informed my analysis of the perspectives and understandings shared by the smaller sample of clinic staff with whom I had conducted in-depth interviews. Finally, during the writing phase of my thesis preparation, I mailed excerpts of several draft chapters to women with whom I had conducted in-depth interviews, who had expressed an interest in providing follow-up feedback. I provided these women with a printed copy of passages that quoted them and described their stories, and included a stamped, self-addressed envelope and a note asking them to provide any corrections or additional comments, if they wished to. None of the interview participants responded with additional comments or corrections.

Throughout all phases of data collection I engaged in participant-observation. For nearly two years during my graduate program I spent ten to fifteen hours per week

at the research site working directly with patients seeking abortion care, as well as regularly volunteering with an abortion referral and funding hotline (Bernard 2006).

Triangulation - Ensuring Reliability and Validity

At each stage of data collection, I triangulated the data I received, in order to identify areas of convergence and divergence in the information, and to address possible areas of researcher bias (Bernard 2006). The value of triangulation lies in approaching research questions from various angles in order to ensure that multiple aspects of the same situation can be captured. This attention to varied facets of the research topic can ensure validity and reliability, by including multiple perspectives (Bernard 2006). In this study, I considered it important to compare the perceptions of both clinic staff, and the women themselves, regarding women's experiences of seeking abortion care. In addition, because the survey tool was based on acknowledged obstacles to access already documented in background literature, I hoped to expand on the body of knowledge by specifically focusing on women's access to abortion care in western Oregon. I sought to do so by adding data from qualitative narratives to the information obtained from surveys. I solicited short surveys from clinic staff in order to compare responses from a larger sample of clinic employees to the in-depth interview comments from a few clinic staff members. By combining a wide variety of research tools and methods, by embedding myself in the clinic, and by grounding the research in participant-observation and the larger literature on abortion access, I hoped to reflect multiple facets of women's experiences and perceptions of seeking abortion care (Bernard 2006). Given the highly-stigmatized and very personal nature of both the abortion decision and the process of seeking care, including women's narratives and their own words was crucial (Inhorn 2006, Ellison 2003). I drew heavily from participant observation and the use of in-depth interviews for both data-collection and analysis, as these can be especially appropriate methods for addressing and documenting women's experiences with life events that can contribute to feelings of stigma (Ellison 2003). These methods may reveal scenes and interactions that might otherwise remain invisible, giving women an opportunity to

speaking confidentially and to tell their own stories (Stacey 1996). As early as 1983, feminist scholar Du Bois (1983, as cited by Stacey 1996) argued for the importance of including women's experiences and voices in social science research, a perspective later echoed by feminist and medical anthropology researchers Emily Martin (1987) and Marcia Inhorn (2006, 2003).

Judith Stacey suggests that ethnography in general, including participant-observation and the use of interviews, emphasizes participants' experiences, in a way that is "attentive" to their lived realities (Stacey 1996:89). Given the widely-perceived stigma related to abortion care and unwanted pregnancy, it is particularly important to approach research in this area through a variety of anonymous and confidential methods that can encourage women to share stories that might otherwise remain hidden (Ellison 2003, Stacey 1996).

Quantitative Data Analysis: Surveys and Vital Statistics forms

I analyzed descriptive frequencies from the demographic and survey data with the software package *Statistical Package for the Social Sciences*, version 17.0 (SPSS). After entering all of the survey and demographic data into spreadsheets, and double-checking any numbers that were outliers relative to the rest of the sample, I calculated frequencies of responses for each survey question. This allowed me to gain valuable information on the demographic, socioeconomic, and social patterns of the respondents' backgrounds and life circumstances (Bernard 2006). A full statistical evaluation of the survey data is beyond the scope of this thesis, however it will form the foundation for future research. For the purposes of this study, I utilized the survey data primarily as a preliminary tool for identifying key obstacles and themes related to social support that could be explored in more detail during interviews. In addition, the survey data on demographics allowed me to explain how the total sample of women who completed surveys, that is more representative of the total population of women who use the clinic, relates to the self-selected subsample of women who agreed to be interviewed. This was important for contextualizing the interview findings.

Qualitative Data Analysis: In-Depth Interviews

Utilizing modified grounded theory techniques to identify emerging themes in the transcripts of interview texts and hand-coding them, I was able to group the key ideas that women discussed into categories organized by main ideas or themes (Charmaz 2000). I identified three key ideas from my interviews: 1) problems getting Oregon Health Plan (OHP) coverage and other financial obstacles, 2) the impact of perceived social support, and 3) the complexity of the abortion decision itself and the role of social support in the decision-making process. Within each category I identified several related subthemes, that I will discuss at length in chapters 3 and 4.

After I categorized the key ideas from the in-depth interviews into groups, I created a Grounded Theory schema or concept map (Fig. 1, see chapter 5) to help illustrate how the main themes of obstacles encountered in the process of seeking abortion care relate to themes of social support, and how these concepts affect women's experiences of progressing from the decision to have an abortion, to the point that they ultimately obtain services (Charmaz 2000). I explain this theoretical model in greater detail in chapter 5.

Applied Anthropology - Future Outreach and Advocacy Plans

As an Applied Anthropology study conducted in the tradition of Merrill Singer and other Critical Medical Anthropologists, this project will ultimately include an outreach and advocacy component, following the oral defense and final committee approval of the thesis. I plan to contact care providers and women's health advocates, to share with them the findings of this study. I hope to offer providers and advocates resource materials that are grounded in women's stories about their experiences of seeking care, in order to help women in western Oregon overcome the obstacles to access identified through this research. I intend to offer resources and suggestions that will help to demystify the process of seeking care, and to empower women and providers to challenge structures that perpetuate disparities in healthcare.

Limitations of this Study

This study describes the experiences and demographic characteristics of a specific sample of women seeking abortion care at one clinic in western Oregon, during the time of the study period (2009). The experiences of women in other parts of Oregon, women going to other clinics in western Oregon, of women in other states or countries, or of women who came to clinic but did not participate in this study, may be different from those discussed here. Women seeking care at the research site primarily represent populations from central and southern Oregon, although some women from eastern Oregon and other parts of the state do come to us for care if they are in the second trimester. The experiences of women seeking care at this particular clinic may have been especially unique due to this reality that the clinic provides care much later in pregnancy than most other clinics in the state, meaning that relatively more women in need of second trimester abortion care may have been surveyed or recruited for interviews, as compared to a clinic that only provides services in the first trimester of pregnancy. Women coming to the clinic often describe their previous efforts to obtain abortion care at facilities closer to where they live, and the subsequent need to come to our clinic if they prove to be too far along to obtain care closer to home. In addition, sixteen percent of women surveyed for this study reported traveling more than 100 miles to reach the clinic, meaning that this population would likely be less interested in participating in an interview, or might have assumed that I would not want to travel that far to interview them.

During data-entry I identified several limitations related to the survey instrument. The survey used the term "barriers," a term widely used in previous research about abortion access, to ask women about problems they encountered in the process of seeking care. After reviewing differences in the data collected from surveys and in interviews, it appears that survey respondents may under-report their experiences with obstacles due to the use of the term "barriers" rather than 'obstacles' or 'challenges.' Women who successfully arrived at the clinic for their appointments may have felt they had already overcome any obstacles to care, and therefore did not

consider such obstacles to be "barriers." The survey also did not ask if women already had Oregon Health Plan coverage, although some women wrote in this answer. Consequently, descriptive statistics may have underestimated the number of women obtaining care who were covered by OHP at the time of their appointment.

Women who participated in interviews for this study were volunteers, meaning that the qualitative sample may have been skewed towards women who did encounter obstacles to access and wanted to talk about the difficulties they encountered. Women who were able to participate in interviews may have been those women who had more free time, more flexible schedules, or who were more comfortable with the idea of me coming to their homes or meeting them in public to interview them. Women who encountered obstacles but for whom it would not be safe to talk to me, because of domestic violence, concern over stigma, or rigid work schedules, etc. are therefore likely underrepresented in the interview sample. Existing literature suggests that women who encounter more barriers in the process of seeking abortion care may also be less likely to participate in research about barriers (Finer et al. 2006, Glander et al. 1998).

It is possible that women who did not perceive enough support during the process of seeking care may have been more inclined to participate in interviews, in order to talk about their experiences in the hopes of receiving acknowledgment or support after the fact. Alternately, it may be that those women completing surveys were more likely to perceive that they had enough support, and perhaps women who were at the clinic alone, after perceiving inadequate support, were less comfortable completing the optional survey.

While this clinic serves Spanish-speaking women, and descriptive statistics from the quantitative surveys suggest up to 10% of patients coming to the clinic are Latina, no Spanish-speaking women participated in interviews. As the only bilingual medical assistant at the clinic, I work directly with all Spanish-speaking patients, and I did receive one study recruitment form from a local Mexican woman, who initially indicated her interest in being interviewed. When I followed up with her, she at first

said she was too busy to be interviewed, and asked me to call her a few weeks later. In a later phone conversation, she told me that she was no longer interested in participating. I suspect that potential overlapping and intersecting stigmas related to issues of citizenship status, language barriers, and other perceived obstacles may have prevented Spanish-speaking women from participating in the qualitative portion of this study. Fortunately, my unique role as the only bilingual medical assistant at the research site ensured that I had ample opportunity to engage in participant-observation with this sub-sample. Future research on obstacles to access would benefit from assessing better ways to include the experiences of marginalized women who might be less likely to volunteer to be interviewed, including Spanish-speakers.

In addition, because study participants were sought through an abortion clinic, and all data collected came from women who actually did obtain an abortion, the sample does not include any women who potentially encountered so many obstacles to access that they could not ultimately obtain an abortion. Finally, the Institutional Review Board protocol approved for my study prohibited me from conducting interviews with minors without parental consent, and so the experiences of teenage women, whose biggest barrier to access might have been the fear of telling their parents about their abortion, are not included in the qualitative portion of this study.

Chapter 3 -- Results: Obstacles to Abortion Access

I had to do an appointment for the next Thursday.
That was hard, my sister had to take a day off work.
We had to find somebody to drive us up there, it was just
a mess. I was a little worried about the gas money, but
I was more worried about how I was going to afford to
eat while I was up there!

Alice, 26 years old, from the south coast

Despite the fact that abortion is a legal procedure in the United States, and that any woman has the right to seek abortion services, women nonetheless appear to encounter a wide array of obstacles when they do attempt to obtain care (Guttmacher 2008, Wright 2006, Jones 2005, Henshaw 1995, Powell-Griner 1987, Dudgeon and Inhorn 2004, Boonstra 2007). Recognized barriers to abortion access, from the literature, include legal restrictions, travel, time off work or school, childcare needs, the cost of the procedure, lack of support from family or partner, concern about protesters, or a lack of providers in the area (Guttmacher 2008, Jones 2005, Henshaw 1995). My analysis of women's experiences seeking abortion care at a clinic in western Oregon suggests that many Oregon women encounter these same obstacles documented in the literature, as well as others.

The women represented in the research reflect a broad spectrum of Oregon women, with measurable variations in markers of social class and socioeconomic status. Because the clinic where I conducted my research provides abortion services up to twenty-four weeks gestation, putting it in the minority of clinics in the state, the patient population includes women who travel from all over the state seeking care that may not be available closer to where they live.

Study Population - Quantitative Survey respondents

I obtained surveys and demographic information from women of many ages and social backgrounds. Respondents reported a wide variety of distances traveled to reach the clinic, reproductive histories, marital statuses, and levels of educational attainment. Short surveys collected from current and former clinic staff reflected a sample pool of medical staff who range in age from their mid-20s to 60s, and represent a variety of levels of education, marital status, parity, and previous abortion experience.

Table 3.1 Characteristics of Interview Sample -- Women Seeking Care (from Ostrach M.A. data)

IDI #	Pseudonym	Age	Children	Relationship status
1	Madeleine	20	0	Boyfriend
2	Gypsy	39	2	Casual
3	Alice	26	2	Boyfriend
4	Annie	24	0	Casual
5	Paztine	26	2	Boyfriend
6	May	26	4 (one deceased)	Husband (abusive)
7	Lynn	22	2	Husband (in Iraq)
8	Jada	25	2	Boyfriend
9	Evangeline	20	0	Boyfriend
10	Virginia	25	1	Boyfriend
11	TeeJay	42	2	Casual

Table 3.2 Quantitative Sample- Education (Ostrach M.A. data & Alan Guttmacher Institute, AGI 2002)

Education	Ostrach M.A.	AGI 2002
Less than high school completion	20%	
GED	3%	

12 years (high school only)	50%+	30%
4 years of college	11%	
Master's degree	Less than 2%	

Table 3.3 Quantitative Sample - Marital Status & Parity (Ostrach M.A. data and Alan Guttmacher, AGI 2002)

Marital Status	Ostrach M.A.	AGI 2002
Never married	75%+	
Currently married	10%	
Divorced	10%+	
Parity (prior pregnancies)		
None		
One child	25%+	
At least two children	19%+	
Previous abortion(s)	44%	48%

Study Population - Qualitative Interview Participants recruited from among clinic patients

All of the clinic patients with whom I conducted in-depth interviews had obtained an abortion within the previous two months. In-depth interview participants ranged in age from twenty to forty-two. Interview volunteers came from a variety of socioeconomic and social class backgrounds, but were mostly unemployed or working in low-paying service industry jobs. Most were white (with the possible exception of one woman who may have been a U.S.-born Latina, although she did not specify her ethnic identity). These women live anywhere from the same town as the clinic, to up to three hours away. Most of the women who participated in in-depth interviews had at least one child, and seven of the eleven had obtained at least one previous abortion. Only two of the women I interviewed are married, but seven of the eleven are in monogamous, stable relationships (based on their own self-reporting). All but one of the women had told the man who got them pregnant about the abortion.

Study Population -- Qualitative Interview Participants recruited from among clinic staff

Clinic staff who participated in interviews ranged in age from their late twenties to early sixties, consisted of three women and one man, and had a wide range of educational and social class backgrounds. One of the medical assistants interviewed, as well as the doctor and his wife, have children. Only the doctor and his wife are married, although both medical assistants I interviewed are in long-term relationships.

Quantitative Responses regarding Contraceptive Usage

One study (Thonneau 2001) indicates that 58% of women in the United States seeking abortion care experienced a contraceptive failure, suggesting that many women who obtain abortion care do so after attempting to avoid an unwanted pregnancy in the first place. While birth control failures do not constitute a barrier to access per se, the lack of any completely effective and widely-available contraceptive does put many women of reproductive age in situations where they may seek abortion care, and thus encounter the most frequent obstacles to care (Thonneau 2001, Guttmacher 2008). Of women in my quantitative sample, 42% reported that they were using a contraceptive method when they got pregnant.

Table 3.4 Quantitative Sample - Contraceptive Usage (Ostrach M.A. data & Thonneau 2001)

Contraception	Ostrach M.A.	Thonneau 2001
Used a method	42%+	58%
Of those who used Contraception		
Birth control pills	41%	
Condoms	38%	
Depo-Provera	About 4%	
Emergency contraception	About 4%	
IUD	About 4%	

Logistical Obstacles

Women in Oregon encounter specific obstacles related to the geography of the state, as the concentration of providers along the I-5 freeway corridor in the western

part of the state requires many Oregon women seeking abortion care to travel 50, 100, 200, or even more miles to reach a clinic (Guttmacher 2008, Powell-Griner 1987, National Abortion Federation, NAF 2010 website). While data from the anonymous surveys suggests that fifty percent of patients coming to the clinic are from the county where the clinic is located (meaning they face up to a one-hour drive at most) women coming from counties to the south and on the coast must drive for two, three, or even four hours to get to the clinic. Some women completing quantitative surveys, as well as interview participants, also described logistical challenges related to arranging childcare, and taking time off work or school, as well as problems getting to state offices to apply for Oregon Health Plan coverage of their medical care.

Table 3.5 Quantitative Responses re: Distance Traveled, Time Off, & Childcare (Ostrach M.A. data)

Distance traveled to get to the clinic	Ostrach M.A.
0-25 miles	52%+
50-75 miles	13%+
More than 100 miles	16%+
Time taken off work or school	
Less than one day	60%+
One day	20%+
Two days or more	10%+
Needed childcare arrangements	
Family members cared for child(ren)	Almost 25%
Paid for childcare	6%+

Table 3.6 Geographic Distribution of Quantitative Sample (Ostrach M.A. data)

Residence	Ostrach M.A.
Oregon residents	98%+

From same county as clinic	50%+
From county directly to the south	12%
From south coast county	6%
From a southern Oregon county	7%+

Social Inequality

Poor women, teenagers, and women of color are more likely to experience unwanted pregnancies, birth control failures, or to lack access to effective contraception (Weitz et al. 2009, Salganicoff and Delbanco 1998). These same marginalized populations are also more likely to experience delays when seeking abortion care, especially related to the need to travel to obtain second trimester procedures, waiting for Medicaid approval, and raising needed funds (Weitz et al. 2009, Guttmacher 2008, NAF 2010, NRO 2010).

Medicaid Status & Medicaid Funding for Abortion

Medicaid eligibility is an issue of particular relevance to my study, as Oregon is one of only seventeen states in the U.S. where state funding covers abortion services for Medicaid recipients (Boonstra 2007). The Guttmacher Institute's research (2008) on Medicaid-eligible women found that women on federally-funded health plans are among the poorest people in the United States, and approximately 40% of low-income women of reproductive age receive Medicaid benefits (Boonstra 2007). Documenting western Oregon women's perceptions of any difficulties and delays they encountered while trying to get the Medicaid card that would pay for an abortion provided important information about the experiences of those abortion patients who are disproportionately affected by social inequality – poor pregnant women (Boonstra 2007). Close to sixty percent of women surveyed for this study reported being aware that Medicaid (Oregon Health Plan) would pay for their abortion care.

As of 1998, one study (Salganicoff and Delbanco) estimated that as many as one in five Medicaid-eligible women in the United States who sought abortion care would have obtained first-trimester abortions instead of second-trimester procedures, if they had been approved for Medicaid coverage earlier – a clear example of one way in that the poorest women in the country are directly affected by financial obstacles to abortion access. In my study, twenty-five percent of women surveyed reported that difficulties applying for, or waiting for, Oregon Health Plan (OHP) approval were "very or somewhat challenging." This represents a quarter of all women completing surveys, not just women who applied for and/or obtained OHP coverage.

Even women whose incomes are not low enough to make them eligible for Oregon Health Plan often find the financial challenge of getting an abortion prohibitive, as evidenced by the 42% of women in my sample who reported that the cost of the procedure was "very or somewhat challenging." Most women who participated in the qualitative portion of this study described significant challenges related to obtaining Medicaid (Oregon Health Plan, OHP) coverage for their pregnancies, as I describe in detail later in this chapter.

Table 3.7 Quantitative Sample - OHP Application process as Barrier (Ostrach M.A. data & AGI 2002 national data for comparison)

Oregon Health Plan (Medicaid) Status	Ostrach M.A.	AGI 2002
Likely eligible for OHP, based on income	Close to 70%	
Aware that OHP would pay for their abortion	60%+	
Applied for OHP	At least 35%	
Got OHP within 3 weeks of applying	85% of applicants	
Covered by Medicaid at time of abortion	30%+	24% (national)
Difficulty getting/waiting for OHP "very or somewhat challenging"	25%	

Legal and other Documentation - a Potential Logistical Obstacle

Immigration and documentation status, as well as basic access to their citizenship documents, can affect women's ability to get contraception and /or Medicaid coverage, as then-President George W. Bush's 2005 passage of the Real ID Act requires recipients of Medicaid and other federally-funded family planning programs to show proof of citizenship – a birth certificate or passport (Jobs with Justice 2008, Network for Reproductive Options 2010). The actual result of this appears to be that it prevents many poor women, not just undocumented immigrants, from receiving free birth control through county health departments and Planned Parenthood affiliates (NRO 2010). For women who cannot afford to buy a certified copy of their birth certificate, the cost of paying for birth control out-of-pocket may be prohibitive (NRO 2010). In fact, at the clinic where I conducted my research, staff noticed an increase in the number of patients who reported that they had previously gotten free birth control, but were denied refills, as well as annual exams and pap smears, due to being undocumented immigrants, or because they did not have a copy of their birth certificate, following implementation of the REAL ID Act. For women born in Oregon, purchasing an official copy of their birth certificate costs between \$20.00 to \$32.50 or more, depending on how it is ordered and delivered (Oregon Vital Records 2010). Women from other states frequently report that ordering their birth certificates result in delays of up to six months while waiting for it to arrive (NRO 2010).

One outcome of this reduced access to contraception appears to be that relatively more poor women and immigrants experience unwanted pregnancies, and therefore end up seeking abortion care (NRO 2010,). By the same token, many women in poverty who would be eligible for Oregon Health Plan coverage for birth control or abortion services, but who do not have access to their birth certificates, have been delayed in applying for, or unable to apply for, Medicaid coverage for their pregnancies (NRO 2010). In fact, in a conversation that took place during the outreach phase of this study, a county health department employee who routinely helps women

apply for Medicaid benefits stated that she believes women in her county on the south coast began experiencing significant delays in receiving Oregon Health Plan (Medicaid) approval when Department of Human Services started requiring a birth certificate or passport to process OHP applications.

Lack of Social Support and Domestic Violence as Obstacles to Care

Lie and co-authors (2008) examined the role of social support, or lack there-of, in women's experiences of abortion, arguing that economic and logistical obstacles to access intersect with social factors. I have observed first-hand the effects of one known, but hard to measure, social factor in abortion access during participant-observation at several clinics in Oregon, when women come in with visible bruises or tell clinic staff stories about manipulation and harassment they experience from a male partner in the process of seeking care. Intimate partner violence is known to affect women's perceptions of abortion as an option -- in fact any male partner can significantly impact a woman's decision-making process about seeking abortion care, whether he is abusive or not (Dudgeon and Inhorn 2004, Ellison 2003). Although only eleven percent of women in the quantitative sample found a lack of partner support to be "very or somewhat challenging," more than half of the women who participated in in-depth interviews described a lack of partner support as a significant barrier to abortion access during either this pregnancy or a previous pregnancy.

Attempts by a male partner to prevent or delay a woman from seeking abortion care can have a significant impact on the gestation of the pregnancy (as determined by ultrasound) when the woman does reach a clinic (Dudgeon and Inhorn 2004). A male partner's reaction to an abortion decision can also affect a woman's feelings of stress or concern about the procedure, and her ability to comply with the follow-up care recommended to avoid possible complications (Dudgeon and Inhorn 2004). Research on intimate partner violence has consistently shown that physical violence is most likely to begin or increase when a woman becomes pregnant, or tries to leave an abusive relationship (Womenspace 2000). With an awareness of this dynamic, it is

clear that delays in obtaining abortion care can increase the dangers facing a pregnant woman in an already-abusive situation (Womenspace 2000). Some women choose not to tell a partner about their decision to terminate a pregnancy, suggesting that these women may have reason to believe their partner will not be supportive (Major et al. 1990). I address the issue of social support, or the lack thereof, and its impact on women's experiences of seeking abortion care, at length in chapter 4.

Table 3.8 Quantitative Responses regarding Partner Support as a Barrier (Ostrach M.A. data & Major et al. 1990)

Partner support	Ostrach M.A.	Major et al. 1990
Not enough support	10%	
Did not tell partner	8%+	15%
Lack of partner support “very or somewhat challenging”	11%	

Table 3.9 Qualitative Responses regarding Social Support, Lack of Support as a Barrier (Ostrach M.A. Data)

IDI #	Pseudonym	Perceived adequate support?	Biggest barrier?
1	Madeleine	Yes	OHP
2	Gypsy	No	Decision & support
3	Alice	Yes	Transportation
4	Annie	No	Driver, no meds.
5	Paztine	No	Childcare, driver
6	May	No	OHP, support
7	Lynn	No	Childcare, support
8	Jada	Yes	Decision
9	Evangeline	Yes	Money
10	Virginia	Yes (this time)	OHP (other times)
11	TeeJay	Yes	Money, decision

To highlight an important aspect of Table 3.9 above, what is evident from these women's stories is that those who perceived adequate social support nonetheless encountered logistical and social challenges, or struggled with the abortion decision. Women reported that receiving adequate support helped them overcome obstacles. Conversely, those women who did not perceive adequate support often mentioned that this was a particularly challenging obstacle to overcome. Women who perceived inadequate support were more likely to report that initial uncertainty about the decision to seek an abortion would have been easier to resolve if they had felt supported during the decision-making process. Finally, Table 3.9 reflects the role of social inequality and poverty in these women's experiences: many women reported that some or most of the obstacles to abortion access they encountered were ones that related to a lack of financial resources.

Impact of Anti-Abortion Protest Activity on Women Seeking Care

Women may arrive at the clinic only to be met by anti-abortion protesters trying to distract and harass them, or even blocking the entrance. Ellison (2004) relates social stigma to the structural violence that often puts women in the difficult position of decision-making about pregnancy outcomes based on economics. Recent research on abortion stigma suggests a link between perceived community-level stigma and negative health effects for women, as women in need of abortion care may delay care or seek unsafe or illegal abortion services, in an attempt to avoid stigma (Kumar et al. 2009).

As a form of coercion and harassment directed specifically at women, and disproportionately affecting women of lower socioeconomic status (who are more likely to experience unwanted pregnancies), anti-abortion protest activity at clinics can be seen as a particularly targeted, visible example of structural violence enacted upon women through social pressure (Farmer 2005).

Table 3.10 Quantitative Responses regarding Concerns about Protesters (Ostrach M.A. data)

Perceived barriers	Ostrach M.A.
Concerns re: protesters “very or somewhat challenging”	16%+

Overlapping and Intersecting Obstacles to Access

The clinic where I conducted my study provides services up to 24 weeks gestation, that puts it in the minority of clinics in the state, and makes it an option of last-resort for many patients (NAF 2010 website,). Most other abortion providers in Oregon only provide services in the first trimester, so many of the women who come to this clinic have already spent months attempting to overcome obstacles to access by the time they find themselves at a point in their pregnancies where they must come to this particular clinic (NAF 2010). Such women face even greater challenges related to the scarcity of late-term abortion providers, and the greater cost of these procedures (NAF 2010, Jones 2005, Henshaw 1995). In addition, Oregon is a comparatively vast state geographically, with many women of reproductive age living in rural areas, thus requiring more travel to obtain services than is necessary for women in urban areas (Guttmacher 2008). As early as 1987, Eve Powell-Griner and co-authors found that abortion rates vary significantly depending on whether women live in rural versus urban areas -- a factor that can affect Oregon women. Twenty-six percent of women in my quantitative sample found travel arrangements to be "very or somewhat challenging," and sixteen percent had to travel more than 100 miles to reach the clinic.

Finally, many Oregon women of reproductive age are at a socioeconomic disadvantage, with the Guttmacher Institute's current estimate (1999) being that at least 14% of Oregon women between the ages of fifteen and forty-four live in poverty, while recent national statistics suggest that 13% of Oregon's population lives in poverty (US Census 2010). A striking forty percent of women in the quantitative sample reported annual incomes below 100% of the Federal Poverty Level.

Table 3.11 Quantitative Sample -- Income and Poverty Levels (Ostrach M.A. data & US Census), FPL = Federal Poverty Level

Income Levels	Ostrach M.A.	Census 2008
Median income	\$10,000/year	
Income equal to or below 250% FPL	80%	
Less than \$2000/year income	Almost 30%	
Below 100% FPL	40%	
100-199% FPL	30%	
200-299% FPL	15%	
300% or more FPL	Almost 11%	
Percentage of state population below FPL	Oregon 13%	National 13%

Increased Risks and Costs related to Second Trimester Procedures

Given the many ways that obstacles to access (travel, stigma, lack of funding, waiting for Medicaid approval, etc.) can cause delays that push women into the second trimester by the time they arrive at a clinic, it is important to consider the increased risks and expenses related to second trimester abortion care (Weitz et al. 2009, Kumar et al. 2009). At the clinic where I conducted my research, a first-trimester abortion (up to 12 weeks from the woman's last period, as measured by ultrasound) costs \$500.00 for cash-paying clients, and the price then increases by week of gestation from 13 weeks on, up to prices of \$1000.00 or more in the late second trimester. Procedures after thirteen or fourteen weeks gestation also may require appointments over two or three days, to begin cervical dilation gradually and safely, although this depends on the woman's unique reproductive history and the doctor's experienced and careful judgment of her medical needs. For women who travel from outside the area, a two-day procedure may also entail getting a hotel room nearby, and paying for food while in town, in addition to increased time off work, increased childcare needs, etc. While

parental notification laws are not currently in effect in Oregon (although minors under the age of fifteen must have a parent or guardian signature on their consent form for the procedure), studies in parental notification states have found that some older minors (women who are about four months or less from their eighteenth birthday) may respond to parental notification or consent laws by delaying an abortion until after they turn eighteen and no longer have to involve their parents (Colman and Joyce 2009). Teenage women are already statistically more likely to seek abortion care later in their gestations, and knowing that minors affected by parental notification laws may delay seeking an abortion, or travel to a state without such laws, can help to explain why some teenage women arrive at the clinic already in the second trimester of their pregnancies (Guttmacher 2008). These women include those traveling from Idaho -- a nearby state that does require parental consent for women under eighteen to obtain abortion services (NAF 2010, Colman and Joyce 2009).

Finally, with increasingly widespread use of prenatal diagnostic ultrasounds, a certain population of women end up seeking second-trimester abortion due to the detection of fetal anomalies that may be incompatible with fetal survival, pose a threat to the pregnant woman's health, or reveal a congenital health problem in the fetus that the woman and her family decide they are not prepared to deal with (Lalitikumar et al. 2006). Many fetal anomalies are not diagnosed until a comprehensive ultrasound that is routinely scheduled in the second trimester, so for women who receive a devastating diagnosis at this time, the only option for terminating the pregnancy, or dealing with a late fetal demise, is a second-trimester abortion (Lalitikumar et al. 2006). In our clinic, while only about 2% of procedures performed during the study period were for women in the second trimester of their pregnancies, women who come to us later in their pregnancies tend to be affected by a multitude of difficult factors. Existing literature, my own participant-observation, and comments from my co-workers suggest that women who are in the second trimester of their pregnancies when they reach the clinic are more commonly younger, live farther away, are in unsafe or unstable relationships,

or waited an especially long time for Medicaid (Oregon Health Plan) approval. The clinic often sees women who applied for OHP while they were in the first trimester, but end up being in the second trimester by the time they get approved. This was true for four of the women who participated in the interview portion of my study, either during this most recent pregnancy, or for a previous pregnancy.

Table 3.12 Qualitative Interview Respondents' Experiences with Delays in Obtaining Care (Ostrach M.A. data)

Participant	Gestation at time of Abortion	Delay?	Reason for Delay
Madeleine	13 weeks	3 weeks	Waiting for OHP
Alice	15 weeks	2+ months	Paperwork needed for OHP
May	13 weeks	2+ months	Waiting for OHP
Evangeline	9 weeks	2 weeks	Insurance copay
Virginia	18 weeks	2+ months	Didn't know she was pregnant, waiting for OHP

Abortion Safety by Gestation at Time of Procedure

In terms of safety, while legal abortion has a very low complication rate, and this clinic in particular has a very good record of few complications and thorough follow-up care, there are nonetheless increased risks associated with second trimester abortions (NAF 2010, Guttmacher 2008). A 2004 study (Bartlett et al.) found that the risk of death from abortion increases exponentially, by 38%, with each additional week of gestation, meaning that women seeking second-trimester abortion care are significantly more likely to experience complications. Most importantly, Bartlett et al.'s study found that 87% of deaths of women who terminated a pregnancy after eight weeks gestation could have been prevented if those women had been able to obtain an abortion earlier – prior to eight weeks gestation (Bartlett et al. 2004). Structured inequalities in healthcare systems which result in delays in receipt of abortion care pose a greater risk for low-income and other marginalized women (Singer 1986, Guttmacher 2008, Boonstra 2007).

In large-scale reviews of abortion-related mortality since the legalization of abortion in the United States, gestational age at the time of the procedure was the strongest risk factor for mortality (Bartlett et al. 2004). When women who are most likely to experience an increased chance of exposure to morbidity and mortality related to second trimester abortion services are low-income women, women of color, and teenage women, this demonstrates the extent to which structured disparities in healthcare access disproportionately affect marginalized populations (Farmer 2005, Singer 1986, NAF 2010, Guttmacher 2008).

Predictors of Second-Trimester Abortion Need

Bartlett and co-authors (2004) echoed existing data from the National Abortion Federation and the Guttmacher Institute, both highly-regarded research organizations, that women under the age of twenty, as well as women of color and poor women, were more likely to seek abortion care later in their pregnancies than older women, women with greater economic resources, and white women (Grimes 1984, Weitz et al. 2009, NAF 2010, Guttmacher 2008). These trends also highlight the impact of social inequality in the forms of class-based income disparities, and racism, and the reduced access that teenage women have to many resources, on women seeking abortion care. These patterns are noticeable among women who come to our clinic for abortion care. The real-world effects of structural violence can thus be seen in the reproductive healthcare experiences of women with fewer resources (Farmer 2004, Singer 1986, Singer 1993). The point of this data is not that second trimester abortions are dangerous – on the contrary, abortion care has a very low complication rate, and terminating a pregnancy, in most circumstances, still presents far fewer health risks to a woman than carrying that pregnancy to term (NAF 2010). However, given that the low level of risk associated with abortion care does increase with later procedures, obstacles to access that disproportionately impact women most affected by social inequality thus directly increase certain populations' risks of being exposed to complications from an abortion procedure (Weitz et al. 2009).

In a 1998 study of late-term abortion in the United States, the *Journal of the American Medical Association* published data that showed 71% of women seeking a second-trimester abortion had not known they were pregnant or had miscalculated their gestations (Epner et al. 1998). In addition 48% experienced delays in obtaining abortion care due to the need to seek funding or make other arrangements. Significantly, in terms of domestic violence and the importance of social support, 33% of women seeking later abortions stated that they had been afraid to tell their partner or parents about the pregnancy, 24% reported difficulty deciding what to do about the pregnancy, and women seeking later procedures were more likely to have experienced rape or incest that led to the pregnancy (Epner et al. 1998, Grimes 1984). As these studies suggest, and as was underscored in the interviews I conducted with women in Oregon, the decision to have a second-trimester abortion, or any abortion for that matter, is not taken lightly or made on a whim – it typically involves much preparation and consideration, as well as logistical effort on the woman's part (Epner et al. 1998, Henshaw 1995). In addition, an earlier study by Grimes (1984) concluded that many factors that increase women's chances of seeking abortion care at later gestations are personal or situational factors that are difficult to address through public health means, meaning that the need for second-trimester abortion care will continue (Grimes 1984). Indeed, the clinic where I conducted my research is one of only three or four clinics in the entire state that routinely provide second-trimester abortion care, making the patient population at this clinic more likely to include women affected by delays in the process of seeking abortion care. Several women in the qualitative sample for this study were delayed into the second trimester due to logistical obstacles.

Once we acknowledge that women who experience delays in seeking abortion care are likely to be those most affected by social inequality, it seems crucial to address both the causes and impacts of structural violence and disparities in healthcare, by reducing obstacles to abortion access. At the same time, ensuring continued access to safe, high-quality second-trimester abortion care is necessary for

improving access to abortion care, since there will always be those women who are informed of serious fetal anomalies in the second trimester, or who experience delays due to domestic violence, the need to travel, bureaucratic or problems with Medicaid approval, and other reasons (NAF 2010, NRO 2010 , Guttmacher 2008). With about 150,000 women per year currently seeking second trimester abortion care nation-wide, the need for accessible, safe, and appropriate later abortion care is vital (Weitz et al. 2009). While the quantitative data in this particular study did not directly measure connections between domestic violence and later-term procedures, based on more than ten years of participant-observation and the one interview in which domestic violence were an underlying issue. It is likely that teenagers, women from rural areas, and women who disclose a history of abuse in their relationship do tend to be further along by the time they come to our clinic. The qualitative narratives gathered in this study also reveal Oregon women's own perceptions of obstacles encountered in the process of seeking abortion care, and their stories illuminate frequent obstacles affecting abortion access.

"Barriers" or Obstacles?

Surveys asked women to state whether or not they felt they had encountered "barriers to access" (question 15, Appendix A1). A subsequent question (question 16, Appendix A1) asked respondents to rank how challenging specific potential barriers were, on a Likert scale (Bernard 2006). Revealing the importance of word choice and question order in social research, fewer than fourteen percent of survey respondents reported that they encountered "barriers." In subsequent questions, forty-two percent of women reported that the cost of the procedure was "very" or "somewhat" challenging. More than twenty-six percent reported the same of travel arrangements, and a quarter of women filling out the survey reported that difficulty getting Oregon Health Plan coverage, or waiting for it, was "very" or "somewhat" challenging. This suggests that while women may not have considered the obstacles they encountered between a positive pregnancy test and the appointment to be 'barriers' per se, when

asked about specific obstacles, many women did indicate that certain issues were difficult to deal with. This contradiction likely stems from two sources: first, that women were filling out the survey after arriving at the clinic, and may have felt that since they succeeded in getting to their appointments, any problems they encountered along the way were not "barriers." Secondly, women may have had problems with specific obstacles, but did not think about them as such, until asked about individual obstacles. Future research on barriers or obstacles to access would need to account for these discrepancies, and control for different reactions to word choice, generality of questions, and perceptions of challenges that had been overcome, versus "barriers."

Table 3.13 Quantitative Sample -- Perceptions of "Barriers" (Ostrach M.A. data)

Perceptions of Barriers	Ostrach M.A.
Women who reported they encountered barriers	13%
Found specific barriers "very or somewhat challenging"	
Cost of the procedure	42%
Travel arrangements and costs	27%
Difficulty getting Oregon Health Plan or waiting for OHP	25%
Concerns about harassment by protesters	16.8%
Time off work and school	16.7%
Lack of family support	12.4%
Lack of partner support	11%

Problems with Oregon Health Plan – Mixed Methods Responses

As stated above, Oregon is one of only seventeen states in the United States where state funds are allocated to pay for abortion services for Medicaid recipients (NAF 2010, Guttmacher 2008,). Despite this opportunity, many low-income women report that they encounter significant problems actually getting Medicaid coverage through Oregon's program, the Oregon Health Plan. This was an important theme that emerged from in-depth interviews with women who sought abortion services at our

clinic, and was a concern for twenty-five percent of women who completed the survey for the quantitative sample.

To all appearances, Oregon Health Plan's process for accepting applications from pregnant women is the same as for all other OHP applications². On their website, the Department of Human Services states that all OHP applications will be processed within forty-five days, and this is also what women are frequently told when they apply for Oregon Health Plan at a local DHS office (NRO 2010, OHP 2010). However, in the history of Oregon Health Plan, there has traditionally been an expedited application process for pregnant women to be able to get quick approval for a temporary emergency medical card (All Women's Health Services, AWHS 2002, Network for Reproductive Options, NRO 2010). Ten years ago, when I first began working in abortion clinics and doing reproductive healthcare advocacy in Oregon, part of my job at a clinic in Eugene at the time was to walk prospective patients through the process of applying for an OHP medical card. As recently as 2002, DHS policy for OHP application processing was that any pregnant woman making less than \$30,000 per year in Oregon could get a temporary emergency medical (OHP) card within 72 hours of applying, if she turned in all of her paperwork (AWHS 2002). At that time, the required paperwork included proof of pregnancy from a clinic or doctor's office, proof of income consisting of bank statements and/or paycheck stubs from the preceding three months, and proof of address in the form of recent mail, or a driver's license (AWHS 2002). In my experience, nearly half of the patients at that clinic applied for and received a medical card, most within three days (AWHS 2002).

In the years since, as a volunteer on an abortion referral hotline, I have observed changes in the OHP application process, especially in terms of what women are reportedly told about how long they have to wait to be approved. While individual Department of Human Services staff members and other advocates with whom I spoke

² Triangulation data was collected from the Department of Human Services following an IRB-approved request for information submitted to the administrators.

during the outreach phase of this study reported that case managers have the option to expedite OHP applications from pregnant women at their own discretion, this option is not readily apparent in the DHS Worker Guides that are provided to case managers for interpreting eligibility requirements. In electronic correspondence from a DHS Policy Analyst, I was informed that complete applications from pregnant women should be processed "within one business day." It is not clear whether the latter guideline is widely known, or enforced. In addition, a DHS Policy Analyst advised me that case managers will "soon" be directed to process all Oregon Health Plan applications within five business days, although this policy transmittal had not been posted on the website where case managers find guidelines as of mid-April, 2010.

With the introduction of the Real ID Act in 2005, women applying for federally-funded programs began having to show proof of citizenship – a birth certificate or passport (JWJ 2008). Even though Oregon Health Plan pays for abortion care through state funds, because OHP is a Medicaid program that receives federal funds, this documentation requirement affects all OHP applicants (NRO 2010). When women started having to show proof of citizenship to apply for OHP, case managers began telling women that the expedited emergency medical card for pregnant women would take closer to a week to process, rather than the three days that had been typical before (AWHS 2002, NRO 2010). More recently, many callers to the abortion referral hotline, and patients at the clinic, report that case managers tell them it will take 45 days before they hear back about their OHP applications – far too long for a woman nearing the second trimester (NRO 2010). A county health department employee on the south coast of Oregon, who frequently helps pregnant women apply for OHP, reported that she observed more delays in OHP approvals after DHS began requiring proof of citizenship. Several DHS Policy Analysts informed me, via electronic correspondence, that case managers will soon have the option of approving Oregon Health Plan applications "pending" proof of citizenship, so that covered clients could use their medical cards while waiting for confirmation of their citizenship status (if a

birth certificate has been ordered and is being mailed, for example), but this policy has seemingly not been transmitted to case managers as of April, 2010.

Just recently, a patient at the clinic told me a story about case managers at her local, rural DHS office sending all pregnant women to a local Crisis Pregnancy Center to obtain their proof of pregnancy form, rather than sending them to the impartial County Health Department office. This recommendation that women visit a Crisis Pregnancy Center subjected this particular patient, and presumably other women, to biased and inaccurate information about abortion, and to harassment by anti-choice activists offering free pregnancy tests (NRO 2010, National Abortion Federation 2010).

Many women reported that the process of applying for, waiting for, or checking on the status of OHP medical card applications caused them delays in obtaining abortion care. This process also reportedly caused stress, anxiety, and the hassle of repeated trips to the Department of Human Services office, and/or many phone calls to seemingly-unreachable case managers, for some women. With the exception of a few women from a particular county on the south coast who talked about the incredibly helpful county health department employee who advocated for them in the process of applying for or confirming OHP coverage, many of the women I interviewed had experienced some kind of problem with the OHP application process.

Of women who filled out surveys about barriers to access, more than sixty percent of them reported being aware that OHP would cover their abortion, and 35% reported applying for it. Of the thirty-five percent who applied for it, 85% of them were approved within three weeks. Without knowing how many women already had OHP, it appears that at least thirty percent of women coming to the clinic had OHP coverage at the time of their appointment. While approval within three weeks may sound acceptable, it is worth noting that many women do not confirm a pregnancy until they are close to eight weeks gestation or later, meaning that a delay of three

weeks while waiting for OHP approval, particularly after taking a few days or a week to gather the necessary paperwork, can frequently push women into the second trimester while they wait for a medical card (NAF 2010, Guttmacher 2008).

Table 3.14 Quantitative Sample -- OHP Awareness & Status (Ostrach M.A. data)

Oregon Health Plan (Medicaid) Status	Ostrach M.A.	AGI 2002
Likely eligible for OHP, based on income	Close to 70%	
Aware that OHP would pay for their abortion	60%+	
Applied for OHP	At least 35%	
Got OHP within 3 weeks of applying	85% of those who applied	
Covered by Medicaid at time of abortion	30%+	24% (national)

Furthermore, what might explain why as few as thirty-five percent of women may have applied for Oregon Health Plan, if more than sixty percent of them knew it would cover abortion services? Based on income levels, it is possible that some of the women who completed the survey already had OHP coverage, and qualitative interview data certainly shows the likelihood of this explanation. In addition, many women at the clinic talk about the difficulty of gathering the required paperwork to apply for OHP. Perhaps some women who would be eligible for OHP do not apply because they are intimidated by the potential difficulty of navigating the application process, reinforcing a common perception among OHP recipients coming to the abortion clinic that the Department of Human Services may deliberately complicate the process in order to deter women from obtaining a medical card. While women seeking care often attribute delays in the OHP application process to the reactions of particular case managers to the decision to terminate a pregnancy, communication

from DHS Policy Analysts and other state and county employees suggests that delays in OHP application processing may in fact result from a lack of communication between the administrators in the main office in Salem, and staff in the outlying offices.

Key themes from interviews suggest that women with few economic resources try to wait out the OHP application process, and hope that they will eventually be approved, even when this delays them into the second trimester of their pregnancies. If women in poverty believe that obtaining OHP coverage is difficult and time-consuming, they may not even bother to apply, thus representing a population disproportionately affected by structural deprivation of public resources. Based on self-reported income levels, it appears that as many as 70% of women seeking abortion care at one clinic in Oregon are living at or below 185% of the Federal Poverty Level (US Census 2010), making them eligible for Medicaid programs. With women in poverty in such apparent need of reproductive healthcare, a perception that Oregon Health Plan will be difficult to obtain could mean that many women in poverty will not apply for or receive the Medicaid benefits that are theoretically allocated to them, constituting a particularly troubling form of structural violence (Farmer 2005).

3.15 In-Depth Interview Participants' Experiences with OHP (Ostrach M.A. data)

IDI #	Pseudonym	Applied for OHP?	How long waited?
1	Madeleine	Yes	2-3 weeks
2	Gypsy	Yes	3 days*
3	Alice	Yes	A few weeks
4	Annie	Yes	A few days*
5	Paztine	Already had it	Already had it
6	May	Yes	3 months

7	Lynn	Already had it	Already had it
8	Jada	Already had it	Already had it
9	Evangeline	No	Did not apply
10	Virginia	Yes	A week or so this time (4 months for a previous pregnancy)
11	TeeJay	No	Did not apply

In Table 3.15 above, Virginia's experience with a recent application for OHP is reflected. However, Virginia also reported that for a previous pregnancy, she had applied for OHP in October of the previous year, and did not receive confirmation of her OHP coverage until the following *February*. The first woman to participate in an in-depth interview, Madeleine, was twenty years old and very well-spoken. Madeleine reported that she spent more than two weeks trying to get a hold of a Department of Human Services case manager who never returned her calls or answered his direct line. Madeleine told me that she began calling the case manager multiple times a day, after going into the DHS office a week after turning in her Oregon Health Plan application and all her paperwork and learning that it had not been processed, and that nobody had bothered to call and inform her that there was some information missing. On her second visit to the DHS office, Madeleine reported that she became very agitated and tried to impress upon the office staff that she was pregnant, and that her pregnancy was progressing while she was unsure of her gestation, and that she asked if there was any way they could expedite the application based on her pregnancy. The news of her pregnancy seemed to come as a revelation to the office worker reviewing Madeleine's application, despite the fact that the application was clearly marked to indicate her eligibility based on a current pregnancy, and her required proof of pregnancy form was attached. In Madeleine's case, she ultimately got a hold of the case manager two or three weeks after applying, learned she was approved for OHP

coverage, and went to her appointment only to find out that in the time she had been waiting for her medical card, she had passed into the second trimester – a cut-off she had been hoping to avoid. Madeleine told me that she felt that she was treated, “like just a piece of paper” while applying for OHP. She said:

The hardest thing was the health insurance [OHP]. If only they'd been more understanding about it, or if they had a way to put regular health insurance applications in one place, and then [process applications from pregnant women separately]. I thought that they would deal with it *quickly*, because it's kind of a fast-moving thing, you can't really wait that long!

On the north coast, May, a 26 year old with three young children who is in a seemingly abusive marriage, assumed she had been "kicked off" of OHP six months after her then-seven month old son was born (as she was told she would be). When she discovered she was pregnant again, May went into her local DHS office to ask her case manager about reapplying for Oregon Health Plan. She stated she was never able to find him in the office or reach him on the phone, and that she was calling him almost every day asking him to let her know if she was covered, or what she needed to do to reapply. May told me that after two or three months of trying to get a hold of him, she finally figured out that she was still covered by OHP when she received a bill for three months' worth of co-pays! By this time, May was in the second trimester of her pregnancy, and faced the possibility of needing a two-day procedure to terminate her pregnancy. In fact, May felt that having better communication from DHS would have made a difficult situation much easier:

Knowing that I had the Oregon Health Plan, them actually getting back to me would have helped! I would not have had to wait so long, you know, "can I *do* this?"

Virginia, twenty-five years old with one child who does not live with her, told me that it was not too difficult to reapply for OHP for her most recent pregnancy – it only took about a week after submitting the paperwork to get approved, although she had to go into the office twice to get them all the information they required, after they

failed tell her everything that was needed during the first visit. However, she reported that for a previous pregnancy, she had applied for a medical card in October of that year, and did not get approved until *February* of the following year. Virginia's story, like those of some of the other women who participated in this study, reiterate concerns raised in the background literature that is, that Medicaid delays frequently push women into the second trimester.

Interviews with clinic staff made it clear that medical assistants who spend up to an hour or more with each abortion patient, sometimes over several days in a row, hear many stories about problems with OHP. One medical assistant, Poppy, thinks that transportation and funding, including access to OHP, are the biggest obstacles for patients, as they try to get to the clinic for abortion care. She shared with me the experience of a patient she had worked with recently:

We had that patient that ended up being very far along and she was told on the phone with OHP that she needed to apply online. Then the caseworker that had taken her online application just walked off the job, and she [the patient] slipped through the cracks. She ended up having to go through a way more complicated [second-trimester] procedure, because of waiting for OHP. OHP is *always* a pain!"

Poppy was also aware of the impact of social inequality on women's ability to apply for OHP, right down to whether or not women have a copy of their birth certificate, or if they can afford the money to buy a new copy. Poppy expressed frustration that a requirement designed to exclude undocumented immigrants from getting free healthcare, instead penalizes poor *citizens*, to the point of preventing low-income women from getting contraceptives to prevent pregnancy:

That's the whole thing with the proof of citizenship, when they leave our office, to be able to prevent [future] pregnancies! "Oh, you're 14 years old and your parents disapprove, you need birth control but you can't ask your mom for your birth certificate! You don't have a passport.." If you don't have proof of citizenship you can't go down to

Planned Parenthood and get birth control [or apply for OHP].

Financial Obstacles to Abortion Access

Among the most obvious obstacles that women seeking abortion care confront, income and poverty levels are stark reminders of the dire straits that many pregnant women find themselves in. While the current estimate is that thirteen percent of Oregon's population live at or below the Federal Poverty Level (\$9,570.00 per month for a single woman with no children, as of 2008 guidelines), survey data from this study indicates that forty percent of women who came to the clinic are living at or below this poverty threshold (US Census 2010). While the self-reported annual income was not adjusted for family size in this sample, the median income of \$10,000.00 per year still indicates that many women seeking abortion care in Oregon have very few economic resources with which to navigate the process of dealing with an unplanned pregnancy. Women at the clinic frequently talk about the role their financial circumstances play in both deciding to terminate a pregnancy, and in determining how to obtain abortion services. For women living so close to the edge, taking even a half-day off from work, driving one hundred-plus miles to a clinic, or paying for childcare during a day they are not earning income, can have implications and repercussions for their budget for the rest of the month, or longer. While women from many income levels seek abortion care, women in poverty or who are otherwise economically disadvantaged may have a harder time overcoming obstacles to access (Guttmacher 2008, Henshaw 1995).

As the doctor who provides all of the abortion services at my research site put it:

I think the need to have an abortion cuts across the whole spectrum of where people are financially. If a significant portion of our patients are young, that means they are either students or unemployed. They are going to have a low income level.

Even women whose income was high enough that they did not qualify for OHP nonetheless faced economic and logistical obstacles. TeeJay, a 42 year old woman, employed full-time, was stressed out about how she and her partner would find the funding for her appointment:

He's unemployed, he just got laid off. That was the whole thing too, we were just really lucky at the time that he could get a loan. I did not want to have to go to my mom, he did not want to have to go to his parents. I couldn't [carry the pregnancy to term].. I'm [already] a single mom!

Alice, a 26 year old from a rural area on the south coast of Oregon, faced multiple logistical and economic obstacles related to her appointment, and mentioned to me that it bothered her to ask her mother and sister for help with travel arrangements and costs. Melanie, a medical assistant at the research site who recently became the clinic manager after many years of working with patients and training other medical assistants, asserts that younger women are particularly affected by financial obstacles to access, and by the impact of perceived inadequate social support, “with younger patients, like in their teens to very early 20s, I would say it's just finding out how to come up with the money and also finding somebody they feel like they can tell.” For patients coming from outside of the immediate area, Melanie believes travel is also a big factor, and that the need to travel a greater relative distance to obtain abortion services also requires women to deal with a whole host of related challenges:

How to take the time off work if they're working, or how to find a ride if they don't have a ride. How to pay for a way to get there, or how to explain to their family or whoever else why they need this time off and why they are going to be gone.

Lack of Social Support and Obstacles to Access

Women at our clinic frequently describe a lack of social support, or outright hostility and harassment from friends, family, partners, or clinic protesters, as a

significant obstacle they encounter in the process of seeking care. Eleven percent of women surveyed reported that a lack of partner support was "very or somewhat challenging," and more than twelve percent reported the same for a lack of family support. More than sixteen percent of women in the quantitative sample reported that concerns about harassment by protesters at the clinic was "very or somewhat challenging." While these numbers may sound low, as discussed previously, women completing surveys had already arrived at the clinic, and may have under-reported their experiences with obstacles related to social support, as they may have felt that they had succeeded in arriving at the clinic, and therefore any challenges they confronted along the way had not constituted 'barriers.' In addition, as mentioned previously, the quantitative surveys are optional, and it must be considered a possibility that women who felt that they had not received enough support were not as inclined to fill out surveys, perhaps preferring to just submit their required paperwork as quickly as possible, in order to get the procedure over with. Women who did receive support might have felt more comfortable completing surveys as they sat in the waiting room with a supportive partner or family member.

Of the eleven women I interviewed, all discussed social support, and the positive or negative impact it had on their overall experience of seeking abortion care. Several women were able to overcome, or did not experience, socioeconomic and logistical obstacles, but nonetheless found the process of seeking care very difficult because of hostility or mistreatment from close people in their lives. Other women found that a lack of social support contributed to delays and made other obstacles harder to deal with. For women who were very concerned about, or strongly affected by the presence of anti-abortion protesters in front of the entrance to the clinic, this form of negative input, perceived as social sanctioning or a manifestation of stigma, had a dramatic effect on their experiences of the overall process of obtaining abortion services (Kumar et al. 2009, Dudgeon and Inhorn 2004).

More than half of the women who participated in interviews discussed not receiving enough support from partners, family, or friends while seeking abortion care during this pregnancy or a previous pregnancy, and at least two women specifically mentioned being harassed by protesters. This disconnect between quantitative responses to questions about a lack of support as a barrier, to access and responses from interview participants, suggests that women who were affected by a lack of social support may have been more likely to agree to be interviewed, perhaps out of a desire to talk about the difficulties they experienced due to a lack of support. Furthermore, three of the eleven women interviewed stated that a lack of support was the biggest, or one of the biggest, obstacles to access they encountered. These three women each felt that they did not receive enough support from partners, friends, and/or family members. While this constitutes a rather small number of individual women explicitly stating that a lack of support constituted a barrier to access, participant-observation in the clinic indicates that many women share this experience of the lack of social support representing an obstacle. On a daily basis, patients at the clinic describe how a lack of support made it difficult for them to overcome obstacles, or talk about how they wish they had gotten more support in the process of seeking care. In addition, many women interviewed, and in regular interactions at the clinic, mentioned that receiving positive social support from partners or family helped them overcome financial, logistical, or other obstacles to access, and helped them initially come to a decision about terminating the pregnancy, with less anxiety.

Qualitative Responses -- Women's Experiences with Perceived Levels of Social Support

Gypsy, a thirty-nine year old recently divorced woman from the south coast, who came to the clinic for a first trimester abortion with a fairly new partner, had support from her new boyfriend (not the man who got her pregnant), but struggled with the reaction she encountered from her best friend: “It was hard, my best friend, she still isn't hardly talking to me. She's distant now, her whole attitude towards me has changed.”

Annie, from the south coast, twenty-four years old with two jobs and no longer involved with the man who got her pregnant, had a good friend who was planning to take her to her appointment, a two hour drive. Unfortunately, the friend had a family emergency the day of Annie's appointment, so Annie ended up driving herself to the clinic and back, meaning she opted not to have the sedative that is routinely given to women for the procedure, and that is contraindicated when a woman must drive herself home. For Annie, because there was only one person she felt comfortable going to for help, and that person was not able to drive her, one of the hardest things about the whole experience was the physical pain she experienced with cramping during and after the abortion:

I wasn't able to get any anesthesia, because I had to drive myself. The whole procedure was extremely painful. Not having the medication, I wouldn't recommend that to anyone!

While Annie felt that she did not have “too hard of a time over-all,” she did wish her friend had been able to drive her: "Had my friend been in Eugene, she could have picked me up from the clinic. It would have been a whole lot easier.”

Paztine, a twenty-six year old from the same community as Annie, with two kids (only the younger one lives with her), already had OHP coverage, and did not need to take time off from work or school to go to her appointment, but she told me that arranging childcare and transportation was difficult, because she had to ask her sister for help. Interestingly, Paztine's boyfriend was sitting nearby while I interviewed her, and said nothing during the whole discussion of what Paztine had to do to get a ride and childcare. Paztine told me that even figuring out gas money and money for food while traveling was difficult, but that asking for help was more difficult:

I felt bad about asking someone to take off work. Sharing that, I was worried that it's going to get out? I felt like my sister was going to give me a hard time, so that part was hard, just asking her if she'd give me a ride. Then again, "who can I ask to take off work?" and take their kids on a long road-trip. And use a car, for a couple of hours!

May, the woman from the north coast whose husband was in jail on domestic violence charges when I interviewed her, discussed negative social support and its effects during our conversation. After talking about her husband being “horrible” on the drive to and from the clinic, May told me: “I think he could have been way more supportive. I would have just liked him to be more supportive.” Lynn, a 22 year old hemophiliac with two toddlers and a previous late-term twin fetal demise, was unable to get in contact with her husband who was in the military during the time from when she found out she was pregnant until she got to the clinic, about an hour north of the small town where she lives. Based on her health history and her doctor's instructions that a subsequent pregnancy would be dangerous for her, Lynn stated that she "knew" her husband would be supportive of the decision to have an abortion, and she wanted to "get it taken care of as soon as possible." Because her husband was on a military base in Germany, on his way back to a third tour in Iraq (and undergoing testing for testicular cancer), Lynn went to the clinic with her husband's closest friend within a few days of her positive pregnancy test. So although Lynn felt that she did have some support, it was hard for her to not actually have her husband there with her: “It was difficult that my husband wasn’t there. The hardest part was being alone.”

In just one recent day at the clinic, I worked with three patients who indicated that their efforts to access care were made more difficult due to a lack of support from their partners. One young woman was agitated throughout her intake and procedure, and expressed to me that, while she was sure of her decision, she was "very upset" with her boyfriend, due to his apparent lack of concern, and failure to give her the emotional support she wanted. On the other side of the coin, women at the clinic often talk about how much it helps them to have a partner or family member who can drive them to the clinic, help pay for the procedure, care for their child(ren) while they come to the appointment, or otherwise provide logistical, financial, or emotional support.

In-depth Interviews: Clinic Staff Members' Perspectives on the Role of Social Support

Staff members at the research site agree that social support is an important factor in women's experiences attempting to access care. Two medical assistants mentioned that patients often talk about what a hard time they had getting to the clinic when their boyfriends or families were hostile or disapproved of their decision. The doctor, Liam, who has provided abortion services to Oregon women for thirty-four years, cited a lack of support as a complicating factor in women's ability to overcome other obstacles, such as transportation:

The transportation ties into whether the patients have someone that's supporting them. If they *don't* have anyone that's supporting them it's hard to ask a friend to drive them. They're kind of on their own with transportation.

The Decision – Potential Emotional Obstacle and Indicator of the Importance of Social Support

A final theme that emerged from the in-depth interviews as something that many of the women struggled with, perhaps not as a measurable barrier to care, but as something they certainly thought about, was the decision to terminate a pregnancy. All of the women I interviewed talked about being sure of their decision ultimately, but many also expressed the difficulty they had along the way, in coming to terms with their choice.

For Gypsy, recently-divorced, one of the biggest difficulties in the process of seeking care came from not being sure who was responsible for the pregnancy:

The hardest decision for me was because of not knowing who got me pregnant. I'm not normally like that, but see, I'd been married for sixteen years, so I've been living under a rock! My ex-boyfriend was very hateful, he said, "I'll never talk to you again, give it a chance, if there's even a possibility..." so that was hard.

Gypsy's current, casual ("friends with benefits") boyfriend took her to the appointment and she felt supported by him. However, hostility from the ex who actually (it turned out) got her pregnant made the over-all decision hard for her. May, on the other hand,

really agonized over her decision, wanting to have another child, but knowing that her financial situation, and her marriage, were not very stable,

It was harder this time because I didn't really have a reason other than the economy being bad and just not being able to afford it. Financially, I couldn't afford it. I'd have tons of babies if I could. It was really difficult. I wanted my husband to go with me but I told him he had to be supportive of me, and he wasn't.

While there may be little that providers or advocates can do to help women determine the best course for their pregnancies and the effects of these decisions on their lives, at the very least, clinics and other stakeholders can consistently refer women to unbiased, non-judgmental talklines. Such hotlines can help women talk through their options, and provide support to women who may feel that they otherwise do not have anyone to talk to about the decision (Backline 2010, Exhale 2010, , NRO 2010). In addition, recent research on abortion-related stigma finds that women who struggle with the decision to seek an abortion due to concerns about stigma at the community level, appear to benefit from receiving adequate social support, and that social support may help to mitigate negative health effects believed to result from stigma (Kumar et al. 2009).

Summary of Frequently-reported Barriers & Ideas for Overcoming Obstacles

Women who participated in this study found problems with Oregon Health plan applications, other financial obstacles, and a lack of social support, including difficulty with making the decision to terminate a pregnancy without such support, to be the most challenging obstacles to access. Institutional and structural factors affect women's access to funding for healthcare services, and determine which women have the economic resources to access care. Women who experienced obstacles related to a lack of financial resources often reported multiple obstacles that related to, or appeared to result from, their socioeconomic circumstance. Finally, women who described struggling with the decision to terminate a pregnancy often mentioned that

they did not get the support they sought from people in their lives. Women who perceived enough support appreciated this support in their processes of making the decision, and felt that it was easier to address this particular obstacle when they knew that their partner would support them whether they terminated a pregnancy, or carried it to term. Women who struggled with the decision and did not receive support described their disappointment that a partner or family members did not help them make the decision. Over all, women reported that social support helped them to overcome obstacles, and that for many, a lack of support was a specific obstacle they encountered.

Women seeking abortion services, and clinic staff, readily suggest ways to help women overcome obstacles to access. Many suggestions relate to helping women more easily access existing resources for funding, Medicaid coverage, or transportation. Women who reported encountering problems applying for the Oregon Health Plan were adamant that the Department of Human Services should develop a better system for expedited processing of time-sensitive applications, and that particular case managers in a given office should be assigned to communicate and follow up with pregnant women who apply for OHP, as was done in the past. These sentiments were echoed by clinic staff. Women who obtained abortion services during the course of my study, and clinic staff, also mentioned how helpful it would be if clinics and advocacy organizations could begin listing referrals for transportation and funding assistance on their websites, and/or provide flyers with local resources, to DHS offices, county health departments, and other places where low-income pregnant women might find them.

Some women who felt that they did not get enough social support during the process of seeking abortion care expressed a feeling that other women seeking care would benefit from receiving referrals to unbiased talklines. Clinic staff suggest that more proactive efforts on the part of providers and case managers to offer resources and information to prospective patients could help women overcome obstacles to care.

Ultimately, reducing the effects of obstacles to care for women seeking abortion services will require policy and community-level changes geared towards reducing structural and institutional obstacles to access, as well as increased efforts on the part of providers and advocates to help women overcome obstacles. I discuss suggestions for addressing these needs in more detail in chapter 6.

Chapter 4 -- Results: The Importance of Social Support

I wanted other people to hear me.
“Listen, just *listen*.” That’s all I need you to do.

Jada, 25 years old, survivor of domestic violence

Social support, especially from the male partner responsible for her pregnancy, and/or from biological family members, has a measurable impact on a woman's experience of seeking abortion care (Ellison 2003, Dudgeon and Inhorn 2004). Many women who participated in this study discussed a lack of emotional support from their partner or family as an obstacle to access, or mentioned that perceived low social support made it more difficult for them to overcome other obstacles. A 2004 study (Dudgeon and Inhorn) found that the reaction of a male partner to a woman's pregnancy has a significant effect on a woman's decision-making process about continuing or terminating the pregnancy, her acceptance or ambivalence about a planned abortion, and her feelings of isolation or connectedness. Ellison's 2003 study went a step beyond examining interpersonal social support on an individual level, arguing that the social environment at a community level can impact a woman's decisions and feelings about having an abortion. The author identifies social stigma affecting women who seek abortion care as a form of structural violence (Ellison 2003, Farmer 2005).

Recent research (Kumar et al. 2009) specifically addresses abortion-related stigma, suggesting that adequate social support may mitigate the negative social and health effects of stigma. The same can be argued about perceived difficulties related to accessing Medicaid programs designed to include pregnant women, such as the Oregon Health Plan. When women with the fewest economic resources experience problems accessing one of the few institutional resources theoretically available to them, this can be seen as an instance of structural violence (Farmer 2005) in which structured inequalities deprive marginalized populations of access to healthcare

services. Similarly, when a pregnant woman knows that her decision to end a pregnancy could be met with hostility or social sanctioning by her partner, family, or her community as a whole, this lack of support and perceived stigma on a broader level may be experienced as a barrier to care that results in delays in obtaining services (Kumar et al. 2009, Ellison 2003).

Major and co-authors (1990) examined perceived social support, its impact on self-efficacy, and the associated emotional processing of an abortion experience, and argued that while social support cannot be conclusively shown to directly affect a woman's level of psychological adjustment following an abortion, a woman's perception of social support prior to an abortion does affect her feelings of self-efficacy, that can in turn can affect her overall adjustment (Major et al. 1990). This study by Major et al.(1990) referred to earlier research which demonstrates the ways that perceived social support can help women experience fewer negative psychological effects from stressful life events (Cohen and Syme 1985, Shumaker and Brownell 1984, and Thoits 1986). In the context of psychological research, self-efficacy is a concept used to describe an individual's sense of how successful they may be as they attempt to carry out certain actions in specific situations (Major et al. 1990). Like the concept of agency in anthropology (an individual's efforts to change his or her own circumstances), in regards to abortion self-efficacy can be applied to a woman's feelings of confidence or trepidation about overcoming obstacles in order to access care (Major et al. 1990, Bourdieu 1977). Major and co-authors found that women with higher measured levels of self-efficacy show better adjustment to an abortion experience (Major et al. 1990). This study considered a lack of perceived social support from a partner, family, or friends as a risk factor for negative psychological outcomes related to abortion, and found that the level of support perceived from a male partner had a greater impact on women's perceptions of social support, self-efficacy, and adjustment than any other form of support (Major et al. 1990). Women who reported higher levels of perceived social support from their partners had significantly higher measures of self-efficacy and adjustment related to abortion experiences,

compared to women who perceived less support from a partner (Major et al. 1990). A recent study of abortion-related stigma (Kumar et al. 2009) found that women who receive adequate social support feel more able to cope with perceived stigma, suggesting that social support may be important for women's ability to manage a variety of emotional aspects of the process of seeking abortion care.

Impacts of *Not* Receiving Social Support

Major and co-authors found that women who disclosed their intent to obtain an abortion to a partner, family, and friends, but did *not* then receive the support they hoped for, actually had lower rates of self-efficacy and adjustment, and were more at-risk for negative mood and other markers of reduced adjustment, than women who did not disclose their decision to anyone (Major et al. 1990). These findings are echoed by a later study (Ryan and Solky 1996) that found that, for pregnant women, the psychological benefit of receiving social support depends on the quality of the relationship in which they receive the support. This suggests that for women seeking an abortion, having negative feelings towards the man who got them pregnant, or encountering opposition to the abortion decision from their parents, for example, results in greater relative distress during the process of seeking abortion care. Given the prevalence of literature suggesting that most women seeking abortion care (one estimate puts the number at 85%, Major et al. 1990), *do* inform male partners of a plan to terminate a pregnancy, understanding how a less-than-supportive reaction from the notified male partner affects women is important for abortion providers, women's health advocates, and others concerned with reducing obstacles to reproductive healthcare access (Major et al. 1990).

Furthermore, a study from the late 1970s (Bracken et al. 1978) found that women who did not tell anyone about their plans to terminate a pregnancy were happier about their decision than women who sought social support. Though not addressed by the researchers, I question whether women who did not tell anyone were already comfortable enough with their decision that they did not feel the need to seek support or perhaps avoiding the critical gaze of un-supportive friends or family made

the difference? One compelling message from these studies is that encouraging women to seek social support in the process of accessing abortion care needs to be done in a nuanced way that acknowledges the potential negative outcomes that may result if a woman seeks support and does not receive it (Major et al. 1990).

Social Support - Protesters

Research on women's reactions to anti-abortion protesters at clinics suggests that the audible and visible reminders of social stigma and sanctioning embodied in the gauntlets of picketers potentially encountered outside an abortion clinic have an intense effect on women seeking abortion care, especially as women may encounter this hostility immediately prior to seeking care (Cozzarelli et al. 2000). A study conducted by Cozzarelli and co-authors (2000) found that women who encounter anti-abortion protesters outside a clinic are more likely to experience stress and anxiety related to the process of seeking care, even if they were comfortable with their decision to terminate a pregnancy before they encountered the protesters (Cozzarelli et al. 2000). The harassment and implied threat of obstruction or interference that patients and clinic staff associate with anti-abortion protesters certainly constitutes a barrier to access, as well as an example of social sanctioning for women seeking abortion care (Guttmacher 2008, NAF 2010). In fact, during the course of my own participant-observation at the clinic, several patients were so distressed by their encounters with aggressive and physically-intimidating protesters amassed just outside the clinic entrance that these women either postponed or canceled their appointments, resulting in delays in receiving care. In addition, with the recent climate of increased anti-abortion violence directed at clinics and providers, leading up to and including the assassination of Dr. George Tiller, a well-known abortion provider, in Kansas in May of 2009, women seeking abortion care may consider the risk of violence occurring while they are at a clinic, and potentially experience this as a barrier to care (NAF 2010). Sixteen percent of women in the quantitative sample for this study reported that dealing with concerns about protesters was “very” or “somewhat” challenging for them, and many women mention the stress and anxiety caused by encountering

protesters when they arrive for their appointments. In fact, a patient I worked with while finalizing this thesis said to me, at the end of her appointment: "I wondered, what if someone comes and shoots up the abortion clinic while I'm in there?!" and mentioned how much she appreciated seeing that photo identification was solicited from everyone entering the building.

Domestic Violence and Pregnancy

Domestic violence is an extreme, but very relevant example of a circumstance where a pregnant woman might be greatly affected by a lack of social support while seeking abortion care. The preponderance of evidence in research related to intimate partner violence finds that many women in the United States, as many as 50%, experience some form of partner abuse in their lifetime, and that physical violence is most likely to begin or escalate when a woman is pregnant, or when she tries to leave the relationship (Womenspace 2000, Berenson et al.1991 and Webster et al. 1996 as cited by Bacchus et al.2006). The likelihood that women in abusive relationships will experience increased violence in a relationship while they are pregnant sheds new light on the findings of Glander et al. (1998) that abused women report different reasons for ending a pregnancy than their non-abused counterparts, and that abused women are less likely to tell their partners about plans to seek an abortion. This pattern bears out at the clinic where I conducted my research. In addition, domestic violence as a factor in abortion access may have been under-reported in quantitative surveys collected for this study, due to the stigma associated with domestic violence (Womenspace 2000). Domestic violence is believed to result in delays in the process of seeking abortion services, causing women in abusive relationships to be farther along in gestation by the time they obtain an abortion, potentially exposing them to a longer time period of increased violence, if the abusive partner is aware of the pregnancy (Finer et al. 2006).

Bacchus and co-authors (2006) investigated the impact of domestic violence on pregnant women in England, and reviewed existing literature on the topic in the course of their study. They found that women in abusive relationships may be more likely to experience an unwanted pregnancy in the first place, as an abusive relationship may

include incidents of the abusive partner tampering with a woman's contraceptive method, refusing to participate in contraceptive methods that require male involvement, or purposely impregnating the abused partner through rape or emotional coercion (Bacchus et al. 2006, Womenspace 2000). In an earlier study by Glander et al. (1998), some women reported a problematic relationship as the reason they were terminating a pregnancy. All of the participants in the study conducted by Bacchus et al. (2006) with abused women seeking abortion care had experienced physical assault during the previous twelve months, 25% of them had been sexually assaulted by their partner, and 25% had experienced miscarriages in the past that they attributed to physical violence inflicted by a partner. Beyond the logistical challenges posed by the need to obtain an abortion without arousing the suspicion or interference of an abusive partner, women in abusive situations are also more likely to report lower levels of self-autonomy, self-esteem, and confidence, possibly contributing to delays that women in abusive relationships experience in the process of seeking care (Bacchus et al. 2006). For a woman living in an abusive situation, the very real threat of increasing physical violence could be an incentive to seek abortion care as soon as possible. However, women in an abusive relationship may be more affected by multiple obstacles to access, causing delays that expose them to more violence -- a dangerous catch-22 (Bacchus et al. 2006). Knowing this, it should be acknowledged that women seeking abortion care later in their pregnancies, even into the second trimester, may be in need of later abortion services precisely because a situation of domestic violence prevented them from seeking care earlier (Guttmacher 2008, Womenspace 2000,). Ensuring access to later abortion care, for some women, could literally mean the difference between experiencing escalating abuse or avoiding increased violence (Womenspace 2000).

Oregon Women's Experiences with Support

All of the eleven women who agreed to be interviewed mentioned social support, or the lack thereof, in some form. Many described a satisfactory level of social support from their partners, although one woman, Paztine, did so despite her

partner's apparent disinterest in her experience, or at least, in her interview. After describing the difficulties she had getting to the clinic, Paztine gestured at her boyfriend, who sat silently staring at a loud television screen throughout the interview, and said, "well, obviously *he* knew about it." While Paztine stated that she received support from her partner, she discussed how difficult it was to ask her sister or other family members for logistical help, due to her concerns that they would give her a hard time. Another woman, Gypsy, a patient I had worked with when she came to the clinic for her procedure, did tell her fairly new partner about her intent to seek an abortion, and felt that he was supportive, although she reported that they "didn't talk about it much." However, his unspoken support was overshadowed by the hostility and disapproval she described experiencing from her best friend.

Gypsy, thirty-nine years old, recently-divorced, and mother to two sons in their late teens or early 20s, cried as she described how her best friend from high school, and current housemate, tried to make her feel guilty about terminating a pregnancy, to the point that Gypsy said they now barely talk. In fact, this very friend showed up at the cafe in a small town on the southern coast of Oregon where Gypsy and I met to do the interview, and when the woman sat down with us, she spent the entire five minutes she was there talking about friends' babies, Gypsy's son's young child, etc. For Gypsy, the lack of social support from someone she "thought would be there" for her was a very difficult aspect of the process of attempting to obtain an abortion.

Similarly, May, a twenty-six years old with three living children and a previous child who died shortly after birth, informed her husband of her pregnancy and intent to terminate it. He reacted with hostility and tried to talk her out of having an abortion, despite their shaky economic circumstances and recent tensions in the relationship. May described the drive to and from the clinic (a three hour drive for them, as they traveled from a small town on the central coast of Oregon), and mentioned how her husband was berating her for the decision to have an abortion on the way there and the way back. May and Gypsy were unhappy with the levels of social support they received during the process of seeking abortion care, and they also seemed to be the

most upset about the process in retrospect. They stated, as did all the women I interviewed, that the abortion was the "right decision" for them, and that they did not regret it, but both Gypsy and May were still angry and hurt over the hostility and negative reactions they encountered from those close to them.

Table 4.1 Survey Data on Perceptions of Support (Ostrach M.A. data)

Social Support	Ostrach M.A.
Lack of partner support "very or somewhat challenging"	11%
Lack of family support "very or somewhat challenging"	12%+
Concerns re: protesters "very or somewhat challenging"	16%+

Table 4.2 Interview Participants' Perceptions of Support (Ostrach M.A. data)

IDI #	Pseudonym	Relationship status	Perceived enough support?
1	Madeleine	Boyfriend	Yes
2	Gypsy	Casual	No
3	Alice	Boyfriend	Yes
4	Annie	Casual	No
5	Paztine	Boyfriend	No
6	May	Husband (abusive)	No
7	Lynn	Husband (in Iraq)	No
8	Jada	Boyfriend	Yes
9	Evangeline	Boyfriend	Yes
10	Virginia	Boyfriend	Yes (this time)
11	TeeJay	Casual	Yes

For other women I interviewed, receiving positive support and understanding from someone in their lives, whether it was a partner, their mother, a sister, or close

friends, made a big difference in their over-all sense of ability to overcome obstacles to access. As Jada, twenty-five years old, said, “I wanted other people to hear me. 'Listen, just *listen*.' That’s all I need you to do.” Women who had to travel to get to the clinic found this less difficult when a partner or family member was available to drive them and go with them. Women who had to raise funds to pay for the abortion were less “stressed-out” by that aspect of the process when a partner or family member was willing to help pay or help them find funds. Women who reported difficulty with getting on the Oregon Health Plan stated they dealt with the anxiety and uncertainty related to waiting to find out if they would be approved more easily when there was a partner or support person around who they could talk to about it. Two women, Madeleine and Annie, ages twenty and twenty-four respectively, who did not have a partner or family member with them during the abortion procedure itself, even mentioned that just having their mother know about the situation was helpful to them. Madeleine and Annie also reported that when they called their mothers to tell them about their pregnancies, both mothers had already known or "had a feeling" that their daughters were pregnant. These stories of intuition and connection with their support people may have been told as a way of acknowledging and affirming the gratitude women feel for their support system.

Clinic Staff Perceptions of the Importance of Social Support

Clinic staff agree that social support seems to help women overcome obstacles encountered in the process of seeking abortion care. As Melanie, a long-term medical assistant who works with many of the patients who are farther along in their pregnancies and may have faced more obstacles, suggests: "What helps is to have someone to go with you, or go through it with you. Just finding a support person to be with you, and to get you there. " Dr. Liam, the clinic physician who has provided abortion services to Oregon women for thirty-four years, observed how social support can help women get to the clinic and deal with the experience of the procedure itself. In our interview, he repeatedly mentioned his belief that having a supportive helpful person with them "makes a big difference" for patients. Furthermore, Dr. Liam often

encourages patients who are struggling with funding or other logistical issues to seek support from someone, if they haven't already: "Sometimes if they're young, we encourage them to go to their parents. Getting some support, finding a good person to talk to is important."

Institutional Support – Can case managers make it or break it for women?

Among the nine women who applied for Oregon Health Plan, applied to have it renewed if they had already had it in the past, or who had to verify that they were still covered, the level of support and response they encountered from state-paid case managers had an enormous impact on the time it took for these women to be able to get to the clinic for an appointment. This form of support also affected women's perceptions of the stress and difficulty involved in seeking abortion care. While the Department of Human Services website and Worker Guides (available online,) state that case managers have up to forty-five days to process Oregon Health Plan applications, in practice some DHS offices have staff members who expedite applications for pregnant women with upcoming medical appointments. However, other women frequently report encountering case managers who are hard to communicate with, or who they perceive to be deliberately stalling the application process (NRO 2010).

Madeleine, the first woman I interviewed, initially learned about Oregon Health Plan coverage for pregnancy-related care, including abortion, soon after her first positive pregnancy test, and she applied for an OHP medical card when she was still early in the first trimester. Madeleine told me that waiting to hear back about her eligibility and trying to contact her case manager delayed her far enough into her pregnancy that she was at thirteen weeks gestation, early in the second trimester, when she finally got approved and came to the clinic. Madeleine, a twenty-year old woman with two part-time jobs, and from the same county as the clinic, went into the DHS office several times, and called "multiple times everyday," over a period of two weeks, to confirm that her application had been received and processed. She tried to find out how long it would be until she was approved so that she could schedule time off from

work and arrange an appointment at the clinic. Madeleine told me that she felt she was “treated like a piece of paper” rather than a person, while she tried to navigate the Oregon Health Plan application process.

In an example of even greater delays occurring due to OHP confusion, May, the woman from the north coast who was in a rocky relationship, told me she contacted her case manager to see if she was still covered by OHP from her youngest son's birth seven months earlier. As described previously in chapter 3, May reported it took almost three months to get confirmation that she was still covered by OHP. In her case, the confirmation did not come from the case manager she had been trying to track down over the phone and by visiting the DHS office. Virginia, a twenty-five year old from Lane County with one child who does not live with her, reported that she had applied to have her medical card reinstated for a previous pregnancy, but was told that because she had initially been approved in one southern county, and had since moved to a larger county where the clinic is located, it would take “several months” for her case to be transferred over, despite her willingness to resubmit all the necessary paperwork. For the women who shared stories about a lack of communication, misinformation, or delays related to receiving or confirming their OHP coverage, these experiences contributed to a common perception that state employees were deliberately stalling and trying to make it more difficult for them to obtain legal, state-funded abortions, thereby creating an unnecessary barrier to access.

In contrast, four women living on the south coast of Oregon had great experiences with a woman at the county health department in their county who helps pregnant women apply for OHP, arrange prenatal care or abortion appointments, and generally has a reputation among patients for being warm and friendly (, NRO 2010). Gypsy, Annie, Paztine, and Alice each spoke with a county health department employee who coordinates their region’s branch of the Department of Human Services Title X-funded Oregon MothersCare program. This particularly helpful county health employee, Roxanne (a pseudonym), assisted these women as they applied for their OHP medical cards (for this most recent pregnancy or for a previous pregnancy), in

some cases actually submitting the paperwork for them. Each of these women were referred to the county health department by a provider who conducted their pregnancy tests. During interviews, all described Roxanne's support as being crucial to their ability to get on OHP and get to their appointments. In addition, Poppy and Melanie, medical assistants at the clinic, talked about the importance of state and county employees who help women overcome obstacles to abortion care by advocating for and supporting them without apparent judgment or bias.

As part of the outreach and dissemination preparations for this study, I recently spoke with Roxanne, and she gave me permission to describe her position and the work that she does. As a "Public Health Aide III" for her county, Roxanne's position as an advocate and case manager for low-income pregnant women is funded by the state through the MothersCare program -- a program which she believes is available in every county. In her area, the local Health Department branch applied to have MothersCare funding within their office, and Roxanne has been in that position for eight years. Roxanne asserts that problems with Oregon Health Plan applications increased when the state Department of Human Services began checking citizenship status, as stipulated by the REAL ID Act in 2005 (JWJ 2008,). Roxanne stated that case managers at DHS were originally directed to not approve medical card applications until citizenship had been confirmed, but that her understanding is that DHS case managers now have the option of approving OHP medical cards pending citizenship confirmation, so that women can use the medical card during the time that a birth certificate or other documentation is being ordered and mailed. This was confirmed by the DHS policy documents I received, however it is unclear if case managers are consistently informed of this option .

In addition, Roxanne commented that when she refers pregnant women to DHS to apply for Oregon Health Plan, she often takes the time to discuss the required paperwork with them, going so far as to call the county where the pregnant woman was born to find out how long it will take for a birth certificate to be mailed, and to try to get it sent more quickly. This level of proactive engagement in the advocacy process

by case managers appears to be a rarity, based on the experiences reported by study participants. Roxanne believes that: "DHS case managers have the option of expediting OHP applications from pregnant women, but they don't *have* to." According to her, expediting an application for OHP is entirely at the case managers' discretion, and subject to individual case managers' opinions about abortion. This was essentially confirmed by a Department of Human Services Policy Analyst in electronic correspondence, however case managers are theoretically instructed to process applications from pregnant women "within one business day". The DHS web-based Worker Guides that OHP case managers use to interpret policy guidelines and to ensure compliance with application requirements do not make it clear what the mandatory and optional time lines for verifying eligibility are. Based on women's stories about attempting to obtain OHP coverage, it appears that many DHS case managers are not informed that they can, and should, process OHP applications from pregnant women within one day. Given state budget and workload constraints described by DHS policy analysts and other spokespeople from the DHS administrative staff, it is also possible that even those case managers who are aware of the one-day timeline for pregnancy-related applications may be too overworked to implement it.

Finally, Roxanne described a new DHS requirement that women applying for OHP must apply for unemployment benefits before their applications are processed, even when women have recently quit a job or otherwise appear to be ineligible for unemployment benefits. She believes that this results in delays for women in need of OHP coverage for abortion and prenatal care.

Support for Overcoming Financial Obstacles

Two women in the qualitative sample who did not apply for or use Oregon Health Plan to pay for their abortion procedures nonetheless described stressors and problems related to the cost of the procedure. Evangeline, a twenty-year old theater student from Lane County whose quote appears at the beginning of chapter one, knew that she was covered on her parents' private insurance plan, and therefore, would not

be eligible for OHP. Evangeline independently checked to see that her parents' insurance would cover her abortion, but was concerned about raising money for the required co-pay of several hundred dollars. Evangeline told me that while her boyfriend was very worried about what they would do, and considered selling his car, Evangeline herself was confident that her parents would help her with the money. However, she was hesitant to ask her parents for help due to her father's chronic health problems and high stress level. Ultimately, she told her mother that she needed money for an insurance co-pay for a "gynecological" appointment, and while the actual purpose of the appointment remained largely unspoken, her mother gave her the money, under the guise of "money for textbooks." While Evangeline stated that both she and her boyfriend were very anxious about raising the money, she also mentioned that they knew they could have gotten the money from a family friend, or from her boyfriend's mother, "if it had come to that." Evangeline explained that she could have raised the funds needed to pay cash for the procedure if she had lacked insurance. However, this did not appear to assuage the anxiety about funding that she experienced prior to her appointment.

TeeJay, forty-two years old with two grown children and a grandchild she helps to care for, had insurance coverage through her work. However, she reported that she did not check to see if it would cover her abortion procedure because she knew she could not meet the deductible that would preclude coverage until it was paid. Instead, she and her partner, a close friend but fairly casual boyfriend, discussed taking out loans, as neither of them wanted to ask their families for money. TeeJay explained that her boyfriend offered to find all of the money on his own, while she offered to split the cost. She was nonetheless relieved when he insisted on taking full responsibility for the financial aspect of it, since "[she] was the one who had to physically go through it." However, TeeJay still found the experience of waiting to hear if her partner's loan was approved stressful, and said that, "the money was the first thing" they were concerned about, after the decision of whether to terminate the pregnancy or not. In both cases, Evangeline's and TeeJay's anxieties and concerns about the financial

obstacles were made easier to deal with because of the support they received from their partners, and because they each had the sense that there would be someone that would help pay for their appointment, one way or another. In fact, Evangeline, TeeJay, and Madeleine all reported that going through the stress of overcoming obstacles to access with the support of their partners, and seeing the efforts these men made to help them, tested and strengthened the relationships. TeeJay felt that she was able to evaluate the relationship in a new way: “I think we both know that we've been through a lot together now. If anything, I think we grew stronger.”

Oregon Women's Experiences with Protesters

May, the woman from the north coast whose husband was unhappy about her decision to get an abortion, told me that she was bothered by the protesters who crowd the entrance to the clinic on a daily basis, but mostly out of concern for several younger women who were coming in behind her. May said that the presence of the protesters made her reluctant to walk up to the door, and that her husband told her to just ignore them. May heard the protesters harassing several girls who came in around the same time, and thought: “That's harsh! You would think they [the protesters] would have their own lives to worry about!” Similarly, Lynn (a twenty-two year old from southern Oregon with two kids under the age of two and a husband in the military in Iraq) was distressed by the presence and behavior of anti-abortion protesters at the clinic on the day of her appointment. Lynn, who considers herself “anti-abortion,” had experienced the fetal demise of twin boys late in the second trimester about six months prior to her abortion. That earlier pregnancy had been a “wanted pregnancy” that ended in major health complications and surgery under general anesthesia to terminate the incomplete miscarriage. Lynn's most recent pregnancy was the result of a birth control failure while her husband was home on leave for sixteen days, and while she would have liked to carry the pregnancy to term, her regular doctor told her it would be unsafe to do so, given her hemophilia, and effects of the recent late-term fetal demise. Given that Lynn already felt conflicted and upset about the circumstances of her abortion appointment, encountering the protesters at the clinic was “horrible” for her.

Lynn was particularly bothered by the fact that the protesters tried to talk to her almost-two year old daughter, who she had to bring with her because she could not find childcare.

Jada, a recovering heroin addict with two kids (only the younger one lives with her) did not encounter protesters at her most recent appointment, but told me a story about an encounter with anti-abortion picketers in California that occurred when she went to a clinic for a pregnancy test during an earlier pregnancy. As Jada explained:

Where I took my pregnancy test before I miscarried, there were so many protesters! There was a huge truck, and the back of the truck was a billboard-size picture of an aborted fetus. It was fucking crazy. I was like “*Ohhh, my god!*” That was big stuff.

For Jada, this previous experience with anti-choice protesters gave her a negative feeling about abortion for many years afterward, and made her afraid of what would happen if she ever had an abortion. Evangeline, on the other hand, reacted to the protesters at the clinic with indignation, rather than feeling stigmatized (Ellison 2003, Finer et al. 2006). She did not see protesters on the day of her appointment, but saw them from the bus, passing in front of the clinic a few weeks later, and in her words:

I got off at the next stop, and walked back and I marched right up to them and I said, "Okay, I appreciate your first amendment rights to be here, but I'm going to exercise *my* first amendment rights and say that I feel like what you're doing is obscene and you should not be here!" You know, this is a health center, women come in here for ultrasounds! Men come in here for *vasectomies!*

Evangeline told me that she tried to engage the protesters in conversations about “choice, responsibility, and who gets to decide what a woman should go through, or what a child goes through when it's born to parents who aren't prepared to raise it.” She felt that they mostly repeated “stock rhetoric and propaganda,” and were unwilling to respond to her immediate concerns about quality of life, “the impact on our planet's

resources," and on children themselves when women are pressured into having children they are unable to care for. Evangeline suggested that growing up in a pro-choice family, and having a supportive partner, made it easier for her to dismiss the protesters' harassment. Evangeline felt aware that other women might have been more affected by the comments from picketers lining the doorway, and stated that her level of confidence in her decision might not be typical of other women seeking care. Evangeline emphasized that while she mostly wanted to make the protesters think about what they were really accomplishing by harassing women seeking care, she realized that other women coming to the clinic might find the gauntlet of picketers very intimidating and upsetting. Based on my observations at the clinic, Evangeline's indignation and comfort level with confronting the protesters is unusual, as many women who interact with the protesters on their way in mention to the receptionist or medical assistants that they find the harassment at least disconcerting, and at worst overwhelming and traumatic. This speaks to the relevance of recent research on abortion-related stigma, that suggests harassment by protesters, family, or friends regarding an abortion decision can have negative mental and physical health effects (Kumar et al. 2009).

Domestic Violence among Study Participants

Domestic violence as an obstacle to care was discussed explicitly and implicitly during interviews and patient intakes, with stories of abuse forming both the text and the subtext of many women's abortion narratives. One story shared with me during my participant-observation dramatically illustrates how domestic violence can serve as a barrier to abortion access. A woman arrived at our clinic after traveling from a part of southern Oregon that borders California. She came in very late in the second trimester, within just a few days of being too far along to have an abortion at our facility, or in the state of Oregon, period. She arrived with visible hand print-shaped bruises around her throat from her husband's most recent beating. Twenty-four weeks pregnant when she finally came in, she explained that she had been trying to get to the clinic since eight weeks gestation, but that she "had to wait until [her] husband beat [her] badly

enough" so that the local police, apparently jaded or unconcerned about the history of abuse towards this woman, would "actually arrest him [the husband]." This woman had literally tried to provoke the next beating, hoping that it would be 'bad enough' that the police would respond to neighbors' phone calls for help. She needed to be sure her husband would be in jail for enough days in a row that she could take the kids to her mom's house, borrow money to put gas in the car, and drive to the clinic -- all steps that she was confident her husband would have directly interfered with. This story echoes in a profound and heartbreaking way the literature on delays in receiving care that result from domestic violence or harassment (Bacchus et al. 2006, Finer 2006).

While May did not explicitly describe her relationship with her husband as abusive, she arrived late to our interview because she had been trying to post bail for him after he had been arrested the week before on charges of attacking her with a knife. May stated that they had gotten into a drunken fight, and that she did not remember him hitting her or attacking her, but that her husband told police he "slapped" her. May described past relationships as abusive, and told me that her oldest daughter's father had gone to prison, partly on domestic violence charges. From previous research on domestic violence, it is well-documented that women who have been in abusive relationships in the past may be more at risk for subsequent abusive relationships (Womenspace 2000, Bacchus et al. 2006).

Both Jada and TeeJay described past abusive relationships in which they had been beaten or otherwise abused during pregnancies, and Jada said that her current boyfriend's unwavering support of her choice, and his willingness to back her up either way, helped her to realize how she actually "deserves" to be treated in a relationship, in marked contrast to the treatment she received from her past abusive partner. As Figure One (chapter 5) illustrates, this study found that social support helps women overcome obstacles -- conversely, a lack of support, and outright coercion or hostility from a male partner, can pose obstacles, and make it more difficult for women to overcome other obstacles. Women in this study who described abusive, unsafe, or un-supportive treatment from male partners not only struggled with these reactions at an immediate

level, but also described increased difficulty dealing with other challenges that arose in the process of seeking care. Difficulties were compounded by the abuse or lack of support. Based on the interviews with women who had dealt with domestic violence in the past, or who seemed to be currently experiencing it, as well as participant-observation in the clinic, an important sub-theme in this study is one of experiences with domestic violence serving as a predictor of negative or inadequate social support, rather than functioning solely as logistical or material obstacles to access. As discussed in chapter three, previous research (Bacchus et al. 2006, Finer et al. 2006) found that domestic violence can result in delays in the process of seeking abortion care. In addition to this trend, unsafe relationships also serve as a primary obstacle by causing women to feel isolated and less supported as they attempt to overcome other obstacles to care.

While the issue of domestic violence arose in only three of the eleven interviews, participant-observation in the clinic suggests that many women make decisions about seeking abortion care based on an internal evaluation of their level of personal safety in a relationship. Women arriving at the clinic frequently describe engaging in an assessment of how continuing the pregnancy might escalate or contribute to existing tensions with a partner. Women often talk about difficulties related to reaching the clinic, or their concerns about coming in for an appointment later in pregnancy, and many women attribute these situations to a lack of support, or opposition, from an abusive or un-supportive partner during the process of making arrangements and overcoming obstacles. Women describe how a lack of support, or outright hostility, relates to financial and logistical obstacles, such that women with fewer economic resources appear to find a lack of support to be a relatively more difficult obstacle to overcome, as compared to women with greater resources for overcoming obstacles. This topic certainly deserves further study, given the implications for improving abused women's safety during pregnancy, and better meeting the social support needs of abortion patients.

Clinic Staff Perceptions of Social Support

Interviews with clinic staff informed my research on the ways that patients at the clinic overcome obstacles. One medical assistant, twenty-seven year old Poppy, who had been a patient at the clinic prior to her employment, described her perception that many of our patients overcome transportation obstacles by asking for help from friends and family, thus seeking social support and practical assistance out of necessity, rather than because they really want to disclose their situation. As Poppy said: “I think that they overcome the transportation barrier by verbalizing their need to get an abortion, to get help.”

This medical assistant's own experiences seeking abortion services affect how she approaches her work as a medical assistant now. In our interview, Poppy described to me how at age fifteen, she had to ask for help getting to a clinic that was an hour and a half from where she lived, and ultimately had to get a ride for the initial consultation from her much older boyfriend, who was "very anti-abortion" and “pissed-off [at her.]” She then had to ask a friend, who only had a learner's permit and should not legally have been driving, to take her to the actual procedure. Poppy felt that she could not tell her mother at the time and was dependent on a few people to help her deal with the situation. Poppy's memories of not feeling supported by the staff at the clinic where she went as a patient when she was 15 were echoed in a story she told me about one of the patients whom she had supported the day of our interview. A twenty year old woman, pregnant for the first time, who had initially called another gynecologist's office to ask questions about whether the procedure would be painful. She was met with the receptionist's cold response: “Well how would *I* know? *I've* never had one!” This patient told Poppy how she [the patient] was told to go into that office for a consultation if she wanted any information, and at the end of the appointment, the doctor, who knew full well that she wanted an abortion, said: “Well, congratulations, I guess.” Poppy felt strongly that the patient ultimately decided to have her abortion procedure performed at our clinic, because, in contrast to how she

was treated at the other office, when she called our clinic she was “greeted with dignity and respect.” Speaking from nearly three years of experience working at the clinic, Poppy highlighted the same themes that patients brought up in interviews -- the importance of social support in helping women to overcome financial and logistical obstacles to access, and in dealing with perceived stigma about an abortion decision.

Melanie, a medical assistant whose many years of experience working with our patients resulted in her recent promotion to clinic manager, pointed to the need for women to have enough time to figure out how to overcome obstacles to access, “figuring it out, thinking about it, and just using their resources... find(ing) the strength to ask for what they need.” I asked Melanie what factors, in her opinion, make the difference between women who are able to figure out how to overcome obstacles to access more quickly, versus women who take longer, and come to the clinic further along in their pregnancies. She responded that the amount of support a woman has makes a big difference:

If you have a partner that's supportive, who says, "You know, we can figure this out together," having somebody that's really on your team. Two people is better than one to figure out, a *way* to figure it out! If not a partner, then a mom, or a dad, or a family member, or a friend, who is close enough to rally for you.

Just as patients described during interviews, this long-time clinic employee observed that women who have adequate social support are better able to overcome obstacles to abortion access than women who feel that they do not have enough support. Melanie also felt that clinic staff, at our clinic or other facilities, as well as DHS caseworkers and other social workers and care providers, could do more to make it easier for women seeking abortion care to get the information and assistance they need:

If the first person a woman talks to says: “You can use a credit card, here's how to apply for OHP, there are three networks that do funding, here's what you need before you call them.” Even a sheet with resources. “Here's what you need to do before you even go to OHP, here

are the qualifications, if you don't qualify, then call these numbers.” Having enough time to just give a little bit more information about all of your options, or having it on our website would help!

Melanie and I discussed our clinic's plan to disseminate information on resources for funding and other ways to overcome known obstacles to access on the clinic's website -- a step that she feels will help some women overcome logistical and financial obstacles. I asked Melanie what she thinks DHS or other public agencies that work with pregnant women and women in poverty could do to better help prospective patients. This led to a discussion about how great it would be if there was a woman like Roxanne in every county and DHS office. Melanie suggested we *clone* that particular county employee, and then in a more serious tone, commented: “DHS offices should just have somebody who is on-board [pro-choice] on their staff, in every office, to help women!”

The Importance of Social Support

Women in need of abortion care report seeking emotional and logistical support to deal with challenges related to funding the procedure, travel, time off, expenses, childcare, concerns about protesters, and uncertainty about their decision. Social support may be sought from partners, family, friends, and/or institutional representatives including case managers, clinic staff, and county health department employees. When women perceive that they receive enough social support during the process of seeking care, this support seems to help them overcome obstacles to access, and largely shapes their over-all perception of the experience of negotiating access to care. For women who seek support and do not receive it at the level they hoped for, or who encounter violence, hostility, harassment, or delays related to a lack of support from partners, family, friends, or institutional personnel who function in a support capacity (such as case managers), this lack of support makes the entire process of seeking an abortion more difficult, often resulting in delays and increased feelings of anxiety and stress.

Women dealing with domestic violence or an unsafe relationship may be particularly at-risk of experiencing delays or interference, making them more likely to arrive at a clinic at a later gestation. For this reason, ensuring access to second-trimester (and later) abortion services is important for protecting abortion access for women potentially affected by more extreme scenarios of inadequate social support. With an awareness that institutional sources of delay, including problems with the Oregon Health Plan eligibility verification process, also appear to push women into later gestational ranges when services are harder to obtain, improvements at the institutional level could ideally result in an increase in structured forms of social support potentially provided by case managers and other institutional representatives. Finally, the potential negative impacts on women who are harassed by protesters when arriving at a clinic can affect their ability to feel able to proceed with their appointments, and may influence the levels of stress and anxiety they feel throughout the process. This is another important consideration for clinic staff who may have the opportunity to buffer or mitigate women's interactions with protesters.

Understanding how women are affected by seeking support and not receiving it is important for abortion providers and women's health advocates, as well-intentioned attempts to encourage prospective patients to seek support could benefit from being delivered in nuanced, appropriate ways that consider both the benefits of receiving support, and the risks of seeking it and not receiving it. In general, women seeking care, and clinic staff, agree that providers and women's health advocates could, and should, do more to help women find sources of social and institutional support, in order to successfully overcome obstacles to abortion access.

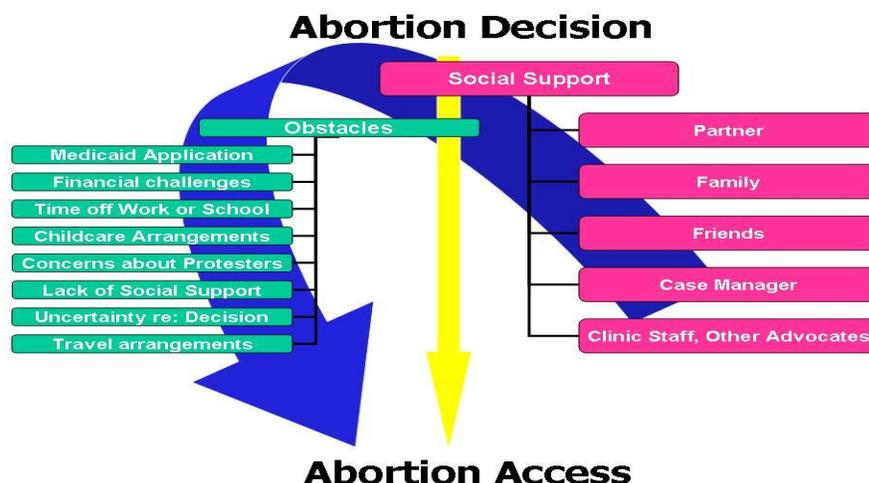
Chapter 5 -- Discussion

Women should just work around [the Oregon Health Plan application process] and beat the system that way. It would help to inform people of what they need to do, and how to take control of the situation, and what they can do to take care of *themselves!*

Madeleine, 20 years old, delayed into the second trimester of her pregnancy while waiting for Oregon Health Plan

Findings from this study indicate that many women in western Oregon encounter obstacles as they seek abortion care. As the Grounded Theory concept map below (Figure One) diagrams, these obstacles consist of difficulties related to getting Oregon Health Plan coverage (and other economic challenges), the need to arrange time off from work or school, travel, childcare, a lack of social support, uncertainty about the decision when faced with inadequate social support, and concerns about the presence of protesters at the clinic. Women described progressing from the decision to have an abortion, to successfully accessing abortion services, by overcoming obstacles with the assistance of various forms of social support from partners, family, friends, and/or institutional representatives such as case managers, clinic staff, and other advocates.

Figure 1 - How Social Support helps Women Overcome Obstacles to Abortion Access



While transcribing and coding the in-depth interviews from this study, I noted that all of the participants had encountered some kind of logistical, economic, and/or social obstacle already recognized in published literature as a “barrier” to access (Guttmacher 2008, Jones 2005). As I utilized a Grounded Theory approach (Charmaz 2000) in the collection and analysis of in-depth interview data, an important connection between perceived social support and women's sense of their ability to overcome obstacles to abortion care emerged. Conversely, a lack of social support makes it more difficult for women to overcome obstacles. Quantitative data informed my analysis of the interview data by revealing that most women seeking abortion care during the period of this study were economically disadvantaged, few received education beyond high school, and many were already raising children. These factors suggest that most women seeking abortion care at the research site had likely already encountered socioeconomic and/or social obstacles (Marger 2008, Guttmacher 2008). Synthesizing the quantitative and qualitative data on obstacles encountered and the role of social support paints a picture of women in western Oregon who experience and negotiate financial, logistical, emotional, and other obstacles to abortion care. Furthermore, women assert their agency and overcome obstacles during the process of seeking care by asking for social support from a myriad of people in their lives.

Obstacles Encountered and the Role of Social Support

Specifically, women in western Oregon described difficulties receiving Medicaid coverage (Oregon Health Plan) to pay for abortion services, dealing with other financial and logistical obstacles, a lack of social support, and ambivalence about their decision to terminate a pregnancy (often due to a lack of social support), as the most challenging obstacles to care. Obstacles often overlap and intersect, compounding the challenges that women deal with. Women in this study described how adequate social support helped them deal with challenges they faced in the process of accessing abortion services. Women who participated in interviews also described their perceptions that Oregon Health Plan case managers, clinic staff, and

other advocates for women's healthcare could do more to reduce obstacles to care and help women overcome obstacles by doing their job in a way that offers social support at the institutional level.

On an individual level, women who struggled with the decision about whether or not to terminate a pregnancy reported that a lack of social support from partners, family and friends, and/or overt harassment by protesters added to their feelings of confusion, ambivalence, and uncertainty. While the clinic that served as my research site prefers not to provide services to patients who are unsure of their decision, and all patients participate in an extensive informed consent counseling process, there are still occasions when women arrive at the clinic expressing uncertainty. When this occurs, women are encouraged to take time (if possible) to evaluate all factors, and to seek support, if appropriate. These patients often mention that the decision-making process would be easier if they had more support, or if protesters outside the clinic had not singled them out for harassment. Recent research on abortion-related stigma (Kumar et al. 2009) shows that women who struggle with the abortion decision because of perceived stigma often suffer negative mental and physical health effects, and that social support helps to mitigate these effects. Kumar's work echoes themes found in my study including the critique levied by abortion patients that providers and advocates need to do more to support women in the process of seeking care. This is especially so for those most affected by perceptions of stigma or inadequate social support.

"Barriers" to Access?

Data from anonymous surveys initially appeared to conflict with qualitative interview data, as all of the women who volunteered to be interviewed described obstacles that affected their ability to access abortion care, while only thirteen percent of women completing the surveys responded that they encountered "barriers" while seeking abortion care (question 15, Appendix A1). In subsequent survey questions, responses indicate that a significant percentage of women, as high as 42% (depending on the barrier) reported that *certain* barriers were "very or somewhat challenging."

While women may under-report experiences with obstacles as a broad category, a significant percentage of women completing surveys reported specific obstacles as challenging in their overall process of seeking care.

Table 5.1a Qualitative Responses Related to Perceived Barriers and Social Support (Ostrach M.A. data)

IDI #	Pseudonym	Perceived adequate support?	Biggest barrier?
1	Madeleine	Yes	OHP
2	Gypsy	No	Decision & support
3	Alice	Yes	Transportation
4	Annie	No	Driver, no meds.
5	Paztine	No	Childcare, driver
6	May	No	OHP, support
7	Lynn	No	Childcare, support
8	Jada	Yes	Decision
9	Evangeline	Yes	Money
10	Virginia	Yes (this time)	OHP (other times)
11	TeeJay	Yes	Money, decision

Table 5.1b Quantitative Responses Related to Perceived Barriers (Ostrach M.A. data)

Perceptions of Barriers	Ostrach M.A.
Women who reported they encountered barriers	13%
Found specific barriers “very or somewhat challenging”	
Cost of the procedure	42%
Travel arrangements and costs	27%
Difficulty getting Oregon Health Plan or waiting for OHP	25%
Concerns about harassment by protesters	16.8%
Time off work and school	16.7%

Lack of family support	12.4%
Lack of partner support	11%

To understand the apparent discrepancy between the lower level of perceived barriers reported in the anonymous surveys, and the experiences of women who participated in interviews, it is important to consider that survey respondents were given the surveys upon their arrival at the clinic. As respondents had already succeeded in reaching the clinic, any obstacles they encountered may not have been interpreted as "barriers," since they were in fact able to obtain the procedure. Another possible explanation may be sampling bias -- that is, women who volunteered to participate in the interviews were potentially more likely to have encountered significant obstacles than the rest of the population utilizing services. Interview participants may have, as a result, been more inclined to talk about their experiences with "barriers." Again, more work is needed to think through and correct for any biases introduced as a result of the timing of the survey. Since the clinic is limited by the legal and professional need to maintain confidentiality, the ability to collect data is likely to continue to be constrained to the waiting room. A closer examination of language – for example, using the terms “trouble,” “difficulties,” or “challenges,” instead of “barriers” – may allow for more accurate assessments. This finding has been shared with the clinic, in order to facilitate adjustments to the survey tool, for possible future data collection.

Finally, while certain challenges did not seem to constitute significant obstacles for many of the women completing anonymous surveys, the 40% of respondents who found the cost of the procedure "very or somewhat challenging" suggests that financial concerns were obstacles for nearly half of women seeking abortion care during the data collection period: a finding confirmed by in-depth interviews. It is estimated that 13% of Oregon's population lives below the Federal Poverty Line (US Census 2010), but survey findings indicate that as many as 40% of women seeking abortion care during the study period fell in this very low-income bracket. Taking into consideration the possibility of a sampling bias where women with fewer economic resources may

have been more likely to complete surveys, this data nonetheless suggests that the experiences of women in the study are relevant to the question of how socioeconomic inequality affects access to healthcare.

Critical Medical Anthropology: The Role of Structural Violence in Women's Experiences with Obstacles to Access

Women from all income brackets and social-class categories utilize abortion services, but current literature and data from this study suggest that women disproportionately affected by structural inequalities encounter more obstacles to care, and have a harder time obtaining services (Jones 2005, Guttmacher 2002, Henshaw 1995). Given the majority of women in the study who were of lower SES, or even below Federal Poverty Level, and their perceptions of increased obstacles to access, this study confirms earlier research that found women in poverty and from other marginalized populations encounter more barriers. Furthermore, the in-depth interviews revealed women's stories about the degree to which socioeconomic challenges affected their perceptions of the overall process of seeking care. In the qualitative portions of this study, women dealing with poverty or other forms of social inequality reported more difficulty dealing with obstacles to access, and described a greater need for social support to overcome barriers.

Focusing on specific delays experienced in the Medicaid (OHP) application process, women whose income is low enough to make them eligible for Oregon Health Plan are among the most marginalized people in the state by virtue of their poverty alone (Marger 2008, Census 2010). Due to the liminal status of pregnant women in need of healthcare, as well as the logistical difficulties experienced by women applying for Oregon Health Plan coverage, economic obstacles to abortion services that result from delays in the OHP application process can be seen as a form of institutionalized violence against women. Structural violence maintains and perpetuates disparities in access to reproductive healthcare (Farmer 2005), while state policies, as interpreted and enforced by state employees, allow institutionalized control over low-income women's lives. This, according to participants, leads to

feelings of helplessness and frustration especially for those who applied for Oregon Health Plan coverage. When a woman living below the Federal Poverty Level is delayed into the second trimester of pregnancy while waiting for her Department of Human Services case manager to process an OHP medical card application (or even just call her back), she may be forced to obtain a more-complicated and time-consuming abortion at a later gestation (Guttmacher 2008). The resulting stress, anxiety, and potential economic losses constitute additional forms of structural violence (Farmer 2005). This disparity-perpetuating dynamic may be observed whenever low-income and otherwise marginalized women continue to experience more substantial delays and obstacles during the process of seeking abortion care, as compared to their relatively more economically privileged counterparts. Women who participated in interviews frequently described a perception that their ability to overcome funding obstacles, by getting OHP coverage, was constrained by delays in the application process that they see as resulting from Department of Human Services policies and verification time lines.

Using a Critical Medical Anthropology perspective to examine women's experiences with obstacles to abortion access was appropriate to this study due to the role of structural violence and unequal power relations in creating barriers to access, and this project's emphasis on women's stories about how they face and overcome barriers by correcting for or challenging systems that create obstacles. Critical Medical Anthropology uses the idea of systems-correcting and systems-challenging praxis to propose ways that healthcare systems can undergo small reforms and adjustments to work better for those who must operate within them, and/or to encourage people to set aside dysfunctional systems and seek new ways of meeting the healthcare needs of those affected by inequality. Traditionally, these two frameworks have been used by Medical Anthropologists to critique healthcare systems which perpetuate disparities in health and healthcare. However, women and clinic staff who participated in this research consistently described steps that women and advocates themselves can and should take, to reduce obstacles to access and improve women's ability to overcome

obstacles to abortion access. For example, to cite some ideas offered by women and clinic staff, Madeleine's suggestions that women in need of Oregon Health Plan coverage call their case managers everyday, and follow up assertively on OHP applications should be seen as systems-correcting praxis. Madeleine, and other women interviewed, deal with their perceptions of delays in the OHP application process by trying to correct for the failings of a system in which they must operate. Jada told me that she had concerns about harassment by anti-abortion protesters at the clinic, and that her perceptions of the process of seeking care were colored by her ideas of how people would view her, if she ended a pregnancy. Jada's efforts to overcome stigma and perceived dominant cultural ideas about women's roles as mothers and reproducers by seeking support from her boyfriend constitute a form of systems-challenging praxis, as she successfully resisted institutionalized patriarchal attitudes about pregnancy and abortion, by finding the social support she needed. These brief examples demonstrate the extent to which systems-correcting and systems-challenging praxis were useful frameworks for evaluating the ways that women seeking care, and clinic staff, can and do attempt to negotiate and resist systems which create and perpetuate obstacles to abortion access.

Gendered Power Dynamics and Social Support

Male partners have a unique effect on women's perceptions of social support, making gendered power dynamics relevant to this analysis of women's experiences with support or opposition from a partner during the process of seeking care (Ellison 2003, Marger 2008). In relationships where the male partner is statistically likely to make more money and to have access to greater economic and social resources, his reaction to his partner's efforts to obtain an abortion has implications not only for the immediate outcome of the pregnancy, but also for the woman's safety, for her children's day-to-day experiences, and for the future of the relationship (Marger 2008, Womenspace 2000, Ellison 2003, Finer et al. 2006). In this way, sexism and patriarchy -- as part of a larger spectrum of structural violence and institutionally entrenched power relationships -- function to restrict women's access to abortion care, and to

affect women's abilities to overcome obstacles (Marger 2008, Farmer 2005). Similarly, the presence of anti-abortion protesters at the clinic, who arguably operate from an agenda based on controlling what women do with their bodies (NAF 2010, NRO 2010), negatively affect women's experiences at clinics and their perceptions of abortion stigma (Kumar et al. 2009, Cozzarelli et al. 2000, Ellison 2003). By serving as a visible and audible reminder of social sanctioning, clinic protesters harass and intimidate women who may already be struggling with a lack of social support from an intimate partner (Dudgeon and Inhorn 2004, Ellison 2003, Finer et al. 2006, Kumar et al. 2009).

Conversely, positive interactions with partners and other supportive people function to mitigate or reduce the impacts of structural violence for women seeking care. Women who reported financial and logistical difficulties but who had a partner or support person to help them arrange payment consistently said that they felt more able to overcome the structural constraints that affected them. Similarly, the process of facing difficulties related to logistics and finances together were described as strengthening some romantic relationships. Meaningful support networks empower women to assert their agency in the face of structured inequality, in the process of seeking abortion services. The dynamics of structural violence, institutionalized disparities, and social pressures are often subtle and covert, and yet, they are pervasive. This study demonstrates that structural violence and socioeconomic conditions shape the lived experience of accessing to abortion care (Ellison 2003, Dudgeon and Inhorn 2004, Guttmacher 2008).

Dysfunctional Systems – Correct, Challenge, or do both?

As introduced in chapter one, Critical Medical Anthropologist Merrill Singer has distinguished between the ideas of systems-correcting and systems-challenging practices in healthcare (Singer 1986). In Singer's model, these two concepts provide a framework for evaluating how well healthcare systems meet the needs of the populations they serve. They are useful for determining whether adjustments can be made in existing systems to improve them, or whether systems need to be set aside in

favor of new, less oppressive approaches (Singer 1986). In systems-correcting praxis, disparities in healthcare access that result from problems within the healthcare system are addressed by advocating for reforms and adjustments, in order to mitigate the ways in which the system perpetuates disparities or causes negative health effects. Systems-challenging praxis involves a more radical approach, calling on healthcare advocates and activists to challenge current systems of healthcare provision, in order to rebuild them from scratch or propose alternate structures that may better meet the healthcare needs of marginalized populations.

Findings from this study indicate that a reduction in obstacles encountered while seeking abortion care will entail addressing social inequality, particularly as manifested in financial and logistical obstacles to access, and increasing advocacy for women as they seek services. To do so will require improving women's access to social support, financial resources, and other logistical, social, and economic forms of assistance. This will necessitate both systems-correcting *and* systems-challenging praxis (Singer 1986). For example, as one medical assistant at the clinic, Poppy, who had previously been a patient, observed:

Applying for Oregon Health Plan is *always* a pain. I'm desensitized from it because we live in this culture and this society, "you're asking for government assistance, it's *supposed* to be a pain in the ass." I see that as a barrier that a lot of people go through, for an abortion or other medical care. This [applying for OHP] is just one more thing that's difficult.

When a medical assistant at the clinic who works with patients who have succeeded in getting Oregon Health Plan coverage has such a strong perception of how difficult it is to obtain that coverage, it suggests that many women living in poverty may also assume that getting OHP will be challenging -- indeed, some women interviewed described their preconceptions that the application process would be hard to navigate. The OHP application example is a perfect scenario for engaging in both systems-correcting and systems-challenging praxis. The institutional forces that dictate the

steps involved in getting Medicaid coverage for abortion care cannot be changed overnight. Improving low-income women's access to reproductive and other healthcare services will ultimately require healthcare reform and universal access to low-cost or free healthcare for all. In the meantime, as systems-correcting practices are pursued, more extensive systems-challenging efforts must also move to the center of women's health care reform debates. In the above example, encouraging the Department of Human Services to clarify and speed up the existing application process for the Oregon Health Plan will improve abortion access for women of lower socioeconomic status in Oregon. In Singer's approach, this is a form of systems-correcting praxis and a good start in terms of reducing financial obstacles to access for low-income women,

However, my research suggests that a more extensive overhaul of the current system that perpetuates health disparities and social inequality is also needed, i.e. systems-challenging praxis).

Systems-correcting praxis by itself will not resolve or reduce the most challenging obstacles to abortion care currently encountered by women in western Oregon. Improving the Oregon Health Plan application process will result in more women getting their medical cards more quickly, thus reducing delays in the process of seeking abortion care. However, these improvements alone will not fundamentally change the power relationships that determine who receives Medicaid benefits. Systems-correcting praxis seeks to make flawed systems work better for those who must operate within them, but it does not directly address institutionalized classism, sexism, racism, and other structural forces that perpetuate these inequalities (Singer 1986). While reform efforts are necessary for gaining short-term improvements in access to care, and abortion providers and advocates can offer information and resources to help fill the gaps that exist in the formal systems intended to help women access care, mere reform will not be adequate to ultimately eliminate obstacles to care.

Systems-challenging praxis goes beyond reform efforts to focus on the power relationships and structural forces that produce obstacles to care and maintain

inequalities. Systems-challenging praxis encourages critiques of inadequate systems, social action, and community organizing (Singer 1986:90). In Singer's model, challenging institutions that perpetuate disparities in healthcare can consist of encouraging members of marginalized populations to get directly involved in the process of breaking down unequal power relationships, thereby "enhancing democratization" (Singer 1986:90). Healthcare providers can also challenge unequal power relationships by "eliminating mystification" (Sanders 1985; Singer 1986:90) -- giving those who seek care relevant information about the systems and processes that directly affect them. In the OHP application example, these two methods can be seen in providers' and advocates current efforts to encourage women to advocate for themselves and to be assertive with DHS case managers. They can also be seen in the work of referral organizations that give women detailed information about the application process, and tell them what to expect. Receptionists at some clinics in Oregon, and abortion hotline volunteers, tell women seeking abortion care exactly which documents they need in order to apply for OHP, and explicitly tell women to go into the DHS office in person and follow up until they get their medical cards -- this constitutes systems-correcting and systems-challenging praxis. Helping women to understand the existing application process facilitates their ability to navigate it, without fundamentally changing how applications are processed. At the same time, empowering women to assert their rights, and providing them with information to demystify the application process, explicitly equips women to challenge the power relationships inherent in the process of applying for state benefits (Marger 2008, Singer 1986).

Care providers and advocates who help women overcome the delays and obstacles that participants assert are institutionalized in the OHP application process see themselves as trying to make a broken system work for those who must rely on it (NRO 2010,). As Madeleine (20 year old patient) stated, after describing the ordeal she went through trying to apply for Oregon Health Plan, get time off work, and get to her appointment:

I wish it would be easier, just to even inform people of how to deal with it. Maybe you can't necessarily change DHS and the way they do things, but you can at least inform people of ways to work *around* it !

Madeleine's suggestion that women seeking abortion care need more information about navigating the OHP application process demonstrates the value of the work that some providers and advocates engage in, to do just that. For example, the Network for Reproductive Options (NRO) is an Oregon-based non-profit organization mostly run by volunteers and supported through small private donations and a few grants. NRO currently allocates thousands of dollars a month to help low-income women who are denied OHP to get their abortion care paid for, without having to accept the disparities inherent in the OHP program (NRO 2010). This method of directly helping women access the services they need is a form of retaliation and systems-challenging praxis against a paternalistic, for-profit health care system that determines who does and who does not “qualify” for services (NRO 2010, Marger 2008). Perhaps a more extensive form of systems-challenging praxis will occur when healthcare consumers and taxpayers collectively demand that the government provide adequately-subsidized national health care, with full access to free contraception and affordable abortion care for all women, regardless of their Medicaid eligibility status (Singer 1986, NAF 2010, Guttmacher 2008).

Women in western Oregon confront many difficulties during the process of seeking abortion care, and engage in a myriad of strategies to navigate and overcome obstacles to access. Women seeking care, and the providers and advocates who serve them, recognize the importance of social support in this process. Populations most affected by structural inequalities, especially poverty, encounter more obstacles to access. Addressing structural and individual dynamics that impact women's access to care will require examining, addressing, and challenging power relationships that perpetuate and maintain social inequality. Reducing obstacles to care, and empowering

women to successfully overcome obstacles will also necessitate evaluating individuals' needs, identifying community resources, and making connections and referrals that assist patients, providers, and advocates to improve access to abortion care in Oregon. Healthcare providers and advocates who want to ensure that women encounter fewer obstacles in the process of seeking abortion care, and who are committed to providing information and resources that will allow women to advocate for themselves, must engage in both systems-correcting and systems-challenging praxis.

Chapter 6 -- Conclusions and Recommendations

I found out I was pregnant in October and applied for Oregon Health Plan right away, and it took until *February* to get it! I asked the case manager, 'why aren't we getting this yet, what do I do?' She just said that the information was incomplete, I said, 'well what do you need?' and she said, 'well we're just waiting for information to be filled in on your file.' It wasn't information I could give them. They had everything. But at least my boyfriend was very supportive -- he wanted me to have my options open, and he wanted me to make my own decision.

Virginia, 25 years old, has one child who does not live with her and reported that with a previous pregnancy she was at 18 weeks gestation by the time she was approved for Oregon Health Plan

Women in Oregon who attempt to obtain abortion care confront many socioeconomic, social, and logistical obstacles in the process. These obstacles affect women's perceptions of the experience of seeking care. Demographic and survey data demonstrate that many women seeking abortion care in Oregon are affected not only by gender inequality that limits women's access to healthcare, but also by disparities that result from poverty and lower social-class status (Marger 2008, Guttmacher 2002, Jones 2005). A variety of social support systems, or a lack thereof, affect women's experiences of seeking abortion care, while also influencing their ability to overcome obstacles to access. Social support, at both an institutional and inter-personal level, can help women seeking abortion care overcome economic and social obstacles. Oregon women's stories demonstrate overlapping and intersecting obstacles that arise in the process of seeking abortion care, the importance of social support in assisting women to overcome obstacles, and include ideas about ways that clinic staff and other women's health advocates can better support women and improve abortion access.

Current literature on reproductive healthcare includes very little data on women's experiences of attempting to access abortion care. This study contributes significant and relevant information that begins to fill these gaps. Due to the emphasis on qualitative data and women's stories, this project brings the lived experiences of women affected by obstacles to access into the silence that has long existed between numbers and narratives. Along with documenting and describing women's experiences, and analyzing patterns that explain the relationship between social support and women's ability to overcome obstacles, the applied advocacy components of this study may contribute to reducing structural obstacles to abortion access. With plans to eventually provide policymakers, care providers, and affected women with relevant and compelling information about how obstacles are experienced and overcome by Oregon women, this project offers possible responses to structural and institutional problems. This study also includes findings that may be used to engage and challenge structural inequalities that result in disparities in healthcare access. Finally, my survey instrument revealed that while women may under-report an overall perception of having encountered obstacles to care, when asked about specific obstacles, many women identify certain issues as being "very" or "somewhat" challenging, demonstrating the value of conducting mixed-methods research to ensure validity and reliability (Bernard 2006).

Addressing Structural Obstacles to Access

Reducing negative impacts of social inequality on access to reproductive healthcare necessitates improving abortion access for all women, but especially for women in poverty, teenagers, women of color, women in abusive situations, and those affected by structural violence. The experiences of women in this study, and demographic patterns found in the survey data, together indicate that women in western Oregon struggle with obstacles related to a lack of financial and social resources when seeking abortion care. For women in poverty, and women without health insurance or Medicaid coverage, financial and logistical obstacles to abortion

care are challenging and intimidating, especially when they perceive little social support to help them confront obstacles. Women from all income and social circumstances perceive varying levels of social support, but a lack of social support has a greater negative impact on women who are most likely to encounter financial and logistical obstacles -- those women most affected by structural and systemic inequalities (Marger 2008, Guttmacher 2008 2002, Farmer 2005). Practical suggestions for addressing structural obstacles, and assisting women to overcome them, are outlined below in women's own words, and in Table 6.1 at the end of the chapter.

Fixing the OHP Application Process through Systems-Correcting and Systems-Challenging Praxis

To reduce obstacles to abortion access and help women overcome obstacles, providers and women's health advocates must directly address gaps in the existing systems that are designed to help women obtain reproductive health services. Overall institutional and social support for women in need of care must also be improved. As discussed in chapters one and five, this will entail both systems-correcting and systems-challenging praxis (Singer 1986) -- advocating for reforms or improvements within current structures to correct existing obstacles, as well as organizing to overturn unequal power relations. For example, women affected by obstacles to care argue that women's health advocates and providers could begin to correct for the apparent failings of the OHP application process in a variety of ways including: 1) better informing applicants of the importance of advocating for themselves and maintaining good communication with case managers; and 2) being direct with DHS staff that the medical card is needed for a time sensitive pregnancy-related medical appointment. Women and clinic staff interviewed for this study also suggest that advocates should challenge DHS at the administrative and funding levels, in ways that will result in meaningful changes to the OHP application process to make it more accessible and less onerous for pregnant women. Systems-challenging praxis related to improving low-income women's access to reproductive healthcare should include lobbying for

new legislation and policy enforcement, in order to identify and address unequal power relationships that affect would-be OHP clients. To emancipate low-income Oregon women from some of the structural inequalities that maintain their marginalized status, women seeking care and clinic staff assert a belief that it will be crucial to hold the Department of Human Services accountable for publicly-funded healthcare programs it is charged with administering. Based on women's stories about applying for Oregon Health Plan, systems governed by state policies and state budgets help to perpetuate marginalization of low-income pregnant women in Oregon, by institutionally delaying their efforts to get OHP coverage. These same systems likely hold the potential for improving women's access to healthcare.

By engaging in community outreach and disseminating the results of this study, I intend to provide abortion providers, women's health advocates, and social workers with information and suggestions for concrete steps that can be taken to improve women's access to abortion care and to assist women who encounter obstacles. For example, as mentioned in chapter five, if clinic receptionists help women learn how to navigate the OHP application process, this will function as a form of systems-correcting praxis, by helping women work within an apparently dysfunctional Medicaid system (Singer 1986, NRO 2010). At the same time, encouraging women to advocate for themselves will also constitute systems-challenging praxis, by modeling more equal power relationships. When clinic receptionists and volunteers at abortion funding organizations help women access community-supported funds to directly pay for an abortion, this constitutes another form of systems-challenging praxis by giving low-income women the immediate resources they need to pay for an abortion, despite the structural realities that keep them in poverty (Singer 1986). By the same token, if women with little or no perceived social support begin to receive referrals to unbiased, non-judgmental talk lines where they can discuss their situation with a sympathetic person, this can serve to challenge some dominant cultural views of abortion that stigmatize the abortion decision and affect women's ability to seek and receive social support while accessing abortion care (Kumar et al. 2009, Ellison 2003, NRO 2010).

Women seeking abortion care in western Oregon have ideas about what clinic staff and other advocates can do to make it less challenging for women to obtain services. Acknowledging women's experiences, and using their stories and suggestions to raise awareness among care providers and advocates about what can be done to improve access, will help reduce some obstacles to care. Women who sought abortion care, and staff members at the clinic where these women successfully obtained services, offered suggestions and recommendations for steps that women's health advocates can take to improve access to care. Many of these suggestions stem from women's recommendations for making Oregon Health Plan and other financial assistance programs easier to navigate, as well as underscoring the importance of social support for assisting women to overcome obstacles (Kumar et al. 2009, Ellison 2003).

Suggested Improvements to the Oregon Health Plan Application Process

As the most challenging obstacles to abortion access for women in Oregon involve dealing with the Oregon Health Plan application process and other financial issues, and a perceived lack of social support, my recommendations for improving Oregon women's access to abortion services focus on these areas. In order to keep the experiences and voices of the women most affected by obstacles front and center, I include specific suggestions provided by study participants, as well as ideas from abortion clinic staff about how providers and advocates can facilitate women's attempts to overcome obstacles to care.

Among the women I interviewed, many of them had very detailed ideas about what would have made the experience easier. Madeleine and May each talked at length about the lack of communication they perceived from their Oregon Health Plan case managers. As Madeleine commented:

It would have been nice for emergency things like that to just have an appointment with your caseworker and sit down with them and fill it out and get it done right then, so they can process it immediately! It would just be so much easier to inform people of what they need to

do, and get it done quickly. I would say, "call your caseworker, make sure that your application is fine, check and see if there is anything you need to verify, is there anything wrong with it?" Have a case manager tell you that the application has been processed, get your caseworker's card and phone number, call them often, leave them messages!

Both women felt that it would have been much easier to access care and avoid delays, if they could have gotten a phone call back from their OHP case managers in response to their many voice mail messages and contact attempts. Madeleine waited two weeks for confirmation of her OHP coverage, and May waited more than two months – both women were unnecessarily delayed in seeking care, exposing them to a greater risk of complications, more time-consuming procedures, and potentially the need for more time away from work and children. As Madeleine described:

I didn't have anyone helping me with [the paperwork], a lot of it doesn't make sense, and I was thinking to myself, "If this doesn't make sense to *me*, I wonder if it makes sense to anybody?!"

Madeleine even went so far as to propose that women need to be very assertive about demanding a response from a case manager, even if that means calling multiple times a day every day, leaving messages, and being the "squeaky wheel that gets the grease." May felt that the total lack of acknowledgment of the urgency of her situation on the part of her DHS case manager was very difficult to deal with, especially as it delayed her ability to obtain an abortion by over two months. May wished that someone at DHS would have just let her know that she was still covered, so that she would not have had to wait so long:

It would have helped if I'd known that I had the Oregon Health Plan, just the [case manager] actually getting back to me! It definitely would have been easier and less painful for sure to not get delayed. I think it's really important not to be put off like that, you know, it's *really* important, it's life-changing!

Without interviewing individual case managers and administrators at the Department of Human Services, it is hard to identify exactly why the lack of communication that many women in this study experienced occurred. That said, women seeking care and clinic staff felt strongly that there could be improvements in the OHP application process so that pregnant women applying for a medical card consistently get a return phone call in a reasonable amount of time. Women who applied for Oregon Health Plan coverage for abortion care also reported that they wished they had received clear information about how long eligibility verification would take. Women and clinic staff propose that assigning a specific case manager in each Department of Human Services branch office to handle OHP applications from pregnant women, having a clear, differentiated process for approving time-sensitive applications from pregnant women, and/or consistently prioritizing these applications would all make a difference in the experiences of poor pregnant women in Oregon as they seek abortion care.

Several conversations with policy analysts and other staff at DHS and the county health department, revealed that DHS used to process OHP applications from pregnant women separately from other applications, even using a separate, easily-identifiable form (,). A few case managers and other social workers reported that, from their perspective, this earlier process facilitated getting women approved for OHP coverage more quickly. Case managers and other advocates repeatedly echoed the sentiments of women seeking care, that the current application process is confusing and difficult for clients to navigate, and for case managers to interpret, meaning that delays may occur because case managers are not adequately trained on the appropriate time lines and options for verifying eligibility. The apparent failings of the OHP application process, as reported by women in this study, seem to result, at least in part, from a lack of adequate communication between the administration and case managers. This specific question deserves further study, at the institutional and administrative levels.

Given that the existing DHS policy stipulates that applications from pregnant women should be processed within one day, the delays in verification and approval reported by women in this study require closer examination. Clinic staff have commented that if DHS administrators would clarify for reportedly overworked case managers that it is not only okay, but preferred, for them to put pregnancy-related OHP applications ahead of other assignments, this might help not only to speed up the process for pregnant applicants, but also to help busy and overwhelmed case managers organize their workloads more effectively. As an example of one way that research participants suggest DHS could make the process easier for pregnant women applying for OHP, Gypsy talked about how helpful it was to have someone at the county health department on her part of the south coast actually submit an OHP application on her behalf. Gypsy appreciated that her county had prioritized a staff position designed to help low-income women get expedited OHP approval:

[Roxanne] did all of that, she was wonderful. Three days after she did my [OHP] paperwork I got something in the mail with my case number, saying I was approved. She was *on* it, she's a great person, we need more of those people in the world, to be honest with you!

Gypsy, and other women in her region, additionally proposed that women in other areas would benefit from DHS and county health departments creating similar positions. Clinic staff suggest that replicating Roxanne's MothersCare position in other county health departments, or creating similar positions in DHS offices, might help streamline the application process for pregnant women, and even take some of the workload burden of following up with OHP applicants off the larger pool of DHS case managers. Roxanne told me that her county had chosen to use state funds allocated to each county to improve access to prenatal care to fund her position, designing it to engage in direct advocacy for low-income pregnant women in need of OHP coverage in the county. Furthermore, Roxanne, and one DHS staff person each mentioned that every county in Oregon could use Oregon MothersCare program funds to create

similar positions, as the program is state-wide, and already approved in the state budget (,). A staff member from the state program that oversees Oregon Health Plan (DMAP) reported that twenty-nine Oregon MothersCare sites officially exist across Oregon, most housed in county health department offices. This raises the question of whether women's experiences with delays in the OHP application process in areas other than the south coast may be due in part to under-utilization of existing MothersCare funding and programs -- certainly an issue that warrants closer examination.

In light of the troubling variation in waiting times for OHP reported by women in this study, research participants argued that DHS should improve the OHP application process. One way to do this might be to encourage DHS to use funds already allocated for improving Oregon women's access to prenatal care to replicate the position that serves the women of Roxanne's county so well. Given that, according to institutional representatives, state funds are already allocated to assist low-income pregnant women in need of prenatal care (including abortion services, under the statutes that originally created Oregon Health Plan), women seeking care and clinic staff believe that DHS and county health department administrators could do a better job of coordinating their communication and efforts to help low-income pregnant women navigate the OHP application process (NRO 2010). The twenty-nine existing MothersCare sites could be evaluated to determine how they assist women in the process of applying for OHP, and counties that do not currently have an Oregon MothersCare position could create such positions to better coordinate efforts between local DHS and county health department offices. Based on research participants' concerns about delays in the OHP application process, efforts to expand utilization of the MothersCare program would very likely improve low-income women's access to OHP coverage.

Finally, DHS staff members who responded to my request for information indicated that while case managers currently have up to forty-five days to process OHP applications, they do in fact have the flexibility to process them much faster at

their own discretion. This suggests that research participants' perceptions of arbitrary delays in the OHP application process may be valid. This suggests that DHS administrators could more effectively direct case managers to prioritize time-sensitive OHP applications from pregnant women, as the women I interviewed repeatedly proposed. The same specialist from the Department of Medical Assistance Programs that oversees OHP for the state, told me that all county health department offices contain “outreach centers” where county health department staff are directed to help low-income Oregonians apply for OHP. However, none of the women interviewed had encountered this option, and in ten years of working with low-income pregnant women in Oregon, I have likewise never heard of these centers. If the state of Oregon is in fact using public dollars to fund outreach centers and staff positions that are designed to assist low-income Oregonians in applying for OHP, then there is apparently a need for further research to determine why women are still encountering such a wide variety of waiting times for eligibility verification. Future research could also investigate whether there is a need for increased accountability and advocacy at the institutional level of DHS, to encourage widespread awareness about, and effective use of, the MothersCare and outreach center options.

Problem-solving for Financial and Logistical Challenges

In terms of other financial and logistical challenges, Paztine and Poppy each discussed how much it would help if DHS or other agencies could provide reimbursement or gas vouchers for medical travel. Women coming to the clinic from some counties in southern Oregon report that DHS provides vouchers for a shuttle driver to bring them to medical appointments. I have also heard anecdotal stories that some DHS case managers approve “medical mileage” reimbursement to clients traveling from rural areas to obtain healthcare in another area, but this option does not seem to be universally available. Paztine explained how much it would have helped if she could have gotten childcare assistance, either through referrals from DHS to state-licensed caregivers, or with the help of DHS-funded childcare payment vouchers. Like other women from that part of the state, Paztine had heard rumors that her OHP

eligibility meant she could have gotten a ride to the clinic paid for by DHS if she had taken a local shuttle, but she was reluctant to use this service:

It would help if DHS would help pay for childcare, and gas. How awkward is it to go, I mean it's a very nice program [Translink/Ridesource], but how awkward is it to go get an abortion with a cab-driver you never met before ?! A gas voucher would have helped so much, really it would have.

In her case, although she had OHP coverage already, Paztine experienced delays related to finding someone who could take time off work to watch her young child, and drive her to the clinic. If DHS reimbursements or arrangements for state-paid childcare or medical travel do exist, it would be of great benefit to poor women in Oregon who need to travel for medical care to have these services advertised more widely.

Clinic Staff Suggestions for Overcoming Financial Obstacles

Clinic staff largely focused their suggestions for improving services on what staff at obstetrics/gynecology offices, county health departments, and at DHS, could do to help women seeking abortion services overcome obstacles to care, especially financial obstacles. Poppy and Melanie, with nearly a decade of experience working in clinics between them, both talked about the important role that clinic receptionists could play. As Melanie suggested:

If the first person a prospective patient talks to says, "you can use a credit card, here's how to apply for OHP, here are the three networks that help with funding, here's what you need before you call them. Here's what you need to do before you even go to OHP" that would help. Just having enough receptionists and enough time to give women a little bit more information about all of your options, or having it on our website!

Likewise, Poppy mentioned that patients who get their first information at Crisis Pregnancy Centers (that are known for promoting anti-abortion propaganda and misinformation, NAF 2010) often seem to be more confused about, or less aware of,

the resources available to them. Poppy talked about the importance of women encountering someone who can give them the information they need early on in the process:

I think the first line of overcoming the funding barrier is talking to the receptionist at the abortion clinic. I think it's really important that our receptionist or any receptionist [or case manager or county health department employee] give women really specific, accurate information on funding, and just try to be slightly more helpful.

Other Obstacles to Access – Resources Needed

As far as other issues that patients and clinic staff felt affected women's access to care, a range of topics were mentioned. TeeJay expressed her frustrations about many insurance companies not covering abortion care. She pointed out that if she had carried her pregnancy to term, her insurance would have ended up paying for a high-risk delivery (due to her age) and all of her prenatal care, but that many insurance companies do not pay for an abortion, that is a fraction of the cost (NAF 2010). TeeJay felt strongly that all insurance companies should cover abortion care, since the alternative actually costs the insurer much more (NAF 2010). Alice mentioned that she thought many women would benefit from better access to resources and information in general, such as pamphlets about OHP, funding options, transportation assistance, and the like: "It would be good to make it easier to find the *resources* that you need. It's kind of, you know, embarrassing to ask!" Alice's assertion that general referrals for resources would be helpful to women seeking abortion services, was echoed by clinic staff. To that end, part of the plan for disseminating the results of this study includes offering resource and referral flyers for abortion funds, transportation, support hotlines, and information on the OHP application process, to be distributed in clinics, county health departments, Department of Human Services offices, and by community health advocates in Oregon.

Lynn was adamant that there should be more ways for clinics to keep protesters away from patients via buffer zones, walkways, or barrier walls:

The clinic should just make it so the patients can come through the back. Maybe you can do an outdoor type walkway, some kind of a wall that runs along the sidewalk, so then patients can come around [from the parking lot] and they're not attacked, and the protesters aren't right there at the entrance!

Unfortunately, there is very little that Oregon clinics can do to limit protest activity as long as the picketers remain on public property. In the case of the clinic where I conducted my research, we maintain a close relationship with local law enforcement, the Federal Bureau of Investigations, and the Department of Justice, so that if protesters do overstep the bounds of legal, free speech, we can immediately report them for trespassing and harassment.

Connecting Women with Resources for Support

Among the women I interviewed who felt that they had enough support, many of them discussed how important this support was for helping them to overcome challenges. They recommended that other women in similar situations seek support. As Jada repeatedly said: "The best thing we can do is share what's going on for us and say, 'Listen, just *listen*. That's all I need you to do,' you know?"

Three young women mentioned how much it helped to have a partner or friend who was there for them, and suggested that a woman seeking support talk to a sympathetic friend, even if they do not have a supportive partner. Evangeline discussed how: "Having an older friend to talk to definitely was a very good thing. She'd been there before, she understood my position." Gypsy, who had not gotten the support she'd hoped for from a close friend, sent me a message later in the day after our interview, saying that she would tell another woman in the same circumstances to call unbiased, pro-choice hotlines, such as the ones I referred participants to as part of the informed consent process for interviews. Jada also talked about the value of going to a support group for survivors of domestic violence, and mentioned that her

involvement with the domestic violence advocacy agency in her town helped her realize that she could make her own choice about a pregnancy, rather than having an abusive partner control her body. While clinic staff and other healthcare advocates cannot ensure that prospective patients have someone supportive in their lives, at the very least, clinics and other providers can offer women referrals to unbiased talk lines, or encourage women to bring a supportive friend or family member with them to the procedure. The suggestions offered by women seeking care, and clinic staff, for reducing obstacles to abortion and empowering women to overcome obstacles, are summarized in Table 6.1, below.

Table 6.1 Summary of Recommendations for Improving Oregon Women's Access to Abortion Care

Oregon Health Plan Application Process:
Improve low-income women's access to prenatal care & Oregon Health Plan
Expand the Oregon MothersCare program in every county in Oregon
Expanded state-wide utilization of Oregon MothersCare should be modeled on the successful example from the south coast
Investigate the existence of OHP outreach centers reportedly housed in county health department facilities to determine whether low-income women who arrive for pregnancy testing could receive assistance with OHP applications at such centers.
Improve, clarify, and simplify the Oregon Health Plan application process for low-income pregnant women, per the reported delays and difficulties experienced by some applicants.
The Department of Human Services should base improvements on aspects of the process that have reportedly worked well in the past: designating a case manager in each DHS branch to process OHP applications from pregnant women, returning to the use of a dedicated OHP application form that clearly indicates it is being submitted by a pregnant applicant, and taking other similar steps streamline the application process.
Travel and Logistics:
Clinics and case managers should provide prospective patients with referrals to Translink, Ridesource, and other funding, transportation, and lodging programs.
Referrals should be listed on clinic websites.
Social Support:

Clinics & case managers should provide women with referrals to unbiased talk lines.
Unbiased talk-lines & other resources for social support should be listed on clinic websites.
Outreach and Advocacy:
Improve communication: providers, case managers, county health depts., etc.
Improve women's access to resources for self-advocacy.

In conclusion, I have argued that structural inequalities influence women's access to resources needed to obtain abortion services. Women often encounter financial, logistical, and/or social obstacles in the process of seeking abortion care, and various forms of social support help women overcome obstacles to access. For women who seek support and do not receive it, or who encounter violence, hostility, harassment, and delays related to a lack of support from partners, family, friends, or institutional personnel who function in a support capacity (such as case managers), this lack of support makes the entire process of seeking an abortion more difficult. Social inequality, in the form of poverty and other forms of marginalization, create more obstacles to access for some women, and make it harder for these women to overcome obstacles. Women assert their agency in the process of seeking care by asking for, and finding, the resources and support needed to overcome obstacles. Women correct for failings in the Oregon Health Plan application process, and in other structures they encounter while seeking care, by working within broken systems and finding ways to deal with delays and difficulties. Women also challenge power structures, attempt to demystify the process of seeking care, and seek democratization in the process by acknowledging and drawing attention to unequal power relationships which create and perpetuate obstacles. Women also challenge existing power structures which affect their access to care by finding the social support that enables them to successfully obtain abortion care, despite the many challenges they come across in the process. In these ways, women and clinic staff unknowingly engage in

systems-correcting and systems-challenging praxis to respond to structured inequalities which result in disparities in abortion care.

As an advocate for women seeking respectful, high-quality reproductive healthcare, I urge abortion providers, policymakers, and social service workers to take into account the evidence of obstacles encountered by women in the process of seeking abortion care, and the value of social support for women seeking abortion care. To reduce obstacles to care, and improve women's access to resources needed for overcoming obstacles, providers and advocates must demystify the process of seeking care, and enhance democratization, by taking steps to refer women to community resources for social and logistical support options that include funding, transportation, and lodging, unbiased, pro-choice abortion hotlines, domestic violence support groups, and other appropriate networks. Empowering women by offering information about resources and the over all process of seeking care will not only help women work within existing systems to get the care they need, but will also create opportunities for clinic staff, advocates, and women themselves to challenge the larger structures which create and maintain disparities.

Ultimately, reducing the effects of obstacles to abortion care will require policy and community-level changes geared towards reducing structural and institutional obstacles to access. Findings from this study indicate areas where abortion providers, women's health advocates, and activists, can begin to challenge the existing structures that perpetuate inequality, in order to reduce obstacles to abortion access. Along with these structural changes, encouraging women to ask for social support from family, partners, and friends, as well as at the institutional level, is of primary importance for helping women to overcome obstacles encountered in the process of seeking abortion care in Oregon.

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APPENDICES

Attachment 1

THIS IS AN OPTIONAL SURVEY. The clinic is gathering anonymous information for research about problems our patients may have accessing abortion services. The anonymous information you provide will be separated from your medical chart and hopefully used to make it easier for other women to access our services. Thank you for your participation !

I do not want anonymous information from this survey to be used for research related to improving access to services.
(check this box or leave the survey blank if you do not want anonymous data about your experiences getting to our clinic to be used)

Date: / /

Q1 - How far did you travel to get to your appointment(s)? (Check one)

- 0-25 miles
- 25-50 miles
- 50-75 miles
- 75-100 miles
- more than 100 miles
- more than 200 miles

Q2 - How much time did you take off work or school to come to your appointment(s)? (Check one)

- none
- less than one day
- one day
- two days
- more than two days
- Not applicable

Q3 - Did you have to make special childcare arrangements in order to come to your appointment(s)? (Check one)

- No
- Yes, family members caring for my child(ren) while I'm here
- Yes, paid for someone to care for my child(ren) while I'm here
- Not applicable

Q4 - What is your approximate annual income ? (fill in an estimate) \$ _____

Q5 - How many people do you support on this income ? # _____

Q6 - How much money did you have to spend on gas or other travel expenses (bus ticket, train, etc.) in order to come to your appointment(s)? (Please fill in an estimate)

\$ _____

Q7 - Did you have to make arrangements for a place to stay to come to your appointment(s)? (Check one)

- No
- Yes, paying for a hotel room
- Yes, staying with friends/family
- Not applicable

Q8 - If you said you stayed in a hotel in the Question 5, please indicate how much you paid: (Check one)

- Less than \$50
- \$50-100
- More than \$100

Q9 - Did you encounter anti-abortion protesters outside the clinic when you arrived for your appointment(s)? (Check one)

- Yes
- No

Q10 - Were you aware that Oregon Health Plan would pay for your abortion if you qualify ?

- Yes
- No

Q11 -Did you apply for an Oregon Health Plan Medical Card (OHP) to pay for your appointment(s)? (Check one)

- Yes
- No
- Not a citizen (not eligible)

Q12 - If you answered Yes to Question 8, please indicate how long it took from when you applied for your OHP Medical Card to when you received it (Check one)

- Less than one week
- 1-2 weeks
- 2-3 weeks
- Denied OHP/couldn't wait any longer to get OHP

Q13 - Do you feel that you had adequate support from your partner for your decision to come to your appointment(s)? (Check one)

- Yes
- No
- Did not tell Partner
- Not applicable

Q14 - Do you feel that you had adequate support from your family for your decision to come to your appointment(s)? (Check one)

- Yes
- No
- Did not tell family
- Not applicable

Q15 - Do you feel that you encountered any barriers to access in your efforts to come to your appointment(s)? (Check one)

- not applicable
- No
- Yes

Q16 - Check the box which best describes your experience with the potential barriers listed:

Barrier	Very Challenging	Somewhat Challenging	Not Very Challenging	Not a Barrier
Travel arrangements and costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare arrangements and costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time off work/school and lost income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of the procedure(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lodging arrangements and costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty getting OHP or waiting for OHP Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of support from partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of support from family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns about harassment by anti-abortion protesters at the clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other barriers (please list)				
Barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Attachment 2

ESTE ES UNA ENTREVISTA OPCIONAL. La clinic pide este información anónima por un estudio acerca de problemas que nuestros pacientes pueden encontrar en el proceso de buscar servicios de aborto. La información anónima que usted comparte será separada de su charta médica y optimistamente lo usamos para hacerlo fácil para otras mujeres conseguir acceso a servicios de aborto. ¡Gracias por su participación!

___ Yo prefiero que información anonima de este entrevista no sera utilizada para un estudio para mejorar acceso a servicios de aborto. (marque esta caja o deje la entrevista vacia si usted no quiere que la informacion anonima sera usada)

Fecha: ___ / ___ / ___

Q1 - Cuanta distancia tuvo Ud. que viajar para llegar a la(s) cita(s) ? (Elige una respuesta)

0-25 millas
 25-50 millas
 50-75 millas
 75-100 milla
 mas de 100 millas
 mas de 200 millas

Q2 - Cuanto tiempo tuvo Ud. que dejar su trabajo o escuela para venir a la(s) cita(s)? (Elige una respuesta)

nada
 menos de un dia
 un dia
 dos dias
 mas de dos dias
 No aplica a mi situacion

Q3 - Tuvo Ud. que arreglar cuidado de sus hijo(s)/a(s) para venir a la(s) cita(s)? (Elige una respuesta)

No
 Si, miembros de mi familia estan cuidando a mi(s) hijo(s)
 Si, pague a alguien para cuidar a mi(s) hijo(s)
 No aplica a mi situacion

Q4 - Cuanto gana Ud. cada 12 meses, aproximadamente ? (llene una cantidad)

\$ _____

Q5 - Cuanta gente les apoya Ud. con este sueldo/cantidad ?

Q6 - Cuanto dinero tuvo Ud. que pagar para gasolina o otros aspectos de su viaje (boleto de tren o autobus, o algo asi) para llegar a su(s) cita(s) ? (Por favor llene una cantidad aproximada)

\$ _____

Q7 - Tuvo Ud. que arreglar un lugar para quedar la(s) noche(s) para venir a su(s) cita(s) ? (Elige una respuesta)

No
 Si, pagando por un hotel
 Si, quedando con familia
 No aplica a mi situacion

Q8 - Si Ud. tiene que pagar para quedar en algun lado para llegar a su(s) cita(s), por favor indica la cantidad que Ud. pago. (Elige una respuesta)

Menos de \$50
 \$50-100
 Mas que \$100

Q9 - Ud. enfrente gente manifestando en contra de aborto afuera de la clinica al llegar para su(s) cita(s) ? (Elige una respuesta)

Si
 No

Q10 - Supo Ud. que el plan de salud de Oregon pagara para su aborto, si Ud. sera eligible para OHP ? (Elige una respuesta)

Si
 No

Q11 - Ud. entrego una aplicacion para obtener una tarjeta medical del plan de salud de Oregon para pagar para su aborto ? (Elige una respuesta)

Si
 No
 No soy elegible para OHP porque no tengo papeles de ciudadanía

Q12 - Si Ud. eligio "Si" a pregunta #9, por favor indica cuanto tiempo paso entre aplicar para el plan de salud de Oregon hasta recibirlo ? (Elige una respuesta)

Menos de una semana
 1-2 semanas
 2-3 semanas
 Me negaron OHP/no pude esperar mas para recibir OHP

Q13 - Siente Ud. que recibio suficiente apoyo de su pareja para su decision de venir a su(s) cita(s) ? (Elige una respuesta)

Si
 No
 No le dije a mi pareja
 No aplica a mi situacion

Q14 - Siente Ud. que recibio suficiente apoyo de su familia para su decision de venir a su(s) cita(s) ? (Elige una respuesta)

Si
 No
 No le dije a mi familia
 No aplica a mi situacion

Q15 - Siente Ud. que encontro cualquier obstaculos en el proceso de llegar a su(s) cita(s) ? (Elige una respuesta)

Si
 No

Q16 - Marque el cajon que describa mejor su experiencia con el obstaculo mencionado:

Obstaculo	Muy dificil	Un poco dificil	No Muy Dificil	No fue un obstaculo
Viajar y arreglar todo para el viaje	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arreglar cuidado de mis hijos y pagarlo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perder tiempo en el trabajo o escuela	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Precio del aborto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arreglar un lugar para quedar la noche, pagarlo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dificultades en calificarme para el plan de salud de Oregon, o esperar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falta de apoyo de mi pareja	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falta de apoyo de mi familia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miedo de enfrente gente manifestando afuera de la clinica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDRESS _____ (CITY OR TOWN) (COUNTY)		PERFORMED: _____ (MONTH) (DAY) (YEAR)	
4. PATIENT'S USUAL RESIDENCE _____ (STATE) (COUNTY) (CITY OR TOWN) (ZIP CODE) (INSIDE CITY LIMITS - YES, NO)			
5. AGE LAST BIRTHDAY _____	6. MARITAL STATUS: 1 <input type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 5 <input type="checkbox"/> Separated 2 <input type="checkbox"/> Now Married 4 <input type="checkbox"/> Divorced 6 <input type="checkbox"/> Unknown		
7. IS PATIENT OF HISPANIC ORIGIN? 0 <input type="checkbox"/> NO <input type="checkbox"/> YES, specify Cuban, Mexican, Puerto Rican, etc. _____		8. Race (select one or more): 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian 4 <input type="checkbox"/> Chinese 5 <input type="checkbox"/> Japanese 6 <input type="checkbox"/> Hawaiian 8 <input type="checkbox"/> Filipino 0 <input type="checkbox"/> Other Asian <input type="checkbox"/> Other (specify) _____	
9. EDUCATION (Indicate a NUMBER for the HIGHEST grade COMPLETED):		None (0)	Elementary/Secondary (1-12)
			College (1-4, 5+)
10. PREVIOUS PREGNANCIES (Complete all four sections; enter number or check "None")			
Live Births		Other Terminations	
a. Now Living Number _____ None 00 <input type="checkbox"/>	b. Now Dead Number _____ None 00 <input type="checkbox"/>	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 <input type="checkbox"/>	d. Induced Abortions (Do <u>not</u> include this termination) Number _____ None 00 <input type="checkbox"/>
11. DATE LAST NORMAL MENSES BEGAN _____ Month Day Year		12. CLINICAL ESTIMATE OF GESTATION _____ Completed weeks	
13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE? 1 <input type="checkbox"/> NO 2 <input type="checkbox"/> YES; If Yes, specify method below. 1 <input type="checkbox"/> Birth Control Pill 2 <input type="checkbox"/> Foam 3 <input type="checkbox"/> Hormone Implant; e.g., Norplant 4 <input type="checkbox"/> Diaphragm 5 <input type="checkbox"/> IUD 6 <input type="checkbox"/> Condoms, Prophylactics 7 <input type="checkbox"/> Rhythm 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Contraceptive Injection; e.g., Depo Provera			
14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one) 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical); specify medication(s) _____ 3 <input type="checkbox"/> Dilation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (Saline/prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 7 <input type="checkbox"/> Hysterotomy/Hysterectomy 8 <input type="checkbox"/> Other (specify) _____			
15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply) 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical); specify medication(s) _____ 3 <input type="checkbox"/> Dilation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (saline or prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 8 <input type="checkbox"/> Other (specify) _____			
16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
17. WAS FOLLOW-UP VISIT RECOMMENDED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
18. COMPLICATIONS AT TIME OF PROCEDURE (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
19. AT THE TIME OF COMPLETION OF THIS REPORT FORM, HAD A FOLLOW UP VISIT OCCURRED AT THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES; If yes, <u>specify complications</u> (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED OUTSIDE THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> UNKNOWN If yes, <u>specify complications</u> (check all that apply) & <u>complete item 20a below</u> : 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 20A. If yes, specify <u>location of follow-up visit</u> : 1 <input type="checkbox"/> Physician's Office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> Other (specify) _____			

IRB Approval #4321

Department of Anthropology

Oregon State University, 270 Waldo, Corvallis, Oregon 97331

Tel 1 541 737 4515 | 1 541 737 3650 | http://oregonstate.edu/cla/anthropology/

STUDY ANNOUNCEMENT -- INVITATION TO PARTICIPATE IN RESEARCH

To Patients of XXXXXXXXXXXXXXXXXXXX in XXXXXXXXXXXXXXXXXXXX:

Patients often tell us about the problems they run into while trying to get to their appointment(s) at our clinic, including having trouble getting on Oregon Health Plan, arranging childcare, taking time off work or school, paying for gas or a hotel room, etc. As a patient, you will be asked to fill out an optional anonymous survey about your experiences with any of these possible barriers to care, or any other problems you may have had getting to your appointment today. I am researching **Social Inequality and Reproductive Health: Barriers to Abortion Care in Oregon**, for my Master's degree at Oregon State University. I hope to use the anonymous information I gather during my research to work with healthcare providers and policymakers to make it easier for women in Oregon to receive abortion services.

As a student researcher, **I am asking for your help. If you are interested in participating in my research, I would appreciate getting your permission to contact you about setting up an interview about your experiences getting to our clinic.** The interview would take place at a time and location of your choosing, to ensure your confidentiality and comfort. If the results of this project are published your identity will **not** be made public. **Your participation in this study is voluntary and you may refuse to answer any question(s) for any reason. Your decision about participating will in no way affect the care you will receive at XXXXXX. Choosing not to participate in this research will not diminish the quality of care you receive.** The answers you provide will be kept confidential to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. There are no foreseeable risks to you as a participant in this project; nor are there any direct benefits. **However, your participation is extremely valued !** If you have any questions about the survey, please contact me, or my advisor, Dr. Melissa Cheyney, at Tel.#(541) 737-2637 or by email at ostrachb@onid.orst.edu (Dr. Cheyney cheyneym@onid.orst.edu). If you have questions about your rights as a participant in this research project, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at (541) 737-4933 or by email at IRB@oregonstate.edu.

Thank you for your interest in this research! I appreciate your cooperation and support.

Sincerely,

Bayla Ostrach, Graduate Student, Oregon State University

If you are willing to be contacted about the possibility of setting up an interview regarding your experiences trying to obtain abortion services, at a time and place most convenient for you, please fill out the slip below, and return the form to the receptionist.

Name _____ Cell phone # _____

Alternate phone # (if available) _____ E-mail address (if available) _____

City where you live _____

Confidentiality (check one): _____ it is fine to say why you're calling

_____ please don't leave a message

IRB approval #4321
Department of Applied Anthropology
Oregon State University, 270 Waldo, Corvallis, Oregon 97331
Tel 1 541 737 4515 | 1 541 737 3650 | http://oregonstate.edu/cla/anthropology/
STUDY ANNOUNCEMENT -- INVITATION TO PARTICIPATE IN RESEARCH

A Pacientes del XXXXXXXXXXXX en XXXXXXXXXXXX:

Pacientes de esta clinica frecuentamente nos avisan acerca de los problemas que han encontrado en el proceso de obtener servicios de aborto, incluso problemas con calificarse por el Plan de Salud de Oregon, arreglando cuidado de niños, tomándose tiempo libre el trabajo o la escuela, pagando por gasolina o una habitación de hotel, etc. Como una paciente de esta clinica, usted será pedido llenar una entrevista anónima opcional acerca de sus experiencias con cualquiera de estas barreras , o cualquier otros problemas que usted encontro en el proceso de llegar a su cita hoy. Yo soy una investigante de la **Desigualdad Social y la Salud Reproductiva: Barreras al Cuido del Aborto en Oregon**, para mi máster en la Universidad. del estado de Oregon (OSU). Espero utilizar la información anónima que reúno durante mi investigación para trabajar con proveedores de cuidado medical y gente responsable de formular la política para hacerlo más fácil para mujeres en Oregon recibir servicios de aborto.

Como una investigante y estudiante, **yo pido su ayuda. Si usted tiene interes en tomar parte en mi investigación, le agradecera conseguir su permiso para contactarle acerca de hacer una entrevista acerca de sus experiencias en el proceso de obtener servicios de aborto.** La entrevista sucedería a la vez y el lugar que Ud. elige , para asegurar su confidencialidad y para hacerle mas comoda. Si los resultados de este proyecto seran publicados su identidad **no** será hecha público. **Su participación en este estudio es voluntaria y usted puede negarse a contestar cualquier pregunta (preguntas) para cualquier razón. Su decisión acerca de participar no afecta de ninguna manera el cuidado que usted recibirá en el XXXXXXXXXXXX. Decidir no tomar parte en esta investigación no disminuirá la calidad de cuidado que usted recibe.** Las respuestas que usted da serán mantenidas confidencial hasta el punto permitido por la ley. Precauciones especiales han sido establecidas para proteger la confidencialidad de sus respuestas. No hay riesgos previsibles a usted como un participante en este proyecto; ni estén allí ningún beneficio directo. **¡Sin embargo, su participación valora mucho !** Si usted tiene cualquier pregunta acerca del estudio, por favor comuníquese conmigo, o con mi consejera, la Dr.a Melissa Cheyney, al Teléfono. #(541) 737-2637 o por correo electrónico en ostrachb@onid.orst.edu o <cheyneym@onid.orst.edu> Si usted tiene preguntas acerca de sus derechos como un participante en este investigación, comuníquese por favor con la Tabla Institucional de Revisión (IRB) en OSU: la Administradora de Protecciones Humanas al Tel. (541) 737-4933 o por correo electrónico en IRB@oregonstate.edu
¡Gracias por su interés en esta investigación! Le agradezco su cooperación y apoyo.

Sinceramente,
Bayla Ostrach, Estudiante de posgrado, -----

Si usted está dispuesto a ser contactado acerca de la posibilidad de establecer una entrevista con respecto a sus experiencias que tratan de obtener servicios de aborto, a la vez y colocar más conveniente para usted, llenar por favor el tropiezo abajo, y volver la forma al recepcionista.

Teléfono celular# _____ Alterna teléfono # (si disponible) _____ dirección de
EMAIL (si disponible) _____ la Ciudad donde usted vive _____
Confidencialidad (elige uno): ____esta bien dejar un recado ____no deja ningún recado

Informed Consent Document - Women seeking Abortion care

Project Title: **Social Inequality and Reproductive Health: Barriers to Abortion Care in Oregon**

Principal Investigator: Melissa Cheyney, Applied Anthropology

Co-Investigator(s): Bayla Ostrach, Applied Anthropology

What is the purpose of this Study ?

This study is looking at problems that women in Oregon run into while trying to access abortion services. The researchers hope to learn more about which problems are the hardest to overcome, according to women coming to one clinic in Oregon. We also want to collect stories from women talking about their experiences with barriers to getting abortion care.

What is the purpose of this form ?

This informed consent document is meant to answer any questions you may have about what will happen if you agree to be a part of this project, and to make sure you understand your rights as a research participant.

Why am I being invited to participate in this study ?:

You are being invited to participate in this study because as a woman seeking abortion care at this clinic, you may have faced certain problems or challenges getting to your appointment(s). We want to collect information from you about what it has been like to deal with any problems you had getting here for your appointment(s). The researchers believe that your experiences and opinions are important to understanding how women's access to abortion could be improved in Oregon.

What will happen during this study and how long will it take ?:

Prior to beginning the interview, the researcher will discuss this informed consent document with you, answer all your questions about the study, and ask you to sign this document. The interview may take up to an hour, or longer, depending on the length of your answers. If you are willing, you may be contacted for a subsequent follow-up interview to discuss and respond to the findings of the project. If you agree to take part in this study, your involvement will continue over approximately a nine-month period of time, consisting of up to two interviews during that time. Interviews may be tape-recorded to ensure accuracy in transcription. All recordings will then be deleted or kept secure in a locked office. Interview transcripts and notes will be kept secure, and any documents linking your real name to the information collected in your interview(s) will be kept in a locked office and will only be seen by the researchers.

What are the risks of this study ?:

It is possible that remembering and talking about any problems you had getting to your appointment(s), or talking about dealing with protesters in front of the clinic, might be stressful or uncomfortable for you. If you get upset or uncomfortable while talking about your experiences trying to get abortion care, the researchers can give you a phone number for an unbiased telephone talkline, Backline, where the volunteers are very comfortable talking with women about any concerns they have related to their abortion(s). In addition, the main researcher has volunteered for many years with an abortion hotline based in Eugene, Oregon, and during her regular hotline shifts she frequently speaks with women who are very stressed-out and upset about the difficulties they encounter seeking abortion care. This researcher will be comfortable talking with you about any discomfort or stress you may feel while recalling your efforts to get an abortion.

What are the benefits of this study ?:

There will be no direct benefit to you, from participating in this study. However, if you would like to see other women in Oregon be able to get abortion services more easily, the researchers hope that the results of this study can be used to improve access to abortion services, for women in Oregon.

Will I be paid for participating ?:

You will **not** be paid for participating in this project.

Who will see the information I give ?:

The information you provide during this research study will be kept confidential to the extent permitted by law. Only researchers and research assistants directly involved in this project will see the information you give. To help protect your confidentiality, all interview notes, tapes, and transcripts will stay in the researchers' possession at all times, or be stored in a secure room. All interview notes and transcripts will have your real name removed. Any information linking your real name or initials to the anonymous data will be kept in a locked office. If the results of this project are published your identity will **not** be made public, and a pseudonym (fake name) will be used instead.

Do I have a choice to be in the study ?:

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide **not** to take part in this study, your decision will have no effect on the care you receive at this clinic. You will not be treated differently if you decide to stop taking part in the study. If you participate in interviews, you will be free to skip any questions that you prefer not to answer. If you choose to withdraw from this project before it ends, the researchers may

keep information collected about you and the information may be included in study reports.

What if I have questions ?:

If you have any questions about this research project, please contact: Melissa Cheyney, #541-737-2637, cheyneym@onid.orst.edu or Bayla Ostrach, #541-737-2637, ostrachb@onid.orst.edu, or the OSU Institutional Review Board (IRB) Human Protections Administrator, #541-737-4933, IRB@oregonstate.edu

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Participant's Name (printed): _____

Signature of Participant _____ Date _____

*Informed Consent Document - Clinic Staff Interviews***Project Title: Social Inequality and Reproductive Health:
Barriers to Abortion Care in Oregon**

Principal Investigator: Melissa Cheyney, Applied Anthropology

Co-Investigator(s): Bayla Ostrach, Applied Anthropology

What is the purpose of this Study ?

This study is looking at problems that women in Oregon run into while trying to access abortion services.

The researchers hope to identify which barriers to care are most challenging for women seeking services at one clinic in Oregon, and to gather stories from women talking about their experience with barriers to abortion care.

What is the purpose of this form ?

This informed consent document is intended to answer any questions you may have about what would be involved in participating in this study, and to make sure you understand your rights as a research participant.

Why am I being invited to participate in this study ?:

You are being invited to participate in this study because as a member of the clinic staff you are in a unique position to discuss which barriers you think are most challenging for women seeking care at the clinic where you work. With many years' experience with women seeking abortion services, you may have suggestions about how providers, policymakers, and advocates could support women seeking abortion care, to make the process easier. The researchers believe that your experiences and opinions are important to understanding how women's access to abortion could be improved in Oregon.

What will happen during this study and how long will it take ?:

If you consent to be contacted for an interview, you will soon be by a researcher to plan a time and place (of your choosing) to interview you about your experiences working at the clinic. This interview can take place at your home, at another location you are comfortable with, or over the telephone. Prior to beginning the interview, the researcher will discuss an informed consent document with you, answer all your questions about the study, and ask you to sign the informed consent document. The interview may take up to an hour, or longer, depending on the length of your answers. If you are willing, you may be contacted for a subsequent follow-up interview to discuss and respond to the findings of the project. If you agree to take part in this study, your involvement will continue over approximately a nine-month period of time, consisting of up to two interviews during that time. Interviews may be tape-recorded to ensure accuracy in transcription. All recordings will then be deleted or kept secure in a locked office. Interview transcripts and notes will be kept secure, and any documents linking your real name to the data gathered in your interview(s) will be kept in a locked office and will only be available to the researchers.

What are the risks of this study ?:

It is possible that discussing the experiences of women seeking abortion care at the clinic where you work may be distressing or uncomfortable for you, particularly if you recall or describe difficult circumstances that patients had to face. The researchers are happy to provide you with referrals to an unbiased abortion talkline (Backline) if you want to talk about any stress you experience related to this study. The researchers are also willing to spend time talking with you during, or after, the interview if you want to debrief and talk about your reactions to being interviewed.

What are the benefits of this study ?:

There will be no direct benefit to you, from participating in this study. However, if you would like to see other women in Oregon have the ability to get abortion services more easily, the researchers hope that the results of this study can be used to improve access to abortion services for women

in Oregon.

Will I be paid for participating ?:

You will not be paid for participating in this project.

Who will see the information I give ?:

The information you provide during this research study will be kept confidential to the extent permitted by law. Only researchers and research assistants directly involved in this project will see the information you give. To help protect your confidentiality, all interview notes, tapes, and transcripts will be in the researchers' possession at all times, or stored in a secure room.

All interview notes and transcripts will have your real name removed. Any information linking your real name or initials to the anonymous data will be kept in a locked office. If the results of this project are published your identity will **not** be made public, and a pseudonym will instead be used.

Do I have a choice to be in the study ?:

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide **not** to take part in this study, your decision will have no effect on your employment at the clinic. You will not be treated differently if you decide to stop taking part in the study. If you participate in interviews, you will be free to skip any questions that you would prefer not to answer. If you choose to withdraw from this project before it ends, the researchers may keep information collected about you and this information may be included in study reports.

What if I have questions ?:

If you have any questions about this research project, please contact: Melissa Cheyney, #541-737-2637, cheyneym@onid.orst.edu or Bayla Ostrach, #541-737-2637, ostrachb@onid.orst.edu_____

If you have questions about your rights as a participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator, #541-737-4933, IRB@oregonstate.edu

Your signature indicates that this research study has been explained to you, that your questions have been answered,

and that you agree to take part in this study. You will receive a copy of this form.

Participant's Name (printed): _____

Signature of Participant _____ Date _____

IRB 4321

Interview Guide (patients)*Modified Grounded Theory Approach: elicit the woman's STORY*

- 1) Introductions, get-to-know-you conversation
- 2) Researcher's background and interest in abortion access
- 3) INFORMED CONSENT EXPLANATION, Consent Forms
- 4) Participant's questions about the project
- 5) Interview Background Info: Participants' age, parity, relationship status, employment situation, etc.
- 6) "Tell me about your abortion experience... " *(use checklist, check off if woman mentions them, probe/clarify/prompt about any she doesn't bring up if it fits in the flow of the conversation... let the woman's STORY determine the questions to ask...)*

Barriers to access which the participant encountered ?

How did they affect her ability to seek care ?

How did she overcome them to succeed in obtaining abortion care ?

What would have made this easier ?

(If a woman states she did not encounter barriers, but then describes any circumstances of her situation which relate to known barriers to access, follow-up by asking why she did NOT consider that she encountered barriers)

Socioeconomic factors ?

Employment, income

Family status, size

Childcare ?

Domestic violence or other extreme circumstances ?

(citizenship ? - if applicable)

Oregon Health Plan awareness, utilization

Logistical factors ?

Travel arrangements

Lodging (if applicable)

Time off work/school/etc.

Childcare ?

Getting onto OHP ?

Social factors ?

Previous pregnancies, abortions, emotional concerns

Partner support

Family support

Anti-choice protesters - fear of harassment ? encountered at clinic ?

(Crisis Pregnancy Centers ?)

IRB 4321

Interview Guide (clinic staff)

- 1) Ask clinic staff what barriers to access they've noticed affecting our patients
Which barriers do they think are most challenging for women ?
How do they think women overcome these barriers ?
- 2) Share initial findings from surveys and interviews, elicit reactions regarding how staff perceptions of barriers to access match up, or don't, with patients' own stories
- 3) Ask clinic staff to suggest ways they think we as clinic staff and healthcare advocates could improve access to care

Ostrach M.A., approved IRB 4321 Oregon State University

Clinic Staff Survey

This is an optional survey. The results of this survey will hopefully be used to improve Oregon women's access to abortion services. If you do not wish to have your answers from this survey used for an IRB-approved research project, please do not fill this form out.

Q1 - What is/was your position or title at the clinic ? _____ (please fill in)

Q2 - How many years have you/did you work(ed) providing abortion care ? ____ (please fill in a #)

Q3 - List the three biggest barriers to accessing care which you believe your patients encounter:

- a) _____
- b) _____
- c) _____

Q4 - For the barriers you listed in Question 3, please describe below how you feel that patients overcome these barriers in order to successfully obtain abortion services:

- a)

- b)

- c)

Q5 - Please list some ways that you believe clinic employees, other providers, and women's healthcare advocates could help women overcome barriers to abortion care: (feel free to continue on to the back of this form if you need more room)

