ABORTION ACCESS IN THE US: IS IT A FADING REALITY? A MIXED METHODS APPROACH

BY

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THESIS

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ABSTRACT

This study investigates the roles of geographic barriers and legislative barriers on women's access to abortion at the state and local levels. Women's access to abortion is determined by legal restrictions that vary across states as well as by the geographic availability of abortion clinics. The past five years have seen an increase in state restrictions against abortion, which has led to the closure of clinics and barriers to women receiving services when needed. This study is conducted in two parts. The first part presents a GIS analysis of changing abortion restrictions and services at the national scale, and a case study of geographical access to abortion services in Indiana. Findings show rising inequality in abortion access among states. Increasing restrictions and decreasing availability of abortion providers are combining to restrict access for women in certain states in the Midwest and South. The second part involves an interview with abortion providers in Indiana, a state that is highly hostile towards abortion. The interviews reveal how abortion clinics and women who need abortion services are coping with the new antiabortion legislation. The study employs GIS analysis and qualitative research methods to demonstrate a pattern of legislative restrictions and geographic barriers that are sweeping the country and making it increasingly difficult to access abortion services.

To my family and friends, for pushing me towards the finish line.

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Chapter 1

INTRODUCTION

Access to abortion services in the US is slowly on the decline. Many countries around the world have made efforts to legalize abortion, but states in the US have restricted the procedure to make it increasingly unattainable within their borders. Abortion opponents have shifted protests away from abortion clinics, and have successfully focused on changing state legislation to limit access to the procedure at a state-wide level. The objective of this research project is to understand how legislative and geographical barriers coalesce to restrict access to the procedure for women and for providers. This research project seeks to investigate the impacts of antiabortion legislation combined with geographical barriers on women's access to the procedure. More specifically, the study investigates legislative barriers and their role in limiting abortion providers' provision of the procedure and women's ability to access the procedure in the time span from 2008 to 2013.

The intellectual merit lies in this study's ability to understand the relationships between the geography of abortion access, feminist frameworks on women's social roles and identities, and the role of state policymakers in reducing access to abortion. Research has shown that the majority of counties in the United States lack an abortion provider, and the ones that do offer abortion, offer the procedure at limited gestational periods (Jones and Jerman 2013; Joones and Kooistra 2011; Upadhyay et al. 2013). This research project will look at how legislative policies against abortion are affecting access at the national scale, as well as through a case-study of Indiana, to better understand the impact of antiabortion legislation at a local scale.

1.1 BACKGROUND

The topic of abortion is a contentious one in the US, with two clear movements existing with opposing views, the prochoice movement and the prolife movement (Jelen and Clyde 2003; Stricker and Danigelis 2002). Since the federal legalization of abortion in the *Roe v. Wade* decision in

1973, both sides have fought to legislate the procedure with very different goals in mind. Although *Roe v. Wade* removed all barriers to abortion, states began to win back power to legislate the procedure within their borders with *Webster v. Reproductive Health Services* of 1989 and *Planned Parenthood v. Casey* in of 1992 (Gober 1994; Harper, Henderson, and Darney 2005; Oakley 2003). Since 1989, states have regulated abortion in many ways, with most states restricting the procedure. Since 1973, various waves of antiabortion legislation and protest in the US have occurred (Gober 1994). The most recent one, and the topic of this research project, is from 2008 to 2013.

The antiabortion movement has affected the US unevenly within the past five years. Conservative states have been at the forefront of the antiabortion movements, with most restrictions being introduced and passed in these states (Guttmacher Institute 2013). A clear gap exists between the policies of Southern and Midwestern states, compared to those of the coastal states. Abortion services have been restricted the most in the South and in the Midwest, but the coastal states have remained fairly neutral to the procedure (Guttmacher Institute 2013). Although the majority of Americans are moderate on their stance toward abortion, ability to access an abortion is on the decline (Jelen and Clyde 2003). The most recent wave of antiabortion activity began in 2008 and has gained momentum since 2010. At this time, many antiabortion governors and representatives were elected, which resulted in state legislatures becoming anti-choice. President Obama also signed the Affordable Care Act into law, which carried stipulations regarding abortion and contraception, and this brought the issues of abortion and contraception to the forefront of American politics (Boonstra and Nash 2014; Hasstedt, 2014).

From 2007 to 2013, 230 new restrictions against the procedure were introduced in state legislatures, and most of these restrictions severely curtail women's access to the procedure by limiting women's ability to obtain the procedure and physicians' and clinics' ability to offer it (Guttmacher Institute 2013) (Table 1). Twenty-seven states have implemented laws setting stringent

clinical and medical requirements for abortion providers that go beyond what is necessary to ensure the safety of women getting the procedure (Guttmacher Institute 2013). Additional restrictions that do not protect a woman's safety are in place to discourage providers from operating clinics and to make it more difficult for women to access the procedure. An example of such a restriction is when policymakers mandate that clinics change the size of janitorial closets. Many of these restrictions are known as Targeted Regulations Against Abortion Providers (TRAP laws), which only exist to decrease access to the procedure (Guttmacher Institute 2013). TRAP laws are designed to force clinics to restructure to meet the qualifications of ambulatory surgery centers. These rules are often unnecessary and do not protect women's safety. TRAP laws are costly and only pertain to abortion clinics, and with their inherent goal aiming to shut down providers.

Table 1: Abortion Restrictions on Providers and Patients

Restrictions on Providers	**Restrictions on Patients**
All abortions must be performed by a licensed physician	A healthcare provider may refuse to perform abortions for ideological reasons
Abortion must be performed at a hospital after a certain age of fetal gestation	Patient must incur state-mandated counseling session prior to abortion
A second physician must be present after a certain gestational period	Patient must incur a minimum waiting period in between state-mandated counseling and abortion
Partial-birth abortion is banned	Minors must notify parents and/or get consent from parents prior to abortion
All clinics performing abortions must be certified ambulatory surgical centers	Abortion is prohibited at a certain gestational period
All physicians must have transfer agreements with a nearby hospital	The state only funds abortions in case of life endangerment, rape, or incest
	Statewide ban on private insurance coverage of abortion

Other antiabortion legislation is aimed at discouraging women from having this procedure (Table 1). Tactics used by antiabortion policymakers include mandating that a woman listen to medically biased information regarding abortion, gestational limits that restrict at what point a woman may have an abortion during pregnancy, parental notification requirements, financial barriers

related to Medicaid, and geographical barriers (Dennis and Blanchard 2013; Guttmacher Institute 2013; Medoff 2011; Russo and Denious 2005).

Overall, the recent antiabortion legislation creates geographical barriers to the procedure. TRAP laws often force clinics to close down, which limits a woman's access to abortion. Mandatory waiting periods and in-person counseling sessions create travel barriers for women, and increase the costs associated with the procedure, while general disadvantages in access in more conservative parts of the US mean that a woman's access to reproductive healthcare is determined by where she lives. According to Jones and Jerman (2013), about 87% of US women live in counties that lack an abortion provider, and 35% of women of reproductive age live in those counties. Disparities in abortion access are evidenced through the geographical landscape of the US. The disparities are only going to grow as new legislation is introduced by states to limit the procedure.

1.2 RESEARCH HYPOTHESES

This thesis project has three hypotheses surrounding restrictions and geographical barriers in the US.

1. Antiabortion restrictions do impact geographical access to abortion services in the US. Antiabortion legislation impacts provider ability to offer the procedure and decreases women's access to the procedure.
2. The number of restrictions has increased over time in some states, which decreases access to services.
3. Geographical access to abortion services varies by class, race, and ethnicity.

1.3 STUDY SITE

This study is conducted on two scales, the national scale and at the state scale. At the national scale, all 50 states and Washington DC were evaluated to see how antiabortion legislation

and geographical access are changing over time. While investigating all 50 states at the national scale, one can get a sense of how antiabortion legislation is changing the landscape of abortion access in the long term.

The second part of this study is conducted at the state scale, in Indiana. All 1,511 census tracts in Indiana were evaluated using network analysis to determine the average distance that women of various population demographics have to travel to reach one of the six abortion clinics in the state. All six abortion clinics in Indiana were evaluated to determine their locations, and the types of abortion services they offer. Semi-structured interviews were also conducted with two reproductive health experts in Indiana, who work for a leading provider of women's healthcare. These interviews helped gauge how providers operate their clinics in a highly restrictive state.

Indiana was chosen due to its strong anti-choice climate. NARAL Pro-Choice America rates Indiana with an "F" for choice-related laws regarding abortion (NARAL 2014). Indiana has instituted eleven legal restrictions on abortion, making it the second most hostile state to abortion after Kansas, which has twelve restrictions.

1.4 METHODS

This study is a mixed-methods analysis consisting of interviews and spatial analysis. The first part consists of a quantitative study using GIS. The GIS analysis is conducted in two parts, one part is at the national scale of the US and the second part is at the state scale, as a case study of Indiana. The national scale analysis investigates how access to abortion services has changed in the US in all fifty states and Washington DC over time. The study includes choropleth mapping consisting of an index of access measures, such as legislative restrictions against abortions and number of providers per 1,000 women. This index evaluates the severity of restrictions against abortion, and these restrictions were mapped out to show the changing legislative and geographical landscape of

abortion access. Maps were constructed for the years 2008 and 2013 to evaluate trends in antiabortion legislation and abortion access at the national scale.

The second half of the quantitative study consists of a state-scale study of Indiana. Network analysis was conducted using a network of roads in Indiana, geocoded abortion clinics, and census tracts with population information. The network analysis demonstrates how far women of various demographics, including race and ethnicity, education attainment, and income have to travel to reach an abortion provider in Indiana.

The qualitative portion of the study consists of one interview with two health experts working in women's reproductive healthcare. The interview was conducted in Indiana in order to gain information as to how providers confront difficult abortion restrictions in order to provide the service to women. Providers' perceptions of antiabortion legislation demonstrate how clinics are coping with the new laws while attempting to serve women. The interviews also help understand how women navigate the restrictions and related geographical barriers to reach an abortion provider.

1.5 PROJECT SIGNIFICANCE

This study contributes to feminist studies, studies on access to reproductive healthcare, and studies on the geography of abortion access. The results from this work demonstrate that access to abortion services is declining at the national scale, as well as at the state scale. The current antiabortion movement is making a significant impact on reducing access to abortion services by eliminating abortion providers, increasing geographical inaccessibility, and by making it more costly for women to have the procedure. The results from this study can be beneficial in planning and evaluating future policies regarding reproductive healthcare and family planning. The originality of this research is that it demonstrates the importance of evaluating geographic barriers alongside legislative barriers when seeking to understand how women access abortion care.

1.6 THESIS ORGANIZATION

This thesis is organized into four chapters. Chapter 2 is a literature review that focuses on the definition of healthcare access, as defined by Andersen (1995) and access to resources, as defined by Ribot and Peluso (2003). It also includes the theoretical framework of this thesis, which is based on feminist studies of women's reproductive roles in a patriarchal society, as presented by Irigaray (1985) and Nast (2002). Finally, it includes a review of recent abortion studies on restrictions and access.

Chapter 3 presents the quantitative analysis of the legislative and geographical barriers to abortion services at the national scale and in Indiana. The national scale consists of the creation of an index of legislative restrictions against abortion that limit the provision of the procedure. Choropleth maps analyze how the landscape of abortion access in the US is changing over time. The second half of the quantitative analysis is a network analysis of Indiana, using TIGER files, street networks, US Census Bureau Census Tracts, geocoded abortion clinics, and population demographics for women of reproductive age. The network analysis consists of two analyses, the *service area* analysis and the *closest facility* analysis. These tests determine how far women of various population demographics must travel to reach an abortion clinic in Indiana.

Chapter 4 is the qualitative analysis, consisting of one interview with two health experts in a well-known women's reproductive healthcare organization, dubbed "National Health Organization" for anonymity purposes. These interviews, conducted in July 2014 for one hour, gain insight as to how abortion providers navigate antiabortion restrictions that are intended to shut them down. The interviews also gained information as to how women operate through these restrictions to overcome geographical and legislative barriers to the service.

Chapter 5 is the final section of the thesis, and the discussion section. This section draws together the results from the spatial analysis and the interviews to give a final picture as to how

access to abortion is changing in the US. This chapter articulates the results from the spatial analysis and the interviews in relation to the literature review to further demonstrate the significance of the thesis project. Future direction and the limitations of this study are reviewed in this chapter, as well.

Chapter 2

LEGISLATIVE AND GEOGRAPHICAL BARRIERS TO ABORTION: THE GROUNDWORK FOR RESEARCH

Countries around the world continue to legalize abortion at an increased rate, but states in the US are instituting barriers to prevent women from accessing abortion (Fried 2008; Ostrach 2013). Abortion opponents have shifted protests away from abortion clinics, and towards legislation (Fried 2008). Their efforts are resulting in increasing barriers, include mandatory and biased counseling requirements, waiting periods, third-party consent, limitations on the range of abortion options (such as restricting the use of Mifepristone, an abortion inducing drug), among others (Finer and Fine 2013; Finer and Zolna 2011). These restrictions limit women's ability to choose reproductive healthcare. As restrictions are instituted, women find that they are geographically limited in accessing an abortion provider due to difficulty accessing transportation, lost wages, and increased treatment costs (Kahane 2000). This literature review explores the changing trends of abortion access in the US and the effects on women's geographic spaces. This chapter begins by the discussion of two key theoretical frameworks that guide the research: theories of access and feminist theories. The next section discusses the recent abortion restrictions, followed by geographical access to abortion. The chapter ends with implications of abortion access and women's reproductive health.

2.1 STUDIES ON HEALTHCARE ACCESS

In order to comprehend how access to abortion services is being restricted by states in the US, one must first study the meaning of access. Significant literature has been dedicated to exploring the meaning and the importance of access in terms of health care. This thesis employs the definitions of access, originally proposed by Andersen in 1968, and by Ribot and Peluso (2003). Theories of access can be broken down by locational access, socio-demographic influences on

access, and gendered notions of access. All three aspects of access are important to explore in order to fully understand the barriers that exist which prevent women from receiving abortion care.

2.1.1 The Andersen Model

This study employs the Andersen model of healthcare access that explains how predisposing factors and enabling factors affect access (Andersen 1995). Andersen states that people's use of health services is a function of their predisposition to use services, factors which enable or prevent use, and their need for care. Predisposing characteristics, enabling resources, and need all contribute to a person's use of healthcare (Andersen 1995). Predisposing factors include demographics, such as age and gender, social structure, and beliefs about health and the medical industry. Enabling resources include a person's family and the community in which they live. Need is described as perceived or evaluated need (Anderson 1995). Many of the factors I consider are actually dis-abling factors that create barriers for women to obtain abortion services if needed. The model was designed to both predict and explain how individuals use the healthcare system (Andersen 1995). The model has proven to be influential for economists and sociologists, who focus on the costs and benefits of healthcare use, but it has been less influential for health geographers, who depend on 'place' to describe access.

Andersen's model can help us gain an understanding of how women perceive abortion restrictions within their states. For pregnant women, enabling resources include family members, friends, medical professionals, and their religious communities. All of these resources play a role in determining whether a woman will have an abortion or continue a pregnancy. Other factors from Andersen include age and gender. While a well-established woman in her late twenties may have greater resources to make a decision about her pregnancy, a teenage girl may not have those same resources. Lastly, distrust of abortion providers due to anti-choice campaigning and a history of distrust of the medical industry may also deter some women from accessing an abortion provider.

Andersen's model is relevant to the discussion of abortion access in the US due to its model of how people access health care, if they even access it at all.

The model follows a path of predisposing characteristics, which include demographics, social structure, and beliefs concerning health. It is followed by enabling resources, such as personal relationships, familial relationships, transportation, and the local community. Finally, it employs aspects concerning need for healthcare services, such as the perceived need, and evaluated need (Andersen 1995). Andersen's discussion on the first part of his model concerning social structure, demographics, and health beliefs apply to abortion access since age, economic status, and personal beliefs can act as barriers in abortion access. Andersen describes enabling resources, as community and personal resources as the second portion of his four-part model. That is, before a person can use a healthcare service, they must have a health facility in their community. They must also know how to reach the facility and know how to use it (Andersen 1995). This is directly related to access to abortion services, since the most immediate barrier to abortion services is lack of a clinic. Many states are seeking to restrict providers so severely, that they have no choice but to close their doors. Andersen would say that this is the first barrier a person may run into when accessing health services.

Informed consent laws, which are based on a state-mandated script intended to discourage women from abortion, and waiting periods between initial consultation and the procedure act as barriers for the second part of his access model, where women may not know how to reach a facility or how to use information given to them. Informed consent laws often give false or misleading information regarding abortion and pregnancy, that women may not be able to make the best informed decision regarding abortion care use. The third portion addresses perceived and evaluated need for services. Abortion providers address evaluated need by providing counseling to patients

prior to performing the abortion. These three aspects of the model address how women access abortion services, as well as the geographic and legislative barriers that limit access.

2.1.2 The Ribot and Peluso Model, and SES

Ribot and Peluso define access in a way that goes further than the legal right to a resource. Their definition of access is vital to abortion access studies, since the definition describes access as something that incorporates 'the right to do something' with 'the power to do something.' Ribot and Peluso define access as "the ability to derive benefits from things" (2003: 153). Ability is explained by the "issues of *who* does (and does not) get to use *what*, in *what ways*, and *when*" (Ribot and Peluso 2003). Their work argues that access can be defined in two main ways: as the legal right to a resource, and as the ability to access a resource. This ability is also defined as the power to access a resource (Ribot and Peluso 2003). Access is defined as a relationship between multiple structures that changes over time.

Ribot and Peluso describe access as a bundle of powers that is organized and maintained by all the possible ways that a person can benefit from a resource (Ribot and Peluso 2003). This theory differs from the traditional definition of the "right to a resource" because it uses measures that are more comprehensive than legal statutes. The theory addresses the fact that access is not stagnant, and changes with time. This thesis addresses how access changes with time, and goes further to address how it changes across geographies. Access also changes according to manipulations in human relationships, and human relationships with institutional structures. We can see this in abortion access, as women with more social and economic power retain access even when others lose access. At the same time, people can also gain access, since relationships are constantly altered.

Using Ribot and Peluso's theory of access is important for abortion access studies because legal structures in the US guarantee the right to an abortion, while at the same time, they limit access to abortion. These limitations take place at the federal and state levels. Their theory discusses

concepts of access *control* versus access *maintenance*. They state that, not only is access determined by *ability* in addition to the *right* to do something, access is further divided into those who control access and those who maintain it (Ribot and Peluso 2003). Control is interpreted as someone's regulation over another's ability to access a resource. Maintenance is interpreted as the action of using resources to sustain access to a resource (Ribot and Peluso 2003). In abortion access, politicians, antiabortion groups, and others control access, while prochoice organizations, lawmakers, and providers maintain it.

Ribot and Peluso also employ various mechanisms by which access is determined or gained. These mechanisms change over time and have no particular hierarchy, as some mechanisms may serve as enabling factors or as dis-abling factors. Ribot and Peluso state that analyzing access involves three steps: 1. figuring out flow of benefits from the resource 2. diagnosing the mechanisms by which people and institutions win control of and control the benefit of the resource, as well as its distribution 3. evaluating power relations that are concerned with the mechanisms of access in relation to gathering benefits from the resource (Ribot and Peluso 2003). These three steps are the preliminary steps before mechanisms of access can be analyzed. After identifying the benefits of the resource, mechanisms of access can be further investigated (Ribot and Peluso 2003).

Ribot and Peluso address mechanisms that form access proceedings. Their theory is divided into "rights-based" access and "structural and relational access" (Ribot and Peluso 2003). "Rights-based" access focuses on access based in law, while "structural and relational" access focuses on changing relationships between humans and institutions that affect access (Ribot and Peluso 2003).They mention several structural and relational mechanisms, but I will focus on *access to technology*, *access to capital*, *access to knowledge*, *access to authority*, and *access through social identity* (Ribot and Peluso 2003).

Ribot and Peluso's structural and relational mechanisms are framed in cultural and socioeconomic processes that enable and dis-able access. The first one that I discuss in relation to abortion access is *access to technology*. Access to technology is related to abortion access through internet access and transportation access. Those who have access to these technologies are better equipped to find an abortion provider and travel to one. Internet access is also related to *access to knowledge*, since the internet gives women the necessary tools to learn about their options concerning their pregnancies. Limiting access to technology can significantly limit a woman's access to abortion services.

The second influential mechanism is *access to capital*. Access to capital is related to abortion access, since medical costs, travel costs, costs associated with wage loss, among others, may be prohibitive to some women. In this case, organizations exist to help fund women's abortions. At the same time, the Helms and Hyde amendments prohibit federal abortion funding, which reduces abortion access through reducing access to capital. The third mechanism is a*ccess to knowledge*. Access to knowledge is important in terms of access to abortion services. Antiabortion legislation includes informed consent laws that manipulate the type of information that a woman receives before her abortion. This information is often misleading, and even false. This "knowledge" acts as a mental barrier to abortion, even though the patient may have legal and geographical access to the procedure.

The fourth mechanism is *access to authority*. Authority is highly influential in abortion access, since lawmakers are the primary legal drivers of abortion restrictions at the state level, particularly when driven to change laws to satisfy interest groups. Women at the local scale arguably have the least amount of access to authority in terms of abortion access. Lawmakers, advocacy groups, and lobbyists have the most access to authority, and the greatest ability to influence lawmaking. Other authoritative figures that may limit access include community and religious leaders, parents, and

family and friends. Discrepancies exist between what the American public wants in terms of abortion access versus what interest groups and lawmakers want. For instance, Americans tend to be moderate on their views regarding abortion, not wanting too little regulation or too much (Dillon and Savage 2006; Stricker and Danigelis 2002). They consistently vote down measures to restrict abortion, even though lawmakers and interest groups continue to place abortion on the political agenda.

The last mechanism that I address is *access through social identity*. Arguably, women's social identity as female both restricts and enables access to abortion. The topic of abortion is primarily seen as a women's issue, with men being removed from the discussion, aside from lawmaking. Women have the most potential to benefit from access to the procedure, but also most to lose if it is restricted. The discussion of access through social identity can further be dissected by membership in economic social groups. For instance, abortion is primarily a women's topic, but access is enabled or dis-abled by a woman's race and ethnicity, economic status, and immigrant status.

The mechanisms discussed in this paper are just as influential as legal access, and potentially even more influential. Anti-choice policymakers have been successful in restricting abortion access by creating laws that affect structural and relational mechanisms. In this way, one can see how structural mechanisms and legal mechanisms interact to limit access to abortion. Adler et al. (1993) also address structural mechanisms as determinants of healthcare access by discussing how socioeconomic (SES) factors affect women's access to healthcare and health outcomes. They argue that people in higher SES hierarchies have more control over their environments, which impacts overall health. They state that healthcare is also designed with higher-ranked SES members in mind, so lower-ranked SES members do not experience full access to services due to structural and relational mechanisms (Adler et al. 1993). Those with high SES also have more control of their environments, and this improves their control over their health, as well (Adler et al. 1993). This

applies to women's access to abortion since lower-ranked SES women may not be offered a full range of services at a clinic and they may not know all of their options regarding healthcare.

2.2 FEMINISM AS A FRAMEWORK FOR ABORTION ACCESS

In addition to theories of access, this project is based on studies of women's roles in society and healthcare policies. I posit that women are still influenced by expectations of childbearing in a society that is increasingly becoming more accepting of women's roles outside of the home. I use Irigaray's (1985) work on reproductive bodies and capitalism, and Nast's (2002) work on reproduction and patriarchal expectations to argue that antiabortion policies have increased in recent years mainly due to decreasing fertility rates in the US.

2.2.1 The Uterus as a Commodity in a Capitalist Society

Irigaray (1985) and Nast (2002) posit that women's status in society is determined by their ability to reproduce. Irigaray posits that in capitalist societies, women are treated as commodities, whose worth is measured by two things: their worth as utilitarian objects and as bearers of value (Irigaray 1985). I use Irigaray's philosophy by applying it to the current antiabortion climate, which seeks to reinforce a woman's role as reproducer, and make her other identities secondary. According to Irigaray capitalism emphasizes women's reproductive roles because a growing population promotes new spending and an expanding economy (1985).

In *This Sex Which is Not One*, Irigaray states that a woman has value only in the fact that she can be exchanged (1985: 176). In relation to abortion services in the US, a woman's value lies in her reproductive capability. A woman has worth only to the extent that she can produce new members of society. Irigaray states that in western societies that are dominated by a patriarchal system that supports capitalism, a woman's worth is determined by her ability to contribute new capitalists to society (1985). Irigaray states that women's worth is divided into *usefulness* and *exchange value* (1985: 176). In the US, abortion services are being restricted because women are straying away from this

purported *usefulness*. Women desire to have children on their own term, which disrupts the patriarchal social order. Irigaray states that "the economy of exchange-of desire- is man's business (1985: 177)." This suggests that in western society, a woman's sexuality must be governed by a man, in so far that it is considered an economic good. This methodology can be seen in US abortion restrictions, as states have become somewhat dismayed at the separation of sexuality and procreation. Abortion allows women to participate in sexual activity without reproducing, and this disrupts the patriarchy, and the phallocratic model that goes along with it (Irigaray 1985).

Irigaray further argues that women act as a mirror of value *of* and *for* man (1985: 177). She suggests that a woman's worth is structured and determined by men. In relation to the US abortion climate, policymakers, who are constrained by patriarchy, determine that a woman's worth lies in her reproductive capabilities. As women seek to have children later in life and decide to have fewer children, the patriarchy is altered, women gain autonomy, and fertility rates decrease. Irigaray would argue that this shift in reproductive activity also gives women worth as autonomous individuals, and diminishes their value to man. As restrictions continue to sweep the US, low-income women's socially-defined roles may shift yet again, as they will be most affected by restrictions. These restrictions could effectively limit their influence in the public sphere, as their power to determine their reproductive future will be limited.

I argue that state policymakers use abortion legislation in part as a means to shape population growth. In this way, reproduction is viewed as a valued economic asset that ensures economic security and economic expansion in the future, and access to abortion threatens that goal by limiting population growth. I argue that some policy-makers oppose abortion, not solely due to their religious beliefs, but also because controlling access to abortion is a means of achieving higher rates of reproduction and population growth.

As Missouri state representative Rick Brattin said in December 2014, the case of abortion restrictions is "…not a woman's body with an abortion. It's a child's body…The woman's life is not altered (Mashable 2014)." The bill that Brattin promotes when making these comments is one that requires a man's consent for a woman to have an abortion. His justification of dangerous abortion restrictions is rooted in the fact that antiabortion policymakers regard women's bodies as little more than vessels. Under Irigaray's theory, Brattin's proposal treats the female body as an object of reproduction, but not as a living organism. His beliefs further demonstrate that the economy of exchanging women's bodies is a masculine business (1985: 177). The bill encourages the notion that a woman's body is not her own, but exists to be managed by men. A woman is reduced to a commodity, with a "socially valued, exchangeable body (Irigaray 1985: 180)."

2.2.2 Paternal Law, Capitalism, and the Nuclear Family

Nast argues that patriarchy is a form of paternal law that controls the products of reproduction. The products of reproduction are children, and the producers of children are members of the now declining "white-oedipal" family (Nast 2002). Nast defines the "white-oedipal" family as "culturally specific and economically and politically conservative" (2002). She argues that, according to this framework, this "ideal" family is composed of the most dominant race in the US (whites), and it consists of a heteropaternal male figure, a motherly figure, and their children (Nast 2000). The notion of the oedipal family is racialized, since, according to the theory, whiteness is associated with privilege and power. She argues that whiteness is vital to reproducing this "idealized" version of the family, since it promotes the regeneration of a particular racial group. I argue that this theory is still relevant today, and that restricting abortion is one method of reproducing an idealized version of "the American family" in the US, namely the traditional, white, nuclear family (Nast 2000). This thesis suggests that conservative lawmakers are conscious of the fact that fertility rates among white women are declining as more women work outside the home, so restricting abortion

(and gay marriage) is one way to ensure the reproduction of the white, nuclear family. It also supports the idealized white maternal figure that recreates this family by restricting her reproductive agency.

In addition, antiabortion discourse often connects this idealized family type with capitalist economic growth and development. . Many conservative lawmakers use rhetoric emphasizing the importance of the traditional family in relation to economic growth and prosperity. By restricting abortion and promoting the renewal of the traditional family, many conservative lawmakers believe that they are also ensuring economic growth in the long run by combatting low fertility rates.

Further, Nast (2010) states that during the 18th century, the white nuclear family was central to capitalism. The importance of the white nuclear family, also known, by Nast, as the oedipal family, has declined in the post-industrial era, but I argue that it is still important in shaping discourses regarding abortion access. In the post-industrial era, Nast argues that fertility rates are dropping, and the workforce is increasingly mobile. Nast states that families are important to creating the nation-state, industrial capitalism, and imperialism, as the idea of the oedipal family is synonymous with the idea of the nation-state (2010:194).The paternal head of the family is similar to the state head (2010:194). In the 21st century, the importance of the traditional nuclear family has declined in society, with people forming families with decreased regard towards heterosexual marriage, which threatens hierarchies of power in society that are promoted by the nuclear family. Nast explains that this racialized oedipal family is actually imaginary, and is not indicative of current American society because it assumes that heteronormative families, especially in their most popular form as the nuclear family, are natural (2000: 222). Although the traditional nuclear family (or the oedipal family) is in decline, the nuclear family is still important to capitalist ideals in the post-industrial era. As fertility rates decline and as the nuclear family changes and is replaced with other "nontraditional" families, some policymakers wish to maintain the nuclear family as the upmost goal

of society. I argue that abortion restrictions are increasingly common due to certain policymakers' fears that nontraditional lifestyles are becoming normalized in US society. I also argue that the nuclear family is representative of capitalist ideologies and that the decline in nuclear family formation may represent a change of power in capitalism. As Nast argues, paternity is constructed through market virility, with the male head of the family also representing the male head of capitalist markets (2002: 878). It is also constructed through paternal law that controls the products of reproduction, namely, children (Nast 2002: 878). Those who uphold the importance of nuclear families also potentially fear that the decline of this arrangement may threaten men's power, as they no longer have a female figure to be responsible for traditional household duties. The combination of paternity through market virility and the construction of paternal law that controls the products of reproduction form the patriarchy (Nast 2002: 878).

Policymakers are attempting to restrict abortion in the hopes that the traditional family will be revived as women have little choice but to become mothers and seek male figures as the authoritative and economic heads of their families. As women continue to control their reproductive capabilities and as they choose whether they wish to marry or not, capitalism is due to change, and those who control capitalist markets (men of privilege) may see a loss of power. A loss of power in the home may also suggest a loss of power in the market (Nast 2002; Nast 2010). I argue that the fear of changing familial traditions and capitalist power is what partially drives the antiabortion movement for policymakers. These fears have become interwoven with orthodox religious arguments that oppose abortion, which has led to success in developing a landscape of support across the US. Although this thesis argues that the antiabortion movement in the political sphere is primarily grounded in increasing white women's fertility rates, the shaping of the discourse within religion allows antiabortion politicians to extend their base of support to include some women, some ethnic minorities, and others.

Researchers can glimpse into this potential reality, as marriage equality is becoming normalized in the US, but abortion restrictions are gaining momentum, as well (Guttmacher Institute 2013; glaad.org 2014). In the US, the same states that are challenging marriage equality are implementing various abortion restrictions (Guttmacher Institute 2013; glaad.org 2014). These challenges to marriage equality and abortion access represent challenges to non-traditional families and decreased childbearing. The dual attack on the Marriage Equality Movement and reproductive rights suggests that the "traditional family," and the fertility rates that accompany it, may be on the decline. For example, many social conservatives oppose marriage equality due to arguments that marriage should promote procreation (Brandzel 2005:182). For fiscal and social conservatives, this means that American population demographics may shift in the future, leading to changes in the economy and to cultural norms. Currently, the US fertility rate is 1.86, well below the replacement rate of 2.1 (The Lewin 2014; The World Bank 2015). The antiabortion movement in the US is partly a response to the rise of marriage equality, decreasing fertility rates, and the decline of the "traditional" family.

2.3 STATE RESTRICTIONS' EFFECTS ON ABORTION IN THE US

Many states have increased the number of restrictions within their borders in the last five years (Finer and Fine 2013; Guttmacher 2013). The momentum of antiabortion restrictions does not appear to be slowing down, as policymakers are finding new ways to restrict the procedure. As policymakers restrict access to abortion, women will experience many consequences, such as increased costs, geographical barriers, emotional barriers, and waiting periods (Boonstra and Nash 2014; Guttmacher 2013). Many researchers have investigated the effects of antiabortion policies on fertility rates, abortion use, and women's attitudes towards abortion (Medoff 2011; Ostrach 2013; Rolnick and Vorhies 2012). These restrictions attempt to prevent women from having abortions by making it more costly, geographically unattainable, or emotionally difficult to have an abortion.

Several researchers have studied the impact of abortion restrictions on women's decisions to have an abortion, women's ability to have an abortion, and restrictions and the emotional and psychological costs associated with restrictions. Medoff (2007; 2011), Joyce (2013), and Gius (2007) find that restrictions do not affect abortion rates or a woman's decision to have an abortion. Oakley (2003) finds that antiabortion restrictions do decrease abortion rates, but as demand for abortion increases, restrictions will also decrease. Researchers who did find that abortion restrictions and antiabortion activity lower abortion rates include Kahane (2000), who investigates antiabortion activity and abortion rates in 1992, and Colman and Joyce (2011), who demonstrate that the enactment of the Women's Right to Know Act in 2004 reduced abortion rates in Texas.

Medoff (2011) conducted a study of states' Medicaid funding restrictions, informed consent laws, and two-visit laws, and whether the presence of these abortion restrictions influenced women to use highly effective contraceptive methods to prevent pregnancy (2011: 161). He conducted this study because he finds that many women use abortion as an insurance policy in the case of pregnancy, but they do not use it exclusively as a method of contraception (Medoff 2011). He is interested in seeing if implementing these three types of restrictions would encourage women to use contraceptive methods, since abortion would be less available to them.

Medoff finds that Medicaid funding restrictions, informed consent laws, and two-visit laws have minimal effect on women's use of highly effective contraceptive methods (2011: 168). He argues that restrictions present women with a "negligible cost" of abortion services, since when presented with informed consent laws, women may not even listen to the documents that are intended to dissuade them from having an abortion (20ll: 168). In states that require women to visit an abortion provider twice to have an abortion, 93% of women live within 100 miles of a provider, and almost all women live within 200 miles of a provider (2011: 168). In states with Medicaid restrictions against abortion, low income women represent less than 9% of all women in these states,

so the effect of abortion restrictions on Medicaid is not widespread through the population (2011:168).

Medoff (2011) states that state-enacted policies increase financial and emotional costs to women, and they also lead to a decrease in availability of abortion services, which leads to an increase in travel and time costs that are associated with finding a provider. General antiabortion attitudes in a state do affect women's use of highly effective contraception, so public intolerance towards abortion encourages women to avoid abortion, and use effective contraception (2011: 169). Medoff concludes by saying that antiabortion restrictions, such as Medicaid restrictions, informed consent, and two-visit requirements negligibly affect women's use of contraception, since the restrictions are not significant barriers. Antiabortion sentiment does influence women to use highly effective contraception, since the social stigma of abortion presents a greater challenge than state-mandated restrictions (2011).

Joyce's research (2013) investigates what would happen if *Roe v. Wade* were overturned. He states that although some states would ban the procedure, other states would keep the procedure legal (2013: 884). He argues that women's lives would not be greatly impacted, since women in need of an abortion would travel to states that do not ban the procedure. Although Joyce's research suggests that women would still be able to obtain abortions, he argues that their distance travelled would only increase by 157 miles (2013: 884). Although, for Joyce, 157 miles may not be a lot, this is a significant increase for many women, who do not have access to transportation or the ability to receive time off from work. Also, many states have additional restrictions, such as mandatory waiting periods and the obligation to visit a clinic twice before having an abortion, so increasing the distance traveled by 157 miles more would have detrimental impacts.

Gius' work (2007) on restrictions that impact individual-level abortion-related decision-making demonstrate that restrictions on Medicaid funding for abortion do not affect abortion rates

in a state, nor do they affect a woman' decision to have an abortion. Medicaid funding restrictions do reduce the number of providers in an area, which does impact a woman's decision to have an abortion, as reduced access to providers is a geographical barrier (Gius 2007). Gius states that during the 1990s, the only discernible external action that caused a drop in abortion was the per-capita drop in abortion providers (2007: 504). Otherwise, abortion restrictions have little to no effect on demand (Gius 2007). Gius suggests that antiabortion legislation does not affect women's attitudes regarding abortion, but it may reduce the number of abortion providers in the US, which ultimately does reduce access.

Kahane's research (2000) on antiabortion activity in 1992 and its effect on abortion rates suggests that picketing and demonstrations were most effective in discouraging women from having abortions. He also states that price increases in abortion services also lead to a decrease in abortion rates. Kahane employed cross-sectional data for the US to estimate the impact of antiabortion activity on the demand and supply of abortion services. A two-state least squares estimation of demand and supply was used. Antiabortion activity was described as picketing, protesting, vandalism, stalking of patients and staff, and physical contact with patients (2000: 471). Kahane states that antiabortion activity, such as demonstrations, decreased the market equilibrium abortion rate by 19%, and raised the price of abortion services by 4.3% in 1992 (2000: 477). Although Kahane's research does not concern official state legislation, his work is still relevant to abortion access since the Second Amendment protects protesters' right to come into contact with abortion patients. In this way, policymakers' inaction to protect patients from protesters is a restriction of access in itself.

Colman and Joyce investigate the impacts of the *Women's Right to Know Act* of 2003, which was enacted in 2004, on women who seek abortions in Texas (2011). The *Women's Right to Know Act* has two major components. The first component is that the Act requires all abortion clinics that

provide abortions at sixteen weeks or later to be approved as ambulatory surgical centers, which means that they have to meet stringent clinical and medical regulations (2011: 775). The second component is that it requires all women to receive state-mandated informed consent, which lists alternatives to abortion, and the option to read an illustrated pamphlet on fetal development, titled *A Woman's Right to Know* at least twenty-four hours prior to an abortion (2011: 775). Colman and Joyce examine whether the *Women's Right to Know Act* has any effects on abortion demand in Texas (2011: 776).

Their results suggest that after the Act was put into law, the number of abortions at sixteen weeks or later severely dropped. The act contributed to a 69% decrease in abortion rates at sixteen weeks or later. The number of women seeking abortions at the post-16 term who travelled out of state quadrupled (2011: 795). Even after the opening of ambulatory surgical centers in four major cities in Texas, the rate of abortion at sixteen weeks or later was at 50% below pre-Act level (Colman & Joyce 2011: 795). The Act had a significant impact on abortion providers. None of the providers were certified ambulatory surgical centers when the Act when into effect in 2004, resulting in an 88% drop in post-16 week abortions (Colman & Joyce 2011: 775). The number of cities with providers who were authorized to perform late-term abortions was still less than half of what they were during pre-Act levels, which contributed to the decline in late-term abortion rates (Colman & Joyce 2011:794-5).

The informed consent and waiting periods had little effect on abortion rates. The mandatory waiting period and the informed consent requirement did not contribute to the decline in abortion rates for women seeking abortions pre-sixteen weeks of the pregnancy, or post-sixteen weeks of pregnancy. Colman and Joyce's work demonstrates that closing providers through restrictions is an effective way to reduce abortion rates in a state. On the other hand, creating restrictions on patients,

such as mandatory waiting periods and informed consent, does not drastically decrease abortion rates.

2.4 GEOGRAPHICAL BARRIERS TO ABORTION SERVICES

Many researchers have investigated the impact of distance on women's abilities to obtain abortion services. Geography and geographical barriers have various impacts on access to abortion services. Distance to a provider continues to be a significant obstacle for women in need of abortion services, and distance has various impacts, such as increasing costs associated with the procedure, psychological costs, and time costs. The distance to services is determined in part by the number of providers, and a decrease in number leads to longer travel distances. Gober (1997) found that access to services has decreased, and the result is partially due to abortion becoming an outpatient procedure that is primarily conducted in clinics, rather than in hospitals. Henshaw (1995), Henshaw and Finer (2003), Jones and Jerman (2013), and Jones and Kooistra (2011) all agree that the number of abortion providers has decreased since the 1980s.

Gober (1997) investigates women's access to abortion services and its relation to geographical location. Gober states that a woman's ability to obtain an abortion depends on where she lives, since state restrictions, antiabortion violence, and antiabortion sentiment all affect a woman's access the procedure (Gober 1997; Gober and Rosenberg 2001). Medicaid funding and availability to hospital abortion services also affect access. Gober's results show that greater access to abortion is associated with higher abortion rates. Higher per capita income, greater diversity, and less restrictive state laws all lead to greater usage of abortion. Gober states that three things have decreased access to abortion services: 1) the isolation of abortion from other medical procedures, 2) increased antiabortion restrictions, and 3) increased violence against clinics and increased anxiety of women seeking abortions (197: 1006). Although antiabortion violence has decreased in the 2000s,

picketing and demonstrations are forms of violence that may discourage women from seeking abortions.

Abortion is a special concern that is different from other medical procedures because it is both a public and private matter which is affected at the local, state, and federal scales. According to Gober, since *Roe v. Wade*, abortion provisions have shifted from focusing on hospitals to clinics, which may be because many hospitals stopped providing abortions (1997: 1006). Many physicians and physicians-in-training are not trained in abortion services or refuse to perform the procedure for personal and professional reasons. Few residency programs for physicians provide training in abortion. Various studies suggest that people living in rural areas have limited access to many healthcare resources, so disadvantages to abortion access are an additional barrier for women living in rural parts of the US (Arcury et al. 2005). The combination of decreased abortion access in hospitals and decreased training in abortion result in a decreased supply of abortion providers and longer travel distances to services for many women.

Henshaw and Finer (2003) investigate the availability of abortion services in the US in 2001 and 2002. Their work focuses on availability of early and late gestation abortion services, as well as the availability of medical abortion services in the US (2003: 16). Henshaw and Finer say that by 2003, more providers than ever had been providing early and late gestation abortion services, but the number of abortion clinics has been on the decline since the early 1980s, partially due to better access to contraception and family planning services and a decreased need for abortion. They also say that the cost of abortion services has increased, and antiabortion protesting continues to be high. They state that cost and picketing may be two reasons that deter some women from seeking abortion services (2003).

Henshaw and Finer's work demonstrates that the geographic accessibility of abortion services has been declining since 1982, with the number of providers falling by 37% by 2003 (2003:

16). The percentage of counties lacking a provider has also increased from 28% to 34%, and in 2000, 86 of the US's 276 urban counties did not have an abortion provider (2003: 16). In 1993 and in 2003, eight percent of women had to travel greater than 100 miles to reach an abortion provider, and an additional 16% were 50 miles to 100 miles from a provider (Henshaw 1995; Henshaw and Finer 2003: 22). Geographical barriers increase the costs associated with an abortion services, since women must take more time off of work for travel, they must pay travel expenses, and they lose time that could spent otherwise.

Other barriers that are associated with geographical in-accessibility include the gestational age that a provider is willing to perform an abortion, and state-mandated counseling laws which require more than one trip to an abortion clinic. Henshaw and Finer state that accessibility for abortion services decreases in the second trimester of pregnancy, since most providers only provide services up to 14 weeks of pregnancy (2003: 22). Henshaw's work from 1993 shows that fewer than half of providers perform abortions at the thirteenth week of pregnancy (1995: 56). In the case that a woman needs an abortion in the second trimester, the chance that she must travel further to reach a provider increases, which increases all costs, including costs associated with the complexity of the procedure.

State-mandated counseling sessions also present geographical barriers, since many women live far from a provider, and have difficulty arranging for multiple trips to an abortion provider (2003: 22-3). Henshaw and Finer found that state-mandated in-person counseling decreased abortion rates in one state that they studied (2003: 23). Henshaw and Finer's work shows that decreased provider availability due to inability to provide early or late-term abortions, gestational limits, and state-mandated in-person counseling all create geographical barriers to abortion services in the US.

Jones and Jerman (2013) examine how far women had to travel for abortion services in 2008. Their study examined the average distance women had to travel to reach abortion services. They also evaluated barriers, such as cost, travel time, and restrictive laws that may prevent women from accessing an abortion provider in time (2013). As of 2008, Jones and Jerman found that 67% of women traveled less than 25 miles to reach an abortion provider (2013: 708). The majority (89.7%) of those women had abortions at fewer than 12 weeks of gestational period, with 54.7% of women paying for the service out-of-pocket (2013: 708). Jones and Jerman say that fewer abortion providers exist in the South and in the Midwest than in the Northeast and West, with 31% of women in rural areas having to travel 100 miles or more to access abortion services (2013: 708).

According to their study, women who live in a state with a 24-hour waiting period were at least four times as likely to travel 100 miles or more for abortion services than women living in states without a waiting period (2013: 708). The authors calculated a predicted probability of women who live in urban areas having to travel more than 100 miles at 2%, while women who live in rural areas have a 24% chance of traveling that far (2013: 711). Seventy-eight percent of women in a state with no waiting period live within 25 miles of an abortion provider, while the corresponding value in states with waiting periods is only 58%. Women living in states with a waiting period mandate are more than twice as likely as those in states without a waiting period to face travel distances of greater than 50 or 100 miles to reach a provider (2013: 710).

Jones and Kooistra (2011) examined national and state-level trends in 2004 and 2005 in the number of abortions in the US, abortion rates, the number of counties and urban areas without providers, and access to abortion services. They found that women are having fewer abortions and at lesser rates. The number of providers has declined, but the introduction of medical abortion, a two-step pill that induces abortion in early stages of pregnancy, has increased access to abortion services. The authors conclude that the number of providers is continuing its gradual decline (2011).

Jones and Kooistra (2011) distributed surveys to over 1,700 abortion providers in the US, including clinics, hospitals, and physicians' offices. Over 900 providers responded to the surveys, and explained what types of abortion they provide, at what gestational ages, at what prices, and at what geographical location. Results show that between 2000 and 2005, the number of providers in the US decreased in 26 states and in Washington DC, it increased in 15 states, and remained the same in 9 states (2011: 12). Between 2000 and 2005, 77 clinics closed and 29 opened (2011: 12). The authors found that geographical barriers and barriers surrounding cost prevent many women from accessing services. For instance, their results demonstrate that the majority of abortions are performed at clinics, with only 2% of abortions occurring in physicians' offices (2011: 13).

More women have greater access to physicians than they do to clinics, yet few doctors perform the procedure due to lack of training, disinterest, and controversy surrounding the topic. Overall, 97% of non-metropolitan counties and 69% of metropolitan counties lacked a provider in 2011 (Jones and Kooistra 2011). While finding an abortion provider is a challenge, finding one that will do the procedure at a specific gestational age is another barrier. Jones and Kooistra found that 40% of providers provided services at four weeks of gestational age or earlier, 96% did so at eight weeks, and 67% did so at various stages of the second trimester of pregnancy, but only 8% offered the service at 24 weeks or later (2011: 14). In general, accessing an abortion provider is a challenge to many women, which may be a reason why abortion rates have declined.

2.5 IMPLICATIONS

The review of the various literatures on access to abortion services demonstrates that although women have gained greater access to contraception and pregnancy rates are decreasing, access to abortion services are decreasing. Lack of Medicaid funding, Targeted Regulation of Abortion Providers, and geographical barriers are providing challenges to women across the US who seek abortion services. Although *Roe v. Wade* safeguards legal abortion to all women, state freedom

to restrict abortion services has made the procedure difficult to obtain in various parts of the US, even various parts of considerably prochoice states.

The research from this literature review shows that access to abortion services has been declining since the 1980s, as political groups and special interest groups have made it their mission to make abortion impossible to obtain, regardless of its legality. Legal restrictions and geographical barriers intersect to make abortion services hard to find and difficult to pay for. Women must circumvent various laws, geographical challenges, and their own stigmatizing communities to access abortion services, often in faraway neighborhoods.

This thesis contributes to the existing literature on abortion access by investigating the role of legislative barriers in restricting geographical access to abortion services. The analysis in this thesis explores the ways that policies manipulate the geographical availability of abortion clinics in the US. The study analyzes the effects of policies at various scales. It affirms the need to study access at multiple scales because access is determined by a combination of policies, contextual factors, and personal characteristics. The current policies aimed at restricting abortion are especially challenging to marginalized, low-income women, and racial and ethnic minorities. Women in these demographics suffer the most from legislative and place-based barriers to abortion.

Chapter 3

QUANTITATIVE ANALYSIS OF ACCESS TO ABORTION SERVICES

The quantitative analysis in this chapter is a multi-scalar analysis of abortion access in the US. Abortion access is defined by a combination of two factors: 1) provider ability to provide the service to clients, and 2) client ability to financially, legally, and geographically access the service. Abortion clinics are defined as lone-standing clinics (not private physicians' offices or hospitals) that provide abortion services as their sole medical procedure, or in addition to other reproductive services.

This analysis is divided into two parts. The first part presents an analysis of abortion restrictions and provider ability at the national scale. I look at how abortion restrictions implemented in various states are affecting abortion access across the US. The second part of this chapter presents a case study of Indiana. I analyze the six abortion clinics in Indiana and women's access to them. I analyze how state-mandated abortion restrictions affect women's access to abortion services, and how these restrictions affect providers' ability to perform the service.

Many studies have investigated antiabortion policies since the decision of *Roe v. Wade*, and many studies have investigated what makes a state lean prochoice or prolife. Few studies have formally investigated the role of geography as a means of access to abortion services in the latest wave of antiabortion legislation that has been occurring since 2008. This analysis combines the roles of policy and geography to better understand how women access abortion services in a time when access to reproductive healthcare is increasing, but access to abortion is decreasing. This analysis focuses on the years 2008 to 2013, a period of time when the Affordable Care Act began to change the landscape of healthcare, and a period of time when a new wave of antiabortion legislation is being implemented by anti-choice policymakers.

3.1 DATA AND METHODOLOGY AT THE NATIONAL SCALE

3.1.1 Data For The National Scale Analysis

A macro-scale analysis was done to determine how access to abortion services is changing in the US over time. The analysis focuses on the years 2008 and 2013, with population data and provider data from 2012 being employed, and abortion restriction data from 2013 being used. Although the population and provider data is slightly older than the restriction data, the analysis was conducted and the results provide an accurate portrait of abortion provider accessibility in the US. Data from 2012 was employed because it is the most recent data that is available for population and for providers, and is still representative of the situation in 2013. Population data, abortion provider data, state-mandated restrictions, and geographical data for all 50 states and Washington DC were used. Population data for women of reproductive age (ages 15-50) was obtained from the US Census Bureau Data for the years 2008 and 2012. Abortion provider data was obtained from the Guttmacher Institute for the years 2008 and 2012. Information regarding state restrictions on abortion was obtained from the Guttmacher Institute for the years 2008 and 2013. Geographical data for all 50 states and Washington DC were obtained as a shapefile from ESRI, and ArcGIS 10.1 was used to develop the choropleth maps.

3.1.2 Methods For The National Scale Analysis

Analysis of State-Mandated Abortion Restrictions

The Guttmacher Institute data was used to determine the number of abortion restrictions each state had implemented in 2008 and in 2013. The Guttmacher Institute has an online research database, which is updated to reflect yearly changes in abortion policy in the US. State-scale and federal-scale data is available for public use. This information was used to determine the types of abortion restrictions that each state and Washington DC had in place in 2008 and in 2013. The dataset was cleaned up and revised to only include 14 abortion restrictions that play a minimal role

or no role in preserving the health of a client seeking abortion services. These restrictions are widely regarded as harmful, rather than helpful restrictions by providers, patients, and women's reproductive healthcare organizations. The index reflects categories that are designed to prevent women from accessing services or to prevent providers from administering services, and do not significantly improve abortion safety.

Table 2: Restrictions

Provider (individual)can refuse to perform abortion
Provider (institution) can refuse to perform abortion
Scientifically disproven breast cancer link
Fetal pain
Negative psychological effects
Waiting period after counseling
Parental involvement
Must be performed by licensed physician
Must be performed in hospital after certain gestational period
Second physician must participate in certain conditions
Prohibited at certain gestation period, except in cases of life/health endangerment
"Partial birth" abortion banned
Public funding of abortion is limited to life endangerment, rape, or incest
Limitations on private insurance coverage

A spreadsheet was created that listed each state and Washington DC, along with how many abortion restrictions it had in 2008 and in 2013. The spreadsheet was imported into ArcGIS 10.1, and a choropleth map was created to examine the landscape of abortion restrictions at the national

scale for all states and Washington DC. Five data classes were used: 0-2 restrictions, 3-5 restrictions, 6-7 restrictions, 8-10 restrictions, and 11-12 restrictions. The resulting maps for the years 2008 and 2013 show a changing abortion landscape across the United States.

Analysis of Availability of Abortion Providers

Data from the US Census Bureau on populations of women of reproductive age (ages 15-50) was obtained for the years 2008 and 2012. Data from 2012 was used since it was the most recent data available from the US Census Bureau at the time this research was conducted. The data was organized into a spreadsheet, with corresponding state names (and Washington DC). Then, abortion provider data was acquired from the Guttmacher Institute for the years 2008 and 2012, since 2012 is the most recent data available from the Guttmacher Institute. This data was organized into the same spreadsheet. Using Excel, a calculation was done to determine the number of providers per 1,000 women of reproductive age in each state. This spreadsheet was imported into ArcGIS, and two choropleth maps were constructed (2008 and 2013), to show how the number of providers per 1,000 women was changing over time.

Index of Abortion Access Limitations Analysis

An index of abortion access limitations was created using abortion provider data and restriction data. The index reflects the concept that access is affected by both the number of abortion providers operating in the state and the number of legislative restrictions on abortion that have been implemented in the state. To create the index, first, state data for abortion providers per 1,000 women was standardized for the years 2008 and 2012. This data was then multiplied by -1 so that a higher value indicates fewer abortion providers per 1000 women and thus more limited access to abortion services. Next, state data for abortion restrictions for the years 2008 and 2013 were standardized. A higher standardized value is associated with more abortion restrictions in the state.

Because I was interested in how access changed over time within each state, the means and standard deviations for 2008 were used in calculating the standardized values for 2013. Thus, the 2013 standardized values show the supply of abortion providers in the state and the number of abortion restrictions relative to the levels that were present in 2008. The two standardized values for the provider data and restriction data were added for each state and Washington DC. This was done for the years 2008 and 2013. Note that a larger value for the index signifies more limited access to abortion services in the state due to a combination of few providers and a large number of access restrictions. The resulting spreadsheets were uploaded into ArcGIS 10.1 and constructed into two choropleth maps that show how the number of restrictions and number of abortion providers affect abortion access for each state.

$$Index_{i08} = \frac{R_{i08} - \overline{R_{08}}}{s_{R08}} - \frac{P_{i08} - \overline{P_{08}}}{s_{P08}}$$

$$Index_{i13} = \frac{R_{i13} - \overline{R_{08}}}{s_{R08}} - \frac{P_{i13} - \overline{P_{08}}}{s_{P08}}$$

Where: i= state

R_{i08}= # restrictions in state i in 2008

P_{i08}= Provider/pop ratio in state i in 2008

$\overline{R_{08}}$= mean # restrictions, 2008

s_{R08}= std dev restrictions, 2008

3.2 Results For The National Scale Analysis

State-Mandated Abortion Restrictions

The number of state-mandated restrictions on abortion services is on the rise. States have implemented several new restrictions against the procedure since 2008. In 2008, the national average for restrictions was 5.45. In 2013, this number crept up to 6.02. States in the Midwest and in the South experienced the greatest increase in abortion restrictions since 2008 (Figures 1 and 2). These states also experienced the largest loss of abortion providers in that time. Nineteen states introduced new restrictions from 2008 to 2013, and five states removed restrictions in that time. The most

common restrictions that additional states enacted in 2013 are a state-mandated statement that a fetus can feel pain during an abortion (6 new states), the banning of abortion at various gestational ages prior to fetal viability (5 new states), banning of "partial-birth" abortion (5 new states), banning or limiting private insurance coverage of abortion (4 new states), and mandatory parental involvement in abortion decisions of a minor (4 new states).

Indiana and Kansas enacted the most new restrictions, three and six, respectively. As of 2013, Indiana had eleven out of twelve possible restrictions in place, while Kansas had twelve. Since 2008, Kansas skyrocketed from six restrictions to twelve to become the most restrictive antiabortion state in the US. As of 2013, 24 states had greater than six restrictions, while in 2008, 22 states had greater than six restrictions. The nature of abortion access is changing, since some states enacted a far greater number of restrictions than others. Other factors of severity include the stringency of restrictions. Some restrictions may place a greater burden on women or providers than others. For instance, mandated counseling requirements might be less severe than waiting periods, which require additional travel costs and costs associated with lost wages. Many states did enact severe restrictions that do not improve women's health and safety by 2013. For example, by 2013, 41 states prohibited abortion at a specific point in pregnancy prior to fetal viability, an increase from 36 in 2008. Also, the number of states prohibiting private insurance coverage of abortion had doubled from four to eight states by 2013. Lastly, in 2013, more states also mandated that providers tell women that fetuses can feel pain during an abortion. By 2013, twenty-two states added new restrictions, with many of the restrictions aiming to limit access rather than improve women's health and safety (Figure 2).

Availability of Abortion Providers

The number of abortion providers per 1000 women in the US is declining, particularly in states that have enacted restrictions against the procedure. In 2008, the number of abortion

providers per 1,000 women was 0.03, but in 2013, it was 0.025. States in the Midwest and the South experienced the greatest loss of abortion providers, coinciding with the greatest number of restrictions (Figures 3 and 4). Twenty-eight states lost providers from 2008 to 2013. Sixteen states had no change in providers, and seven states gained providers. In 2008, the US had 1,793 abortion providers, and in 2013, that number had decreased to 1,660. The US lost 133 abortion providers in five years. Alabama, Ohio, and Texas saw the greatest decline in number of providers per 1,000 women. The states that lost providers were also states that instituted new restrictions by 2013. Women living in these areas have new hurdles to overcome when seeking abortion care, such as patient-centered barriers, in addition to geographical barriers. The combination of losing providers and restricting access through legislation will further limit how and where women seek abortion care.

Index of Abortion Access Limitations

Abortion restrictions and the supply of services often go hand in hand, because restrictions make it difficult for providers to operate, forcing some providers to close. As the number of abortion restrictions increases in states, the number of providers per 1,000 women declines further. The data show that abortion restrictions and number of providers are negatively correlated (Figures 5 and 6). In 2008, Southern states provided the least access to abortion, and by 2013, barriers in access had expanded north and east. States that experienced the greatest amount of restrictions also lost more providers than states with fewer restrictions. The Midwest and South experienced the greatest surge in restrictions, and these states saw the most prominent rise in restrictions, as well (Figures 5 and 6). Seven states saw a significant shift in abortion access (Alabama, Alaska, Indiana, Kansas, Montana, North Carolina, and Ohio). These states experienced the most dramatic declines in abortion access in the five-year period examined (Figure 5 and 6).

Further analysis is necessary, but an association may exist between number of restrictions and number of providers per state. As was true of restrictions and providers, states in the Midwest and in the South have the greatest disadvantages in access to abortion. Women living in those areas have to overcome the most barriers to reach abortion services. Figures 5 and 6 suggest that the dual effects of provider loss and new restrictions will continue to limit how women operate within this most recent antiabortion climate. Providers will also have to adjust their practices to comply with state standards in order to stay open.

3.3 DATA AND METHODOLOGY: THE CASE STUDY OF INDIANA

3.3.1 Data For The Indiana Case Study

A case study of Indiana was done to explore how antiabortion restrictions are affecting women at the state-scale. Indiana was chosen as the study site, due to its highly unamicable climate to abortion. Network analysis was conducted to reveal how far women in Indiana must travel to reach an abortion provider. Data on women of reproductive age in Indiana was obtained from the 2012 American Fact Finder. Data on women ages 15-50, data on education levels, data on income, and data on race and ethnicity was obtained at the Census tract level. A shapefile of the Indiana Census Tracts was obtained from the US Census Bureau. An Indiana state shapefile was obtained from ESRI. TIGER files containing primary and secondary road data was obtained from the US Census Bureau. A network was also obtained from ESRI Data & Maps. Finally, clinic data on all six abortion clinics in Indiana was obtained from the Guttmacher Institute and from the National Health Organization.

3.3.2 Methods For The Indiana Case Study Analysis

Service Area

The national scale analysis reveals that access to abortion is changing throughout the entire country, but state-level analysis must be done to better understand how access to services varies

within states. As providers close down or stop providing the procedure, certain places and populations will be affected more than others. Abortion providers are usually not located evenly throughout a state, with most providers located in mid-size and large cities, so uneven access to providers exists. A state-wide assessment of Indiana was conducted to determine the distances women must travel to reach the nearest abortion provider within the state. This analysis contributes to a better understanding of inequalities of access within a state. The case study was conducted in Indiana because it has enacted some of the most stringent abortion restrictions of any state in the US.

ArcGIS 10.1 was used to run a network analysis in order to understand the distance that women travel from their Census tracts to the closest abortion clinic. First, a network was built in ArcCatalog, using TIGER files containing primary and secondary roads in Indiana. This network was added to ArcGIS, along with geocoded abortion clinics, an Indiana state shapefile, and Indiana Census tracts. Then, tables containing population data were joined to the Census tracts. Population data used for this analysis includes race and ethnicity of women ages 15 to 50 living in each tract, as well as their poverty status, and education levels.

After the tables were joined with the Census tract shapefile, a *service area* analysis was done to establish the number of Census tracts that each clinic can cover. The analysis was done to see how many women are located within 50 miles of an abortion clinic – assuming that this distance, which can be covered in 1 – 1 ½ hours by car, represents a reasonable level of geographical access. The resulting data contained information as to the population of women living within a 50-mile radius of each abortion clinic, women's income levels, and women's education levels. A map was created to show areas that are 50 miles from an abortion clinic, as well as areas that are located more than 50 miles from an abortion clinic.

Closest Facility

ArcGIS 10.1 was used to run a *closest facility* analysis to determine how far women of various demographic characteristics have to travel in miles to reach an abortion provider in Indiana. A road network from ESRI Data & Maps was used to run the analysis. This network was used in conjunction with the geocoded abortion clinics, and US Census Bureau Census tracts from 2012. Six geocoded abortion clinics were used, and all 1,511 Indiana Census tracts were employed. Tables containing demographic information on women ages 15 to 50 were joined to the centroids of the Census tracts. The demographic information included in this analysis is race and ethnicity, education levels, and poverty status. The analysis calculated the distance from each tract centroid to the closest abortion clinic in miles. The resulting routes calculated 1,470 out of 1,511 distances. The final 41 distances were calculated using nearby centroids. Four census tracts did not have any population and were not included in the analysis.

The resulting data from the *closest facility* analysis was exported as an Excel Spreadsheet. A weighted average was calculated using the Census tracts, distance in miles, and population demographics. A weighted average was calculated for black, Latino, and white women's average distances traveled to a clinic. A weighted average was also calculated for women of various education attainment levels, as well as for women living below 100% of the federal poverty level. These average distance values reveal race- and class-based differences in geographical access to abortion clinics in the state.

3.4 RESULTS FOR THE INDIANA CASE STUDY ANALYSIS

Service Area

The results from the case study demonstrate that access to abortion services is limited in Indiana. Fewer than 500 Census tracts are covered by each abortion clinic in Indiana. Six clinics are expected to serve all women in Indiana, which is a population of over 1.5 million women (Figure 7).

Three of the six clinics are located in Indianapolis, and the other three are located sparsely throughout the state. The three clinics that are located in Indianapolis are Clinic for Women, Georgetown Health Center, and Women's Med Center. Bloomington Health Center is located in Bloomington, Lafayette Health Center is located in Lafayette, and Merrillville Health Center is located in Merrillville. Currently, there is one abortion clinic for every 250,000 women in Indiana. About sixty percent of women of reproductive age live within fifty miles of an abortion clinic in Indiana (Figure 7).

Clinic for Women serves 492 Census tracts within its 50-mile radius around Indianapolis. The population breakdown is as follows: mean percent of black women of the 50-mile radius is 16%, mean percent of Latina women is 6%, mean percent of white women is 75%. On average, 19% of the population is living below 100% of the federal poverty level, 44% of the population has a high school degree or less, 49% has a bachelor's degree or some college, and 7% has a graduate degree.

Georgetown serves 469 tracts within its 50-mile radius and has nearly the same racial/ethnic population breakdown as the Clinic for Women. The mean population of black women is 16%, 6% Latina, and 74% white. Nineteen percent of its female population ages 15-50 is living below 100% of the federal poverty level, 46% have a high school degree or less, 48% have a bachelor's degree or some college, and 7% have a graduate degree.

Women's Med Center, the final clinic located in Indianapolis, covers 480 tracts within its 50-mile radius. As is the case with Clinic for Women, the mean population for black women is 16%, for Latina women, it is 6%, and for white women, it is 75%. Nineteen percent live in poverty, 45% have a high school degree or less, 48% have a bachelor's degree or some college, and 7% have a graduate degree.

The abortion clinic in Bloomington, IN, covers 308 census tracts within a 50-mile distance. Its mean population of black women is 11.4%, its mean population of Latina women is 6%, and its mean population of white women is 88%. About 17% of women living within 50 miles of this clinic are in poverty, 46% have a high school degree or less, 48% have a bachelor's degree or less, and 6% have a graduate degree.

The abortion clinic in Lafayette, the only one providing solely medical abortions, serves a population that is only about 2.8% black, 6% Latina, and 88% white. About 17% of the population in the 50-mile radius is living in poverty, 46% have a high school degree or less, 48% have a bachelor's degree or some college, and 6% have a graduate degree.

The Merrillville Health Clinic covers 202 census tracts. The mean population of black women for this 50-mile radius is 24%, for Latino women it is 12%, for white women, it is 59%. Twenty-two percent of its population is living below 100% of the federal poverty level, 46% have a high school degree or less, 48% have a bachelor's degree or some college, and 4.2% have a graduate degree.

Closest Facility

The results from the *closest facility* analysis demonstrate that access to abortion services in Indiana varies significantly among women based on class. Access to abortion is not necessarily determined by race and ethnicity, but according to income and education. The results demonstrate that non-white women travel shorter distances to abortion clinics than white women. Results also show that the more educated a woman is, the less she has to travel in miles to an abortion clinic.

In regards to race, black women travel the fewest miles, on average, to reach an abortion provider, at 28.95 miles. Latino women travel 38.06 miles to reach a provider, and white women travel the furthest at 50.19 miles. White women are also the largest population, with 1,260,833 women ages 15-50 living in Indiana as of 2012. Latino women are the smallest population studied,

with 97,753 Latino women of reproductive age living in Indiana as of 2012. These racial and ethnic disparities

When analyzing educational attainment of women ages 15 to 50 in Indiana, the most highly educated women traveled the fewest miles to an abortion provider. Women with a high school degree or less traveled the furthest. Women with a high school degree or who have not graduated high school travel 49 miles to reach a provider. Women with a bachelor's degree or have some college experience travel 46 miles, and women with a graduate degree or a professional degree travel 38.39 miles to reach an abortion provider. Additionally, women who are living at 100% below the federal poverty level (278,892 women) travel 44.6 miles to reach an abortion provider.

Table 3: Weighted Average Of Distance Women Have to Travel for Abortion Services in Indiana in Miles

Demographic	Distance Traveled in Miles	Population (2012)
Black Women	28.95	157,000
Latino Women	38.06	97,753
White Women	50.19	1,260,833
Women with a High School Degree or Less	49.00	697,908
Women with a BA or Some College	46.01	787,528
Women with a Graduate/Professional Degree	38.39	89,089
Women Living 100% Below Federal Poverty Level	44.60	278,892

In summary, the results suggest that disadvantages to access are primarily class-based. Women with a high school degree or less, and low-income women travel the furthest to reach an abortion provider. The more educated a woman is, the less she has to travel for an abortion. This data supports other research studies that find that low-income women have greater difficulties in

accessing an abortion provider than wealthier and more educated women. Low-income women living in rural areas are especially disadvantaged in geographical access to abortion, facing long travel distances to reach clinics. Black women travel the shortest distance to reach a provider, while white women travel the furthest. These results could be due to the fact that many minorities live in urban areas, where clinics are located, and their populations are much smaller than the population of white women. Thus, they are geographically close to clinics located in the large cities where Black and Hispanic populations tend to live. However, it is important to keep in mind that the travel distance measure ignores access to transportation. A sizable percentage of black and Hispanic women who live in cities do not have access to a car and thus must rely on slow and infrequent public transportation to travel to clinics. For these women, relatively short travel distances may not correspond to easy access to services.

3.5 Discussion and Conclusion

The creation and enactment of new restrictions against abortion are creating new barriers for women seeking abortions. They are also creating new barriers for providers who do the procedure. Between 2007 and 2013, 230 new restrictions were introduced at the state level. Some were enacted, others were defeated in court, and some were enjoined. The results from this analysis reflect the findings from the literature review. The analysis from the national scale suggests that the US is experiencing a nationwide rise in abortion restrictions. The rise in restrictions is coupled with a decline in number of providers, and these trends are especially prominent in Southern and Midwestern states. Previous literature on abortion access demonstrates that many states have restricted the procedure in the last five years, and this analysis further demonstrates that these restrictions are occurring across all regions in the US. Access is uneven across states, as some states are more restrictive than others. States in the Midwest and South are most restrictive to services, which compliments the findings from previous literature.

The case-study of Indiana suggests that access to abortion services is class-based. Recent literature on abortion services finds that abortion access is often most difficult for low-income women. The Indiana analysis finds that most of Indiana's clinics are located in Indianapolis and three other mid-size cities. The findings agree with previous literature that access is geographically limited to more urban areas, leaving out rural women's needs to services. Six clinics are expected to serve the entire population of women of reproductive age, demonstrating that access is very limited and providers are expected to serve large populations with limited resources. Literature shows that some restrictions are intended to close providers, further increasing geographical barriers. Further analysis is needed, but one can expect a continuing momentum of antiabortion bills to be introduced in states in the future. These bills will continue to threaten abortion access and make it difficult to obtain, even though abortion is a guaranteed right due to *Roe v. Wade*. Unfortunately, the "right" to do something does not guarantee the access to do so.

Some limitations to the quantitative analysis are that the data on national-level abortion restrictions is constantly changing and outdated by the time of the writing of this thesis. New restrictions have been introduced in states, and older restrictions are being challenged in courts. Also, 40 routes in the *closest facility* analysis had to be estimated, since ArcGIS could not create the routes on its own. In this case, nearby centroids were used to estimate the 40 un-routed tracts. Another limitation is that greater research is needed on the implications of income and geography on abortion access. Financial difficulties are a significant challenge in accessing abortion, even though a provider might be located nearby. Many restrictions intend to make abortion so expensive that women cannot handle the costs associated with accessing the procedure.

Figure 1 Choropleth Map of Abortion Restrictions in 2008

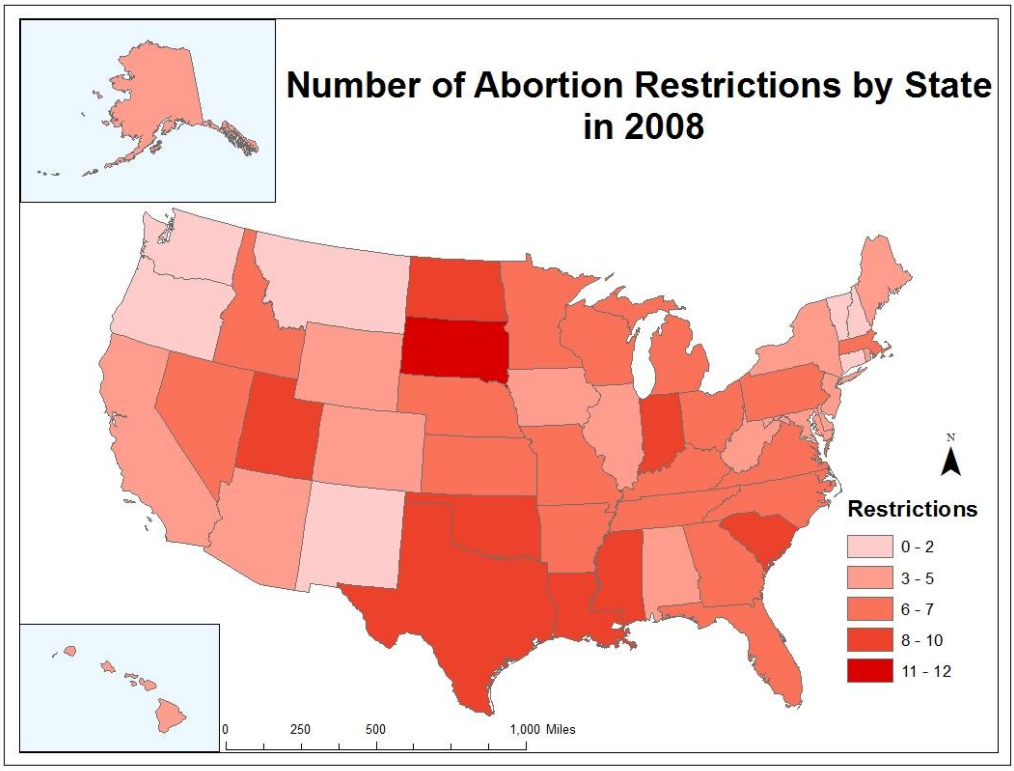


Figure 2 Choropleth Map of Abortion Restrictions in 2013

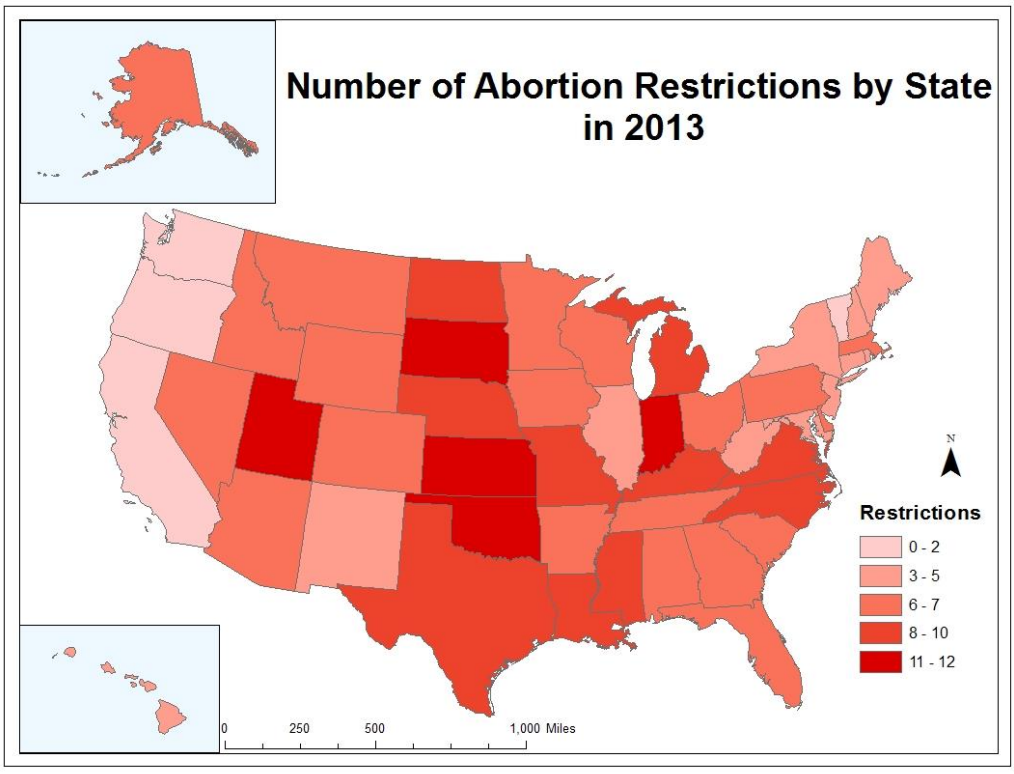


Figure 3 Choropleth Map of Abortion Providers in 2008

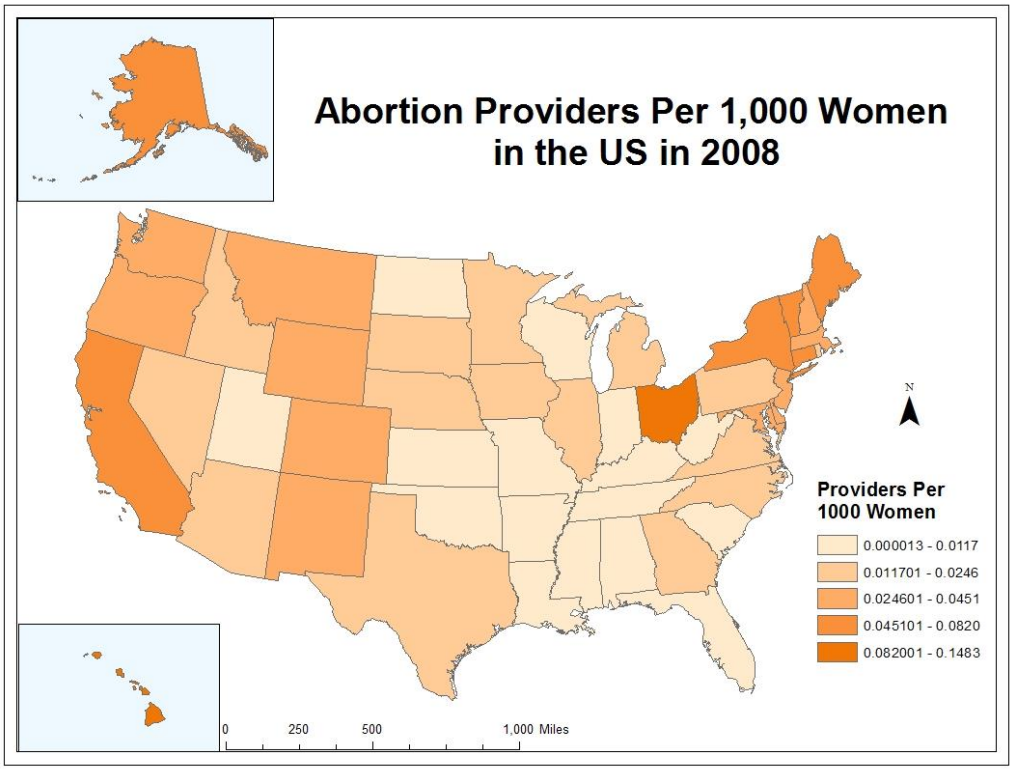


Figure 4 Choropleth Map of Abortion Providers in 2013

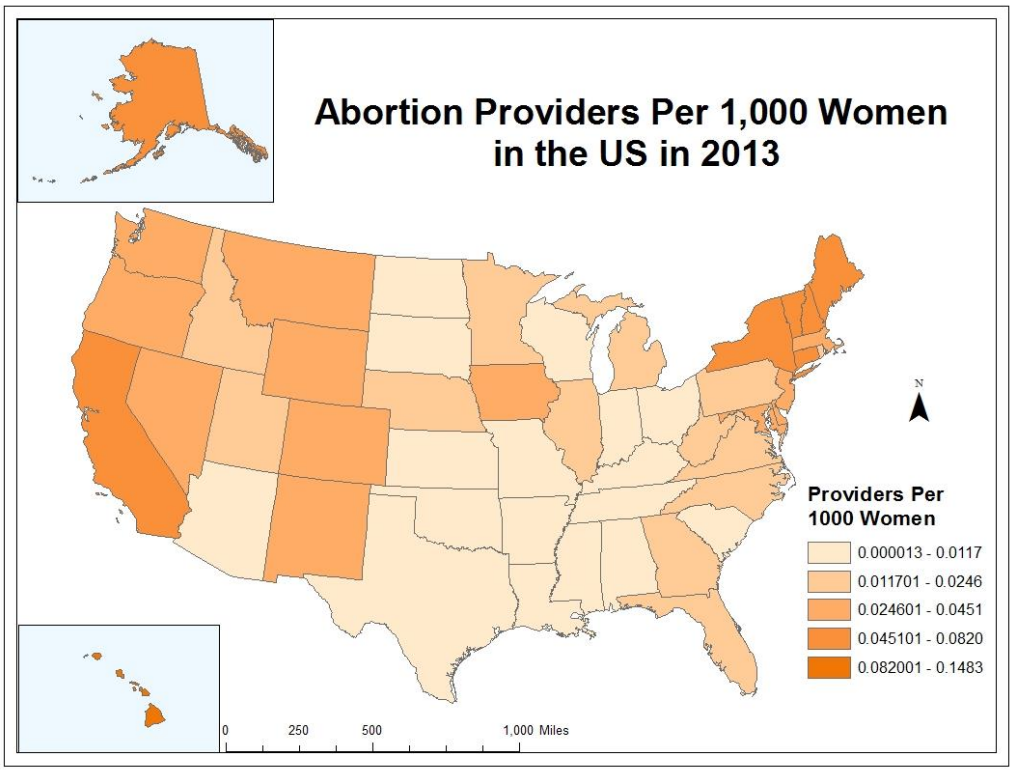


Figure 5 Choropleth Map of Index of Access Limitations in 2008

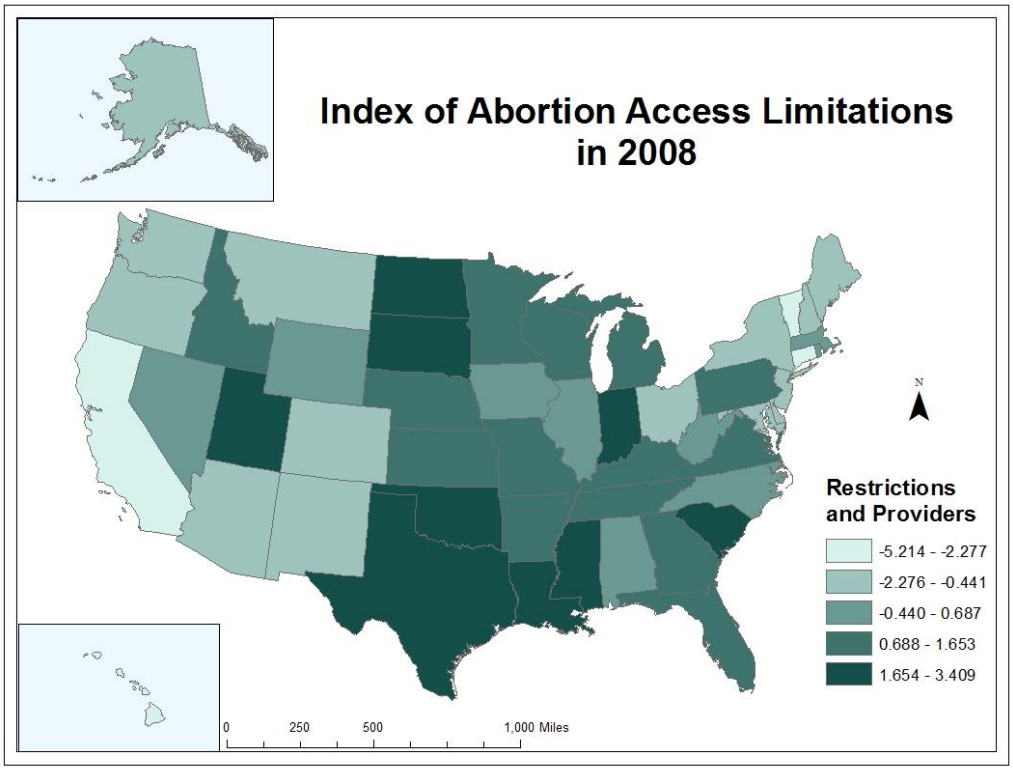


Figure 6 Choropleth Map of Index of Access Limitations in 2013

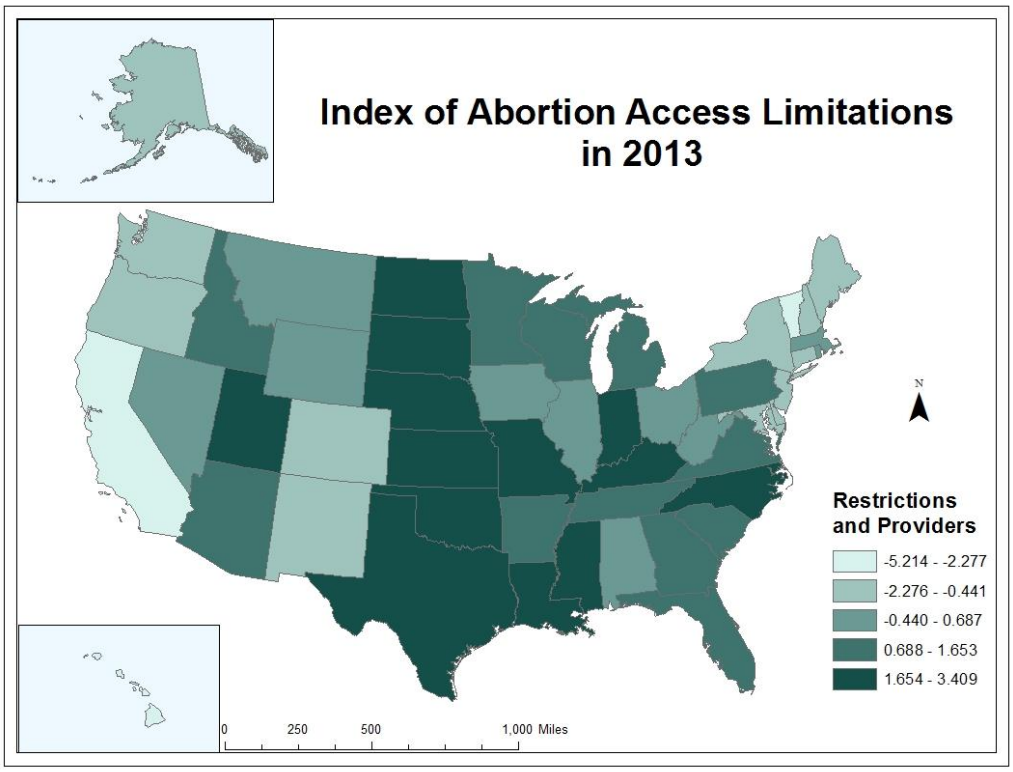
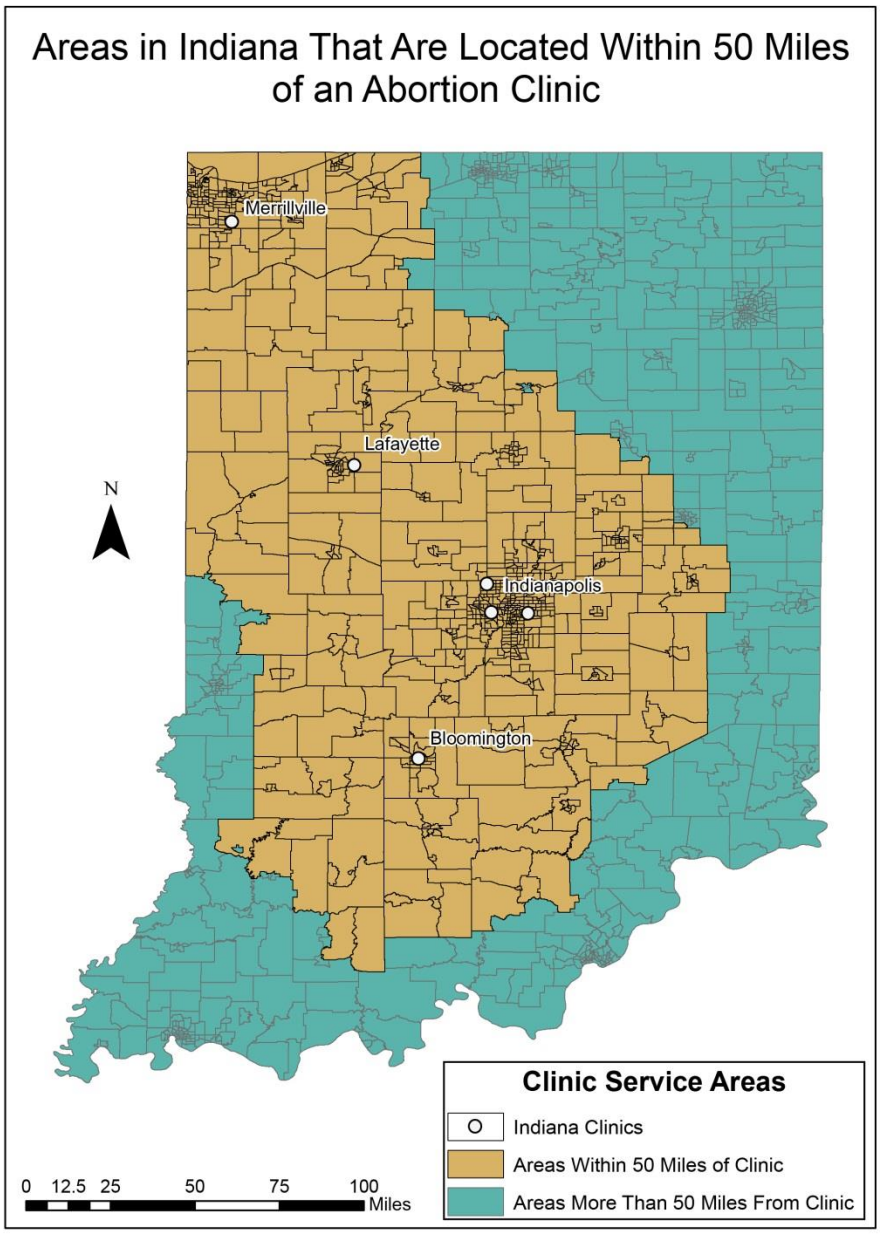


Figure 7 Areas in Indiana Located Near Abortion Clinics in 2014



Chapter 4

QUALITATIVE ANALYSIS OF ABORTION ACCESS IN THE STATE OF INDIANA

This chapter discusses and presents a qualitative analysis of the impacts of increasing restrictions on abortion access in the state of Indiana. Semiformal interviews were conducted with two experts in the field of women's healthcare in Indiana in July 2014. The experts are both high-ranking employees of a prominent women's reproductive healthcare provider, which I call the "National Health Organization" for the purposes of this thesis. The interviews that were conducted help reveal how abortion providers circumvent antiabortion legislation to provide services to their clients. The interviews also offer knowledge on how women circumvent antiabortion restrictions to gain access to the procedure. The interviews present a local scale analysis of the barriers posed by antiabortion legislation, and geographical barriers. The first section of this chapter discusses the data and methods used to gain findings on access in an antiabortion atmosphere. The second section of this chapter discusses findings gained from the data.

4.1 DATA

The data were collected from one interview in July 2014 with two healthcare experts in a major urban city in Indiana. A semiformal interview was conducted with two experts who work for a nationally recognized women's reproductive healthcare advocate and provider, that I call the National Health Organization. This provider has affiliate administrative offices that act as headquarters for each state or region in the US. The administrative offices serve as oversight and administration for their health clinics, whose numbers vary throughout each state in the US. This provider is a registered non-profit whose main goal is to provide preventative healthcare to women in need. It is also the most widely recognized abortion provider in the US.

The administrative office of the National Health Organization in Indiana caters to 23 clinics located throughout Indiana, four of which perform abortions. This office also oversees two clinics

in Kentucky, which do not offer abortion services. Prior to 2013, Indiana and Kentucky each had their own administrative offices in each respective state, but a merger, partially conducted as a result of the Affordable Care Act and a decrease in federal funding for family planning, caused the two administrative offices to merge. The interviews were conducted at the headquarters located in Indiana. The author spent one hour with both interviewees. The interview was recorded and transcribed. Initially, the author planned on interviewing three abortion providers in three separate clinics in Indiana; however, permission for these interviews was denied. Due to bureaucratic gatekeepers, sensitivity of the topic, and ongoing controversy surrounding abortion in the political sphere in Indiana, one interview with two experts was granted to the author. These two experts are knowledgeable on the politics of abortion in the state and they oversee all activity in clinics.

The interviews were conducted to gain insight as to how abortion providers deal with various legislation that is intended to restrict abortion services. The questions were devised to measure access, as defined by Ribot and Peluso (2003) and Andersen (1995). The questions were devised ahead of the interview, but follow-up questions were asked as appropriate. The questions were primarily open-ended, with a few questions directed at gauging statistical information from the participants. The interviews provide insight into how abortion providers bypass laws that make it difficult to operate, as well as how women deal with these laws when seeking an abortion. I asked questions that were aimed to reveal how women access abortion services in a largely antiabortion climate, and how abortion providers navigate through restrictions to provide the procedure. The questions apply to legislative barriers to abortion in Indiana, as the state legislators are primarily publicly prolife, and the questions apply to geographic barriers which are highly influenced by legislative restrictions placed on abortion. The interviews shed light on how women and providers adapt to new legislative barriers at a local scale that may also increase geographical barriers.

The questions asked pertained to the structure of the healthcare provider, both at a national and local scale, federal and state funding for the provider, the cost of unplanned pregnancy to the state, Medicaid funding, prenatal care funding, and the number of clinics in Indiana that perform abortions. Other questions regarded antiabortion restrictions and the role of the state legislature in limiting abortion access. These questions explore topics including Targeted Regulation of Abortion (TRAP) laws, informed consent laws, gestational age limits, geographical barriers, and state mandates regarding multiple trips to a clinic for an abortion. Lastly, questions regarding medical and surgical abortion, staffing at clinics, and who is allowed to perform abortions were asked to better understand availability of abortion services.

Table 4: Interview Questions

General Structure of Organization and Care in Indiana
What is the structure of the National Health Organization clinics?
What is the landscape of reproductive health care clinics in Indiana?
Clinic Staffing and Patient Loads
How many medical professionals does the National Health Organization employ?
On average, how many nurses and doctors are present on a daily basis per clinic?
Do you think that the Indiana National Health Organization is able to serve their patients adequately or are they short-staffed or low on resources?
Does Indiana have underserved areas in reproductive healthcare?
How many medical professionals are allowed to perform abortions per clinic?
On average, how many patients does a clinic see per day?
Which clinic is the largest provider of women's reproductive healthcare in Indiana?
Clinic Services
What is the primary service that the Indiana National Health Organization provides?
What are some of the reasons that women visit the National Health Organization?
Do many patients see the doctors as a primary physician?
What type of abortion service does the Indiana National Health Organization provide? How many of these clinics offer surgical abortion? How many offer medical abortion?
Is it common that medical and surgical abortions are offered in the same area? Is this intended to give women more choices and better access to abortion?
What kind of abortion service (first trimester, second trimester, or late-term) do you mostly perform at your clinic?
What is the relationship between access to abortion and access to other forms of reproductive health care? Meaning, if abortion is restricted through state-mandated information, does this affect other forms of reproductive health care?
Abortion Restrictions and Effects on the Clinic and Women
What is the difference between TRAP laws and other laws?
What types of abortion restrictions has the state enacted upon abortion-providing clinics in Indiana?
How do the various abortion restrictions affect the women that you serve?
Have the current abortion restrictions on the national level changed the way that clinics operate in your state?
Have the current abortion restrictions affected how many patients visit clinics for treatment?
Have the current abortion restrictions affected clinics at all?
How do restrictions against abortion place geographical barriers for women who seek abortions?

4.2 FINDINGS

4.2.1 Organization And Staffing Of The Health Clinics

Organization

The health experts from the National Health Organization who were interviewed state that 86 counties in Indiana lack an abortion provider. At the moment, six abortion clinics exist in Indiana, and half of those are in Indianapolis. The other three are located in Merrillville, Lafayette, and Bloomington. The health experts discussed the structure and organization of the National Health Organization nationwide, stating that the number of affiliates has decreased over the years, falling from more than 200 in the past to the current 68 affiliates. The health experts describe an affiliate as a group of health clinics that are managed by one administrative office. Each state or region of the US either runs its own affiliate or belongs to an affiliate of the National Health Organization. The unevenness of the geographic distribution of affiliates can be attributed to differing populations in states, varying needs for the health clinics, and tolerance of the clinic. For instance, some state legislatures are unsupportive of this healthcare organization because it provides abortions, so expanding clinics is difficult, while other states are more tolerant of the organization, so expansion is easier.

According to the health experts, the decline in number of affiliates is due to many reasons, ranging from financial changes, improvements in healthcare technology, and changes in federal health policy. A decrease in federal family planning funds has led to the closure of many health clinics across the US. Another reason for the decline in affiliates is the Affordable Care Act of 2010. The Affordable Care Act, signed into law by President Barack Obama in 2010, mandated significant changes in the American healthcare system. One implication that this had for the National Health Organization was to switch from paper recordkeeping of data to electronic recordkeeping. According to the interviewees, this switch resulted in significant costs for the health clinics. The new

technology had to be implemented in clinics, staff had to be trained, and all patient data had to be transferred into the online system. According to the interviewees, the switch was very expensive and some affiliates could not bear the costs.

In the excerpt below, one of the health experts describes the number of affiliates when she began working at the Indianapolis headquarters of the National Health Organization. She discusses the challenges that the Affordable Care Act has brought to the organization's business model and the effects that this has had on profit and patient traffic. She notes the additional expenses that the Affordable Care Act brought to the healthcare organization, as well as the loss of patients.

> Um, when I signed in twelve years ago there were 128 [affiliates], and a huge driver of merger activity has been… was first the falloff of federal family planning funds, and, uh, and then, secondly, the Affordable Care Act, and all the uncertainty that that introduced and the challenges to our existing business model, and in some cases, most specifically, the imperative that you find the one-time investment financial resources to put electronic health records in place. And then the ongoing impact on the annual operating budget to keep those electronic health records in place. So, while that's a great advancement in terms of allegedly, *hmm*, efficiencies, every affiliate in the country that did come up with the money to put them in and train the staff, there was a falloff… you know, staff-training is vigorous, there's a falloff of patient traffic. Sometimes you retrieve [patients], you get those back. Sometimes you don't.

She goes on to explain how the Affordable Care Act has affected the National Health Organization in Indiana, and how a relationship with the Kentucky affiliate of the National Health Organization developed. In the excerpt below, she mentions "National," which is a reference to the administrative office that oversees all state headquarters. The national offices for the National Health Organization are located in New York and in Washington DC.

> Um, and so, where all that's going is…the bottom line became more and more challenge for some of the affiliates and that was true of Kentucky, and that's why National asked us if we would contemplate a merger with Kentucky, so that they could survive, so that the National Health Organization could continue to be a presence, at least in Lexington and Louisville. Um, and of course we would like to be in more places in Kentucky, as well as in more places in Indiana…

According to the interviewee, the Affordable Care Act's demands for technological upgrades at the administrative level have caused some affiliates to close or restructure. The Kentucky affiliate is one of those affiliates. With only two health clinics in Kentucky, the affiliate had to contemplate a merger with Indiana in order to stay open. As of 2013, the Indiana affiliate is now the Indiana and Kentucky affiliate. Although the restructuring has led to efficiencies in terms of patient management, it has caused a strain in staffing and management. As the interviewee states, the National Health Organization hopes to expand its presence in Kentucky and introduce more health clinics. A successful merger is the only potential way to do that at this point in time.

Staffing

Indiana currently has six health care organizations that provide abortions. Four of those providers are operated by the National Health Organization. The National Health Organization operates 25 health centers, with four centers offering abortion services. Three centers, Bloomington Health Center, Merrillville Health Center, and Georgetown Health Center offer both surgical and medical abortions, while the Lafayette Health Center only offers medical abortion. Five doctors work for all 25 health centers, with one being the medical director. The clinics employ many nurse practitioners with prescriptive authority. Each clinic has a manager and administrative assistants. Only the doctors are authorized or trained to provide abortions. This means that four doctors provide abortions at four health centers. The interviewees did not state whether the medical director provides abortion services at this point.

Inequality Between Affiliates

According to the interviewees, the National Health Organization affiliates experience a wide range of problems during daily administrative and medical work. They state that unevenness between affiliates exists, since each state does not have one affiliate associated with it, but many states may be under the administrative supervision of a single affiliate. Varying populations and

general tolerance for abortion services determine how many health clinics can operate in a state. The interviewees state that the provision of abortion services dramatically changes the way an affiliate operates in a state. The affiliates that offer abortion services often have a tougher time operating than those who do not. The excerpt below demonstrates this struggle.

> Yeah. And so, the point here is, you've got smaller states like Florida, where there are three or perhaps four affiliates. Um, Ohio, where they've tried mightily to be one and keep falling out before they actually get the merger document signed… Um, and what used to be the biggest difference was that those who didn't do AB [abortion] services. Your life's a lot different if you don't do abortions. Uh, at this point in time, I'm going to say there are six of sixty-eight that still don't. Yeah, and they will. It's just that it's not the easiest thing in the world to get that done, quite frankly…starting with finding a provider.

The affiliates and their associated clinics that do provide abortions must deal with political, religious, and legal ramifications associated with the procedure. The interviewee explains how affiliates who provide abortions must have lobbyists in the state governments to ensure that abortion restrictions do not impede their provision of services. The affiliates also must spend money on legal fees associated with fighting abortion restrictions. The legal ramifications associated with providing abortion services lead to an uneven expenditure of resources between affiliates, which, in turn, may lead to uneven access of women to abortion services.

4.2.2 Primary Purpose Of The National Health Organization

The National Health Organization primarily provides women (and some men) with preventative care. According to the interviewees, 94% of their work is providing preventative care to patients. The National Health Organization provides pap smears, breast and testicular exams, and STD testing and treatment. Some clinics also provide abortion services, but not all clinics.

4.2.3 Healthcare Changes And Financial Challenges

The National Health Organization has encountered many financial challenges in the last decade. The Affordable Care Act led to upgrading of technology and data systems, which was a resource drain on the organization, and led to restructuring and mergers. Other financial factors

include lobbying and legal fees associated with operating in states that do not have a favorable attitude towards abortion. As the interviewees stated, affiliates that do not offer abortion services spend fewer resources on battling discriminatory and restrictive abortion mandates in state legislatures.

A third reason for the decline in healthcare clinic affiliates is the Affordable Care Act's requirement that the morning after pill be available on stocked shelves in pharmacies and in grocery stores for girls and women. The Affordable Care Act also gives women full coverage of all contraceptive methods under most insurance plans, so women are becoming less dependent on health clinics for contraception. The morning after pills known as "Plan B" and "ella" are also covered by most insurance plans. The Affordable Care Act's expansion of contraception and access has decreased the need for patient's to visit the health clinic, and has resulted in a loss of about 7,000 patients in Indiana and Kentucky, which is a major cut to funding streams. Although this advancement is a tremendous one for women's access to reproductive healthcare, it is a potential financial loss for health clinics.

A fourth cost to the clinics has emerged from a change in policy regarding how often women need to get pap smears. As of 2012, the American Cancer Society, US Preventative Services Task Force, and the American College of Obstetricians and Gynecologists, recommend that women who are at average risk of developing cervical cancer need to have pap smears once every three years, as opposed to every year (CDC.gov 2014). The interviewees state that the new policy change has resulted in a reduction of funds, since the number of women getting pap smears per year has declined. They say that in 2004, the National Health Organization did 55,000 pap tests, and in 2013 they conducted only 9,000 pap tests. The policy change has led to a loss of 46,000 patients.

4.2.4 Legislative Restrictions Against Abortion In Indiana

Indiana has instituted eleven out of a possible twelve common abortion restrictions against women and providers. These restrictions are aimed at creating barriers for women who need abortions, and at the providers who perform them. Many of these barriers are structural and aimed at forcing clinics to remodel or have very advanced medical facilities; many barriers force women to make several trips to clinics after mandatory waiting periods; and many restrict abortion at gestational ages before viability.

The Indiana legislature has informed consent laws, which control the type of information that women receive when going to a clinic for an abortion. Informed consent laws are notorious for being politically motivated and guided by false medical claims concerning abortion. In Indiana, a woman must receive this state-mandated information from a medical professional in person. The interviewees refer to the consent laws as "misinformed consent," since they were written under the guise of protecting women who want abortion services and offering them alternatives, such as adoption and paid child support, but the language used is designed to be pro-natalist and antiabortion. The consent script contains information about adoption, paid child support, a statement that says human life begins at conception, and color pictures of fetuses at various stages of development. The patient also must be given the opportunity to see an ultrasound image of the fetus and hear the fetus' heartbeat. Policymakers also attempted to include language claiming that a fetus can feel pain prior to gestational viability, and that abortion may increase risk of breast cancer. These two claims did not make it into the Indiana script, as they are scientifically disputed.

A second restriction is a ban on abortion after twenty weeks gestational age. The federal government, under *Roe v. Wade*, protects a woman's right to have an abortion up to viability, which many US doctors determine is at 24 weeks gestational age (State Policies on Later Abortions 2015). The ban is inherently unconstitutional and is a barrier to women who discover that they are

pregnant later in their terms, who cannot afford an abortion earlier in their term, or who cannot arrange appropriate transportation to a clinic in a timely manner. The state also does not allow insurance coverage of abortion, except for cases of rape and incest.

A third major restriction is the requirement that a woman wait 18 hours in between her informed consent consultation and her abortion. This law is intended to encourage women to change their minds regarding the abortion and to increase geographical and financial barriers to women. A fourth restriction is the requirement that all abortion providers have admitting privileges, a transfer agreement, or a backup agreement with a nearby hospital. Admitting privileges are difficult to acquire because abortions are low-risk and the agreements generally do not bring profit to the hospital. Abortion is also a controversial procedure, so hospitals are hesitant to grant admitting privileges to physicians who perform them. Below, one of the interviewees details the difficulty of acquiring admitting privileges for abortion providers.

> Under a doctor's regular life, it's probably standard operating procedure. The reason it's difficult for our docs is: one, there's such a low incidence of medical claims when it comes to abortion, like compared to even having your wisdom teeth taken out, even. And so, they don't bring in any book of business to the hospital. They don't have a patient portfolio that is going to cause patients to come through the doors of the hospital and contribute to their bottom line. And, they bring controversy.

Requiring an abortion provider to have admitting privileges is a very common way of forcing that abortion provider to shut down or stop performing the procedure. This requirement has been appealed to state courts across the nation due to its notoriety for being hazardous to providers. Currently, Indiana abortion providers have transfer agreements or backup agreements with hospitals. When a provider has a transfer agreement with a hospital, the provider may send a patient to that hospital, in the case of an emergency or in the case of medical complications associated with abortion. According to the Guttmacher Institute, when an abortion is performed in a professional medical setting, less than 1% of patients experience complications (Are You In the Know? 2015).

All of the restrictions outlined above are intended to make it more difficult for providers to administer abortions and more difficult for women to access the procedure.

4.2.5 Barriers Faced By Patients, Providers, And Donors

Barriers Faced by Patients

The interviewees described many barriers that women face when trying to gain access to abortion services. Barriers faced are psychological, financial, personal, and geographical. The legislative polices put in place to restrict access to abortion have effects on how women get abortions, when they get abortions, and where they get abortions. The experts at the National Health Organized described how the process women go through to have an abortion affects their health status, financial status, and mental wellbeing. The interviewees described four major barriers that women must deal with when seeking abortion services in Indiana.

The first barrier that women face when seeking abortion services is a psychological barrier. The interviewees describe how young women do not know much about pregnancy and about options regarding pregnancy, so their choices regarding their reproductive healthcare are often limited due to lack of knowledge. A lack of knowledge regarding the human body during pregnancy, as well as a lack of knowledge about reproductive resources prevents many young women from finding abortion services in a timely manner. The interviewees discuss how each passing day of a young woman's pregnancy leads to a riskier pregnancy or a riskier abortion. The passing time also results in more difficulties in accessing abortion services. The psychological barriers are exacerbated by the state-mandated anti-choice consent documents that providers must read to their patients.

The second barrier that women encounter is a financial barrier. Many women pay for abortion services out-of-pocket, and do not or cannot use insurance to pay for the procedure. The cost is already a financial burden to some women, but other state-mandated policies make that cost worse. For instance, Indiana mandates that women seeking an abortion must wait 18 hours after

being read informed consent documents. For many women, this requires at least two trips to the health clinic. Making two trips is a burden which requires additional money spent on transportation and time off of work. Women also must make arrangements for childcare for current children. Additionally, if women live far away from the clinic, they may have to pay hotel fees for lodging. Medicaid funding rarely pays for abortions, since the bureaucratic system is stringent on abortion funding. Even in cases of rape or incest, or life endangerment for the mother, Medicaid will rarely cover the costs for an abortion.

The third barrier is one that addresses personal challenges. The interviewees mention familial issues when women attempt to access abortion services. These familial challenges include taking time off from caring for the family, such as finding childcare for children or aging parents, and circumstances associated with being a single mother. According to the interviewees, abortion rates among the poor are not decreasing at a significant rate, and many single mothers desperately need access to contraception and abortion.

Lastly, women also experience geographical barriers to services. Most patients must travel a significant distance and travel time to reach a provider. Indiana only has six abortion providers, and these providers only provide abortions up to about 13 weeks. No provider in Indiana will provide abortions at 20 weeks gestation. Since half of all abortion providers are located in Indianapolis, women living in more rural areas have a significantly difficult time overcoming geographical barriers. As shown in the previous chapter, low-income women living in rural areas face particularly long travel distances to clinics. The excerpt below details the geographical in-access to abortion-providing clinics in Indiana.

> Most [women] have to travel. That is one of Guttmacher's fits… We are bad. We are bad here. And it's just that much worse in Kentucky… I mean, it's a big state. It's a pretty sizeable geography, and we are in few places… It's 92 minus 6, is what I think. You've got Bloomington, which is the only one south of US-40, which is a national highway. You've got Indianapolis, the provider where Fort Wayne is no longer doing services. It's barely hanging on here in St. Joe County. There are providers in Lake

> County. And then, we are here in Tippecanoe County. That's it. And, could you find a hospital where somebody would say, "Yeah we do abortions?" I don't think so.

The interviewee explains how the combination of distance, lack of providers, and no support from hospitals creates hardships for women who need services. The interviewees also go on to explain that about 0.4% of hospitals in Indiana provide abortions. The unwillingness of hospitals to provide the service, combined with the increase in number of religious hospitals suggests that access to abortion services is becoming scarcer every year.

An additional challenge that increases geographical barriers is the fact that women must make several trips to a clinic when obtaining a medical abortion. With a medical abortion, a woman must make three trips to a clinic. The first trip is to hear the informed consent script read out loud to her. The second trip is to receive the first medical abortion pill (known as Mifepristone). Lastly, the woman ingests the second pill at home, but must come back to the clinic after 14 days to ensure that the pregnancy has been terminated. The geographical concerns affect all women using this method, but can be a significant burden on women living 50 miles or more from a clinic.

Barriers Faced by Providers and Clinic Supporters

Providers and clinic supporters also face many barriers when working for the clinics. The interviewees discuss how legislation is designed to restrict abortion services or close down providers. TRAP laws, in particular, are designed to make running an abortion clinic too expensive. A recent TRAP law was proposed that was intended to shut down abortion services in Lafayette, Indiana. This legislation, known as Senate Bill 371, states that all abortion providers must restructure and renovate their facilities to meet the stringent medical and clinical requirements of ambulatory surgical centers. The bill would negatively affect the Lafayette clinic, which only provides medical abortions. This clinic does not perform surgeries of any kind, yet the bill called for expensive renovations to turn it into a surgical center. In December 2014, the bill was blocked in federal court,

and it will not affect the Lafayette clinic. TRAP laws like this one have true intentions of shutting down providers under the guise of protecting women's health.

Abortion clinic supporters often face criticism and protests from anti-choice groups. National Health Organization fought a legal battle in court to maintain the privacy of providers and donors of abortion clinics. A bill was proposed by anti-choice legislators that would have required all admitting privileges to be on record at the State Department of Health. This means that all providers would have their names publicly registered with the state. The proposal failed because providers and donors have been harassed by protesters in their homes. The interviewees tell a story of one donor and supporter of the National Health Organization who was harassed by Indiana Right to Life at their home:

> …we had a donor who was publicly acknowledged and they [Indiana Right to Life], I think it was on Easter Sunday, they showed up. The parents were gone, and the twenty-year-old daughter was there. They actually went up to the front door and rang the bell, which they don't…they normally know where their boundaries are and they don't abuse them. And they said, "Do you know that your father supports the murders of babies?" and blah blah blah. And then they posted on YouTube three photos. The first photo was a computer keyboard with a big, huge bladed knife laying across it, the second was a stack of boxes and boxes of 38 bullets, and the third was her. And you show that to legislators, they say "You don't need to sacrifice these doctors who are doing something legal under the guise of patient safety.

The National Health Organization fought for language mandating the public acknowledgment of doctors and donors to be removed to protect anyone associated with abortion provision or the National Health Organization. Anti-choice groups, such as Indiana Right to Life aim to reduce abortion access by intimidating those who provide it or support it financially or politically.

The barriers faced by patients, providers, and donors coalesce to restrict access to abortion in Indiana. Many TRAP laws are intended to shut down providers, but those that do not, make an effort to prevent women from having an abortion in a cost-effective and time-effective manner.

Intimidation in the form of protests and picketing deter patients, providers, and donors from publicly being involved with abortion services. The restrictions and protests also create stigma and psychological challenges to those involved in abortion services.

4.2.6 The Cost Of Unplanned Pregnancy To The State

Unplanned pregnancy is a major cost to the state, with about half of Indiana pregnancies being funded by Medicaid. According to the interviewees, Medicaid births cost the state half a million dollars per year, but policymakers are trying to restrict access to abortion and associate contraception with abortion which will increase Medicaid costs by increasing the number of unplanned births. According to the interviewees, a publicly funded birth costs an average of twelve thousand dollars, while a non-publicly funded birth costs an average of eight thousand dollars. Policymakers in Indiana are also cutting funds to Medicaid and prenatal care for pregnant women. As seen in the following quote, a gap exists between appropriate maternal healthcare and access to contraception and abortion.

> And if you think about it, it's poor baby spacing, it's poor prenatal care, it's probably more likely at-risk, there's more likely substance abuse, there's more likely alcohol, there's more likely abuse…Stress…a challenged household, generally. And, you put all that into the nine-month pregnancy, isn't there a much greater likelihood that you'd then have a developmentally challenged birth and child, which further stresses that household? And start with…chances are, that a lot of those cases, that wasn't a planned pregnancy. And then you add that kind of a challenge to the household. And so then, all that contributes to the cycle of poverty and further bad societal outcomes. And, why don't they care?

The state has failed to create a constructive way to lower abortion rates and support pregnant women and their children. The future of reproductive care is at stake in Indiana, where poor access to contraception and abortion, coupled with inadequate funding for mothers and children, is having troubling results for healthcare.

4.3 SUMMARY AND CONCLUSIONS

The interview demonstrates that Indiana, a highly unsupportive state to abortion rights, has made many efforts to restrict access to the procedure. Anti-choice legislatures have attempted to curb both the supply and demand sides of abortion by restricting gestational age at which a woman may have an abortion, by instituting waiting periods, and by forcing clinics to remodel. They have also done little to protect providers and financial donors to the National Health Organization, sending a message suggesting that abortion is not tolerated by the state.

The interviewees state that they would like to open more health clinics throughout Indiana and Kentucky, since geographical barriers are a significant limitation for women who seek abortions. Since 97% of National Health Organization's work is spent providing preventative care, this means that the opening of more clinics might actually lead to a decrease in abortion because more women would have access to contraception. The Affordable Care Act has led to a decline in providers, since mandatory contraception coverage by insurance will mean that fewer women will depend on clinics like the National Health Organization for pregnancy-related services.

Restrictions create challenges for providers and limit how they can do their job. State-mandated consent laws impede on providers' medical authority and force providers to provide disputed and medically inaccurate information to already vulnerable women. The 18-hour wait period creates financial and geographical barriers, since women must make at least two trips to a clinic and pay all costs associated with travel and finding childcare costs for current children. Mandates requiring providers to have admitting privileges with hospitals can actually make abortion more dangerous, as the procedure is so low-risk (and controversial) that hospitals do not gain profit from entering the admitting privileges agreement. Hospitals also do not wish to be associated with such controversial procedure, so they may refuse to grant admitting privileges. Creating a stigma around a legal and safe procedure decreases access and prevents many women from reproductive

healthcare. It also leads to riskier pregnancies, and has negative effects on income, class, and the health of women and their families.

Overall, these restrictions decrease access to abortion and increase financial and psychological costs to women. They decrease incentive for providers to do abortions and they may overall decrease the pool of future healthcare providers who are trained in abortion services. Inability to access abortion services has detrimental effects on the state as well, as half of Indiana pregnancies are funded by Medicaid. These births also cost four thousand dollars more than non-publicly funded births. Improving access to contraception and abortion can actually lead to decreased abortion rates, and a healthier society.

Chapter 5

DISCUSSION AND CONCLUSION

This thesis has investigated access to abortion services and providers' ability to provide the service to their clients. The thesis has presented multiple perspectives on access to abortion in the US. The first perspective is a quantitative GIS analysis, focused on both the national scale and the state scale, with the case study of Indiana. The second perspective is a qualitative study, focusing on providers' responses to state-enacted abortion restrictions to provide the service to women in Indiana. The first portion of this study gives a national overview of general trends regarding abortion access in the US from 2008 to 2013. The second portion of this thesis is an in-depth case study of Indiana, a highly anti-choice state, where women and providers struggle to access and provide abortion services. While the quantitative study provides an analysis of how abortion access is changing temporally and across space, the qualitative study presents an in-depth micro-scale examination as to how providers are dealing with restrictions in attempts to keep their clinics operating.

5.1 QUANTITATIVE ANALYSIS OF GEOGRAPHICAL AVAILABILITY OF ABORTION CLINICS

The quantitative analysis at the national scale suggests that access to abortion is changing temporally and spatially across the US. Maps of abortion providers and restrictions show that abortion access is increasingly unequal. In many states, accessing an abortion provider is becoming increasingly difficult, as more restrictions are being enacted by state policymakers. New legislation that is restricting abortion services is leading to shutdowns of clinics. These results are reflective of geographical studies on abortion. Henshaw (1995) and Henshaw and Finer (2003) found that the number of providers has been decreasing since 1982, and similar findings are reported by Jones and

Kooistra (2011). My findings echo the comments of Gober (1997) who affirms that a woman's ability to access abortion services is impacted by where she lives.

Since the Supreme Court granted rights to states to legislate abortion in the 1980s, states have taken the opportunity to control the procedure. Since 2008, the average number of providers per 1,000 women has decreased from 0.03 to 0.25. The average number of restrictions per state has increased from 5.45 to 6.02. These results suggest an inverse relationship between restrictions and providers, an indication that TRAP laws may be forcing providers to shut down. The national-scale analysis also demonstrates that states in the Midwest and in the South are instituting the most restrictions against abortion, where geographical challenges to abortion access already exist. The most recent anti-choice activity will lead to greater in-access to abortion in many states, and we can expect that a woman's ability to have an abortion and other reproductive services will be determined by where she lives.

The quantitative analysis of abortion clinics at the local scale, in Indiana, presents population demographic information regarding how far women of various ethnicities, educational levels, and income have to travel to reach a provider. The data shows that women with higher levels of education travel smaller distances to reach abortion services than women with less education. Women who have a high school degree or who did not graduate high school travel the furthest distance of any other education group, and women with incomes below poverty also face long travel distances. The results demonstrate that disadvantages in access are class-based. The results from this study are reflective of literature on class-based disparities in access to reproductive healthcare. Arber's (1991) study on gender and health status suggests that women's health status is associated with social class, since financial wellness alters personal health. Adler, Boyce, Chesne, Folkman, and Syme (1993) find that people in higher socioeconomic groups have greater control over their environments, which results in greater control over their personal health. This relates to class-based

healthcare disparities, women's ability to access abortion clinics, and their own reproductive outcomes. Dyck (1995) also discusses the relationships between women's health status and culture, place, and class. Relatedly, women who experience unintended pregnancy experience limited educational opportunities and work opportunities (Dehlendorf, Rodriguez, Levy, Borrero, and Steinauer 2010). The relationships between unintended pregnancy, limits in abortion access, and socioeconomic status are cyclical.

Although *Roe v. Wade* affirms a woman's right to abortion services, it does not guarantee her right to access those services. Many states are taking advantage of this gap in *legal right* versus *right to access* and creating laws to make abortion access unattainable, particularly to low-income women. The quantitative study on national access and access in Indiana reaffirm the hypothesis that abortion access is spatially and socially unequal and is declining across the country.

5.2 QUALITATIVE ANALYSIS OF PROVIDERS' ABILITY TO OPERATE IN INDIANA

The results from the qualitative interviews provide a local-scale analysis of how providers confront anti-choice restrictions to maintain abortion access to women. Indiana has many anti-choice laws that do not improve women's health, but threaten to shut down clinics and prevent low-income women from accessing abortion services. The interviews reveal the financial and geographical barriers that restrictions place on women, and how women navigate through those barriers. They also reveal how providers continue to challenge some restrictions in court, in order to avoid unnecessary laws that may threaten women's health.

The interviewees also discuss the cost of unplanned pregnancy and publicly-funded pregnancy to the state. They state that a publicly funded birth is costlier than a non-publicly funded birth, both to the state and in general. The interviewees discuss the effects that family planning funding cuts and prenatal care funding cuts have on the state. They state that cutting access to family

planning and prenatal care negatively affects the state, since it contributes to poverty, and disadvantages in public health. Women who have unintended pregnancies often receive inadequate or delayed prenatal care. The women and their babies are at risk of poorer health outcomes, such as low infant birth weight, infant mortality, and maternal mortality or morbidity (Dehlendorf, Rodriguez, Levy, Borrero, and Steinauer 2010). These cuts are also detrimental to women and their families, since they discourage women from seeking prenatal healthcare while pregnant, thereby increasing the risk of unhealthy pregnancies and childbirth.

The results from the qualitative study contribute to a vast literature on effects of abortion restrictions on women's healthcare. Boonstra and Nash (2014), the Guttmacher Institute (2013), and Finer and Fine (2013) show that the recent momentum of abortion restrictions is not slowing down, and that these restrictions are causing hardships to women who need abortions. This qualitative study adds to this body of literature, and demonstrates that restrictions are successful in preventing women from accessing abortion services, and in impeding providers' ability to provide the procedure. As the number of restrictions in each state increases, women's ability to access the procedure will decrease, as is happening in Indiana. The restrictions increase emotional and financial costs to women, and also may contribute to an increase in travel and time costs associated with locating a provider and making the multiple visits required to obtain the procedure (Medoff 2011).

5.3 CONCLUSION

A vast literature exists on abortion restrictions in the US. This literature demonstrates that abortion restrictions do have a significant role in limiting women's geographical access to the procedure. The research presented in this thesis show a geographical relationship between legislation and access. Using Ribot and Peluso's (2003) access model, this thesis demonstrates that *legal access* to a resource is not the same as *demonstrated access*. Abortion restrictions are aimed to reduce actual access to abortion, all while working within the boundaries that *Roe v. Wade* had set in 1973.

Although states may seek to limit abortion services to women, this does not mean that women will stop using the service. Medoff (2002) shows that abortion restrictions do not influence a woman's decision to get an abortion. Most women already make a decision regarding abortion versus parenting upon discovering their pregnancy (Finer, Frohwirth, Dauphinee, Singh, and Moore 2006). In cases where women are unable to get an abortion in their state, they may travel to a bordering state for the procedure. Their access may further be limited if bordering states implement similar restrictions. This thesis demonstrates that states in the Midwest and in the South are already progressing towards making this situation a reality.

Currently, women are underrepresented in conversations surrounding healthcare, which impedes their overall experiences with health (van Wijk, van Vliet, and Kolk 1996). As van Wijk, van Vliet, and Kolk state, women use healthcare differently than men, but these differences are not accounted for by the healthcare industry. *Quality* of healthcare is defined by governments, insurance providers, donors, and healthcare providers, but women define *quality* of healthcare differently than these groups (van Wijk, van Vliet, and Kolk 1996). In order to improve women's experiences in healthcare and to stem the current antiabortion momentum, women's needs and experiences must be taken into account in decision-making and political discourse. In addition, the US population tends to be moderate on abortion, with the majority of the public viewing abortion in a situationalist manner (Glendon 1989; Lopoo and Raissian 2012). The public believes that one right answer does not exist for abortion, and that no one solution exists for all women (Glendon 1989; Jelen and Clyde 2003).

The national study and the case study further evaluate the realities that women face when seeking reproductive care. Current antiabortion policies target healthcare providers who do abortion in addition to other services. Policymakers seek to defund these organizations due to their abortion provision, but this has larger implications. Women depend on these organizations for many essential

health services including primary care and contraception. By defunding these organizations, policymakers are effectively denying women primary healthcare and contraception, which may lead to unhealthier populations. The connection between abortion, contraception, and primary healthcare is one that cannot be ignored. Although abortion is often viewed as being separate from reproductive healthcare, it must be understood as being a part of women's healthcare. As abortion access continues to depend on a woman's geographical location, one can expect that a women's health will also depend on her location, as well.

5.3.1 Limitations

The quantitative analysis in this thesis has several limitations. On the national scale, the data on abortion restrictions continues to change, as new restrictions are implemented, fought against in court, enjoined, or deemed unconstitutional. The national scale analysis is already outdated, as laws have changed in many states. For the Indiana case study, an important limitation is the lack of data on transportation access and temporal access in relation to women's daily responsibilities and activity patterns. Although women living in cities were found to be geographically close to clinics, they may face significant barriers due to limited transportation options and difficulties in balancing employment, household and childcare responsibilities with the need for essential health care.

The qualitative analysis of this thesis has some limitations, as well. Only one interview with two health experts was granted for the semi-formal interview part of this research study. Although the two health experts are high-ranking members of a major health organization, more interviews with health providers must be done in order to better understand how clinics are coping with new antiabortion legislation. Also, interviews with women seeking abortions or who have had abortions should be done to better understand how women navigate legislative and geographical barriers. Further, financial limitations should be studied in conjunction with geographical barriers to see the role that monetary in-access has on women's ability to get an abortion. Many abortion restrictions

limit access by making it unaffordable to have an abortion due to transportation costs, wage loss, and healthcare costs.

5.3.2 Future Directions

Although *Roe v. Wade* guarantees women the right to an abortion, and it allows states to restrict abortion without placing an undue burden on women, there are inconsistencies as to what "an undue burden" means. State policymakers and the Supreme Court judge "undue burden" differently, leading to an uneven landscape of abortion access across the US. The current Supreme Court is conservative and is generally unfavorable towards abortion rights. Its view of "undue burden" is drastically different than the Supreme Court's view that legalized abortion in 1973. Future directions of this topic of study should explore the future of abortion access in the US. Many policymakers and researchers are no longer confident that *Roe v. Wade* will guarantee abortion rights into the future.

Researchers should further investigate how states are restricting abortion at the local level in order to chip away at *Roe v. Wade* in the long-term. For example, the most recent efforts aimed at restricting abortion seek to ban abortion at 20 weeks of gestational period, claiming that a fetus can feel pain at this point. The medical field concludes that a fetus is not viable at 20 weeks, making these restrictions unconstitutional. Although the bans are unconstitutional, many states have been successful in banning abortion at 20 weeks. These attempts to decrease access on a smaller scale will lead to big changes in the future.

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