Original Research Article

Abortion as obtainable: Insights into how pregnant people in the United States who considered abortion understand abortion availability.²,³

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ABSTRACT

Objective: In the United States, restrictive abortion policies are concentrated in a subset of states. Little research has examined how people who consider abortion make sense of abortion obtainability and the extent of regulation of abortion care in their state.

Study design: We conducted in-depth interviews with 30 pregnant women in Maryland, a state with high abortion service availability and few policies restricting abortion, and 28 pregnant women in Louisiana, a state with low service availability and numerous restrictions, who had considered but not obtained an abortion for their pregnancy. We analyzed findings using inductive qualitative analytic techniques.

Results: All participants were financially struggling. Most participants in Maryland considered abortion easy to get, while a plurality of participants in Louisiana considered abortion difficult to get. Yet, despite their measurable differences in access, participants in both states considered abortion generally obtainable. Participants in Louisiana who thought abortion difficult to get, but nonetheless obtainable, cited strategies that they already employed for other challenges in their lives as options for overcoming abortion barriers.

Conclusions: Pregnant women who consider abortion and are subject to restrictions do not necessarily perceive restrictions as barriers. Their accounts illustrate how those impacted by restrictions adapt to constraints on their reproductive autonomy just as they manage many other challenges that restrict their freedom to live self-determined lives.

Implications: Financially struggling pregnant people who considered abortion in Louisiana did not perceive restrictions as barriers to abortion, illustrating the broader adoption of strategies to deal with constraints among women living on low incomes.

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1. Introduction

Restrictive abortion policies and low service availability do not exclusively affect people who present for abortion care. They can affect abortion decision-making prior to presentation at an abortion providing facility [1–3]. Little research, however, has examined how people who are considering abortion make sense of the availability of abortion and extent of policies regulating abortion care in their area.

Although abortion is legal in the United States (U.S.) through the second trimester of pregnancy per the U.S. Supreme Court’s 1973 Roe v. Wade decision, the availability of and required steps to obtain abortion care vary substantially by state. Abortion care providers are not distributed evenly by geography, with some geographical areas so far from a provider that scholars have termed them “abortion deserts” [4]. Abortion care itself varies from state to state in terms of what is required of patients seeking abortion. Since 2010, states have passed a record number of policies regulating abortion care, many, though not all, of which have taken effect [5]. These policies are concentrated in a subset of states, sometimes described as “very hostile” states [5].

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Research examining pregnant people’s experiences of obtaining abortion care suggests that they adapt to the regulations they encounter upon presenting for care, such as 2-visit requirements, mandatory ultrasound viewing, and bans on public insurance coverage of abortion [6–13]. Moreover, scholars have shown that abortion patients often understand parts of their care mandated by policy, such as mandatory ultrasound viewing, as normal and acceptable [14,15], although other research has found that at least some patients are negatively surprised to learn that their public insurance will not cover abortion [9]. This body of research suggests that, for people who present for abortion care, policies regulating their care, even those without a medical justification, have been normalized.

Here, we add to this growing body of research on how people make sense of the lived experience of abortion restrictions. Drawing on interviews with pregnant women in 2 states, one with few restrictions on abortion and high service availability and one with a high number of abortion restrictions and low service availability, we examine how they understand the obtainability of abortion in their state.

2. Methods

We use interviews collected as part of a larger study, the Abortion Prenatal Study, which was designed to understand women’s pregnancy experiences in Maryland and Louisiana. At the time of data collection, Maryland had a parental involvement law and relatively high service availability (25 clinics at the time of data collection) [16,17]. Louisiana, meanwhile, had a high number of policies restricting abortion, including state-mandated counseling, mandatory waiting periods and ultrasound, a parental involvement law, a 20-week ban, and a prohibition on state funding for abortion [18]. At the start of data collection, Louisiana had just 5 abortion clinics; by the end of data collection, one had closed [17].

Investigators describe the Abortion Prenatal Study methods in depth elsewhere [19,20]. Briefly, between June 2015 and May 2017, an on-site research coordinator recruited patients presenting for their first prenatal appointment at prenatal clinics in Maryland and Louisiana for a self-administered survey and an in-clinic structured interview. Patients were eligible if they were over 18, spoke English or Spanish, and were attending their first prenatal appointment. Those interested and eligible provided written consent. The in-clinic data collection included questions about participants’ initial and current preferences for their pregnancy, including if they had considered abortion “even for one second” and what, if any, steps they took toward obtaining an abortion. We remunerated participants for their time with a $30 gift card.

The study invited participants who reported that they had considered abortion for this pregnancy to complete an in-depth phone interview, scheduled 1 to 3 weeks after initial recruitment. KK conducted the interviews, which averaged 1 hour in length and, relevant to this analysis, included questions about participants’ consideration of abortion, perception of whether it was easy or hard to get an abortion in their state, and knowledge of abortion availability and regulation in their state. We remunerated interview participants for their time with a $50 gift card.

The institutional review boards at the University of California, San Francisco (UCSF) and Louisiana State University Health Sciences Campus approved study protocols. The institutional review board of the University of Maryland relied on the approval of the UCSF institutional review board.

2.1. Analysis

A professional transcriptionist transcribed the interviews verbatim. KK had extensive familiarity with the data given work on previous projects. The inductive analysis presented herein expands into themes not explored in other work, consistent with common approaches to analyses of data from large-scale qualitative interview projects [21]. KK coded the transcripts thematically in ATLAS.ti 7.5, using abortion availability and abortion restrictions as sensitizing concepts [22]. KL reviewed excerpts from transcripts and both authors met to discuss emergent findings and impressions of the data, developing the framework for how participants made sense of abortion restrictions in their lives following discussion. We use pseudonyms below for all participants.

3. Results

3.1. Sample characteristics

Fifty-eight cisgender women who reported considering abortion for this pregnancy completed an interview, 30 from Maryland and 28 from Louisiana. No participants identified as trans, nonbinary, or gender nonconforming. Participants ranged in age from 18 to 38, with an average age of 27. Almost all (n = 50) identified as Black, with 4 identifying as white, 3 as Hispanic, and 1 as biracial. More than half (n = 34) identified as religious, with all who considered themselves religious specifying adherence to Christianity or a Christian denomination. Nineteen reported formal education beyond high school. All reported financial insecurity, including food insecurity, housing insecurity, and/or the inability to regularly meet their basic needs. More than two-thirds (n = 40) took a concrete step toward obtaining an abortion: 13 called a clinic or spoke to their doctor about abortion; 20 called a clinic and made an appointment; 8 called a clinic, made an appointment, and went to their appointment. Louisiana participants were subject to a 2-visit requirement, and none of the 4 Louisiana participants who went to their first clinic appointment returned for their second appointment.

3.2. Maryland: Perceptions of abortion obtainability

Maryland respondents commonly perceived abortion as easy to get, perhaps because of the high service availability in the state and few policy restrictions on abortion. Most (n = 21) Maryland respondents thought it was easy to get an abortion, 3 thought it was hard, and the remainder (n = 6) said they did not know. They cited having previous personal experience of abortion, knowledge that many people they knew had abortions, confidence that they could find clinics without much difficulty, and awareness that most public insurance covered abortion as reasons for believing that abortion was easily obtainable. Melissa (age 26, considered but did not take any steps toward obtaining an abortion) explained, “I think it is a little bit easy. Because with me living here in Maryland, I’ve heard so many people saying that they’ve had abortions at this time, at that time.” Ebony (age 30, made an appointment) referenced her personal experience of previously obtaining an abortion in Maryland, saying that it was “easy, I guess. I never had any problems getting one.” The 3 Maryland respondents who perceived abortion to be hard to get all cited the difficulty of paying for abortion. While public insurance in Maryland does not ban coverage of abortion, these participants either were unaware of this or had private insurance and believed they had to pay out-of-pocket for abortion care.

Those who thought it was easy to obtain an abortion in Maryland largely believed the current way people access abortion care was acceptable and that it should not be made more difficult. Often, they emphasized a belief in the pregnant person’s rationale for their pregnancy decision. For example, Aliyah (age 18, made an appointment) said, “I mean I think if someone calls to make an appointment, it must be for a reason.” Similarly, Martina (age 25,
made an appointment) argued that that the existing ease of obtaining an abortion was acceptable, citing the importance of bodily autonomy. She said,

I just think that everybody should have the choice to do what they please. It's their body, it's their decision, you know what I mean? [...] I don't think that someone should be able to tell you what you can and cannot do with your body.

The few participants who thought abortion was difficult to obtain did not think this was a good thing. Broadly, then, the Maryland participants thought that abortion should be and, for most, was obtainable.

3.3. Louisiana: Perceptions of abortion obtainability

Despite experiencing a starkly different regulatory environment and much more limited service availability, participants in Louisiana also believed that abortion was obtainable even if not easy to get. The largest group (n = 12) believed abortion was difficult to obtain in their state, 7 said it was easy, and the remainder (n = 9) felt unsure. Among respondents who considered abortion difficult to obtain, several pointed to the difficulty of paying for abortion, just as their Maryland counterparts did. Some also mentioned additional state-mandated requirements, such as mandatory counseling and the 2-visit requirement, as aspects of abortion care in Louisiana that make it hard to get an abortion. And some pointed to difficulties finding an abortion provider or the dearth of local providers. As Michelle (age 36, considered but did not take any steps toward obtaining an abortion) summarized, “It’s definitely not easy. There’s just no resources. I mean, there’s no places to go to. They’re not advertised, and there’s just no resources for it.”

Those who described abortion as easy to get acknowledged barriers to abortion but asserted that people could overcome the obstacles. For instance, April (age 20, called clinic) dismissed the idea that laws regulating abortion could matter for someone's decision-making and, more specifically, for hers. She said:

I know it’s like 2 appointments, so that's fine. I know there’s like money. You can always find money somewhere. You can always take out a loan. There’s like no limitation. I don’t see it as a limitation to me. If I wanted to do it, I would have done it. It’s able to be done.

Abortion, in her conceptualization, was obtainable, using strategies such as taking out a loan that she might employ for other needs. The consequential factor in whether one can obtain an abortion, in April’s formulation, is desire for abortion.

Most Louisiana participants, including those who considered abortion difficult or somewhat difficult to get in their state, believed abortion was ultimately obtainable. For example, Luciana (age 28, considered but did not take any steps toward obtaining an abortion) acknowledged the ways that obtaining an abortion was “a little bit more” difficult in Louisiana recently:

If you follow through with all the processes and the hoops they make you jump through, I think it’s easy in that sense, but I feel like they push you more to not having it [an abortion] rather than having it. They also closed down, I think, 2 clinics—they said that they closed down [those clinics] out here. I think they’re making it a little bit more difficult.

Even with what she perceived as slightly increased difficulty, Luciana believed that if one really wanted an abortion, “you could go and make it happen. Definitely.” She elaborated that she thought several of the state-specific requirements were unnecessary, notably the mandatory ultrasound viewing requirement and the 2-visit requirement, but she stopped short of considering either requirement a serious obstacle to obtaining an abortion. In this construction of abortion obtainability, Luciana and others described a story of abortion decision-making that was about individual effort rather than structural constraints. While respondents were aware of structural obstacles to abortion, they evaluated these obstacles’ import in affecting a pregnancy outcome as small compared to the import of the person’s desire for abortion.

Similarly, Paige (age 31, made appointment) thought it was difficult to get an abortion in Louisiana but assessed the structural obstacles that she personally faced to be inconsequential. After explaining her substantial financial constraints, including her current inability to afford the copay for the morning sickness medication her doctor prescribed, Paige asserted that her inability to obtain enough money to pay out-of-pocket for an abortion owed primarily to her lack of deep desire for the abortion. She explained, “I could’ve gotten money if I would’ve tried extra, extra, extra hard. But I didn’t even feel like going through all that.” In this way, Paige considered a policy-related barrier to obtaining an abortion to be something she could have circumvented had she wanted an abortion badly enough, even as the existence of the barrier fundamentally shaped her decision to continue the pregnancy.

4. Discussion

Pregnant women who considered abortion in Maryland, a state with high service availability and few policy restrictions, and in Louisiana, a state with low service availability and numerous policy restrictions, both generally considered abortion obtainable in their respective state. Research has shown that low service availability [3] and specific policy restrictions affecting patients, including bans on public insurance coverage [2] and gestational limits [1,23], reduce pregnant people’s ability to obtain a wanted abortion. Both characterize Louisiana abortion care. Nonetheless, we found that Louisiana participants did not believe that these barriers were significant for their own and others’ abortion decision-making. Even as they recognized obstacles, they believed they could overcome them. This perception is in line with research showing that women living on low incomes must regularly learn to manage bureaucratic barriers that make it difficult to get their needs met in order to eventually receive an abortion [24], perhaps explaining why many participants in this study did not believe that barriers were insurmountable.

These findings, drawn from a population of women who considered but did not obtain abortion care, join other evidence showing that people continue to strive for agency amid reproductive constraints. Specifically, findings that most pregnant people who are able to present for abortion care figure out how to successfully navigate obstacles to abortion [6–13] and that many people denied a wanted abortion who carry their pregnancy to term emotionally adjust to the abortion denial, even coming to consider the denial a good thing [25].

While one way of understanding these adaptations is through the lens of individual resilience, we suggest that a focus on the characteristics of individuals is at risk of overlooking systemic patterns of deprivation and adaptation by socially marginalized populations. Indeed, the broader international literature highlights the promises and pitfalls of using resilience as a frame to understand how marginalized people navigate life in light of material challenges and structural inequalities [26,27]. We echo colleagues in asserting the importance of systems-level change for supporting marginalized populations [28]. Our findings suggest the need to consider people living on low incomes’ social context to understand how they perceive the abortion landscape in order to develop a systems-level response to their challenges. When abortion is understood as generally obtainable, then people’s responses to questions about how to improve care might not encompass their
complex mix of needed resources. Instead, an exploration of how they adapt to constraints might provide useful guidance.

We note that our findings may not be transferable to the experiences of pregnant women in other states or even other populations within our focal states. Participants had, for the most part, decided against seeking an abortion at the time of the interview, so it is also possible that they came to understand abortion as obtainable only after they experienced constraints and had to make sense of not getting an outcome (an abortion) that they may have wanted previously. Still, these limitations are outweighed by this analysis’s primary strength of offering insight into the under-examined question of how people considering abortion, particularly those who do not present for abortion care, understand its obtainability.

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