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Original article

A Qualitative Exploration of Low-Income Women's Experiences Accessing Abortion in Massachusetts

Amanda Dennis, DrPH, MBE *, Ruth Manski, MPH, Kelly Blanchard, MSc

Ibis Reproductive Health, Cambridge, Massachusetts

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ABSTRACT

Background: At a time when most states are working to restrict abortion, Massachusetts stands out as one of the few states with multiple state-level policies in place that support abortion access for low-income women. In 2006, Massachusetts passed health care reform, which resulted in almost all residents having insurance. Also, almost all state-level public and subsidized insurance programs cover abortion and there are fewer restrictions on abortion in Massachusetts compared with other states.

Methods: We explored low-income women's experiences accessing abortion in Massachusetts through 27 in-depth telephone interviews with a racially diverse sample of low-income women who obtained abortions. Interviews were digitally recorded, transcribed, coded, and analyzed thematically.

Results: Most women described having access to timely, conveniently located, affordable, and highly acceptable abortion care. However, a sizable minority of women had difficulty enrolling in or staying on insurance, making abortion expensive. A small minority of women said their abortion care could be improved by increasing emotional support and privacy, and decreasing appointment times. Some limited data also suggest that young women and immigrant women face specific barriers to care.

Conclusion: This study provides important, novel information about the need for state-level policies that support access to health insurance and comprehensive abortion coverage. Such policies, along with a well-functioning health care environment, help to ensure that low-income women have access to abortion. However, not all abortion access challenges have been resolved in Massachusetts. More work is needed to ensure that all women can access affordable, confidential care that is responsive to their specific needs and preferences.

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Background

The U.S. health care system has been described as strained and unreliable, leaving many people unable to access the health services they need (U.S. Department of Health and Human Services, 2015). Further, low-income populations, racial and ethnic minorities, people with less than a high school education, and people living in rural areas experience disparate challenges accessing health services (Agency for Healthcare Research and Quality, 2003; Centers for Disease Control and Prevention, 2013; Commonwealth Fund, 2013; Smedley, Stith, & Nelson, 2002; U.S. Department of Health and Human Services, 2015). State of residence matters too; people living in different states can experience vastly different health care environments and, therefore, access to services (Commonwealth Fund, 2013).

We focus here on access to abortion care for low-income populations in Massachusetts. We consider access to abortion to mean that there is an adequate supply of the service and that it is physically accessible, affordable, and acceptable across population groups (Gulliford et al., 2002). It is critical to evaluate access to abortion as it is a common experience that affects a broad cross section of women in the United States (Guttmacher Institute, 2014). We focus on low-income women's access to the service; 69% of women who obtain abortions face economic difficulties (Guttmacher Institute, 2014) and such difficulties are often impediments to accessing health services (U.S. Department of Health and Human Services, 2015). We focus in Massachusetts because it is one of the few states where abortion, along with other reproductive health services, is considered reasonably

* Correspondence to: Amanda Dennis, DrPH, MBE, Ibis Reproductive Health, 17 Dunster Street, Suite 201, Cambridge, MA 02138. Phone: 617 349 0040; fax: 617 349 0041.

E-mail address: adennis@ibisreproductivehealth.org (A. Dennis).

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accessible (Burns, Dennis, & Douglas-Durham, 2014; NARAL Pro-Choice America, 2014a; Population Institute, 2015). This is in part because Massachusetts led the nation and implemented health care reform in 2006, which resulted in almost all adult women in the state being insured (Kaiser Family Foundation, 2014a; Seifert & Cohen, 2010). Further, there are few state-level restrictions on abortion in Massachusetts compared with other states (Burns et al., 2014). Also, almost all public and subsidized insurance programs cover abortion in Massachusetts (Massachusetts Legislature, 2015).

To our knowledge, only one study has investigated abortion access among low-income women in Massachusetts. An evaluation of women who contacted abortion funds, which are designed to provide assistance to low-income women who cannot afford abortion, found that some low-income women in Massachusetts experienced difficulties enrolling in public or subsidized insurance programs that cover abortion. This led to women being delayed or prevented from obtaining abortions, or prevented from obtaining medication abortion, which can only be accessed early in pregnancy (Bessett, Gorski, Jinadasa, Ostrow, & Peterson, 2011). As the authors of the study acknowledge, the study was limited in that it only included women who contacted abortion funds and who received some level of support from the abortion funds. This support may have impacted their abortion access.

Given the dearth of literature in this area, and the limitations of the one existing study on the topic, more investigation is necessary. We aimed to explore low-income women's experiences accessing abortion care in Massachusetts to determine if there is an adequate supply of the service across the state, and if it is physically accessible, affordable, and acceptable. We believed the findings would provide insights about what is working to support abortion access in Massachusetts and what—if any—improvements in abortion access are needed in the state; such findings may also provide important information for other states where abortion is often deemed accessible, such as California, New Mexico, and New York (Population Institute, 2015).

Methods

Between December 2011 and March 2012, we conducted in-depth telephone interviews. Qualitative methods were selected because they are well-suited for exploring the barriers and facilitators to abortion access in a real world setting (Bradley, Curry, & Devers, 2007). Of qualitative methods, we selected in-depth interviews as they prioritize women's voices and experiences (Patton, 2015), necessary because they are the ones primarily affected by abortion access issues.

To participate in the study, women had to be age 18 or older, have had an abortion after January 2009, and, at the time of the abortion, resided in Massachusetts, been uninsured or on a public insurance plan, and met the financial criteria for enrolling in a Massachusetts public insurance plan (≤300% of the federal poverty level; MassResources.org, 2015). To ensure some ethnic and racial diversity in our sample, we also planned to implement quota sampling and stop enrolling non-Hispanic White women once they constituted two-thirds of our sample. However, we reached our target number of interviews with a reasonably diverse sample and did not end up screening women out based on race/ethnicity.

To recruit study participants, we posted flyers in community-based organizations throughout the state and on community-based websites such as Craigslist. Study advertisements invited women to contact the research team via phone or email to learn more about the study. Interested women were screened for eligibility. If eligible, a telephone interview was scheduled at a time and on a day most convenient to the participant.

Two interviewers trained in qualitative data collection conducted all interviews. The interview guide was semistructured to ensure consistency across interviewers, while also allowing new ideas and themes to emerge (Patton, 2015). We developed the topics of the interview guide by considering the previously described features of accessible health care (Gulliford et al., 2002) and the documented barriers to abortion access in Massachusetts (Bessett et al., 2011). The major domains of the interview guide were participant's experiences: 1) enrolling in and staying on health insurance, 2) obtaining and paying for an abortion, and 3) obtaining and paying for contraceptives; this analysis focuses on results from the first two domains of the interview guide.

All interviews were digitally recorded, transcribed verbatim, and uploaded into the qualitative analysis software program ATLAS.ti 6.2 (Scientific Software Development, Berlin, Germany). We first coded transcripts with a small set of codes based on our central research questions. We then iteratively developed and applied new codes as new topics emerged from the data. We continued this process until topical saturation was reached, at which point the codebook was considered final. To ensure intercoder reliability, all coding was reviewed by another member of the research team. We then created summaries of individual codes and groups of codes and discussed the summaries within the research team. These code summaries and discussions helped the team to explore the relationship between individual codes and discover the major study themes. Throughout the process, we searched for negative evidence to disprove emerging themes, which helped to refine our themes. Once themes were finalized, illustrative quotes were selected (Bradley et al., 2007). All quotes below are presented verbatim, although we did remove common filler language ("umm," "like," etc.) for readability. We identify quotes by a pseudonym, and the participant's region of residence, race/ethnicity, and age.

All study participants gave verbal informed consent before the start of the in-depth interview and were given a $50 gift card for remuneration. All study procedures were approved by the Allendale Institutional Review Board (IRB), a private IRB.

Results

Participant Characteristics and Abortion Histories

Twenty-seven women completed in-depth interviews. Participants were on average 34 years old (range, 24–46; Table 1). Most participants self-identified as White (44%) or Black (37%). The majority of participants were in a relationship or married (59%), had at least some college education (59%), and were unemployed at the time of interview (63%). Most participants resided in or around the Boston area (74%). The majority of participants (74%) had insurance at the time of interview, and all of those who were insured had public insurance.

Participants reported having had an average of two abortions (range, 1–5; Table 2). The majority of participants' most recent abortions were surgical procedures (85%) that occurred in the first trimester (88%; data not shown). Women's most recent abortions were obtained at local hospitals (48%), stand-alone abortion clinics (48%), and private doctor's offices (4%).

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