



# Abortion patients' preferences for care and experiences accessing services in Louisiana<sup>☆</sup>

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## ARTICLE INFO

### Article history:

Received 13 October 2019

Received in revised form 22 November 2019

Accepted 25 November 2019

### Keywords:

Abortion

Policy

Health care access

Qualitative

Louisiana

## ABSTRACT

**Objective:** The objective was to compare abortion patients' expectations and preferences for care with their experiences accessing services in Louisiana where there are numerous restrictive abortion laws.

**Study design:** Between June 2018 and January 2019, we conducted in-depth interviews with 35 English-speaking Louisiana residents who were  $\geq 18$  years of age and seeking care from the three in-state facilities to explore their perspectives and experiences locating, obtaining and paying for abortion services. We analyzed interview transcripts using a theme-based approach and categorized themes into dimensions of health care access: availability/accessibility, accommodation, acceptability and affordability.

**Results:** Participants were surprised to learn that there were so few facilities providing abortion, which required some of them to drive between 1 and 3 h to the nearest clinic. Many were unable to schedule their visits at a convenient time or obtain care as early in pregnancy as desired because the next available appointment was often a week or more away. Protestor activity and congested waiting rooms did not provide most patients their desired level of privacy, but participants expressed diverse views about other approaches to care that would maintain their confidentiality. To pay for an unplanned health care expense that was not covered by insurance, many participants deferred paying monthly bills and borrowed money, which contributed to financial hardships and additional delays in care.

**Conclusions:** Many Louisiana abortion patients' expectations and preferences for care are not being met across multiple dimensions of health care access assessed in this study, and the state's highly regulated policy environment may limit options for tailoring services to patients' needs.

**Implications:** Abortion patients in Louisiana value accessible, timely, private and affordable services, but a constrained network of providers and medically unnecessary requirements make it difficult for them to obtain patient-centered care. Federal- and state-level policy changes, as well as local initiatives, could ensure abortion patients have access to quality, evidence-based services.

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## 1. Introduction

Louisiana has one of the most restrictive abortion policy environments in the United States [1]. State laws include a mandatory in-person consultation, 24-h waiting period, restrictions on using Medicaid and private insurance for abortion services, a prohibition on abortions after 22 weeks' gestation and extensive abortion facility licensing

regulations [2]. Between 2000 and 2018, the number of facilities providing abortion in Louisiana decreased from 13 to 3, which currently serve a population of more than 900,000 reproductive-aged women [3–5]. If a 2014 state law requiring abortion providers to have hospital admitting privileges goes into effect following legal challenges, the number of providers will decrease further and the distance people will need to travel for care will increase [6,7].

Studies conducted in other settings have demonstrated that laws similar to those in Louisiana adversely affect pregnant people's ability to obtain care, and the National Academy of Sciences, Engineering and Medicine concluded that many state-level regulations negatively impact the quality of care women receive [8]. For example, patients in states with mandatory waiting period requirements often are delayed returning for abortion care beyond the time frame required by law

<sup>☆</sup> Conflicts of interest: none. Role of the funding source: This project was supported by a grant from the David and Lucile Packard Foundation (2017-66910). The funder played no role in study design; in the collection, analysis and interpretation of data; in the writing of the report and in the decision to submit the article for publication.

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[9,10]. Restrictions on insurance coverage and increased travel distance also create financial burdens that can result in some people obtaining services later in pregnancy when there is a somewhat higher risk of complications or being unable to obtain an abortion at all [11–15].

A recent study indicates that Louisiana's policies prevent some pregnant women who consider abortion from having one [14,16], but additional research is needed to examine the cumulative effect these policies have on people when they try to access abortion care. This study helps fill the information gap by assessing whether and how the service and policy environment in Louisiana affects the care people seeking abortion receive and whether people's experiences match their expectations. Findings from our in-depth interviews can identify opportunities to ensure the policy and service environment in Louisiana meets patients' needs.

## 2. Methods

Between June 2018 and January 2019, clinic staff at each Louisiana facility referred patients to an on-site research assistant who screened them for study eligibility. Patients were eligible if they were an English-speaking Louisiana resident 18 years of age or older and attending an abortion-related visit. After determining eligibility, the research assistant described the study and asked if patients would be willing to complete a semistructured in-depth interview by phone to discuss their experiences accessing abortion. Based on our prior qualitative studies, we anticipated conducting approximately 30 interviews before concluding that additional participants would unlikely provide considerably new information (i.e., data saturation) [17]. Two research assistants with extensive knowledge of abortion service delivery and policies were trained to conduct in-depth interviews with participants; interviews took place within 3 weeks of recruitment.

We developed the interview guide based on our prior research and other literature about women's experiences accessing abortion care [18–21]. Specifically, we asked participants about their processes identifying a facility, making arrangements for and obtaining care, the perceived usefulness of the counseling information and waiting period, and how they covered the costs of care. We also explored the acceptability of alternative models of care by asking participants how comfortable they would be obtaining information included at the consultation visit through other means, such as remotely communicating with clinic staff (e.g., FaceTime) or from a health care provider in their community and having the consultation and abortion visit on the same day.

Prior to beginning an interview, research assistants asked whether participants felt they were in a safe and private place to discuss their experiences and, if so, obtained their oral consent to participate and have their interview recorded; otherwise, we rescheduled the interview for another time. Interviews lasted 30 min, on average, and after the interview, we mailed participants a \$30 Visa gift card. Interview recordings were transcribed and reviewed for accuracy, and identifying information was removed. We monitored participant characteristics (e.g., age, gestational age, recruitment site) to ensure we included a diverse sample with a range of experiences. We also regularly reviewed interview summaries and transcripts to assess data quality and variability and, based on these assessments, decided to stop data collection after 35 interviews. The authors' university Institutional Review Board approved the study protocol.

Given the numerous laws regulating abortion in Louisiana, we anticipated they would affect access to care across multiple dimensions: availability (a satisfactory amount of providers offer the care an individual needs), accessibility (an individual's ability to reach care), accommodation (sufficient flexibility enables an individual to get care when it is best for them), acceptability (an individual is comfortable accessing care from a provider) and affordability (an individual can reasonably afford to get care) [22]. We considered these dimensions of access as we developed a preliminary coding scheme to assess abortion patients'

preferences and expectations for care and their descriptions of their experiences obtaining services.

As a first step in our analysis, the research team read several transcripts and discussed emerging ideas to create a preliminary coding scheme. The team then independently reviewed and coded four transcripts and reconvened to compare coding and refine and add codes to the codebook. Next, they divided the remaining transcripts into two sets, which two members of the research team coded independently following the same process. They resolved coding discrepancies through discussions and meetings with the senior author. We used NVivo 12 for coding and data management.

In the second phase of our analysis, we reviewed and organized codes into the dimensions of health care access described above. We combined the domains of availability and accessibility because participants' responses related to these concepts frequently overlapped. Finally, we summarized the main ideas in each domain and assessed patterns of responses according to participants' characteristics. We did not ask about participants' gender identity and use female pronouns only if other interview information indicated they self-identified as a woman (e.g., said they were a "mom").

## 3. Results

Of the 113 patients approached about the study, 8 were ineligible, 28 declined to participate, and 42 could not be reached when recontacted by phone following recruitment. Most the 35 study participants were between the ages of 18 and 24, identified their race as black and had children (Table 1). Approximately half reported living fewer than 30 min from the facility where they received care, six traveled more than 1 h one way, and seven drove over 2 h one way to reach the facility. Eleven participants had a medication abortion (<10 weeks' gestation), 14 had a first-trimester abortion, and 7 had a second-trimester abortion. Two participants reported having miscarriages after their consultation visit, and one, who was at 8 weeks' gestation at her consultation visit,

**Table 1**  
Participant characteristics

	<i>n</i>	(%)
Age, years		
18–24	14	(40)
25–29	13	(37)
30–34	5	(14)
≥35	3	(9)
Race/ethnicity		
Black	18	(51)
White	11	(31)
Hispanic	5	(15)
Multiracial	1	(3)
Health insurance		
Medicaid	13	(37)
Private	18	(51)
None	4	(12)
One-way distance traveled, min		
<30	16	(46)
30–59	6	(17)
60–119	6	(17)
≥120	7	(20)
Parity		
0	13	(37)
1	13	(37)
≥2	9	(26)
Previous abortion		
Yes	16	(46)
No	18	(51)
Unknown	1	(3)
Recruitment site		
New Orleans	11	(31)
Baton Rouge	12	(34)
Shreveport	12	(34)

had not returned for her abortion because she was still trying to gather the \$400 needed for the procedure.

### 3.1. Availability/accessibility

Once participants decided to get an abortion, they typically expected to find a provider close to them and easy to get to, particularly those who had not had an abortion before. A few commented that they thought they would be able to get an abortion from their regular health care provider. Participants were frequently surprised to learn that options for abortion care were limited. For example, a 22-year-old said of trying to find a local provider, “There was only one location [...] That was kind of crazy to me. I thought I could go to your local, your normal doctor and they’ll be able to help you out. It wasn’t like that. It was just literally one place.” Participants living in cities without clinics often expressed disbelief that the nearest facility could be more than 1 h and up to 3 h away. Although some characterized the drive as uneventful, several others reported out-of-town travel was stressful because they were unfamiliar with the area, encountered traffic or bad weather, did not think their car would be able to make the trip, or would have to lie about their absence to parents or former partners. Making arrangements for multiple out-of-town trips and missing work was the biggest source of concern for a 27-year-old who drove 3½ h one way, “I was worried [...] I’d have to miss a bunch of work because there [are] not any centers close to home for me. That was one of the biggest stressors. I wasn’t too worried about any of the procedures, it was just the timeframe of trying to schedule it around my [work] schedule.”

In addition to noting that it would have been easier and more convenient to get care if there had been more clinics, some participants also suggested it could be easier to identify clinics online that actually provided abortion. As they tried to identify closer facilities, participants reported that internet search results frequently retrieved websites for pregnancy resource centers (PRCs; also known as crisis pregnancy centers). Several discerned that these organizations, described as women’s clinics — sometimes religiously based — that offered pregnancy testing and counseling and emphasized “keeping the baby” did not offer abortion care or referrals, but reported these results made it “more of a headache,” “confusing” and “stressful” to find a facility. A few participants called or visited PRCs without initially knowing they did not provide abortion. Like others who first contacted a PRC, a 24-year-old was frustrated to learn that abortion was not offered at organizations she found online, saying “I had to go through two numbers before I got to the place that I was looking for. I was looking for something closer because [the clinic] is two-and-a-half hours away [...] I wish that wouldn’t be on the internet as an abortion clinic if it’s not.”

### 3.2. Accommodation

Participants wanted to get an appointment at a time that accommodated their work, school or childcare schedules, but this was not always possible. Many also said they could not get in as soon as they wanted because appointments at some locations were limited. Participants frequently reported waiting a week or more for the next available consultation and another week to 4 weeks for their abortion visit. A 27-year-old college student who lived in the same town as a facility was unable to attend the consultation visit for 2 weeks because, “they were only scheduling on Thursdays, and I couldn’t miss school in order to go there. I actually had to reschedule twice before I was able to [go].” A 36-year-old also struggled to get a consultation appointment that aligned with her scheduled day off work and decided to drive an hour and a half to another facility to be seen sooner, “They couldn’t find an appointment for like a week and a half, so she gave me the number of [another] clinic [...] They could get me one [appointment] within a few days that matched my schedule.”

Additionally, many participants believed the in-person consultation and waiting period requirements, which they primarily learned about

after calling to schedule an appointment, were not useful because they had sufficient information and confidence in their decision. The long wait times at their appointments, which ranged from 2 to 6 h at some facilities, also were frustrating and seemed unnecessary to many. A 24-year-old whose consultation visit lasted 4 h explained, “You’re just waiting. You’re only in a room with the doctor for, maybe, 20 minutes [...] That was kind of frustrating, especially taking off work in the middle of the day. So, it’s not very accommodating if you’re a working person.” The majority of participants also stated they would have been comfortable having counseling and their abortion on the same day. A 20-year-old working two jobs illustrated several participants’ views that the two-visit waiting period requirement was “inconvenient” because “every time I have to go to the doctor, I have to miss a day of work [...] Not all jobs are ok with you missing work.” She did not call to schedule an appointment until she was sure about her choice and preferred a single visit, saying “If the woman is secure about the decision she is making, then there’s no reason to elongate the process [...] Let me decide if I want to take the pill there and then.”

Participants also wanted to get care in early pregnancy, but challenges making arrangements, combined with the two-visit waiting period requirement, resulted in some being unable to get their preferred abortion method and left others worried they would have to continue an unwanted pregnancy. Four participants who initially contacted the clinic in the first trimester of pregnancy had a second-trimester abortion because they were unable to return for their procedure for at least 2 weeks. Three others wanted and were eligible for medication abortion when they scheduled their consultation, but the intervals between visits delayed them beyond 9 weeks’ gestation, as a 32-year-old college student who missed an exam to make the consultation visit explained, “from the first appointment to the second appointment [two weeks later], that pushed me over so I couldn’t have the medical [abortion].” Some participants, however, noted that clinic staff tried to accommodate their scheduling constraints and preferences, when possible. A 24-year-old concluded “the [abortion] pill was really my only option” because, if she had a surgical procedure, she could not rely on her husband or mother to drive her home, nearly 2½ h away; “They said you had to have a driver, and I was like, well, that boots me out.” When her abortion visit was scheduled a week after the consultation, she expressed her concerns to a sympathetic nurse, who was able to get an appointment 2 days later.

### 3.3. Acceptability

Overall, participants felt that clinic staff were friendly, helpful and supportive, but they were less comfortable with other aspects of their experiences that did not maintain their desired level of privacy. This was particularly the case for protestor activity outside facilities. While most participants expected to see protestors when they arrived, this led to enhanced anxiety for some. A 29-year-old who worried her ex-husband might learn of her decision commented, “Whenever you get there, you know, sometimes [there’s] protestors outside, and you’re wondering [...] gosh, who’s seeing me right now [...] you know, see your car pull in or recognize you.” Nearly all participants encountered protestors at the three facilities. Some mentioned people saying “don’t do this” or preaching as they walked to the clinic entrance, and others recounted protestors trying to hand them pamphlets and plastic babies. Participants said they tried to ignore these interactions but still considered the protestors’ presence “awkward,” “uncomfortable” and “nerve-racking.” A few relayed more confrontational and difficult encounters. A 21-year-old, stressed to discover her pregnancy after undergoing cancer treatment and ending an abusive relationship, recalled arriving at the consultation visit to find “protestors on the street who stopped our car when we pulled up. There were also ladies on the other side of the street yelling things.” While she felt supported by her family, she said her interactions with protestors walking toward the clinic entrance made her “very, very sad. I do believe in God [...] One of the men said to

me, 'You're so beautiful. I'll tell everyone about you in Heaven since you won't be there.' That hit me really close to home, because these people [...] don't know what you're going through."

Participants' experiences sitting in waiting rooms full of people and attending group information sessions aimed at accommodating the large number of patients seeking care also did not align with their privacy preferences, although a few commented that the presence of other patients felt supportive. Participants had varied perspectives about the extent to which alternative approaches would provide them with their desired level of privacy and comfort. Several mentioned they would be comfortable having the consultation with a local clinician because both the provider and location were familiar and convenient, but others, particularly those living in smaller communities, expressed concerns about confidentiality and worried local clinicians would provide biased information or judge their decision. Because of this, they preferred the anonymity of getting care from providers elsewhere. Many also would be willing to get the information provided at the consultation by phone or FaceTime. A 21-year-old said a remote consultation would have been preferable to spending several hours at the consultation visit after a 2½-h drive because it "would've felt more personal, being face-to-face with someone, even on FaceTime, or talking on the phone versus sitting in a room with 30 other women."

### 3.4. Affordability

Nearly all participants had private insurance or Medicaid, and although a few were surprised to learn they could not use insurance to cover their costs, most assumed they would have to pay out of pocket for care. Two privately insured patients said they did not even inquire about coverage to prevent the policyholder from learning about their abortion. Because the costs of abortion and related expenses were not part of their monthly budget, the majority of participants — regardless of insurance and gestational age — said it was difficult to pay for care. Participants commonly reported using any savings they had and delaying expenses, such as rent, utilities and car payments; some took out payday loans and picked up additional shifts at work to cover their costs. Many also contacted local abortion funds, which can cover a portion of the procedure costs, but only a few received assistance. A 27-year-old with private insurance said the combined cost of the medication abortion (\$600) and \$120 in gas for two 3-h trips to the nearest facility "was a hefty sum." Ineligible for financial assistance, this participant paid expenses with a credit card and called the cell phone and electric companies to "just let me do a different amount and pay it [bill] at a later date."

Other participants using these strategies still did not have enough money to cover the funding gap and had to ask family members or the man involved in the pregnancy to assist with costs. Even with this assistance, it was stressful for them to gather sufficient funds and avoid procedure costs that increased weekly if they progressed into the second trimester. This left some in more difficult financial circumstances. For example, a 21-year-old with Medicaid was able to get \$250 from a national abortion fund to offset the \$650 procedure at 13 weeks' gestation but still had to borrow money from family and delay bills to cover the remaining amount, childcare for her 3-year-old son and travel to the clinic 2 h away. She said, "I am playing catch-up right now, and it's still stressful [...] I'm working double time to try to get back on track because that \$400 — it took a lot out of me."

Although financially difficult for many, the overall costs of care were almost insurmountable for several participants, leading them to reschedule appointments and delay care, which further increased costs. Among these was a 27-year-old who recounted "I did this thing of, 'Okay, how the hell am I going to pay for this being a single mom, being a student, not working' [...] My biggest concern was, 'Okay, how am I going to do this in the time that I need to get it done.'" With a funding shortfall and a broken-down vehicle, she continued to postpone care and was 16 weeks' gestation by the time she attended her

consultation visit. She was concerned she would still be unable to pay \$2125 for the 2-day procedure plus an overnight hotel stay until she received a text back from a local abortion fund a week later. She recalled, "Literally, that morning I was driving to the clinic [...] and [the woman at the fund was] like 'They're going to go ahead and give you an additional \$400' [...] I cried so much [...] She saved my life."

## 4. Discussion

The Louisiana residents seeking abortion in this study wanted to easily access care as soon as they decided they needed it, and they desired services that felt comfortable and private — values expressed by abortion patients in other studies [23–25]. However, we found that these criteria often were not met when we compared these expectations and preferences with participants' experiences. The disconnects related, in part, to the limited number of facilities and providers, and the two-visit waiting period requirement, which contributed to congested waiting rooms and lengthy appointments for many patients and long-distance travel and delayed care for some. These findings are similar to challenges pregnant people report obtaining abortion care in other restrictive policy settings [9,18,20,26]. They also highlight how the service environment cannot be easily disaggregated from the constellation of policies regulating care and together operate in a manner that adversely affects indicators of health care quality, such as patient-centeredness and timeliness [8].

By considering multiple dimensions of access, we also found that it was difficult for participants to cover the costs of their abortion and other expenses associated with attending their visits. Specifically, the lack of insurance coverage for abortion contributed to financial stress and hardship for many, and assistance from abortion funds, while much needed by those who received it, was insufficient to cover a procedure costing several hundred to more than \$2000. Our study adds to prior research on cost barriers to abortion [11,21,27] by identifying how patients' financial strains persist following abortion as they try to make up for lost wages, repay borrowed funds and catch up on delayed bills. Other studies have found that coverage restrictions in Louisiana can prevent women, especially those with low incomes, from obtaining abortion [14,16], and together, these findings support the need to ensure public and private coverage for abortion is comparable to other reproductive health services [28].

Additionally, participants in this study commented that other ways of receiving care would be acceptable and more accommodating to their schedules and needs. Similar to other reports [29,30], some participants would be comfortable obtaining information about abortion and getting care from their regular provider, but this may be difficult under the state's abortion licensing requirements and stigma around providing this service [31]. Additionally, participants were largely comfortable making a single visit to a facility and having their abortion the same day or would be interested in having a remote consultation with staff at the abortion facility rather than making a separate in-person consultation visit [32]. There is evidence that consultation and waiting periods do not change abortion patients' confidence in their decisions [9,20], and lack of awareness of and need to comply with these laws may adversely affect people's ability to obtain timely care. Further, like patients in other studies [33], participants reported protestors were an unwanted presence that negatively affected their clinical experience, but few federal and no state laws limit the physical distance protestors must maintain from clinics and patients. While providing patient-centered care has been a priority since the Institute of Medicine's 2001 report [34], Louisiana's current policy environment precludes many options for tailoring abortion services to patients' preferences.

Federal- and state-level policy changes that facilitate access to abortion may take time to achieve, but other initiatives could improve patients' experiences in the meantime. For example, in June 2019, Google changed its advertising policy to require any entity paying to run ads for "keywords related to getting an abortion" to certify whether

they provide abortions [35]. This may make it easier for pregnant people to distinguish PRCs from facilities providing abortion. Further, city policies could be considered that would make care affordable and better accommodate patients' desire for privacy in their health care decisions, such as those in Austin, TX, and Jackson, MS, that, respectively, provide funding for logistical support to obtain abortion and create buffer zones around health care facilities [36,37].

Our study provides a broad view of how the current service and policy environment affect pregnant people seeking abortion in Louisiana by focusing on multiple dimensions of access to care and responds to recent calls to consider people's reproductive health care preferences [38], but it also has limitations. We interviewed people who had reached one of the three in-state facilities, but we may not have captured other aspects of the service and policy environment that affect access to care for those who did not make it to a clinic. However, other research indicates that cost and policy-related barriers to abortion are important for Louisiana women who consider abortion but end up continuing their pregnancies [14,16]. Additionally, we did not interview minor teens and non-English speakers, who may experience other challenges finding services and navigating access to care [39,40].

Despite these limitations, our results point to notable gaps between abortion patients' preferences for and how they currently are able to access care in Louisiana. Overall, the state's current abortion policies adversely affect several domains of health care access and quality and negatively impact pregnant people's experiences obtaining abortion services.

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