

UTILIZATION OF ABORTION SERVICES:
A LOCAL LEVEL ANALYSIS

by

Carol J. Hanson

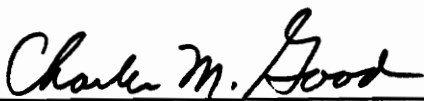
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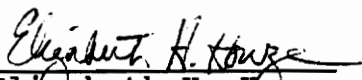
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Geography

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(ABSTRACT)

Utilization rates of an abortion provider located in Roanoke, Virginia were compared with the national abortion rates. This study also examined the barriers that women must overcome in order to obtain abortion services. Green's PRECEDE model of health care behavior was used as a framework for the study.

Generally, the Roanoke sample was very similar to the national rates, with any differences mostly explained by the demographic make up of the Roanoke region. Distance was found to be a barrier to the rural poor. Over half of the women who had their pregnancy tests performed at a health care facility were not given information on abortion services. Because the cost of a procedure increases with gestation and the number of providers declines with second trimester abortions, the findings suggest that this lack of timely information could put the option of abortion out of reach for some women.

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TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION.....1

CHAPTER TWO: ABORTION AND POLITICS.....10

CHAPTER THREE: STUDY MODEL AND METHODOLOGY.....43

CHAPTER FOUR: RESULTS AND ANALYSIS.....56

CHAPTER FIVE: CONCLUSIONS.....83

BIBLIOGRAPHY.....91

APPENDIX A: Research Approval.....97

APPENDIX B: Questionnaire.....98

VITA.....106

Figures and Tables

Table 1.1	Abortion Rates and Provider Rates for Selected States, 1988.....	4
Table 4.1	Employment Status and School Enrollment of Abortion Patients.....	57
Table 4.2	Age Distribution of Abortion Patients.....	58
Table 4.3	Family Income of Abortion Patients.....	59
Table 4.4	Distribution of Education Levels Ages 18 and over.....	60
Table 4.5	Distribution of Race, Marital Status, and Religion of Abortion Patients.....	62
Table 4.6	Most Helpful Source of Information on the Clinic and Percentage of Women Responding....	66
Table 4.7	Time Before Scheduling the Appointment, Lead Time to Appointment, and Convenience of Appointment Hours.....	71
Table 4.8	Travel Distance of Patients to Abortion Service.....	74
Figure 4.1	Source of Patients of the RMCW.....	75
Table 4.9	Travel Distance to Abortion Service v. INCOME.....	77
Table 4.10	Travel Distance to Abortion Service v. Race.....	78
Table 4.11	Reasons for Choosing Abortion.....	80

Chapter One

Introduction

In January of 1973, the Supreme Court handed down its landmark decision, Roe v. Wade, that guaranteed a woman's right to a safe, legal abortion. Prior to this decision, abortion services were only available in a few states. Immediately following Roe v. Wade, abortion became available in every state in the union.

Over the years, due to pressure from anti-abortion groups, accessibility to abortion services has become increasingly more difficult. This decline in accessibility can be attributed in part to fewer abortion providers as well as the urbanization of these providers. Legislation and public policy have also made it structurally more difficult for a woman to obtain the desired services. Most of the data published on abortion are at a state or national level. This study compares local level utilization rates in Roanoke, Virginia, a small city surrounded by a large rural hinterland, with national rates. It is well documented that rural areas are medically underserved. This study examines the barriers that women must overcome in order to obtain abortion services.

There is a geographic aspect to the provision of abortion services. Access to abortion providers varies with location. Since the late 1970's, the proportion of U.S. counties that have a known abortion provider has been declining. In 1988, 83% of U.S. counties had no identified abortion services (Henshaw and VanVort, 1990). The decline has occurred primarily in rural areas and among hospitals, resulting in a concentration of abortion providers in major population centers, thereby increasing distances women must travel to obtain abortion services. According to Henshaw and VanVort (1990, pg.105),

"Lack of local services makes it harder for women to obtain information about facilities, and, if they do, they may face other difficulties: Prohibitive travel expenses, the need for overnight lodging and the loss of pay due to absence from work. In addition, rapid diagnosis and treatment of post-abortion complications are more difficult, and privacy is jeopardized by the need to be away from home and work for a longer period."

Belkin (1989) attributed the decline in the number of providers in rural areas to the unwillingness of doctors to perform the procedure. Their reluctance may be due to the increased aggressiveness of anti-abortion protesters, as well as the tendency for rural areas to be more conservative. In general, the rising cost of malpractice insurance and an increase in the number of malpractice suits

has caused a decline in the number of doctors entering the ob/gyn field. Furthermore, the number of doctors trained in abortion procedures has also declined. Gorney (1990) found that fewer than 25% of the 282 ob/gyn residency programs in the United States included abortion training in their curriculum.

Abortion rates also vary with location. In the United States, variations among the states may be the result of a number of different factors, including differences in the availability of abortion services, the proportion of the population that is nonwhite or Hispanic, the degree of urbanization, and state policies (Henshaw and VanVort, 1990).

Generally, abortion rates are highest on the East and West coasts. In 1988, California had the highest rate with 46 abortions per 1,000 women of childbearing age. New York (43), Hawaii (43) and Nevada (40) were the other states with rates of at least 40 per 1,000. Washington D.C., which is completely urban and also has a high minority population, had the highest rate of 163 abortions per 1000 women of childbearing age. The states with the lowest rates were rural and had relatively few places where women could obtain abortion services. Wyoming had the lowest rate (5),

followed by South Dakota (6), West Virginia (8), Idaho (8), and Mississippi (8). The states that recorded the lowest abortion rates were among the states that had higher rates of residents obtaining abortions outside their states of residence. The following table compares the abortion rates with the percentage of counties in the states with an abortion provider for the above mentioned states.

Table 1.1

Abortion Rates and Provider Rates for Selected States, 1988.

<u>State</u>	<u>Abortion Rate per 1000 women aged 15-44</u>	<u>% of counties with a provider</u>
United States	27	17
California	46	69
New York	43	77
Hawaii	43	100
Nevada	40	12
Wash. D.C.	163	100
Wyoming	5	17
South Dakota	6	2
West Virginia	8	5
Idaho	8	9
Mississippi	8	4
Viginia	24	21

Source: Family Planning Perspectives, May/June 1990.

Although the Supreme Court's decision guaranteed a woman's right to a safe, legal abortion, it did not guarantee equal access. Subsequent Court decisions permit new and greater regulation of abortion services, which in

many cases impede access to a safe abortion provider. But even if equal access were mandated, research on similar social problems such as public school desegregation shows the difficulty of providing something as simple as physical access under geographically diverse conditions.

Of the six million American women who get pregnant each year, 1.6 million choose to terminate their pregnancies by legal abortion (Henshaw and VanVort, 1990). Women who seek abortions come from all segments of American society, though most are young, single, and of modest economic means. Women who are under age 25 make up 58% of all abortion patients, while only 20% are over age 30 (Gold, 1990). Unmarried women are 5 times more likely to have an abortion than are married women, and women with incomes less than \$11,000 are 4 times more likely to have an abortion than women whose incomes are greater than \$25,000.

Abortion rates vary among differing subgroups of women. White women obtain 65% of all abortions, but women of color have an abortion rate more than twice that of white women. Hispanic women are 60% more likely than non-Hispanic women to have abortions. Education, religion, and employment status are also factors. Women who are attending school are twice as likely as those who are not to have an abortion.

Catholic women are 30% more likely than Protestants to have abortions and two-thirds of all abortion patients are employed (Gold, 1990).

The health impact of legalized abortion has been studied by groups such as the Institute of Medicine of the National Academy of Science. In 1975 they concluded:

"Many women will seek to terminate an unwanted pregnancy by abortion whether it is legal or not... Evidence suggests that legislation and practices that permit women to obtain abortions in proper medical surroundings will lead to fewer deaths and a lower rate of medical complications than restrictive legislation and practices. The substantial differences between the mortality and morbidity associated with legal abortion in the first and second trimesters suggest that laws, medical practices, and education programs should enable and encourage women who have chosen abortion to obtain it in the first three months of pregnancy."

Estimates of the annual number of illegal abortions in the 1950's and 1960's ranged from 200,000 to 1.2 million (Tietze and Henshaw, 1986). Abortion is classified as illegal if the history indicates it was self induced or was not performed under the supervision of a licensed physician or if evidence of instrumentation (trauma to the reproductive tract suggestive of clandestine intervention) is found. In 1965, seventeen percent of all deaths attributed to pregnancy and child birth were a result of

illegal abortions (National Center for Health Statistics, 1967). Since Roe v. Wade, deaths from illegal abortions have fallen more than eighty percent between 1972 and 1974.

The rapid decline in abortion-related deaths is just one of the positive health effects of legalized abortion. A decline in pregnancy related deaths by the replacement of abortion of unwanted and mistimed births -- along with the averted life threatening complications has also been noted. Since Roe v. Wade, there has also been a significant drop in neonatal homicides (Lester, 1992). A more controversial benefit has been brought about by an increase in medical technology. By detecting birth defects in utero by methods such as amniocenteses, we have the possibility of preventing the births of infants with major physical or mental impairments.

The risk of complications with abortion is minimal, and there is no evidence of problems with later childbearing among women who have had an early abortion (Hogue, Cates, and Tietze, 1982). The risk of death associated with child birth is 11 times higher than that associated with abortion. It is important to note that the risk of death increases with the length of gestation, ranging from 1 death for every 500,000 abortions at 8 weeks gestation to 1 death per 8,000

at 21 or more weeks. Of the 1.6 million abortions performed each year, 50% take place at 8 weeks gestation or less, and only .6% are performed at 21 weeks or more (Alan Guttmacher Inst., 1990). Complications following an abortion are rare. The earlier in the pregnancy an abortion is performed, the less likely it is that major complications will develop. The most common of these complications are pelvic infections with a fever of 100.4 degrees (.19%), uterine perforations (.09%), and hemorrhages requiring transfusion (.05%). Fewer than one half of one percent of abortion patients require hospitalization due to complications (Tietze and Henshaw, 1986).

Nationally, 83% of all abortions are performed by large scale providers, which make up 31% of all providers (Gold, 1990). A large scale provider is one that performs more than 400 abortions per year and is generally an abortion clinic. Hospitals account for 13% of all procedures, and the remaining 4% are performed in physicians offices.

The cost of a procedure varies greatly depending on where the procedure is performed and the length of gestation. In 1989, the average abortion clinic charged \$245.00 for an abortion performed with local anesthesia at 10 weeks gestation or less. Physicians offices charged an

average of \$360.00, and hospitals had an average charge of \$1,757.00 for the same procedure. With a second trimester abortion, the cost increases and the number of providers willing to do the procedure decreases. Only 43% of all abortion facilities provide services after the 12th week of pregnancy. Clinics charged an average of \$500-\$600 at 16 weeks while hospitals charged \$1,539.00. The decrease in cost from the first trimester to the second trimester at hospitals exists because hospitals that perform second trimester abortions are high volume facilities and are subject to economies of scale (Henshaw, 1991). Because of this great discrepancy in costs, even if a woman has a provider in her area, if it is not a large scale provider, it may be cost-prohibitive for her to utilize that service.

Legalized as a private act two decades ago, abortion has become a very divisive public issue. Since Roe v. Wade, abortion has permeated public policy and politics, often overshadowing more pressing issues. The following chapter reviews the role abortion has played in American politics.

Chapter Two

Abortion and Politics

At first, one would imagine abortion and politics to be strange bedfellows. A closer look reveals that at a fundamental level, politics and law determine if and when a woman is even able to obtain an abortion. Women gained the right to a legal abortion through the political process. This chapter looks at how politics has played a vital role in shaping legislation and public policy and the effects politics has had on the accessibility to abortion providers.

Abortion is not a recent phenomenon in the United States. Until the middle of the 19th century, traditional common law permitted early abortions. Beginning in 1821 and throughout the remainder of the century, state legislatures began passing laws making abortion a crime. During this time, most abortions occurred among married women as a method of limiting family size. Contraceptives were never reliable. Concern of the medical profession for regularization, improved professional standards and elimination of substandard practitioners lay behind the earliest anti-abortion legislation (Rubin, 1982). As time went on, the laws became broader and more restrictive. From

the viewpoint of women, who had always had access to abortion services, the new laws were repressive and restrictive - decreasing control over their reproductive choices. By 1900, abortion was illegal throughout the United States.

Making abortion illegal did not eliminate the practice of abortion. Estimates of the annual number of illegal abortions in the United States in the 1950's and 60's range from 200,000 to 1.2 million (Tietze & Henshaw, 1986). During this time, the abortion rights issue began to surface again. Ironically, it was the medical profession that was calling for reform of the restrictive abortion laws it helped to create. It believed that the doctor and not the law should dictate medical treatment and that physicians should decide when abortion was in the best interest of the patient (Rosen, 1967).

It is not surprising that the abortion issue surfaced at this particular time. Society was concerned with such issues as the population explosion, the environment, and the depletion of the world's natural resources. The pill, the IUD, and other contraceptives were being introduced. Abortion could be viewed as another viable means of controlling the Earth's population. People were speaking

more frankly about sex, marital problems and contraceptives. The developed countries began to liberalize their abortion laws. In 1967, abortion was available on demand in Japan and Eastern Europe. Western Europe and Scandinavia had more moderate laws. Only the Catholic countries continued to have abortion laws as completely restrictive as the United States (Rubin, 1982).

More specifically, two incidents forced abortion into the political arena in the United States. The first was the 1962 case of Sherry Finkbine, a television actress from Arizona. Ms. Finkbine had obtained a tranquilizer from Europe (thalidomide) which she was taking for nervous tension caused by her pregnancy. After taking this drug for two months, she had read in the paper that thalidomide had caused terrible birth defects among women in Europe. Ms. Finkbine sought an abortion at a hospital in Arizona. She was denied her request and took her case to court, where she once again was denied a legal abortion. She then went to Sweden, where the abortion laws had been reformed, to terminate her pregnancy. Her court case and subsequent trip to Sweden received wide publicity. Secondly, and more widespread than the thalidomide scare, was the outbreak of the rubella epidemic during 1962-65. About 82,000 pregnant women in the United States contracted German measles

resulting in an estimated 15,000 defective births. Many pregnant women who had contracted the disease sought legal abortions and were denied. In California, some doctors ignored the restrictive laws and performed abortions for these patients. Charges were brought against nine physicians in the San Francisco area, and 39 additional physicians were threatened with charges. Medical professionals from across the country came to their defense and began to directly challenge the restrictive abortion laws (Tatalovich & Daynes, 1981).

American feminists were relative late-comers to the abortion reform movement. When the National Organization for Women (NOW) was founded in 1966, their focus was centered on securing wider opportunities for women in the workforce, politics and education. Two years later they added reproductive freedom to their agenda (Rossi & Sitaraman, 1988). NOW's position on abortion was centered on access to legal abortion for whatever reasons the women found sufficient. Feminists rejected the notion that physicians should hold the power to grant or deny a woman's request for a legal abortion.

Responding to the rising tide of public opinion, as well as to the calls of major medical, legal and social

welfare organizations, state legislatures began to reconsider the abortion laws. Between 1967 and 1973, 17 states reformed or repealed their anti abortion laws. This created a two tiered system in which a woman's ability to obtain an abortion depended largely upon her place of residence as well as her financial resources. The inequality of access was particularly discriminatory to poor women who were unable to overcome the costs of travelling great distances. A national ruling was needed to remedy the situation. In 1973, the Supreme Court handed down its landmark decision in Roe v. Wade that stated that a woman's constitutional right to privacy included her right to decide whether or not to terminate her pregnancy. It did not guarantee equal access.

During the time of the abortion reform movement in the late 1960's, anti-abortion movements were quietly forming in the background. Roe v. Wade was to meet with much controversy. The country was about to be divided over an issue that continues to plague us nearly two decades later. The question of legal access was not over and focus was turned to policy and the implications it had on women who desired abortion services.

Abortion, Politics, and the Catholic Church

Though many different groups opposed the Supreme Court's decision in Roe v. Wade, it was the Catholic Church that brought the abortion issue into the political arena. In February of 1973, immediately following the Supreme Court's decision, the Catholic Bishops called for civil disobedience of any law requiring abortion. The bishops argued that moral issues took precedence over obligation to any law. The church began funding anti-abortion activities. They spent over 4 million dollars in 1973 alone (Rubin, 1982). Part of their strategy was to identify congressman as being for or against abortion. The Church kept detailed files and took steps to defeat those candidates it viewed as being pro-abortion.

In March of 1974, four U.S. Cardinals appeared before the Senate Judiciary Subcommittee on the Constitution, which was holding hearings on proposed anti-abortion constitutional amendments. Never before had Catholic bishops testified at a congressional hearing. Their presence was indicative of the strong stand the Catholic Church was taking on this issue. In September of 1975, after months of deliberations and despite the Cardinals' appearance, the subcommittee refused to report out any of

the pending anti abortion constitutional amendments. This "crushing blow" persuaded the National Conference of Catholic Bishops that a stronger action was needed to convince Congress to act (Jaffe, Lindheim, & Lee, 1981).

The "big plunge" into political activism was made public at the National Conference of Catholic Bishops in November of 1975. The bishops called for a well organized grass roots level campaign against abortion through such methods as education and counseling pregnant women. They sought to mount an all out effort on the three branches of government to defeat pro abortion policies of any kind. These "pro-life" agencies were not to be organized as agencies of the church, but rather as public interest groups or citizens lobbies. Any connections with the church hierarchy were to be de-emphasized because they could cause problems of tax exemption for the church (Weber, 1976). The results of those efforts would show up in the 1976 elections.

The bishops were never able to mobilize the vast voting bloc they sought. The pro life movement had failed to make a candidate's position on abortion a crucial factor in the election. Jimmy Carter's campaign poll showed that abortion ranked last of 25 issues in importance among voters, including Catholic voters (Donovan, 1988). Clearly, the

views of the church's hierarchy were not the views of the majority of American Catholics.

The Republicans

At first, the controversy over abortion was narrow in scope, but it has broadened and intensified over the years. Conservative Catholics and Protestants viewed Roe v. Wade as a symbol of America's moral decline - driven by their own government's actions such as a ban on prayer in school, welfare policies, minors' access to contraceptives and abortion without parental notification. The Catholic Church vehemently opposes any form of contraceptives, even the use of condoms to prevent the spread of AIDS. The fundamentalist right preaches on the importance of family values and the traditional role of women (McKeegan, 1992). These beliefs were shared by many in the political conservative right. They were also weary of the U.S. losing its military strength, held a distrust of big and liberal government, and accepted religion in public life. A coalition of these groups enabled the conservative right to take over the GOP in the late 1970's.

Two men in particular spear-headed the right's take over of the GOP: Richard Viguerie and Paul Weyrich. Viguerie was the computer mail genius. Through the use of computer generated mail, he directly appealed to millions of rank and file conservatives for small donations that added up to millions of dollars. Keeping names and addresses in the computer banks, Viguerie, with a touch of a key, could instantly send out letters regarding any issue of concern to the conservative right. By 1984, Viguerie had the names of almost 20 million Americans in his computer files (McKeegan, 1992).

Paul Weyrich was the founder of the Committee for the Survival of a Free Congress, a political action committee. He was aware that there were several single issue groups whose interests matched those of the conservative right. Of all these single issue groups, the anti-abortion group was the most effective. Though there were some multi-issue conservative groups, the total number of members in the single issue groups out numbered them ten to one. By forming a coalition of the single issue groups, Weyrich enabled them to become a major player in the political arena (Wohl, 1979).

Also joining this GOP coalition were the Evangelical Christians. Their existing radio and television networks provided a powerful direct communications link to the conservative constituency. The audience was huge, led by televangelist stars such as Pat Robertson and the Moral Majority's Jerry Falwell. In 1980, the National Association of Religious Broadcasters set the number of weekly religious television viewers as high as 130 million (Haddon & Swann, 1981). One of the major themes of these religious broadcasts was the traditional role of women. At the time, the Equal Rights Amendment was headline news. The Evangelicals viewed the ERA as tool that would be used to upset traditional family values. Jerry Falwell even went as far as to claim that by integrating the armed forces, ERA backers were undermining American military strength (McKeegan, 1992). According to sociologist Kristen Luker, this traditional view of women held by the fundamentalists lies at the root of the abortion controversy. They hold that abortion upsets the natural division of roles by allowing women to control their fertility and compete with men for a place outside the home (Luker, 1984).

Falwell met with the conservative right in 1979 and joined the coalition. By the fall of 1980, the Moral Majority had chapters in every state. A Gallup poll

conducted late that year showed that only 8% of Americans approved of the Moral Majority's goals, but that 8% represented a hefty voting bloc (Gallup Report, 1981).

This coalition with the religious right exerted its power at the 1980 GOP convention. At the convention, the GOP retracted its endorsement of the ERA, hardened its position opposing abortion, and called for the appointment of judges "who respect traditional family values and the sanctity of human life" (New York Times, 1980). With the GOP's selection of Ronald Reagan as its presidential candidate, the right had achieved its take over of the Republican Party.

Through out the 1980 campaign, the coalition of hard right fundamentalists, and anti abortion groups targeted and attacked pro-choice candidates. This anti-abortion rhetoric received extensive media coverage; greatly magnifying its importance in the campaign. Abortion was an issue in some of the races, but it did not appear to be decisive in any of them (Donovan, 1988). Although the Republicans were very successful in the 1980 election -- capturing the presidency, a net gain of 45 congressional seats, 4 governorships, and 220 legislative posts (New York Times, 1980), it was mostly

due to the unhappiness with the Carter administration, not because of the abortion issue.

Despite this landslide victory, the Republicans still did not have the two-thirds majority needed in Congress to defeat Roe v. Wade. Over the next twelve years they set about the task by chipping away at the underpinnings. Abortion was not the only target of the conservative right; they were also opposed to family planning and sex education. This opposition became a vital part of the Republican party's agenda in the 1980's (McKeegan, 1992). The Reagan-Bush administration packed federal appointments with anti-abortion personnel. They also purged pro-choice employees from the staff at the Department of Health and Human Services (DHHS) which directed the Title X program (federal family planning funds), as well as at the Centers for Disease Control (McKeegan, 1992).

As a recipient of 25% of Title X funds, Planned Parenthood Federation (PPFA) was the victim of many attacks. The Combined Federal Campaign (CFC) was a program through which military and civilian employees could donate money through payroll deductions to an approved list of charities. PPFA had been on the CDC list for over a decade. Following Reagan's 1980 election, Donald Devine, a Reagan devotee and

avid abortion foe, was appointed head of the Office of Personnel Management which meant he also directed the CFC. By changing the eligibility requirements and staffing the eligibility board with anti-abortion personnel, Devine attempted to bar PPFA from the CFC list. He called for numerous audits of PPFA files, changed PPFA's status so they had to submit over 500 applications for membership instead of one national application, and tried to eliminate its share of donations not earmarked for specific charities (McKeegan, 1992). Planned Parenthood challenged these obstacles in court and consistently won, at the cost of enormous amounts of time and money to PPFA as well as to American taxpayers.

The DHHS also launched an attack on Planned Parenthood. Staffed with Reagan pro-life appointees, the DHHS reorganized the Title X program so it was one of only a handful of health programs run by a political appointee rather than by a public health executive in the civil service (McKeegan, 1992). With control in political hands, the DHHS announced a new rule in 1983, which required family planning clinics to notify the parents of teenaged girls getting contraceptives at Title X funded clinics (referred to as the squeal rule). Planned Parenthood announced it would turn back their federal funds before violating the

confidentiality of teenaged patients (Public Affairs Action Letter, 1982). A federal judge slapped an injunction on the rule noting that "It is quite clear that, as a result of these regulations, substantial numbers of adolescents will become pregnant and will either elect abortion or suffer the consequences of unwanted pregnancies." (New York Times, 1983). The DHHS lost the subsequent appeal and the court ordered the federal government to pay for most of the \$290,000 in litigation costs incurred by PFFA.

The Centers for Disease Control (CDC) also fell victim to the political right. Its data showing that legal abortion was 7 to 10 times safer than carrying a pregnancy to term had provided a strong argument for Roe v Wade. In its decision, the Court declared the government could not force a women to carry to term when her chances of dying were vastly higher than if she had been able to terminate the pregnancy (McKeegan, 1992). The purging of pro choice physicians from the CDC was one form of the right's attack. Studies involving the safety of abortion were no longer conducted and the CDC stopped publishing data supporting public health benefits of legal abortion.

By 1984, the political right was growing disenchanted with the Reagan Administration. Congress had failed in its

attempts to outlaw abortion, the battle with PPFA did not end in victory, and family planning was still being funded with the exception of monies for abortion. Despite these defeats, the religious right was still backing Reagan. Jerry Falwell announced that his Moral Majority intended to spend \$12 million to register 2.5 million new voters (Newsweek, 1984).

The Catholic Bishops appeared once again on the political scene, especially in New York, waging war against vice presidential candidate Geraldine Ferraro and Governor Mario Cuomo, both Catholics with pro choice stands. The Bishops contended that abortion was the critical issue of the campaign and Reagan avidly pursued Catholic voters. Results of the 1984 election do not support this claim. Reagan won handily but the New York Times reported Reagan benefitted overwhelmingly from the perception that he had restored health to the economy (New York Times, 1984). Abortion was not the decisive issue for the voters. A survey by the Center for Political Studies found only 1 percent cited abortion as an important problem facing the nation (Donovan, 1988). Results of the Senate races in 1984 ended with a net gain of one pro-choice seat. The conservative right failed to deliver deciding votes.

Following the 1984 elections, the coalition of right wing groups began to falter. The Catholic Bishops reframed their pro-life stand into a "consistent ethic of life" that opposed not only abortion, but nuclear arms, capital punishment, poverty, and all social and economic injustice (McKeegan, 1992). The fundamentalist right disagreed with this "ethic of life", especially with the issues of nuclear arms and capital punishment. Patrick Buchanan, speaking for the religious right, proclaimed "The bishops effectively eliminated any possibility that conservative Catholics could find common ground on which to stand alongside them" (Conservative Digest, 1985). This proclamation by the bishops separated the Catholics from the coalition. By becoming so narrow minded and extremist, the religious right was becoming a political liability.

The fundamentalists were also beginning to experience some difficulties. The televangelists had reached a regular viewership of 13.3 million. But it was expensive to run these networks and many had over-extended their budgets. Pat Robertson was forced to sell three television stations and Jim and Tammy Bakker, as well as Jerry Falwell, were forced to lay off staff. The real problems of the fundamentalist right came with the charges of sexual misconduct leveled at some of the preachers. In 1987, Jim

Bakker was accused of using ministry funds to hush up a brief sexual encounter, as well as milking his ministry for \$4.6 million in salaries and bonuses (Marty, 1988). In 1989, Bakker was sentenced to 45 years in jail. In February of 1988, Jimmy Swaggart made headlines when he was accused of consorting with a prostitute (New York Times, 1988).

Though this coalition of the right was no longer a political threat, political policy continued to chip away at abortion rights. In 1985, Jo Ann Gasper was appointed director of the Title X project, despite the fact that she personally opposed most methods of birth control. She claimed that her personal views on contraception would not interfere with her job performance (Sheeran, 1989). Gasper had two goals she wanted to accomplish: to defund Planned Parenthood and to change the guidelines on pregnancy counseling.

Planned Parenthood advocates public funding for abortion, while federal law forbids Title X funds to be used for abortions. In January 1987, Gasper announced her orders to refuse funding to Planned Parenthood citing a passage in a 1977 grants manual that specified that grant funds could be denied to certain "exceptional organizations" that took

positions in conflict with that of the grant program. Because of PPFA's stand on public funding of abortions, Gasper alleged that PPFA ran a higher than usual risk that funds would be misused. In the past, intensive audits of PPFA revealed no misuse of Title X funds. Gasper's superiors at DHHS cancelled her order.

In mid-May the same year, Gasper announced she was withholding \$30,000 for two long standing nurse practitioner grants to Planned Parenthood while she investigated if they qualified as "exceptional organizations". She refused her superior's orders to renew the grants, claiming the President was pro-life and insisted she was doing what he wanted. Negotiations over the next few weeks did not resolve the controversy and Gasper was fired on July 2, outraging members of the pro-life movement.

After the Gasper firing, Reagan attempted to appease the pro-life forces. In July 1987 after a meeting with the Right to Life leaders, Reagan directed Surgeon General Koop to prepare a comprehensive report on the physical and psychological health consequences of abortion. The pro-life movement planned to use this report to reverse Roe v. Wade. In January of 1989, Koop sent a letter to Reagan explaining there would be no report because there was not enough

scientific evidence to draw conclusions about the effects of abortion (Koop, 1989).

After receiving copies of the report, Congressman Ted Weiss (D-New York), Chairman of the Human Resources and Intergovernmental Subcommittee, conducted hearings on what he considered to be discrepancies between the report and information made public. Dr. David Grimes, formerly of the CDC's abortion surveillance branch, testified that "we know more about the safety of abortion than about any operation ever practiced in the history of medicine". The Subcommittee's report, released in November 1989, found that Koop had suppressed the draft report which concluded that abortion was a safe surgical procedure. The final draft of Koop's report dated January 17, 1989, found that abortion does not pose a physical risk to the mother and that psychological effects were unclear. Witnesses repeatedly testified in front of the House Subcommittee that abortion was medically safe and psychologically benign.

Concerned about loss of right to life support for the Republicans in the 1988 elections, Reagan promised new family planning guidelines regarding abortion counseling, the second of Gasper's goals. Dubbed the "gag rule", these regulations would prohibit family planning clinics supported

by Title X funds from providing any information about abortion, even neutral information and even when the information was specifically requested.

The gag rule generated immediate and abundant outcry. Dr. John Graham of the American College of Obstetricians and Gynecologists claimed it was unethical, it was bad medicine, and it was inhumane (Time, 1988). Faye Wattleton of Planned Parenthood called it an attempt by the Reagan administration to "pay off its debt to a handful of anti-abortion extremists" (Public Affairs Action Letter, 1987). In all, 36 states and 78 national organizations protested the new regulation (McKeegan, 1992). Congress failed several times to reverse the gag rule while it was under court consideration. Two out of three appeals courts found the regulations to be unconstitutional, violating the First and Fifth amendments.

Rust v. Sullivan was the case that brought the "gag rule" to the Supreme Court. The decision handed down in May of 1991 found that the gag rule did not violate constitutional rights. Congress, responding to the Supreme Court's decision, attached a rider to a health appropriations bill in mid 1991 that barred enforcement of the gag rule (Wall Street Journal, 1991). This was met with

a Presidential veto by George Bush. Bowing to political pressure, Bush announced in March of 1992 that doctors were exempt from the regulations. This did little to help women who desired abortion information since most clinics are staffed with nurses and counselors, who were still bound by the regulations of the gag rule.

The gag rule went into effect in October, 1992, when the House failed by 10 votes to override Bush's veto. On November 3, a federal appeals court invalidated the Bush administration's counseling ban stating the modifications made in the spring were improperly imposed (New York Times, 1992).

Reagan's announcement of the gag rule was another attempt to keep the religious right in the Republican voting bloc. Anti-abortion forces were at work once again at the 1988 GOP convention, adding more anti-choice planks: calling for "fetal protection" in scientific research, supporting parental consent requirements for minors wanting birth control, and opposing funding for pro-choice population organizations (McKeegan, 1992). George Bush courted the conservative right with his choice of Dan Quayle as his running mate. Quayle had both a pro-life record and a deeply evangelical wife (Wills, 1990).

The election results showed a weak Republican victory, with Bush receiving only 53% of the popular vote. More importantly, the GOP lost ground in the Senate, House, and state legislatures. The Senate gained 2 pro-choice seats and the House gained 8 pro-choice congressmen.

As the 1980's were coming to an end, pro-choice forces were becoming galvanized. The Reagan-Bush administrations anti-abortion policies, as well as decisions handed down by the Supreme Court, had many Americans concerned that Roe v. Wade might be overturned. Where once candidates tried to conceal their views on the issue, many were now campaigning on strong pro-choice platforms. Democrat Doug Wilder made his pro-choice stand a central issue in his victorious 1989 Virginia gubernatorial campaign. The passion over the abortion issue was shifting to the pro-choice side. The 1990 elections brought another net increase in pro-choice House and Senate seats, as well as to state legislatures. The abortion issue was becoming a GOP liability.

At the 1992 GOP convention, the right maintained a strong hold on the Republican platform. The anti-abortion plank was passed with a 84-16 vote in committee, despite the fact that the pro-choice position was overwhelmingly supported by delegates to the convention. During the

campaign, both Bush and Quayle expressed pro-choice opinions when asked hypothetical questions regarding members of their families, but campaigned opposing the rights of others to choose (Newsweek, 1992). The GOP was attempting to portray themselves as a diverse group and break the gender gap. The Democrats, Clinton and Gore, both actively campaigned for pro-choice.

The 1992 campaign season started off being the year of the women. Two incidents in particular galvanized women into political action: the Clarence Thomas - Anita Hill hearings, and the Supreme Court's decision upholding abortion restrictions in the Pennsylvania case. In April of 1992, over 500,000 abortion rights advocates marched in Washington, D.C.; one of the largest political events in the city's history (Washington Post, 1992). Several women candidates addressed the crowd claiming women's issues would be a decisive factor in the elections.

Exit polls from the 1992 elections show that women represented 54% of the voters, but the abortion issue took a back seat to the economy, the deficit, and health care (Newsweek, 1992). Several women won their races, sending a record number of women to the Senate, and bringing the total up to six. The Democrats will take over the White House and

maintain majorities in both the House and the Senate, giving hope to abortion rights advocates. The Reagan-Bush appointees to the Supreme Court remain in power and will have lasting effects on the abortion issue.

Abortion and the Courts

Two Supreme Court decisions led the way to the passage of Roe v. Wade. The first being Griswold v. Connecticut in 1965. Estelle Griswold, the executive director of Planned Parenthood in Connecticut, challenged a state law that made it illegal for married couples to use contraceptives or for physicians to provide such information (Rubin, 1982). By a 7-2 vote, the liberal Warren Court held that law unconstitutional, declaring a right to privacy. Justice William Douglas, writing for the majority, reasoned that although the Bill of Rights did not explicitly discuss a right of privacy, six different constitutional amendments created zones of privacy, which include the relationship between husband and wife. In 1972, in the case of Eisenstadt v. Baird, the court extended this right to include unmarried couples (Rubin, 1982). Writing for the 6-

1 majority, Justice William Brennan Jr. said "If the right of privacy means anything , it is the right of the individual, married or single, to be free from unwarranted governmental intrusions into matters so fundamentally affecting a person as the decision whether to bear or beget a child" (Eisenstadt v. Baird).

In the Roe v. Wade decision handed down on January 22, 1973, the Supreme Court ruled 7-2 that the right to obtain an abortion was protected by the same constitutional guarantee of privacy outlined in Griswold v. Connecticut. According to Roe, states could not bar a women from getting an abortion in the first 3 months of pregnancy, and could interfere in the second trimester solely to safeguard her health. After fetal viability, in the third trimester, the government, in order to protect the unborn, could prohibit abortion, except where necessary to preserve the mother's life or health (Rubin, 1982).

Prior to the Roe v. Wade decision, several states had repealed or liberalized existing abortion laws. With Roe, many abortion rights activists felt they had achieved their goal and suspended their efforts. This landmark decision galvanized anti abortion forces, and their movement dominated much of the media and politics in the 1980's.

Through out the 1970's, state legislatures passed laws restricting abortion under certain circumstances, testing the limits of Roe v. Wade. The Supreme Court showed no inclination of reversing its decision. In 1977 two cases, Maher v. Roe and Poelker v. Doe, did allow some limitations to access, ruling that a state or municipality could refuse use of public funds or hospital services for abortion. The court went one step further, ruling in 1980, in Harris v. McRae, that the federal government was not required to pay for abortions for poor women under the Medicaid program. Also, in 1979, the court ruled in Belotti v. Baird, that a state could require parental consent for a pregnant minor wanting an abortion if it also provided her with the option of proving in court that she was mature enough to make her own decision or that the abortion would be in her best interest. The implications of these decisions are such that unequal access to abortion providers was allowed. Because of these decisions, poor woman and young woman have fewer choices.

Toward the end of the 1970's, the pro life movement was picking up momentum and the conservative right had gained control over the Republican party. Knowing that it lacked the votes for a congressional override, any progress in reversing Roe would have to come from the courts. The 1980

GOP platform called "to work for the appointment of judges at all levels of the judiciary who respect traditional family values and the sanctity of innocent human life" (New York Times, 1980). The election of Ronald Reagan in 1980 offered the abortion opponents new hope of reversing Roe completely.

Reagan nominated Sandra Day O'Connor as his first appointment to the Supreme Court. The conservative right objected to her views on abortion, the ERA, quotas, aid to private schools and criminal law. The right felt that Reagan had betrayed them, and within days the White House logged over 4,100 calls, telegrams, and letters opposing O'Connor and fewer than 550 in her favor (New York Times, 1981). O'Connor's nomination was easily confirmed by the Senate, but the uproar from the right over her nomination had embarrassed the Reagan administration and had upset some of his most ardent backers. Future nominees to judicial positions were subject to intensive background checks and grueling interviews to ensure their conservative credentials. This was the beginning of Roe as a litmus test.

By the beginning of Reagan's second term, the Court had a pronounced tilt to the right, due to the number of

conservative appointees to the White House and Justice Department. In some instances, the quality of nominees to the courts suffered due to the insistence of ideological conformity. The American Bar Association gave a higher proportion of appellate court nominees the lowest passing grade during Reagan's second term than in any of the four previous administrations (Aron, 1988).

In mid 1986, Reagan elevated William Rehnquist, one of the two Roe dissenters, to Chief Justice of the Supreme Court. He also nominated Antonin Scalia, a vocal Roe opponent, for Rehnquist's seat. Both nominations were confirmed by the Senate, decreasing the number of pro-choice justices to a 5-4 majority (McKeegan, 1992).

In 1987, fearing the reversal of Roe v. Wade was near, the pro-choice movement showed massive opposition to Reagan's next Supreme Court nominee, Robert Bork. Anti-Bork groups raised over \$2 million to defeat his confirmation (Schwartz, 1988). Bork was subjected to 30 hours of testimony over a 5 day period, and lost the confirmation by a margin of 58 to 42. Reagan's next nominee was Douglas Ginsburg, a law professor who had never practiced law and had been a judge for only one year. Ginsburg was forced to withdraw his name nine days later when it was found out he

had smoked marijuana several times in the 1960's. Four days later, Anthony Kennedy was nominated. Kennedy denied having any fixed views on abortion. With no clear evidence he was anti-Roe, he met with only token resistance from abortion supporters and was easily confirmed.

In 1989 Roe was dealt another blow by the Supreme Court's decision in Webster v. Reproductive Health Services. This was a Missouri law barring physicians from performing abortions after 20 weeks of pregnancy without first doing tests to determine fetal viability; it outlawed the use of public funds, facilities or employees to perform abortions; and the preamble declared that life began at conception. The Court declined to vote on the preamble but upheld the other two restrictions by a 5-4 margin. The three Reagan appointees joined the two original Roe dissenters in this decision. Chief Justice Rehnquist acknowledged that the decision would "undoubtedly allow more governmental regulation of abortion than was permissible before" (San Francisco Examiner, 1989). The Court stopped short of formally overturning Roe. Justice Harry Blackmun, the author of Roe's majority said "For today, at least, the law of abortion stands undisturbed, but the signs are evident and very ominous, and a chill wind blows" (San Francisco Examiner, 1989).

George Bush was the next President with an opportunity to nominate a Supreme Court Justice. In the fall of 1990, in an effort to avoid a repeat of the Bork battle, Bush nominated New Hampshire judge David Souter. He was nicknamed "the Stealth candidate" because his positions on pressing legal issues were so difficult to make out. Without solid objection from either side of the abortion argument, he, too, was easily confirmed by the Senate. In 1991, Souter voted with the majority to uphold Rust v. Sullivan, popularly known as the gag rule. Polls showed an overwhelming negative reaction to Rust with 69% of the public against the decision and only 30% supporting the law (Harris and Assoc., Inc. 1991).

Justice Thurgood Marshall, a strong supporter of Roe v. Wade, announced his retirement in the summer of 1991. Bush nominated Clarence Thomas, a 43-year-old appeals court judge as Marshall's replacement. Thomas' judicial experience was meager, but his conservative credentials were intact. He received considerable backing from a variety of conservative groups. During his confirmation hearings, Thomas declined to answer any questions that would have revealed his views on abortion, claiming he had never even held an opinion about Roe (Washington Memo, 1991). Late in the hearings, Anita Hill, an Oklahoma law professor who had worked for

Thomas ten years earlier while he was the head of the Equal Employment Opportunity Commission (EEOC), accused Thomas of sexually harassing her during her tenure at the EEOC. Despite the fact that Anita Hill passed a polygraph test, Republican committee members dismissed her testimony (New York Times, 1991). Thomas was confirmed by the Senate with a 52-48 margin.

By early 1992, the Reagan and Bush appointees accounted for 5 of the 9 Supreme Court justices, and the two dissenters of Roe, Rehnquist and White, were still on the bench. The end of Roe appeared to be in sight. In the case of Planned Parenthood of Southeastern Pennsylvania v. Casey, Roe would be put to the test. The Pennsylvania law required: 1) married women to notify their husbands of their abortion plans; 2) a 24 hour waiting period before having the abortion after receiving counseling on risks and alternatives; 3) that minors under the age of 18 must get one parent's informed consent or a judge's approval for an abortion; 4) Doctors must keep detailed record of abortions and reason for performing late term abortions; and 5) No abortions after 24 weeks of pregnancy unless needed to protect the woman's life or prevent permanent physical harm (Washington Post, 1992).

On June 29th, 1992, the Supreme Court upheld by a 5-4 vote all but one of the new restrictions. The new "moderate core" consisting of Justices O'Connor, Kennedy, and Souter, were the plurality that kept Roe from being overturned. They rejected the trimester framework adopted in Roe and applied the new "undue burden" test to the law. They described an undue burden as one that "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus". They went on to say that the trimester framework "undervalues the state's interest in the potential life within the woman", which it said exists and is substantial throughout pregnancy. Applying this new test, the plurality found the spousal notification clause constituted such a burden because it did not merely make abortion a little more difficult or expensive to obtain, but in practice allowed some husbands to exercise a veto over their wives' decision. "Women do not lose their constitutionally protected liberty when they marry" (Casey, 1992). Justices Blackmun and Stevens were the other two justices who prevented Roe from being overturned.

Roe v. Wade guarantees a woman the right to terminate a pregnancy as a matter of privacy and therefore abortion services should be made available. But the political process

has restricted access to abortion in two ways: by manipulating public policies through government agencies and by the conservative make up of the Supreme Court. What does all this mean in terms of providing access? The legal battle still exists. States continue to pass laws restricting abortions and the effects of the current Supreme Court could be felt for a very long time. What remains is even after a decade of anti-abortion policies, the number of abortions performed in America each year has not changed and we can expect the issue to continue being a divisive one in future political decisions.

Chapter Three

Study Model and Methodology

A great deal of attention has been paid to the number and characteristics of women who have abortions each year, but very little research has been done on the accessibility of these services to the women who need them. The availability of and accessibility to medical services influence the utilization of those medical services. Joseph and Phillips (1984) identify two main types of accessibility, physical and socio-economic. Physical accessibility implies that a service and the means of reaching it are available (Mosely, 1979), while socio-economic accessibility "involves people's ability to pay for a service, whether they feel it is appropriate, and whether they are permitted to use it (organizational and institutional restrictions on accessibility)" (Joseph and Phillips, 1984). Donabedian (1973) claimed "the proof of access is use of service, not simply the presence of a facility," leading Joseph and Phillips (1984) to argue that utilization can be taken to be **revealed accessibility**.

The social and demographic compositions of places vary greatly and may be reflected in different utilization patterns. While most published data on abortion utilization is at a national or state level, one basis of this research was to compare local utilization patterns of a large scale abortion provider (one that provides over 400 abortions per year, generally an abortion clinic) with the national rates of abortion utilization. In Virginia, 88% of all abortions are performed by the eleven large scale providers located in the commonwealth. Through examining utilization rates at the local level, this study is based upon **revealed accessibility** to an abortion provider.

Numerous models have been developed to analyze health care behavior, though no single model has been universally accepted (Green and Kreuter, 1991). A detailed discussion of some of these models was produced by Veeder (1975). The approaches are similar, with changing emphases on different variables. The theoretical framework used in the current study is Green's PRECEDE model (predisposing, reinforcing, and enabling constructs in educational/environmental diagnosis and evaluation). PRECEDE is largely a framework for study and not presented as a theory.

Green's model identifies three categories of prebehavioral factors:

- * **Predisposing factors** are those antecedents to behavior that provide the rationale or motivation for the behavior.
- * **Enabling factors** are the antecedents to behavior that enable a motivation to be realized.
- * **Reinforcing factors** are factors subsequent to a behavior that provide the continuing reward or incentive for the behavior and contribute to its persistence or repetition.

(Green and Kreuter, 1991, p.151)

According to Green (1991), "any given behavior can be explained as a function of the collective influence of these three types of factors." Several variables can be identified as having some impact on accessibility and utilization. Melnyk (1988) identified nine barriers that influenced health related behavior. The classification of these factors using Green's model is presented below. The three categories are not mutually exclusive, hence, some variables may overlap into other categories.

Predisposing Factors

Patient Characteristics. The contradictory research findings make it difficult to specify which characteristics of the individual consistently act as barriers. Among the demographic factors, Coburn and Pope (1974) found education

level had a positive effect on the use of health services and Gaitz (1974) and Hagebak and Hagebak (1980) suggest low income as a barrier. Income and education level were not associated with the low rate of pap tests of rural black women (Sawyer, Earp, Fletcher, Daye, and Wynn, 1990).

Studies have shown age to be both a positive factor and a barrier to health care depending on the type of service and the age of the individual (Coburn and Pope, 1974). Other barriers may include attitude (Pender and Pender, 1980), knowledge (Finnerty et al, 1973), effort (Gaitz, 1974), cultural factors (Quesada and Heller, 1977) and family characteristics (Salkever, 1976).

Discrimination. Discrimination by sex, social status and age (Jackson, 1977), race (Cornely, 1976) and mental status (Miller, 1981) have been suggested as other barriers. Udry, Morris, and Bauman (1976) reported that patients prefer either all white providers and clients or a combination of black and white providers and clients, but not all black providers or clients. Henshaw (1991) identified HIV status as limiting health care choices. More than one-fourth of abortion providers say they will not serve women who have tested positive for HIV. Lewin-Epstein (1991) found that language and culture served as barriers to health care for minority populations.

Enabling Factors

Time. Some studies have supported travel time to the appointment as a barrier (Finnerty et al, 1973, Hershey, Luft, and Gianaris, 1975), while Wan and Yates found it insignificant (1975). Finnerty et al (1973) determined waiting time at the appointment an important factor, but Salkever (1976) discounted it as a barrier. Another study concluded waiting time acts as a barrier for the poor who use clinics, but not for those who have private physicians (Dutton, 1978). Grembowski and Conrad (1986) reported long lead time to an appointment also acted as a barrier. This is extremely critical with abortion since women also face time limits regarding length of gestation.

Distance. Studies of utilization have consistently demonstrated that distance acts a deterrent to therapeutic behavior (Shannon and Dever, 1974), though Aday (1975) singled out the poor as being most affected by distance. Gaitz (1974) suggested transportation as a barrier, but another study found it insignificant (Wan and Yates, 1975). Licciardone (1990) found travel time to be a barrier and Buekens (1990) determined distance was a barrier to women seeking antenatal care.

Cost. Cost of service, rising costs, and inadequate insurance coverage have been suggested as barriers (House, 1978; Harris, 1975). Gift (1978) identified lost work and the cost of transportation as obstacles. A study to determine why women do not have mammograms found the cost of the procedure to be a deterrent (Bastani, Marcus, and Hollatz-Brown, 1991).

Availability. Dutton (1978) reports that unavailable or inaccessible services can significantly deter utilization as well as a low provider/consumer ratio (Wan and Yates, 1975). Antczak and Branch (1985) cited the appointment system in general as creating obstacles to care.

Organization of services. Barriers may also be created by a shortage of qualified personnel (Keenan and Richardson, 1980) or by the fragmentation of services (Gaitz, 1974; Harris, 1975). Emergency rooms are often chosen for routine care because they offer multiple services (Jacoby and Jones, 1982). Hershey et al (1975), Salkever (1976), and Wood and Valdez (1991) found the lack of a primary provider served as an obstacle.

Reinforcing Factors

System barriers. System barriers are either perceptions of the consumer or observable characteristics of the system. Finnerty, Mattie, and Finnerty identified excessive waiting time and poor doctor-patient relationships as the major barriers to follow-up care in their study of an inner city hypertension clinic (1973). In Antczak and Branch's study of elderly people who had not sought needed dental care--cost, transportation, appointment scheduling, and the belief that their problem stemmed from aging rather than pathology were found to be the primary obstacles (1985).

Provider - Consumer relationship. Problems with the provider - consumer relationship may present further obstacles to care. Gaitz (1974) suggested some of these problems as the provider showing lack of interest or expertise in the client's problems, discomfort with client characteristics, and inadequate knowledge of insurance payment mechanisms. Hagebak and Hagebak (1980) cited individual biases and prejudices. Cultural difference (Quesada and Heller, 1977), disagreement between client and physician regarding solutions to health problems (Gaitz, 1978) and poor communication (Gift, 1978) were also

identified as barriers. Frame (1992) determined that adequate time for preventive services must be allocated.

Patients who utilize abortion services share some of these barriers, but also have a set of barriers that is unique to their particular health care needs. To address this issue, the research for this study was conducted at an abortion clinic, the Roanoke Medical Center for Women (RMCW), located in the southwest quadrant of Roanoke City. Roanoke, a mid-sized city with a population of approximately 90,000, serves a very large and rural hinterland. Leaving Roanoke and going southwest, one finds Appalachia, a well-documented, medically underserved area. The next major population center in this direction would be Kingsport, Tennessee, located about 160 miles from Roanoke. The RMCW is isolated geographically from the other large scale providers in Virginia, with the next closest being located in Charlottesville, which is 115 miles northeast.

The RMCW is a privately owned clinic that performs approximately 2000 abortions per year. They offer abortion appointments every Wednesday during the day and every other Tuesday evening. Because they cannot find a doctor locally to perform the procedures, two doctors alternately fly in

from Richmond to provide abortion services. Back-up physicians are available locally if any complications arise.

After obtaining permission from the VPI&SU Human Subjects Committee, I collected data through a non-random convenience sample of patients who were asked to complete a questionnaire while they waited for their appointments. I distributed the survey between April 15 and May 5, 1992, to 137 women, and yielded 104 responses (76%). The RMCW experiences seasonal fluctuations in the number of patients. The busiest times for the clinic are when the area colleges are in session. These dates were chosen so the respondents would include the student population, a large segment of their clientele. Each woman, after paying the bookkeeper for the procedure, was asked to complete the questionnaire. Only two women refused the questionnaire. In order to maintain the privacy and anonymity of the patients, the clinic prohibited any personal interviews. The surveys were collected before the patients left the building.

Using Green's PRECEDE framework, the questionnaire developed for this study was designed to address the more specific barriers to an abortion provider as well as the factors mentioned above that pertain to abortion patients. The barriers selected and their classifications follow.

Predisposing Factors

Patient characteristics: Abortion rates vary among subgroups of the population, hence the following patient characteristics were studied: Age, income, race, religion, marital status, education, and employment. Even though HIV status was previously identified as a barrier under predisposing factors, it was not included in this study because the RMCW does not discriminate against HIV positive patients.

Enabling Factors

Information: Knowing if and where one can obtain an abortion is a crucial first step in the decision to terminate a pregnancy. The so called "gag rule" may serve as a barrier to abortion. Many women may seek referrals from health care providers as well as other sources. The survey asked for sources of information on the RMCW as well as referrals.

Time: The time between scheduling an appointment and having the appointment has been identified as a barrier. This time is very crucial to abortion patients since they also face

gestational limits. The limited availability of appointment hours may also serve as a barrier.

Distance: Shelton, Brann, and Schulz (1976) found that abortion rates tend to decrease with distance from a provider. Henshaw (1991) identified the declining number of providers also posed a barrier, forcing women to travel greater distances to obtain the desired services. Distance may also serve as a barrier to obtaining information. Clinics may not advertise in phone books for distant localities and health care workers may be unaware of services offered at distant facilities.

Cost: Many abortion patients are of modest economic means, and the cost of an abortion may well put the option out of reach for many women who desire abortion services. Because of the great variability in costs associated with the different types of abortion providers, unless a woman has access to a large scale provider, the abortion may be cost-prohibitive.

Harassment: In addition to overcoming barriers to get to the abortion provider, many women must pass through lines of demonstrators just to enter the health care facility and risk being exposed to other anti-abortion activities.

Though incidents of violent or threatening activities such as death threats, bomb threats, vandalism and forceful entry into clinics peaked during 1982-1986, they continue to occur. In 1988, 85% of large scale providers experienced some form of harassment - mostly picketing, blockading, and demonstrations resulting in arrests (Henshaw, 1991). Still, 36% of the clinics received bomb threats and 34% reported incidents of vandalism, up from the 28% reported in 1985.

Length of Gestation: There are many reasons why women seek later abortions. Torres and Forrest (1988) found the most common to be the late realization or miscalculation of the length of pregnancy; fear of telling one's partner or parents about the pregnancy; taking time to decide how to resolve the pregnancy; and having difficulty finding a provider, making arrangements and obtaining enough money to pay for the abortion. If a woman's pregnancy is beyond the first trimester, finding a provider gets even more difficult. Two-thirds of abortion providers will not serve women at fifteen weeks gestation or later (Henshaw, 1991). Second trimester abortions are more difficult to provide, thereby making them more costly and less accessible. The RMCW has a gestational limit of 12 weeks. Any women who is further along in her pregnancy must either travel to

Richmond, the sole provider of second trimester abortions in Virginia, or seek abortion services out of state.

Reinforcing Factors

Provider-Consumer relationship: Green identifies reinforcing factors as incentives for continuing or discouraging the behavior. Health care workers' attitudes toward abortion may influence women's decisions to seek abortion services, thus they are classified here as reinforcing factors. Personal biases may be a barrier in providing information on abortion, and supportive and non-judgemental referrals would go a long way in reducing the stress level of the patients.

Peers: The attitudes and available support of peers may also play a role in the accessibility of abortion. Because of the psychologically stressful nature of the procedure, many women may desire accompaniment to the provider. This study addressed the issue of accompaniment to the clinic as well as the role of friends in the information process.

The results of the survey of patients at the RMCW follow in chapter four.

Chapter Four

Results and Analysis

The questionnaire was distributed at the Roanoke Medical Center for Women between April 15, 1992 and May 5, 1992. One hundred and four women returned completed questionnaires. The results are classified using the PRECEDE framework. The classifications are not mutually exclusive and some variables may overlap into other categories.

Predisposing Factors

Patient Characteristics. Women who have abortions come from all segments of American society, though most are young, not married, and have limited financial means. Nationally, 31% of women having an abortion attend school. Those women who are in school are almost twice as likely to have an abortion than those who are not in school. Of all abortion patients, 68% are employed and are slightly more likely to have an abortion than those who are unemployed (Gold, 1990).

Table 4.1

Employment Status and School Enrollment
of Abortion Patients

	<u>National figures for abortion patients*</u>	<u>Roanoke Sample (N=104)</u>
Enrolled in School	31%	35%
<u>Working Outside of the Home</u>	68%	53%

*Source: Abortion and Women's Health, R.B.Gold, 1990.

In the Roanoke sample (Table 4.1), 35% of the women were currently enrolled in classes and 53.4% were currently working outside the home. Among the women employed, 69.6% were working full time and 30.4% worked part time. When asked if they were missing time from other obligations such as work or school in order to obtain the abortion, 65.4% said "yes" and 20% said the lost time would cause them to lose money. Though the rates of school enrollment in this study are very similar to the national average (31%), there is a substantial difference in the number of women who are employed outside of the home. This has particular significance for women in Roanoke area. These women may lack employment opportunities and serve more in the traditional family role. Because fewer women in this area may have an income of their own, it may be more difficult for them to overcome the economic barriers.

Table 4.2

Age Distribution of Abortion Patients

<u>Age</u>	<u>National figures for abortion patients*</u>	<u>Roanoke Sample (N=104)</u>
under 15	1%	1.0%
15-17	11%	12.5%
18-19	13%	12.5%
20-24	33%	35.5%
25-29	22%	21.2%
30-34	12%	6.7%
35-39	6%	8.6%
over 40	2%	2.0%
<u>TOTAL</u>	<u>100%</u>	<u>100%</u>

*Source: Family Planning Perspectives, Vol.20, 1988.

The age distributions of the two groups is very similar (Table 4.2). The only exception to this is in the 30-34 year olds. This difference may be attributed to the small sample used in this study and the limited time frame in which the data was collected. Another possible explanation is the national rates include utilization of all providers, not just large scale providers. Women in this age group may have better insurance coverage and higher incomes and can therefore afford to have the abortion at a more expensive facility, such as a doctor's office. It may also be possible that women in this age group are under-represented in the Roanoke area or may have a higher marital rate, thereby decreasing the likelihood of them seeking abortion services.

Income. Whether or not a woman has the money to pay for an abortion may be dependant on her income. Most abortion patients are of modest economic means (Table 4.3).

Table 4.3

Family Income of Abortion Patients

<u>Family Income</u>	<u>National figures for abortion patients*</u>	<u>Roanoke Sample (N=93)</u>
under \$11,000	33%	40.9%
\$11,000-\$24,999	34%	28.0%
\$25,000-\$34,999	12%	11.8%
\$35,000-\$49,999	10%	9.7%
over \$50,000	11%	8.6%
TOTAL	100%	99%

* Source: Family Planning Perspectives, Vol.20, 1988.

Once again, the distributions tend to be very similar. The larger gap in the lowest income interval may be attributed to more of the patients being students, fewer of the women working outside the home, and the lower wages of the area. This analysis implies an even greater need for access to a large scale provider because of their lower costs. The level of education completed may also have had an impact on income levels. Information on education of abortion patients at a national level is not available. The

responses I received regarding education levels are shown in Table 4.4.

Table 4.4

Distribution of Education Levels Ages 18 and Over (%)

<u>Level of Education Completed</u>	<u>All U.S. Women*</u>	<u>Roanoke Sample (N=90)</u>
Some High School	22.0	13.3
High School Graduate	39.2	31.1
Trade or Vocational School	2.7	7.8
Completed Community College	4.4	5.6
Some College	17.2	26.7
College Graduate	11.0	14.4
<u>Graduate/Professional School</u>	<u>3.6</u>	<u>1.1</u>
TOTAL	100.1%	100%

*Source: Current Population Reports, Series P-70 No.21, 1987.

Overall, the Roanoke sample tends to be quite well educated, showing higher percentages in all categories above high school level with the exception of graduate/professional school. The national rates include all women over age 18 and the Roanoke sample only includes women over 18 and up to age 44. The lower rate of the Roanoke sample in the graduate/professional category may be attributed to the lower ages of women in this sample. These rates suggest

that education may be a tool in gaining skills to obtain information on abortion services and a woman's commitment to education may predispose her toward abortion.

Other factors that influence abortion rates are ethnicity, marital status, and religion. Nationally, minority women are more than twice as likely as white women to have an abortion. Women who have never been married are five times more likely to have an abortion than are married women. Women who identify themselves as being Protestant or Jewish are less likely to have an abortion than are all women. The abortion rate among Catholics is very close to the national average. Women who claim no religious affiliation are much more likely than women nationally to obtain abortion services (Henshaw and Silverman, 1988). The profile of the Roanoke sample is displayed in table 4.5.

Table 4.5

Distribution of Race, Marital Status,
and Religion of Abortion Patients

	<u>All Abortion Patients*</u>	<u>Roanoke Sample</u>
<u>Race (N=103)</u>		
White	69%	81.6%
Black or other		
<u>Minority</u>	<u>31%</u>	<u>18.4%</u>
<u>TOTAL</u>	<u>100%</u>	<u>100%</u>

Marital Status (N=104)

Divorced	11%	9.6%
Married	19%	15.4%
Never Married	63%	65.4%
<u>Separated</u>	<u>6%</u>	<u>9.6%</u>
<u>TOTAL</u>	<u>99%</u>	<u>100%</u>

Religion (N=95)

Protestant	41.9%	53.7%
Catholic	31.5%	12.6%
Jewish	1.4%	0.0%
Other	2.9%	3.2%
<u>None</u>	<u>22.2%</u>	<u>30.5%</u>
<u>TOTAL</u>	<u>99.9%</u>	<u>100%</u>

*Source: Family Planning Perspectives, Vol.20, 1988.

Compared to national data, there is a substantial difference in the Roanoke sample regarding statistics on race. Traditionally, there are fewer blacks in the Appalachian region because most of it was not part of the plantation agriculture system during slavery. Also, the

non-metropolitan South has a disproportionately low percentage of other ethnic and racial minority groups. Regarding marital status, the Roanoke sample has a slightly higher percentage of women who were never married, and slightly lower percentage of divorced and married women. This may possibly be attributed to the larger proportion of students in the Roanoke sample. The religious distribution of the Roanoke sample is indicative of the predominantly protestant rural south. There is a substantial difference in the number of women who claimed to have no religious affiliation, but I am unable to offer an explanation.

Contraceptives play a vital role in determining abortion rates. Ninety-two percent of all women who are at risk of unintentional pregnancy use contraceptives. The eight percent who do not use contraceptives account for 57% of all unintentional pregnancies (Forrest and Fordyce, 1988). Nationally, 47% of unintentional pregnancies end in abortion. In the Roanoke survey, 59.6% of the women did not use any form of birth control, while 3.8% responded that they were not sure if they were using contraceptives at the time. Of the 36.5% who said they were using contraceptives, 38.9% were on the pill, 27.8% were using condoms, 11.1% the sponge, 5.6% a diaphragm, 5.6% suppositories, 2.8% IUD, and the remainder did not specify. This shows an exceptionally

high failure rate for oral contraceptives, compared to the standard failure rate of 5% (Newsweek, 1993). It is more likely that the women were not taking the pill correctly or had stopped taking the pills altogether. All women who obtain abortions at the RMCW are counseled extensively on the use of contraceptives. With nearly 60% of the patients not using contraceptives before they sought the services at the clinic, clearly there is a need for education on the proper use of the various forms of birth control as well as making contraceptives more affordable and readily available.

When asked about previous pregnancies, 42.3% said this was their first pregnancy and 64.1% said that this was their first abortion. Only 12.6% had miscarried and 44.2% had previously carried a pregnancy to term. Nationally, 58% of the patients surveyed said it was their first abortion (Henshaw, Koonin, and Smith, 1991). The higher percentage rate in the Roanoke sample may indicate poorer access to contraceptives or a greater frequency of unprotected sex.

Enabling Factors

Information. The majority of women (88%) went to a health care facility (such as the clinic itself, Planned

Parenthood, privated Physicians and Hospitals) for their pregnancy tests. Home pregnancy tests were performed by 4.9% of the women, and 6.8% of the women went to Crisis Pregnancy Centers which are funded by anti-abortion groups. Of the women who had pregnancy tests performed at a health care facility, 52.1% were not given information about where they could obtain abortion services.

Women were asked to check all sources of information on the clinic (Table 4.6), and 40.4% responded that they were told by a friend about the clinic. Family planning services provided 23.2% of the women with information on the clinic and doctors were the source for an additional 11.5% of the respondents. The health department was a source for 12.5% of the women, and 5.8% of the women found out about the clinic from health services at a university or college. Advertisements were the sources of information for 21.2% of respondents. When asked to specify where this advertisement was seen, 90% responded with the phone book and 6% answered with the newspaper. The remaining sources with low responses included a parent, a sister, and one patient indicated directory assistance as her source. When asked which one of the sources was the **MOST** helpful in making the decision to choose the Roanoke Medical Center for Women, the following results were given.

Table 4.6

Most Helpful Source of Information on the Clinic and
Percentage of Women Responding

<u>Source</u>	<u>Percentage (N=103)</u>
Friend	39.6
Family Planning Service	21.8
Doctor's referral	9.9
Advertisement	8.9
Health Department	7.9
University/College	
Health Services	4.0
Parent	3.0
Guidance Counselor	1.0
<u>Other</u>	<u>4.0</u>
TOTAL	100.1%

Obtaining information on abortion services is a fundamental step in making one's decision whether or not a woman is able to terminate a pregnancy. These results show a variety of information sources, though most women found out about the clinic from friends, family planning services, doctors, advertisements and health departments. While more than 80% of the women had their pregnancy tests performed at a health care facility, over half of these women were not told where they could obtain abortion services. These offices are staffed with personnel qualified to provide such information and by not doing so, women may have to rely upon less reliable sources for their information, perhaps leading to a delay in obtaining the desired abortion and therefore increasing the health risks involved in the procedure.

Information regarding safe and reputable abortion providers should be more readily available from these sources and information should include costs, gestational limits and quality of care.

Sixty-two percent of the women were not aware of the services offered by the Roanoke Medical Center for Women before they needed them, and 51.9% did not know of any other place to obtain an abortion. Of those who knew locations of other abortion providers, 75.5% of the other known providers were located in Virginia, 18.4% in North Carolina, while Washington D.C., Tennessee, and West Virginia each had 2%. When asked if they would travel to a different state if abortion were illegal in Virginia, 65% said yes they would, 6.8% said no, and 28.2% said they were not sure. Because of the geographic location of southwest Virginia and its proximity to North Carolina, Tennessee, and West Virginia, many women may find the border states accessible; consequently the rate of women who said they would cross state lines may be high, but there is no national data available with which to compare.

Women chose the Roanoke Medical Center for Women for five main reasons: it was less expensive (36.5%), close to home (34.6%), they did not know of any other

abortion provider (29.8%), recommended by friend or family member (26.9%) and referral by a health professional (24.0%). Some women chose this particular clinic because it was further from home and they wanted to maintain privacy (12.5%), and 10.6% chose it because of its reputation. The fact that some women chose a provider further from home goes against the geographic principle of distance decay.

Of the women who were referred to the clinic, 42.4% were referred by a friend, 22.8% by Planned Parenthood, 12% by a health department, and 10.9% by a private physician. Referrals were also made by boyfriends, university/college health services, parents, other family members, and boyfriends parents.

Gestational Limits and Availability. One well known barrier to health care is convenience of appointment hours. There is not a local doctor in Roanoke who is willing to perform abortions on a large scale. Consequently, the two doctors who perform the procedures at the Roanoke Medical Center for Women fly in from Richmond. Because of this situation, the days on which abortions are performed are limited. The Roanoke Medical Center for Women performs abortions every Wednesday during the day and every other Tuesday evening. They perform abortions for up to 12 weeks gestation. Fifty one percent of the women were at or before 8 weeks in their

pregnancy, while 75% were at or before 10 weeks. An additional 11.5% were between 11 and 12 weeks, and 12.5% were not sure how far along they were. One woman said she was 13 weeks.

The further along a woman is in her pregnancy, the more difficult it is to find an abortion provider. The increased length of gestation also increases the risks involved as well as the cost of the procedure. If a woman waits too long before scheduling an appointment, she may limit her ability to obtain the desired services. Three questions in the survey addressed appointment scheduling. The first question determined the length of time between when a woman first found out she was pregnant and the date she called for an appointment. In 21.2% of the cases, the respondent called for an appointment the same day she received the results of her pregnancy test. An additional one-third phoned for an appointment within a week, and 21.3% called within two weeks. The majority of women phoned for an appointment within 4 weeks, though 11.1% waited over 4 weeks before scheduling an appointment.

The second question was to determine the lag time between when they called for the appointment and the actual day of the appointment. Because of the limited availability

of abortion services in southwest Virginia, some women do not have the option of waiting for an appointment. Consequently, 4.9% of the women had the abortion performed the same day they called for the appointment. Including these women, 32.4% were able to schedule an appointment within a week of calling, an additional 39.2% within 2 weeks, 17.6% more had appointments for within 3 weeks, and 4.9% for within 4 weeks. Only 5.9% had to wait over a month for an appointment. When scheduling appointments, 82.7% were able to take the first appointment offered them. Of the 17.3% who were unable to take the first appointment, 43.8% said it was because of money, 18.3% because of work, and 12% said they wanted an earlier appointment. The third question addressed the matter of convenience. When the women were asked to rate the convenience of appointment hours, 46.2% said excellent, 45.2% good, 7.7% fair, and only 1% poor. These high ratings may be due to the availability of evening appointments. The results are displayed in Table 4.7.

Table 4.7

Time Before Scheduling the Appointment, Lead Time to Appointment, and Convenience of Appointment Hours

Time Between Results of Pregnancy Test and Calling for Appointment. (N=99)

<u>Number of Days</u>	<u>Percentage</u>
Same day	21.2%
1-7 days	33.3%
8-14 days	21.3%
15-21 days	9.0%
22-28 days	4.0%
<u>over 28 days</u>	<u>11.1%</u>
TOTAL	100%

Time Between Calling for Appointment and Having the Appointment. (N=99)

<u>Number of Days</u>	<u>Percentage</u>
Same day	4.9%
1-7 days	36.3%
8-14 days	34.3%
15-21 days	15.7%
21-28 days	3.0%
<u>over 28 days</u>	<u>6.0%</u>
TOTAL	100.2%

Convenience of Appointment Hours. (N=104)

<u>Rating</u>	<u>Percentage</u>
Excellent	46.2%
Good	45.2%
Fair	7.7%
Poor	1.0%
<u>TOTAL</u>	<u>100.1%</u>

These responses reinforce the fact that time is crucial when it comes to abortion. Women need to be able to recognize pregnancy symptoms early and to be tested for these symptoms. If a woman chooses to terminate the pregnancy, she must call for an appointment early since many women have to delay appointment times due to finances. The availability of abortion services is very limited in this area and delays could put the option of abortion out of reach. The affects of a 24 hour waiting period would be especially felt by women in rural areas. In this study, 25% of the patients were beyond 10 weeks gestation and 25% could only get appointments after a 2 week lag time. Every other week, appointments are only available on Wednesday. If a woman was forced to return after 24 hours, in reality, she would have to wait a full week for another appointment, assuming it was available. The two separate trips to the clinic would double the time and cost and further jeopardize a woman's privacy. Another reason the convenience ratings were high may be due to the ability to receive counseling and obtaining the abortion on the same day.

Cost. The cost of health care and the topic of health insurance came to the forefront in the last election year. It is estimated that between 35-37 million Americans either lack adequate health insurance or have no health insurance

at all. The truly indigent are eligible for the Medicaid program, though Medicaid does not pay for abortions. As a result of stricter regulations, the number of federally funded abortions plummeted from 294,600 in 1977 to only 165 in 1990. Consequently, subsidized abortion services are now the responsibility of the states. In 1990, the Commonwealth of Virginia paid for abortions for 86 indigent women with no federal aid (Gold and Daley, 1991). Very few private insurers will pay for elective abortions.

In the Roanoke survey, 66.3% of the women had health insurance. Of the women with coverage, 98% said their insurance company was not paying for the procedure and the remaining 2% said they were not sure. Financial hardship as a result of the abortion was expected by 63.1% of the women, and 43.1% said they had to borrow money to pay for the procedure. Only 17.5% said it was very easy to get the \$265.00 needed to pay for the abortion. In fact, on the five point scale used to rate the difficulty of coming up with the money (very easy to very difficult), most women said it was very difficult for them to come up with the money. There is no financial assistance available from the RMCW for women in need. Three-quarters of the women said they chose to terminate the pregnancy because they could not afford to have a baby. A few women said they had to delay

their appointments because they needed more time to raise the money to pay for the abortion. These results show that the cost of the abortion is definitely a hardship to women while low income is a motivating factor in seeking abortion services.

Distance and the declining number of providers. In recent years, the number of abortion providers has been declining. Abortion services are becoming concentrated in metropolitan areas making it more difficult for some women, especially in rural areas, to obtain an abortion. In 1988, 9% of all women who had abortions travelled over 100 miles to reach their abortion provider and 18% travelled between 50-100 miles (Henshaw, 1991).

The results of the Roanoke survey are displayed in Table 4.8 and the spatial distribution is shown in Figure 4.1.

Table 4.8




Travel Distance of Patients to Abortion Service
(N=104)

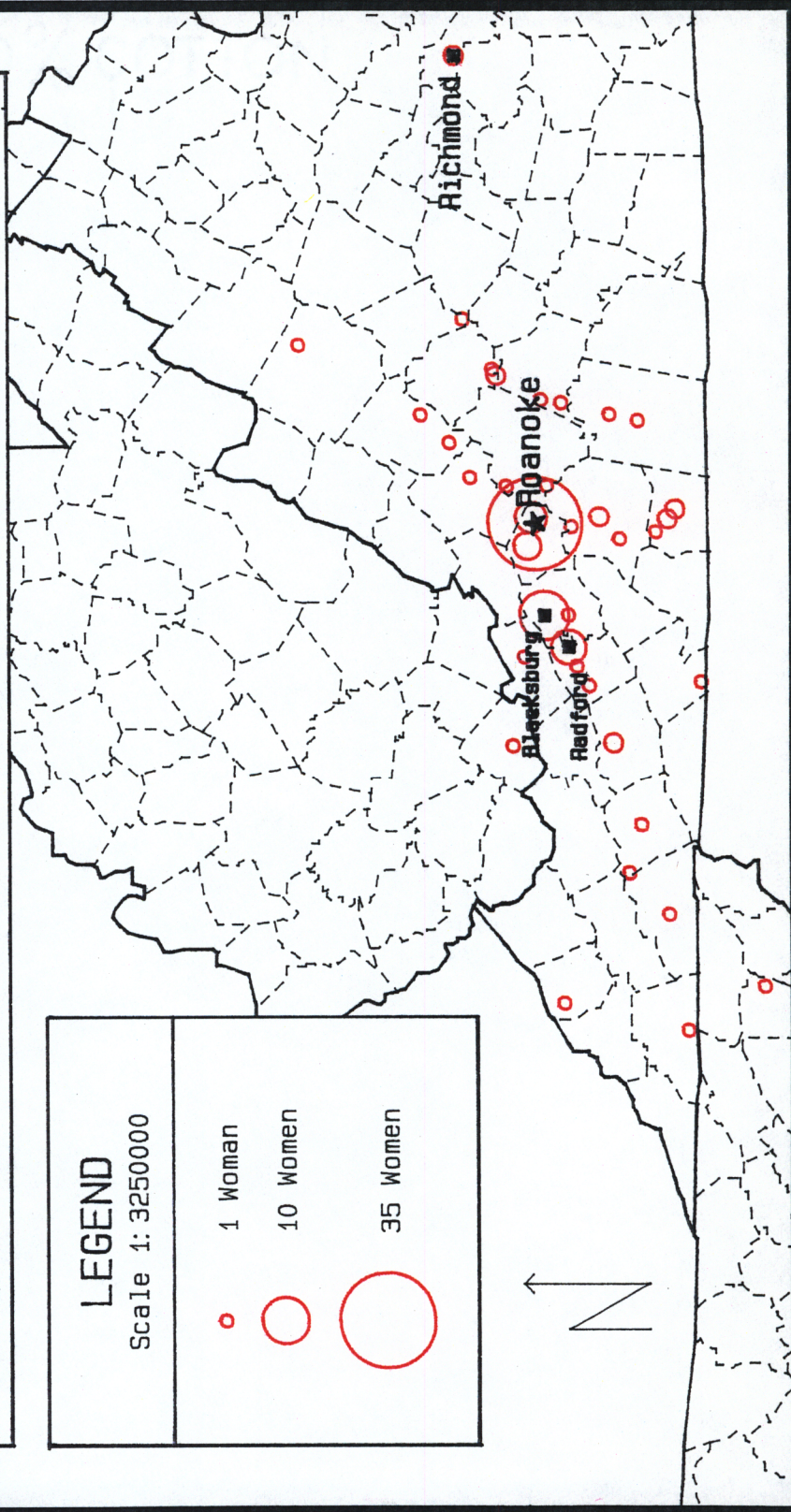
<u>Distance Travelled to Clinic</u> (miles)	<u>Percentage of Patients</u>
under 10	28.8
11 - 25	19.2
26 - 50	26.0
51 - 100	18.3
<u>over 100</u>	<u>7.7</u>
TOTAL	100%

Figure 4.1

LOCATIONAL PATTERN OF WOMEN SEEKING
ABORTIONS IN ROANOKE (RMCW) April-May 1992

LEGEND
Scale 1: 3250000

	1 Woman
	10 Women
	35 Women



Only 4.2% of the women had to stay overnight in the Roanoke area because they lived so far away. One-quarter of these women had to pay additional costs to stay in the area. In terms of modes of transportation, 97.1% travelled by car, 1.9% by taxi, and 1% by bus. For 96.1% of the respondents, their form of transportation to the clinic was their usual means of transportation. Just over 90% had both a drivers license and regular access to a car, therefore transportation did not appear to be a problem.

The geographic principle of distance decay is the exponential decline of an activity with increasing distance from the point of origin. Numerous studies have shown the effect of distance decay on health care services (Shannon and Dever, 1974). The results in Table 4.6 do not follow the expected distance decay pattern. The elevated score in the 26-50 mile category can be explained by the fact that two major universities (Virginia Polytechnic Institute and Radford University) are located within this distance of the clinic. University towns have a greater proportion of women of reproductive age and women who are enrolled in school are more likely to seek abortion services. It is also likely that they have the resources to see an abortion provider.

The effect of distance decay changes when distance and income are combined (see Table 4.9). The lowest income category (<11,000) displays sharp distance decay, and the second category (11,000-24,999) has mixed results. There is almost no effect of distance for categories 3, 4, and 5. These results indicate that women with a greater income can more easily overcome the distance barrier, just as would be expected. There may also be a greater number of poor women in the rural areas that are unable to obtain abortion services. This survey is unable to address that issue.

Table 4.9

Travel Distance to Abortion Service v. Income (%)
(N=93)

Distance (in miles)	Income (\$)				
	1 <11,000	2 11,000- 24,999	3 25,000- 34,999	4 35,000- 49,999	5 >50,000
<10	14.0	10.8	2.2	2.2	1.1
11-25	11.8	4.3	3.2	0	0
26-50	8.6	5.4	3.2	5.4	3.2
51-100	3.2	7.5	2.2	0	3.2
>100	3.2	0	1.1	2.2	1.1
TOTAL:	40.7	28.0	11.9	9.8	8.6

The effect of distance on minority patients is shown in Table 4.10. There is a sharp decrease in the utilization rates of black women as distance to the clinic increased. This may be due to the concentration of minorities in cities

in southwest Virginia. A study conducted in other areas of the state may show different responses.

Table 4.10

Distance to Abortion Service v. Race (%) (N=103)

Distance (miles)	Race Asian	Black	White
<10	1	8.8	19.4
11-25	0	4.8	14.6
26-50	1	1.9	23.3
51-100	0	1	17.5
>100	0	0	6.8
TOTAL	2	16.5	81.6

Parental notification is one subject that always surfaces in the abortion debate. Nationally, minors (under age 18) account for 12% of all abortions (Henshaw and Silverman, 1988). In this study 13.5% of the respondents were under 18 years of age. Sixty-four percent of the minors said that at least one parent knew of the abortion, up from the national average of 55% (Torres, Forrest, and Eisman, 1980). Due to the rural nature of the study area, minors may not have many employment opportunities available to them. In this study, over 70% of the minors were not working outside of the home. I would speculate that minors who live in more urbanized areas have a higher employment rate. Without their own source of income, the women in this study may have had to get the money from their parents. The

RMCW conducted its own study on minors and found the closer the minor was to age 18, the less likely she was to tell a parent.

Abortion is a very complex decision for most women. Ninety three percent of all abortion patients say that more than one factor influenced their decision (Gold, 1990). When asked in this survey to specify the single most important reason for having the abortion, 35% said they could not afford a child now, 27.2% said having a baby would dramatically change their life in ways for which they are not ready, 8.7% responded having a baby would interfere with school, 6.8% said they were having problems with their relationship, 6.7% said they did not want any more children, and 5.8% cited either personal health problems or possible problems affecting the health of the unborn baby. This study found the main reasons women choose abortion are 1) their economic situations, 2) their responsibilities, and 3) unstable relationships (Table 4.11). Some abortion critics are willing to make exceptions for abortions when the pregnancy results from rape or incest; they may also make exceptions when the health of the mother or fetus is jeopardized. The Roanoke results clearly show, however, that these are not the reasons why women choose abortion. Limiting abortions to such restrictive situations would

force many women to seek illegal abortion providers or administer self-induced abortions. The serious health consequences of such actions have been well documented.

Table 4.11

Reasons for Choosing Abortion* (N=104)

<u>Percent Responding</u>	<u>Reason Given</u>
75	I cannot afford a baby now.
56.7	Having a baby would dramatically change my life in ways I'm not ready for.
31.7	I don't want to be a single mother.
29.8	Having a baby now would interfere with school.
29.8	My husband/boyfriend wanted me to have an abortion.
29.8	I didn't want my parents or other people to know I got pregnant.
26.0	I already have as many children as I want.
25.0	I do not feel I am mature enough to raise a(nother) child.
24.0	There are problems in my relationship with my husband or partner.
16.3	There are possible problems affecting the health of my unborn baby.
8.7	My parents wanted me to have an abortion.

cont'd.

Table 4.11 (cont'd.)

5.8	I have a physical problem or a problem with my health.
3.8	I didn't want my parents or other people to know I had sex.
1.9	I'm concerned about the quality of life for my baby.
<u>1.0</u>	<u>I was raped.</u>

* Percentages will not total 100 because women could choose more than one answer.

Reinforcing Factors

Attitudes of health care workers have also been known to be barriers to health care. The real barrier to abortion services was with the health care workers the women saw before they got to the clinic. Over half of these workers did not provide the women with information on abortion services.

The staff at the RMCW received very high ratings, with 54.8% of the women rating the staff's attitude as excellent, 40.4% responded good, and 4.8% said they had a fair attitude. The other question directly related to the staff at the RMCW was regarding the quality of information provided to the patients on abortion. Over 63% said they

received excellent information, 32.7% good, and 3.8% fair. These rates may have been different if the survey was completed after the patients received their counseling.

The other reinforcing factor mentioned was the role of a support system. There appears to be a strong relationship of friends with utilization of abortion services. Sixty-nine percent of the patients had someone accompany them to the clinic. One patient chose to take a later appointment because she could not find someone to go with her on the first available date. This indicates another segment of the population that must overcome some of the same barriers. They, too, must be able to afford the costs of travel and perhaps lodging, as well as arranging time away from work or school. Friends were also the most recognized source on obtaining information on the clinic as well as for referrals. Also, peers were influential in the decision making process since 29.8% of the patients said they chose to have the abortion because their partner wanted them to terminate the pregnancy.

Chapter Five

Conclusions

Each year, approximately 1.6 million women obtain abortions in the United States (Henshaw and VanVort, 1990). Women have to cross several barriers in order to obtain abortion services. Legislation, public policy and a declining number of providers have made it increasingly difficult for a woman to obtain the desired health care. Though the number of abortions performed each year has remained the same, recently the proportion of pregnancies that end in abortion has declined (Forest and Singh, 1990). This trend suggests that for a proportion of women, the structural and physical barriers to obtaining an abortion may be insurmountable.

This study compared the national abortion statistics with the local utilization rates in Southwest Virginia, and also assessed the barriers women faced in obtaining abortion services in a rural area.

Generally speaking, the women who utilized the RMCW were very similar to U.S. abortion patients -- young, not married and of modest economic means. The most substantial

differences showed a greater proportion of lower income patients as well as a fewer number of minority patients in the Roanoke sample. The lower income group may be explained with a slightly higher percentage of students in the sample, fewer women working outside the home, and the lower wages of the area. The lower minority rate is indicative of the lower percentage of minorities in the study region. A higher proportion of Protestants was also observed in the study area, but this is indicative of the predominantly Protestant rural south.

Information on health care services has long been noted as a barrier to obtaining care. In this study, over 90% of the women said it was easy or very easy to obtain information on the clinic, despite the fact that over 50% of the women who had their pregnancy test done at a health care provider were not told where they could obtain an abortion. This lack of timely information could cause a delay in obtaining the abortion, which increases the risks involved in the procedure, or prohibit the women from obtaining an abortion at all. This study only looked at the women who were successful in obtaining information, it did not address the women who never made it to the RMCW. Information regarding safe and reputable abortion services should be more easily obtainable from health care workers and the

information should include costs, gestational limits and quality of care.

Gestational limits pose a great barrier to women in southwest Virginia. The RMCW is the only large scale provider and their gestational limit is at 12 weeks. After this, a woman must either travel to Richmond -- the only location second trimester provider in Virginia -- or cross state lines. Most women (65%) said they would seek abortion services out of state if abortion were illegal in Virginia. This willingness may be due to the relatively close proximity to North Carolina, Tennessee and West Virginia. Lag time to an appointment is also crucial. If a woman has to wait too long for an appointment, she may exceed the gestational limits. Over 25% of the women had to wait at least 3 weeks for an appointment. The longer lag time may be due to the limited times that procedures are offered, even though patients rated appointment availability very high. The high rating may have been due to the availability of evening appointments.

The cost of an abortion imposed a great hardship on many women; over 40% had to borrow money to pay for the procedure. Some women had to postpone their appointments because they did not have the money. Even though cost was a

barrier, low income was a motivating factor in seeking abortion services.

The effect of distance was a problem for the rural poor. A sharp distance decay effect was observed in the low income category. Women who were in the higher income bracket were not affected by distance. Generally speaking, rural areas are disproportionately poor. These results reinforces the notion of a two tiered system -- a woman's ability to obtain an abortion depends largely upon her place of residence and her financial resources. A comparison of the difficulty of obtaining information with distance to the clinic showed that distance did not appear to be a barrier to getting the information.

The role of peers was found to be very important. A high number of women chose abortion because their partner wanted them to terminate the pregnancy. This suggests that a number of women may have had the abortion against their own wishes. In addition to accompanying patients to the clinic, friends were also a major source for providing information to the patients. This points to a second segment of the population that must overcome many of the same barriers faced by abortion patients, such as getting time off from work and transportation costs. I could find no

national statistics on the role of peers. Such information could enhance the value of future studies of the delivery of abortion services.

The main problem with this study -- as with any utilization research -- is that there is no way of obtaining information from those women who, for whatever reasons, did not ultimately obtain the desired services. Though some women in rural areas may not choose abortion because of their conservative views, this study suggests that the need for abortion services is there; only the financial and geographic barriers impede access to the services. Further research needs to be conducted on maternity patients who kept the pregnancy because they were unable to overcome obstacles to obtain abortion services.

The results of this study show that the issue of access to abortion services presently hinges on the availability of providers. Medical schools and residency programs rarely teach abortion techniques. It becomes a question of whether mid-level practitioners such as nurse practitioners, nurse midwives and physician assistants be taught to perform the procedure. Presently, Vermont is the only state that allows mid-level practitioners to perform abortions. A study conducted there found the incidence of complications for

these mid-level practitioners was lower than for M.D.'s (Freedman, 1986). Their skills and services could be integrated with existing health clinics and private practices at an affordable cost. This option could greatly increase access for women in rural areas.

My study addresses one of the issues in the larger problem of delivering complete health care services to the chronically underserved rural poor. The benefit of this study is it becomes clear that further research needs to be conducted at local levels to identify barriers to health care services. The Clinton administration has promised health care reform, but it is unwise to think that sweeping federal reforms to social problems such as health care and unintended pregnancy are the only solution. Each geographical area needs research studies that are germane to its region which will identify problem sources and lend toward more workable solutions.

Ultimately, the ideal solution would be to eliminate the need for abortion. Increasing sex and family life education, and increasing access to affordable contraceptives are ways to address the issue. Further research needs to be done on new contraceptive methods, such as RU 486 and male contraceptives.

With the election of a pro-choice president, there is some hope on the horizon for keeping abortion safe and legal. Many restrictions imposed by the Reagan-Bush administrations, such as the "gag rule" and the ban on fetal tissue research, have already been lifted. Increased funding for family planning services may now be possible, and funding for foreign aid to family planning programs that include abortion services will be resumed. Removing the geographical barriers is only one step in the larger scheme of the abortion dilemma. Preventing unintended pregnancies in the first place is the ultimate goal.

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Appendix A

Research Approval




Research Division

PO Box 600-110
Blacksburg, Virginia 24061-0110
(540) 231-9389 FAX (540) 231-2382

April 2, 1992

TO: Charles M. Good and Carol Hanson
Department of Geography
Campus

FROM: E. R. Stout 
Associate Provost for Research

SUBJECT: IRB EXEMPTION / "Utilization of Abortion Services:
A Local Level Analysis"
Ref. 92-095

I have reviewed your request to the IRB for exemption for the above referenced project. I concur that the research fall within the exempt status.

Best wishes.

ERS/php

Appendix B

Questionnaire

1. How did you find out about the services offered by the Roanoke Medical Center for Women? (Please check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> A. Friend | <input type="checkbox"/> F. Teacher |
| <input type="checkbox"/> B. Parent | <input type="checkbox"/> G. Guidance counselor |
| <input type="checkbox"/> C. Doctor's referral | <input type="checkbox"/> H. Health department |
| <input type="checkbox"/> D. Family planning service | <input type="checkbox"/> I. Advertisement |
| <input type="checkbox"/> E. University/College health services | <input type="checkbox"/> J. Other (please specify) _____ |

2. Once you found out about the services offered by this clinic, which ONE of the above sources was the MOST helpful to you in making your decision to choose this clinic? (please circle the letter below which corresponds to your choice)

A B C D E F G H I J

3. Were you aware of the services offered by the Roanoke Medical Center for Women before you needed them?

Yes No

Based on your experience, how would you rate the following? (Please circle)

	Very Easy				Very Hard
4. Getting information about the clinic	1	2	3	4	5
5. Arranging transportation to the clinic	1	2	3	4	5
6. Getting money to pay for the abortion	1	2	3	4	5
7. Getting time off from work or school	1	2	3	4	5

8. Do you know any other places where you can get an abortion?

Yes No

If yes, in what city, town, or county are they located?

9. Why did you choose the Roanoke Medical Center for Women? (Please check all that apply.)

- Close to home
 - Further from home to maintain privacy
 - Close to work
 - Referral by a health professional
 - Reputation of clinic
 - Recommended by friend or family member
 - Less expensive
 - Did not know of any other place to get an abortion
 - Other (please specify)
-

10. If you were referred to this clinic, who did the referral?

(Please check)

Professional

Other

- | | |
|---|--|
| <input type="checkbox"/> Private Doctor | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Private Nurse | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Planned Parenthood | <input type="checkbox"/> Other family member |
| <input type="checkbox"/> Health department | <input type="checkbox"/> Boyfriend/Husband |
| <input type="checkbox"/> University/College health services | <input type="checkbox"/> Boyfriend's Parent(s) |
| | <input type="checkbox"/> Minister or church official |

11. When did you have your pregnancy test done? (Please circle the date) If you don't know the exact date, give your best estimate.

12. Where did you go for your pregnancy test?

- Roanoke Medical Center for Women
 - Planned Parenthood
 - Health department
 - University/college health services
 - Doctor
 - Crisis Pregnancy Center
 - Did a home pregnancy test
 - Other (please specify)
-

13. If you went to a testing service, did the staff there tell you where you could get an abortion?

Yes No

14. How far along are you in your pregnancy?

4-6 weeks 9-10 weeks
 7-8 weeks 11-12 weeks not sure

15. Were you or your partner using a birth control method when you became pregnant?

Yes No Not Sure

If yes, what method of birth control were you using?

16. Have you been pregnant before? Yes No

17. Do you have any children? Yes No

18. Did you ever miscarry? Yes No

19. Is this your first abortion? Yes No

20. If you are under 18 years old,
did you tell either of your
parents before coming here? Yes No

I'm at least 18

21. Why did you choose to have an abortion?
(Please check all that apply.)

- A. I cannot afford a baby now.
- B. I don't want to be a single mother.
- C. Having a baby now would interfere with school.
- D. There are problems in my relationship with my husband or partner.
- E. Having a baby would dramatically change my life in ways I'm not ready for.
- F. I have a physical problem or a problem with my health.
- G. There are possible problems affecting the health of my unborn baby.
- H. Other (please specify) _____

22. From the above list, which ONE was your MOST important reason for choosing to have an abortion? (please circle)

A B C D E F G H

23. What other reasons contributed to your decision to have an abortion? (Please check all that apply.)

- A. My husband/boyfriend wanted me to have an abortion.
- B. My parent(s) wanted me to have an abortion.
- C. I didn't want my parents or other people to know I had sex.
- D. I didn't want my parents or other people to know I got pregnant.
- E. I was raped.
- F. I became pregnant as a result of incest.
- G. I do not feel I am mature enough to raise a(nother) child.
- H. I already have as many children as I want.
- I. I have another reason
please specify: _____
- J. None of the above

24. As near as you can determine, when did you make your appointment for your abortion? (please circle the date)

25. Were you able to take the first appointment offered you?

_____ Yes _____ No

If no, why not?

Based on your experience, how would you rate the following?

	Excellent	Good	Fair	Poor
26. Convenience of clinic appointment Hours	_____	_____	_____	_____
27. Attitude of the clinic staff	_____	_____	_____	_____
28. Information on abortion provided by the clinic staff	_____	_____	_____	_____
29. Were you worried about meeting any anti-abortion protesters?		_____ Yes		_____ No
30. Did you see or hear any protesters at the clinic today?		_____ Yes		_____ No

31. Approximately how long did it take you to get to this clinic?

_____ Hours _____ Minutes

32. What is the approximate travel distance to this clinic from your home?

_____ under 10 miles
_____ 11-25 miles
_____ 26-50 miles
_____ 51-100 miles
_____ over 100 miles

33. Did you or do you plan to stay overnight in the Roanoke area because you live so far away? _____ Yes _____ No

If yes, did this cost you extra money? Yes No

34. If abortion were illegal in Virginia, would you have travelled to another state to obtain this abortion?

Yes No Not sure

35. Did someone come with you today? Yes No

If yes, what relationship is this person to you, for example, a friend, sister, boyfriend, etc...?

36. How did you travel to get here today?

Car

Public transportation

Bus

Taxi

Other

(Please specify) _____

37. Is this your usual means of transportation?

Yes

No

If no, how do you usually get around? _____

38. Do you have a driver's license?

Yes

No

39. Do you own or have regular access to a car?

Yes

No

40. What is the Zip Code of your current mailing address? _____

41. Is this your permanent address?

Yes

No

42. If no, is this your school address?

Yes

No

43. What is the highest level of formal education you have completed? (Check the answer which best describes you)

- | | |
|---|--|
| <input type="checkbox"/> Grade School | <input type="checkbox"/> Completed |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Community College |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Some College |
| <input type="checkbox"/> Trade or | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> Vocational School | <input type="checkbox"/> Graduate School/
Professional School |

44. Are you currently in school or enrolled in classes? Yes No

45. Do you currently work outside the home? Yes No

46. If yes, do you work Full time or Part time?

47. What is your primary occupation?

- | | |
|--|---|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Retail Services |
| <input type="checkbox"/> Sales/Marketing | <input type="checkbox"/> Management |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Professional/Technical |
| <input type="checkbox"/> Clerical or secretarial | <input type="checkbox"/> Laborer/Machine Operator |
| <input type="checkbox"/> Student | <input type="checkbox"/> Craftworker/Artisan |
| <input type="checkbox"/> Other (please specify) | |

48. Are you missing any time from other obligations such as school or work to obtain this abortion?

- | | | |
|--------|------------------------------|-----------------------------|
| School | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Work | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

49. Will you lose money because of this missed time? Yes No

50. Do you have health insurance? Yes No

51. Is your health insurance company paying for your abortion? Yes No

52. Will the cost of this abortion cause you any financial hardship at this time? Yes No

53. Did you have to borrow money to pay for this abortion? Yes No

54. How old are you?

_____ Years

55. What race are you?

<input type="checkbox"/> White	<input type="checkbox"/> Black/African American
<input type="checkbox"/> Hispanic	<input type="checkbox"/> American Indian
<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Other (please specify)

56. What is your marital status?

<input type="checkbox"/> Never married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
<input type="checkbox"/> Separated	<input type="checkbox"/> Other (please specify)

57. What is your religious affiliation, if any?

<input type="checkbox"/> Protestant	<input type="checkbox"/> Roman Catholic
<input type="checkbox"/> Jewish	<input type="checkbox"/> No formal religious affiliation
<input type="checkbox"/> Other	

(Please specify) _____

58. What is your yearly family income before taxes?

<input type="checkbox"/> under \$11,000	<input type="checkbox"/> \$35,000-49,999
<input type="checkbox"/> \$11,000-24,999	<input type="checkbox"/> over \$50,000
<input type="checkbox"/> \$25,000-34,999	

Thank you for your time and for your cooperation.

Please return this completed questionnaire to the reception area before you leave today.

VITA

Carol J. Hanson is originally from Massachusetts. After several years of travelling the United States and foreign lands, she settled down and received her Bachelor of Arts degree in Geography from Framingham State College in December 1989. In the fall of 1990, she began her graduate work in Geography at Virginia Tech.

Following the successful completion of her Master's degree, Carol plans on returning to her native Massachusetts to seek gainful employment in order to finance her wanderlust.

A handwritten signature in cursive script, appearing to read 'CJ Hanson', located in the lower right quadrant of the page.