

# An Untold Story of Access: Title X Grantees and Abortion Referrals in Rural America

By

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Senior Thesis

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## **Introduction**

Abortion is a medical procedure that has been performed in every society ever studied (National Abortion Federation 2010). In the U.S., state legislation banning or restricting abortion began in the 1880s (National Abortion Federation 2010). Outlawing abortion did not lead to a decrease in the number of abortions performed; rather, it caused many women to attempt the procedure themselves. The methods of self-inducing abortion varied but they were all dangerous and often resulted in death or serious medical complications (National Abortion Federation 2010).

Abortion is one of the safest medical procedures when performed under sanitary conditions by trained practitioners (World Health Organization 2005) yet 68,000 women living in countries where abortion is illegal die from unsafe abortions every year (National Abortion Federation 2010). The legalization of abortion in the United States played an important role in advancing the medical field to improve the safety of the procedure (NAF 2010).

While legality is extremely important, the story of abortion in the United States since its legalization in 1973 has proved that keeping abortion safe requires accessibility as well. In 1992, The US Supreme court ruling *Planned Parenthood v. Casey* allowed for a slew of state laws to be passed limiting access to abortion; ranging from parental consent laws to waiting periods and mandatory counseling. Virginia requires women considering abortion to have an ultrasound and wait 24 hours before having the abortion. South Dakota requires providers to warn women that abortion is linked to high rates of suicide, which is medically inaccurate.

In addition to dealing with legal complications, finding an abortion provider has become even more difficult. The number of abortion providers decreased by 38 percent between 1981 and 2008 (Guttmacher 2012). 87 percent of all counties in the US lack an abortion provider, and that number increases to 97 percent when excluding metropolitan areas. Women living in rural communities have an even more difficult time accessing abortion, since providers are mainly located in metropolitan areas, and more heavily concentrated in the west and northeast (Guttmacher 2012).

Access to abortion services in the United States has become largely dependent upon class status and geographic location; these restrictive laws disproportionately affect low-income women and those living in rural areas. Waiting periods are a huge deterrent for women that work because they have to take time off work, arrange for transportation and a hotel, and come up with the resources for gas, a hotel room, and the procedure itself. This is extremely expensive and most insurance policies do not cover abortion services.

Abortion services are not only extremely difficult to access but they are isolated from mainstream health care. Most abortions are performed at abortion clinics rather than at primary care providers; this physical separation of abortion services allows for abortion providers to be targeted by legislation and the anti-choice movement. The isolation of abortion services is growing more and more due to extreme legislation that targets providers. These laws take form in the shape of facility requirements, requiring abortion doctors to obtain hospital-admitting privileges, or banning telemedicine.

Abortion is regulated legally but also through financial means. Cost is the largest barrier to access. Insurance policies have become more and more restrictive following in the Hyde amendment's footsteps, often excluding abortion services from coverage. If abortion coverage is offered it is likely that the insurance company will charge an extra monthly fee.

The isolation of abortion delegitimizes it as a medical procedure necessary for comprehensive health care for women. It allows for abortion providers to be targeted physically and ideologically. Physically, through violent attacks and assaults by the "pro-life" movement; ideologically as medical schools fail to train Ob/Gyns to become abortion providers. The isolation leads to a further decline in the number of abortion providers, higher cost for women at the time of the procedure, and ultimately makes abortion inaccessible to low-income women.

The goal of this project was to gain a better understanding of the barriers low-income women in rural states face in accessing abortion services. One key factor essential to abortion access is obtaining accurate information about providers. Since abortion referral practices play a critical role in determining how quickly women will be able to find a provider, I wanted to find out if Title X grantees were referring for abortion services upon request. I decided to call Title X grantees because they receive government funding to provide women's health care and are required to give referrals for abortion services upon request. I chose rural states because it is generally agreed upon that women in rural states have more difficulty accessing abortion due to the long distances they must drive to find a provider.

I called over 700 Title X grantees in 8 rural states posing as a pregnant woman seeking abortion services. I discovered that Title X grantees are not consistently referring for abortion services upon request. The inconsistency in referral practices indicates confusion about the Title X referral policy and a lack of adequate training or misinformation given in training. When Title X grantee staff is uninformed or misinformed on abortion referral practices, it is their pregnant patients seeking abortion services that suffer the consequences.

I will argue that the inconsistency in abortion referral practices at Title X grantees is reflective of a larger problem of access: denying low-income women medical information, adding another barrier to abortion access. In addition to restrictive state legislation, isolation of abortion services, and abortion stigma, low-income women in rural states are unable to access information on abortion services. While abortion remains legal, it has become increasingly inaccessible for low-income women, especially those in rural states. These women need a trusted and reliable source of medical information.

In Chapter 1 I will contextualize my research on Title X abortion referral practices within the larger framework of abortion access in the United States. I will explain my research methodology and review literature on abortion referral practices and abortion access more broadly.

In Chapter 2 I present the results of my phone calls with a brief analysis of the results in each state, followed by a comparative analysis of my results and how they impact access in Chapter 3.

In chapters 4 and 5 I analyze what factors contributed to the inconsistency in Title X abortion referral practices, focusing on restrictive legislation in Chapter 4 and the isolation of abortion services in chapter 5. In Chapter 6 I review my results and what they mean for abortion access; I analyze the political implications of the inconsistency of Title X abortion referral practices and provide recommendations on how these inconsistencies can be addressed.

I would like to acknowledge that my research focuses on the specific experience of low-income rural cisgendered women seeking abortion services. It doesn't account for the experiences of transgender or gender variant individuals nor does it address racial disparities in access. It focuses specifically on Title X abortion referral practices in 8 rural states. Despite the limitations of my research, the inconsistencies in abortion referral practices at Title X grantees is relevant to anyone interested in addressing the gap between legal rights and accessibility.

## **Chapter One: Title X Abortion Referral Practices & Abortion Access**

### **The significance of Title X for rural communities and low-income women**

Title X was created in 1970 through the Public Health Service Act (Health and Human Services (HHS) 1970). It is administered through Health and Human Services and is run by the Office of Population Affairs (HHS 2013). Title X is the only government program devoted solely to women's health and family planning; the program serves millions of low-income Americans, and is a critical component of the social safety net. The program provides access to family planning services and information as well as preventative health services mainly for low-income families. 72 percent of US counties have one or more Title X clinics that provides these services (HHS 2013).

Title X grantees provide health services regardless of ability to pay. The 4,500 clinics receiving Title X funding provide basic health care services for 5 million young low- income women (HHS 2013) and six out of 10 women who receive services at Title X clinics consider it their primary source of medical care (Napili 2013, 2).

Clients that are at or below the poverty level receive fully subsidized services through Title X, and compromise 69 percent of all Title X clients (Napili 2013, 2). Clients with incomes above 100 percent but below 250 percent of the poverty level are billed on a sliding scale; and patients that have incomes at or above 250 percent of the poverty level are charged in full for services (Napili



2013, 3).

Title X grantees provide basic health care for many low-income women that lack health insurance but do not qualify for Medicaid. 64 percent of Title X clients did not have health insurance in 2011 (Napili 2013, 2). Many women rely on Title X clinics as their only source of health care (Dailard 2001, 8).

### **Poverty rates in rural America**

The poverty rates in rural America are consistently higher than in urban communities. The average poverty rate in rural counties in 2011 was 18.3%, nearly 3 percent higher than the national average (Daily Yonder). There were 9 million people living under the poverty line in rural counties in 2011 (Daily Yonder). Rural populations often rely on clinics that receive Title X funding for health services because often they are some of the only clinics in their county.

### **Title X facing funding cuts**

As more and more Americans are suffering from the economic crisis, they turn to social programs like Title X for assistance for basic health care services. However, despite the increase in demand for Title X services, funding for the program is facing extreme funding cuts. Title X Clinics are well known for the women's health care services they provide and for that reason they have been under widespread attack by the Republican Party since 1980. In 2011 and 2012 alone, Title X lost 7.4% of its funding (National Family Planning Reproductive Health Association 2013). Maintaining Title X funding has been a vital objective for pro-choice organizations, with good reason considering the wide range of women's health services they provide.

Access to abortion and class are invariably linked and as abortion becomes more isolated and excluded from the rest of women's health care services, it becomes less accessible especially for low-income women. The gap between legality and accessibility is growing and self-determination is becoming more and more dependent on resources.

Because of the stigma surrounding abortion and the increase in legislation passed limiting access, I became interested in finding out where low-income women in rural states could turn for accurate information if they were seeking abortion services. I started with Title X clinics, because Title X is a resource for healthcare and information for many low-income women.

### **Abortion Referral Practices critical to Access**

The client services section 7.0 of Title X guidelines requires grantees to give accurate referrals relating to family planning clients that want such services, including referrals to abortion providers upon request.

Because accurate referrals directly impact how quickly a woman will find an abortion clinic, they are critical to access. Low-income women are especially dependent upon Title X clinics and are likely to contact them for information regarding pregnancy options and abortion services because of the health services they provide.

I decided to call Title X clinics in an attempt to better understand whether or not Title X clinics were providing rural women with information on abortion services. The study that I did was an attempt to better understand barriers to abortion access, especially for low-income women in rural states.

## **Overview of results**

My expectation that Title X clinics and all of their employees would offer undirected guidance for pregnant women was substantially unmet. The hoops I had to jump through to get basic information about the nearest abortion provider were appalling. And many times, I wasn't even able to get the information I was seeking.

I have been prayed for over the phone. I have been told over and over again that I shouldn't have an abortion and that I will regret it for the rest of my life. I have even been told that it is murder and that the least I could do is put it up for adoption. I have been questioned multiple times about whether or not the father knew about the pregnancy, if my parents knew, about my age, and what I do for work. As a "pregnant woman" I felt I had become free range for questions and scrutiny.

Over half of my phone calls in Kentucky, West Virginia, and North Dakota, and nearly half in Oklahoma and Wyoming resulted in a direct refusal of information, a referral to the phonebook or Internet, or a referral to another health care provider. All of these responses denied me the medical information I was seeking and that were required by law and left me completely on my own in my search for an abortion clinic.

Sometimes I was flat out rejected, told, "we don't do that here" or "we're not allowed to refer for that because we get government funding." This is in complete contradiction to the guidelines of Title X. Other clinics told me that in order to get that information, I would have to come in and receive options counseling.

Information referrals, or those that directed me to the phone book, google or information line were very common. This is problematic for a couple of different reasons. First of all, information about abortion clinics is becoming less accessible; for example, in Louisville, Kentucky's latest edition of the phone book, there are multiple "abortion alternatives" listed, yet the only abortion provider listed is Planned Parenthood. Planned Parenthood does not even provide abortions in Kentucky; the one abortion provider in the state is not listed in the yellow pages. Secondly, it has become extremely difficult to decipher what abortion clinics are legitimate due to the increase of Crisis Pregnancy Centers (CPCs) using misleading advertizing tactics. CPCs are fake medical clinics that intentionally deceive pregnant women in order to persuade them to carry their pregnancies to term. When searching for abortion clinics online, it is easy for the untrained eye to mistake a CPC as an abortion provider, or a counseling center that could refer for abortion services.

While the lack of information was the dominant response, a more extreme threat to access were direct referrals to Crisis Pregnancy Centers. In the state of Kentucky, I was referred to nearly twice as many CPCs as abortion clinics; nineteen percent of all calls were referrals to CPCs and only ten percent were provider referrals. While CPC referrals were not in any case the most dominant response I received from the Title X Clinics, the fact that they are referring to CPCs at all is appalling.

The deceptive practices of many CPCs are well understood by members of the reproductive health community, but may be less known to women, or even to

the agency or staff referring to them. Crisis Pregnancy Center websites present themselves in one of two ways; authentically as a “pro-life” Christian pregnancy center, or as an unbiased options counseling center for pregnant women. The latter is the dominant approach, used to reel in women that are looking for guidance and persuade them to carry their pregnancy to term, paying no regard to the women or their wishes. They have a very specific political goal and do not care if achieving it means deceiving pregnant women.

Accurate referrals are critical to abortion access. In a climate where abortion is constantly under attack and a time when deception is common and intentional, women need a trusted source of medical information. Misinformation runs rampant on the Internet; CPCs and their message is everywhere.

It is the government’s responsibility to ensure that women have access to medical information regardless of their class status. *Roe* declared that abortion is protected by the constitution under the 14<sup>th</sup> amendment, but a legal right means nothing if its not accessible.

To be fair, most of the refusals can be attributed to a lack of clear policy and training. There seems to be confusion around policy illustrated by a wide variety of responses to a simple question. Title X clinics are intended to be a trusted source of health care and medical information for low-income women. If they are not consistently giving referrals for abortion services upon request, Title X grantees cannot be trusted as an unbiased resource for pregnant women seeking medical information. Granting medical information is a small concession to make for women that need access to a health care service.

## **Literature review**

Title X clinics are often assumed to be champions of women's health by pro-choice organizations for the unbiased family planning service they provide to women about all of their options. For that reason they have largely escaped the scrutiny that other medical providers have endured. There has been little research done surrounding the referral practices of Title X clinics.

The only study I found that resembled the work I did was published in January of 2012 by the Journal of Family Planning and Reproductive Health Care (JFPRHC). The study used a simulated patient to call health care providers that do not provide abortions, requesting referrals to abortion providers. The simulated patient called 46 non-providers twice, and two once, totaling 146 phone calls. They were testing whether there would be a difference in the referral practices between non-abortion provider facilities in the five most and six least restrictive states. In the simulated patient's first round of phone calls they did not directly ask for a referral, in their second round of phone calls they prompted the clinic staffer for a referral to an abortion provider. They categorized the responses they received as "direct", "indirect", "inappropriate", and "none". A direct referral gave the name or phone number, an indirect referral suggested Planned Parenthood by name but did not give details. An inappropriate referral was a referral to another health care facility that did not provide abortions, and "none" was when there was no referral given.

They found that there was no significant difference between the most and least restrictive states in the number of direct referrals. The average number of direct referrals given was 45.8% when prompted, and 26.8% did not provide a

referral. 97.9% of the facilities they called were within 19.5 miles of an abortion provider listed on the National Abortion Federation's (NAF) website. This study shows that even when health centers are located relatively close to an abortion provider there is no guarantee the staff will know about it or refer to it.

If only 45.8% of these facilities are referring when they are in that close proximity to an abortion provider, I would hypothesize that the number is even lower in rural communities, since abortion providers are much farther away.

This was the only study I found that attempts to find out if abortion referrals are being given. The sample size they are testing is fairly small, out of only 147 phone calls and 42 facilities. These facilities were not necessarily Title X clinics. They were referred to as women's health care providers that do not perform abortions. This could of course include Title X clinics, but I would like to focus solely on Title X clinics because they have a responsibility as government funded clinics to provide medical information to their patients.

### **Research Methodology**

The objective of this project was to conduct research on Title X Clinics, evaluate whether or not referrals to abortion providers are being given when asked and analyze what the results mean for access. I posed as a "pregnant woman" seeking an abortion clinic. The goal of my project was to find out if Title X clinics in rural states were making the appropriate referrals to abortion clinics when asked. These clinics are legally required to give referrals to abortion clinics when requested.

I began my research in the summer of 2012 as a Reproductive Rights Activist Service Corps intern through the Civil Liberties and Public Policy

program at Hampshire College. I was placed at Provide (formerly the Abortion Access Project) where I worked with the Senior Director of Programs; however, I conducted my research independently.

I made phone calls to the Title X clinics posing as a “pregnant woman” seeking an abortion. The question I asked was: “I just found out that I’m pregnant, and I’m thinking about having an abortion. Could you tell me where the closest place to go for that is?” The question was simple and directly requested a referral to the closest abortion provider.

I recognize the chosen methodology can be considered problematic given the use of deception. However, this was the only way to test if abortion referrals were occurring in Title X clinics in each of these states. In addition, all the information was collected anonymously and reported in an aggregate manner by state creating no problems for those employees that answered my calls.

I called grantees in Iowa, Maine, Kentucky and West Virginia as research for my internship. I called grantees in Maine, Kentucky and West Virginia twice for research asking a slightly different question in the second round of calls, I changed “I’m thinking about having an abortion” to “I’ve decided to have an abortion”. My results remained virtually unchanged from the first round of calls so I only called once for the rest of the states. Here, I will include my results from the first round of calls only for consistency purposes.

My project focused on these states because they are all part of Provide’s rural initiative, and the data I collected helps form a better understanding of how accessible information on abortion clinics is to women in rural areas. I expanded



my project in the fall of 2012 to include Oklahoma, Vermont, Wyoming and North Dakota in order to see if these problems existed there as well. I chose these states in order to get a range of geographic representation. I included two states from each geographic area where the most rural states, states with 50% of the population or more living in rural areas, are located. The northeast, the mid-east region, the south and the Midwest are each represented by two states. I've decided to focus on the most rural states because it is generally agreed upon that access to abortion is especially limited in rural states due to the distance women must travel to find an abortion provider, in addition to restrictive laws, especially waiting periods.

I categorized the data by what type of information I received upon requesting a referral to an abortion provider. The categories are provider referrals, information referrals, referrals to another provider, planned parenthood (non abortion provider) referrals, Crisis Pregnancy Center referrals, and unavailable. When evaluating referral practices, I took out the unavailable calls to base my results in percentages on clinics I engaged with.

In my analysis of the results, I draw from a variety of sources to illustrate barriers to abortion access and theorize about the impact that these barriers could have on Title X referral practices. I look specifically at restrictive legislation and the isolation of abortion services.

Guttmacher Institute was the source that I used for abortion statistics; they are a trusted research institute that focuses on collecting information on abortion internationally.

Many of the events and legislation I describe have recently taken place. In order to provide the most up to date and telling story of abortion access, I gathered much of my information from recent news articles and stories. My goal is to examine how Title X's inconsistent referral practices are a barrier to access and explore the factors that cause them. I aim to illustrate this untold story of abortion access through a variety of perspectives and bring to light the complexity of access as well as what's at stake for low-income women when Title X grantees do not consistently refer for abortion services.

## Chapter Two: Results by State

### **Maine**

Figure 1

Type of Referral	Number	Percentage
Abortion Clinic Referrals	21	75
Direct Refusals	4	14
Information Referrals	2	7
Referrals to another Provider	1	4
Unavailable	3	0
Total	31	100%

Overall, Maine had the largest percentage of Title X grantees that referred to abortion providers out of all eight states. None of the grantees in Maine referred to Crisis Pregnancy Centers. The percentage of counties without an abortion provider in the state of Maine is 69%, eighteen percentage points lower than the national average of eighty seven percent. I think this can partially be attributed to the fact that there are 13 abortion providers in the state, with a population of only 250,005 women of reproductive age (Guttmacher 2011).

### **Kentucky:**

Figure 2

Type of Referral	Number	Percentage of total
Abortion Clinic Referrals	17	10%
Clinic and CPC referrals	6	4%
Clinic and Planned Parenthood	4	2%
CPC referrals	32	19%
CPC and Planned Parenthood	3	2%
Direct Refusals	36	21%
Information referrals	40	24%
Referrals to another	27	16%

provider		
Planned Parenthood (non provider) referrals	3	2%
Gave a wrong number	1	
Unavailable	22	
Total	191	100%

Figure 3: CPC follow-up

Referral in round two	Number of grantees that referred to CPCs on my first call	Percentage of grantees that referred to CPCs in round one
Abortion Provider Referrals	7	18
Refusals	6	16
Information Referrals	15	39
Referrals to Another Provider	5	13
Planned Parenthood (non provider)	2	5
CPC and an abortion provider	2	5
CPC only referral	1	3
Total	32	100

Kentucky had the lowest percentage of referrals to abortion providers in comparison with the other states. In my first round of phone calls, I received only seventeen referrals for the abortion services that I requested, amounting to ten percent of responses in the state. 32 of the Kentucky grantees referred me to Crisis Pregnancy Centers, or nineteen percent, nearly twice the number of Title X grantees that referred to abortion providers.

## Iowa:

Type of Referral	Number	Percentage
Abortion Clinic Referrals	14	64

Clinic and CPC referrals	1	5
CPC referrals	2	9
Direct Refusals	2	9
Information referrals	2	9
Referrals to another Provider	1	5
Unavailable	7	
Total	29	100%

Figure 4

Sixty four percent of the Title X grantees in Iowa referred me to an abortion clinic. Fourteen percent referred to a Crisis Pregnancy Center, Nine percent CPC only referrals and 5 percent referred to both an abortion clinic and a CPC.

23 percent either directly refused, gave a referral to an information source or another medical provider. Iowa has both a parental notification law and mandatory state directed counseling, and 91 percent of counties that lack an abortion provider (Guttmacher 2011). However, the number of Title X grantee grantees in Iowa that referred to an abortion clinic was relatively high at 64 percent.

## West Virginia

Figure 5

Type of Referral	Number of total referrals	Percentage of total referrals
Abortion Clinic Referrals	53	37%
Clinic and CPC referrals	1	.7%
CPC referrals only	6	4%
Direct Refusals	34	24%
Information Referrals	16	11%
Referrals to another Provider	30	21%
Planned Parenthood (non-provider) referrals	1	.7%
Gave a wrong number	1	.7%
Unavailable	22	
Total	164	100%

I called 164 Title X clinics in West Virginia. 53 title X grantees or 37 percent, referred to an abortion clinic; six (4 percent) referred to a CPC only, thirty-four of the grantees directly refused. Sixteen, or 11 percent referred to an information source, thirty or 21 percent referred to another provider. 37 percent of West Virginia’s Title X clinics gave referrals to abortion providers upon request in round one. While these numbers may seem insignificant, and the state as a whole has a long way to go before meeting the Title X guideline requirement of referring for abortion services upon request; in comparison to neighboring Kentucky, West Virginia’s Title X clinics had a relatively high number of Title X clinics that referred for abortion services.

Ninety six percent of counties in West Virginia have no abortion provider, nine percentage points higher than the national average of eighty seven percent (Guttmacher 2011). The two abortion clinics in the state are located in Charleston.

56% or the majority of West Virginia’s Title X clinics gave information referrals, referrals to other providers or direct refusals. All of these clinics refused to give medical information requested by a “pregnant” patient.

## North Dakota

Figure 6

Type of Referral	Number	Percentage
Abortion Provider	5	45.4%
Information Referral	2	18%
Direct Refusal	3	27.3%
Referral to another Provider	1	9%
Unavailable	3	
Total	11	100%

In 2008, there was only one abortion provider in North Dakota, the Red River Women’s clinic in Fargo. This leaves 98 percent of North Dakota counties without an abortion provider, which is 11 percent higher than the national average of 87 percent; 74 percent of North Dakotan women live in those counties (Guttmacher 2011).

The majority of North Dakota’s Title X grantees refused to give the information I requested as a pregnant patient by either directly refusing or referring to another provider or information source.

The extreme hostility towards women seeking abortion care in North Dakota is growing. The fact that over half of all clinic staff in Title X grantees directly refused, referred to an information source or another medical provider is a sign of a culture of hostility and stigma around abortion services in North Dakota. However, when I was given a referral however it was to an abortion provider. I was never referred to a Crisis Pregnancy Center.

## Wyoming

Figure 7

Type of Referral	Number (out of 15)	Percentage
Abortion provider	8	53.3%
Information referral	2	13.3%
Refusal	2	13.3%
Referrals to another Provider	3	20%
CPC Referrals	0	0%
Unavailable	2	
Total	17	100%

Wyoming is the state with the fewest abortions in the country, representing 0% of the abortion in the US in 2008 (Kaiser 2008). The lack of access is extremely high: ninety six percent of counties in Wyoming had no abortion provider in 2008, and 96 percent of women lived in those counties. In 2008, there were 3 abortion providers in Wyoming; this represents a 50% increase from 2005, when there were 2 abortion providers (Guttmacher 2011). Despite reports of there being three abortion providers in Wyoming, there is only one that is known for performing abortions in the state, it is possible that the other two only provide abortion services for their current patients.

## Oklahoma

Figure 8

Type of Referral	Number (85 total)	Percentage
Abortion Clinic Referrals	32	41.6
Clinic & CPC referrals	1	1.3%
CPC referrals only	5	6.5
Refusals	28	36.4%
Information Referrals	7	9
Referrals to another Provider	2	2.6
Planned Parenthood (non provider) referrals	2	2.6
Unavailable	8	
Total	85	100%

48 percent of Title X grantees in Oklahoma referred to another provider, an information source or directly refused. Many of the refusals in Oklahoma were because clinic staff told me they could not give me the information over the phone, but that they had a reference sheet if I could come in to pick it up. They would leave it at the front desk as a resource sheet.



The large number of clinic staff that were adamant that they may have a policy in Oklahoma that only patients that come in get information on pregnancy options, which shows that there is confusion about what the policy is exactly regarding referrals. This lack of information is extremely problematic.

## Vermont

Figure 9

Type of Referral	Number	Percentage
Abortion Provider	4	100%
CPC referrals	0	0
Information referrals	0	0
Referrals to another provider	0	0
Direct Refusals	0	0
Unavailable	2	
Total	6	100%

I engaged with 4 grantees and three of them referred me to their call center, Planned Parenthood of Northern New England. I was connected to them and on each call they referred me to an abortion clinic. The other grantee referred me directly to an abortion provider.

Vermont was different than the other seven states that I called in that it has not passed any major kind of restrictions regarding abortion access. It is also different from the other states because all of the Title X grantees located in Vermont are Planned Parenthoods. These two factors contributed to the consistency of abortion referral practices. Planned Parenthood is well known as a resource for women's health, and when I engaged with the Vermont grantees I was able to receive information regarding abortion services upon request. The

consistency in referral practices suggests that Planned Parenthood has comprehensive referrals training.

## **Chapter Three: Comparative Analysis**

My expectation that the information I was requesting as a pregnant patient seeking abortion services would be granted to me by health professionals was not met. While I did receive referrals that were straight forward, I was more likely to receive a direct refusal, a referral to the Internet, or a referral to another health care provider.

The Title X clinics in all eight states varied in their responses when asked for an abortion referral. However there is a common theme that unites them all: Title X grantees are not consistently giving information regarding abortion services when directly asked. The failure of Title X grantees to refer upon request contradicts the Title X guideline in “Client Services” which states that:

“Projects funded under Title X must provide clinical informational, educational, social and referral services relating to family planning to clients who want such services” (HHS 2000)

Despite the misinformation surrounding Title X referral policy, the language of the guidelines is clear: pregnant women who request options counseling will be offered information on all pregnancy options; including adoption, carrying a pregnancy to term, and abortion unless they refuse information on a particular option (HHS 2000). An abortion referral must be provided upon request (HHS 2000).

Refusals, referrals to Crisis Pregnancy Centers and the inconsistency of Title X referral practices all pose a threat to access to information on abortion services. Although all eight states vary in degrees to which access to abortion

referrals were granted, refusals to give information regarding abortion were an issue in every state except Vermont. Although only a few states had an issue with Title X grantees referring to Crisis Pregnancy Centers, these referrals illustrate that there is a fundamental flaw in Title X training. Refusals and CPC referrals leave pregnant women without the information they requested on an abortion provider. The inconsistency in referral practices shows that there is a lack of clear policy on abortion referrals at Title X grantees and little to no information and training given.

**Direct referrals to Crisis Pregnancy Centers:**

Before starting this project I had never heard of a Crisis Pregnancy Center (CPC). Most CPCs advertise themselves as health centers that provide counseling for pregnant women. While CPC referrals were not in any case the most dominant referral I received from the Title X Clinics, the percentage of CPC referrals was significant. The fact that grantees are referring to CPCs when directly asked for information on abortion services is appalling. These referrals directly contradict Title X guidelines and undermine the pregnant patient as capable of making her own decisions.

CPCs are anti-choice organizations that aim to reduce the number of women that choose to terminate their pregnancies. For CPCs, the end justifies the means; they are willing to jeopardize the health and safety of pregnant women in order to achieve their goal. They are well funded, well organized, and expanding quickly; there are already around 4000 CPCs in the U.S (NARAL 2013). CPCs use manipulative tactics to get women into their clinics. They link abortion to

breast cancer, depression and suicide to scare women from accessing safe legal abortion (NARAL 2013). They use deceptive tactics in order to delay women from seeking abortion services hoping they will wait too long to go through with it, sometimes telling women they aren't pregnant when they are or promising "natural pregnancy termination" (NARAL 2013).

They treat the women as victims, and attempt to "save" them from the emotional and psychological harm they insist is an inevitable consequence of abortion. CPCs attempt to convince women that are undecided or considering abortion that they are doing something wrong; they do so by presenting them with false information and aim to inflict guilt and shame. The use of false information undermines the patient's ability to make her own decision. CPCs target low-income women by advertising with free pregnancy testing and ultra sound services (NARAL 2013).

In Kentucky I was referred to nearly twice as many Crisis Pregnancy Centers (CPCs) as abortion providers; nineteen percent of all Title X grantees referred to CPCs, while only ten percent of grantees referred to abortion providers. Other states had smaller percentages of CPC only referrals: 4 percent in West Virginia, 9 percent in Iowa and 6.5 percent in Oklahoma.

These CPCs not only present themselves as neutral, unbiased counselors, but they distribute false information about abortion. On their websites they list the three options that pregnant women can take: parenting, adoption, and abortion. However, the description of abortion is extremely biased - one site claims, "This

option will result in the death of your fetus;” and yet another says “Your pregnancy will end in death.” (Lifeshouse 2013)

Under abortion risks they list medically inaccurate information linking abortion to higher rates of breast cancer and risks of miscarriage for future pregnancies, clinical depression, Post Traumatic Stress Disorder (PTSD), suicide, eating disorders, and drug and alcohol abuse. They warn that if you choose to have an abortion, you will feel regretful, empty, and have trouble communicating with your partner. (Opportunities for Life 2013)

Many frame adoption as the alternative to abortion with the tagline “Each year more than 50,000 American women lovingly place their baby in an adoptive home. This decision is often made by women who first thought abortion was their only way out. Adoption can be a loving option for birth mother, baby, and adoptive family (Cumberland CPC 2013) ” The message is clear: abortion is not an option, or at least not a loving option.

Some CPCs even have testimonials from women that were once considering abortion, but decided to raise the babies themselves and attest to how happy they are that they carried their pregnancies to term. There is nothing wrong with what these women decided about their pregnancies, but their stories present parenting as the best and the only right option. These fear tactics are psychologically and emotionally intimidating for women considering abortion; and they have a clear-cut motivation: to reduce the number of pregnant women that choose to have an abortion. CPCs operate under a biased vision that does not consider the patient’s interest, directly contrasting with what options counseling is meant to provide -

information on each option that leaves room for the pregnant woman to make her own decision. (Assurance for Life 2013)

**CPC referrals**

**Figure 10**

State	Percentage of CPC referrals
West Virginia	4%
Kentucky	19%
Iowa	9%
Maine	0%
Oklahoma	6.5%
North Dakota	0%
Wyoming	0%
Vermont	0%

CPC follow up calls:

In Kentucky and West Virginia I did a follow up call to clinics that referred me to a CPC. In my follow-up call I told the clinic staff that I had been referred to a crisis pregnancy center and that they had tried to talk me out of my decision. I was calling to find an abortion clinic. And I asked again: Do you know where the closest abortion clinic is?

In West Virginia there were 7 CPC referrals. ON my CPC follow-up calls 43% of those clinics referred to a CPC again, 28% referred to an abortion clinic, 14% refused and 14% referred to the phonebook or internet on round two.

In Kentucky there were 38 CPC referrals in round one. On my follow up calls 15 or 40 percent of them referred me to the phonebook or Internet. 18 percent referred to an abortion clinic, 16 percent directly refused, 13 percent referred to another provider, 5 percent referred to a CPC and a clinic, 5% referred to Planned Parenthood (a non provider in Kentucky) and 3%(one) referred to a CPC again.

The results from my CPC follow up calls demonstrate the inconsistency in referrals between the same clinic. Below is a chart of my results from the CPC follow-up calls made to Kentucky Title X clinics. Even though all of these clinics referred to a Crisis Pregnancy Center when I first called, the responses varied greatly when I called back. Still, only 18 percent of these grantees gave me the abortion referral I was seeking.

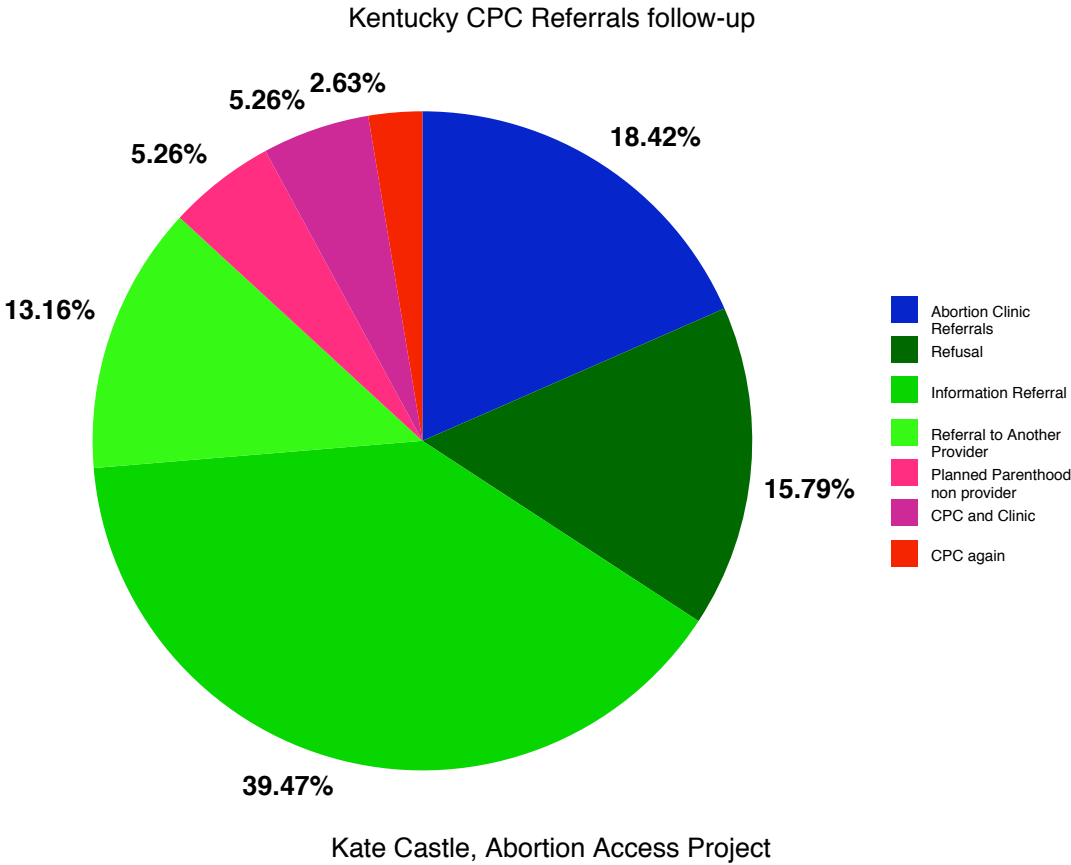


Figure 11

Kentucky had the lowest percentage of referrals to abortion providers in comparison with the other states. In my first round of phone calls I received only seventeen referrals for the abortion services that I requested, amounting to ten percent of responses in the state. 32 of the Kentucky grantees referred me to



Crisis Pregnancy Centers, or nineteen percent, nearly twice the number of Title X grantees that referred to abortion providers.

Kentucky has a large number of restrictions limiting access to abortion including a parental consent law, a 24-hour waiting period and required state directed counseling. Because abortion services in Kentucky have become isolated from other health care services through state legislation, it is likely that clinic employees feel uncomfortable, or even fear they are doing something wrong by giving out information regarding abortion.

In addition to the stigmatization of abortion services, the discrepancy in responses between rounds one and two indicate that the majority of clinics fail to train their employees on how to give an accurate and detailed abortion referrals. This lack of information and training regarding Title X guidelines allows for whoever answers the phone to determine whether or not the pregnant patient will receive the medical information she is seeking.

The difference between rounds one and two indicates that there was a large decrease in the number of CPC referrals given in round two, from 32 to 11. However, the decrease in CPC referrals is in large part due to the research method I used in round two. When a grantee referred to a CPC in round one, I called back and told the staff that they had referred me to a practice that had tried to talk me out of my decision and that I was looking for an abortion clinic. I asked them again where I could find the nearest abortion provider. 68 percent of these grantees gave me an information referral, referred me to another provider or directly refused to provide me with that information. 7, or about 18 percent of

these grantees gave me the information I was looking for and only one grantee referred me only to a CPC again. What's interesting to note is that while only one of the grantees that had previously referred to a CPC in round one referred to a CPC a second time, there were ten additional referrals to CPCs in Round two given by grantees that had not referred to a CPC in round one.

While by no means were the majority of referrals I received to CPCs, the fact that as a "pregnant woman" asking government funded clinics for information on abortion I was sent to Crisis Pregnancy Centers, anti-choice organizations specifically designed to attempt to manipulate my decision, demonstrates a fundamental flaw in the system. By referring to CPCs, these agencies are not only violating Title X guidelines by denying medical information, they may be construed to be overtly supporting an anti-choice political agenda, which undermines their public and professional role as a trusted provider of the medical care and information to which their patients are entitled.

Title X grantees, as government funded clinics, referring to Crisis Pregnancy Centers is problematic because they directly contradict the referral guidelines and the mission of Title X. If someone directly requests a referral for a specific service a direct referral should be given. Not only is it common practice for a provider that does not perform a certain procedure to refer to a facility that does provide that procedure; it is spelled out in the Title X guidelines. A direct referral avoids pregnant women becoming reliant on another source to get that information.

Crisis Pregnancy Centers directly contradict the idea of women's health.

They treat women as if they are incapable of making an informed decision on their own, and see them as a vessel for an unborn life. Their interest is in “protecting” the fetus. They are not concerned with the pregnant woman or her health. If they were, they would be providing all options counseling and referrals to abortion providers when requested.

Title X was designed to be a program for women’s health. It is understood that Title X funding does not go towards abortion, but abortion referrals are not intended to encourage or advocate for abortion; they are informational. Any person that needs medical information should be given it. Why would it be any different when it comes to referring for abortion services? Accurate information about all options is necessary for making an informed decision. By referring to CPCs, these grantees denied me accurate information, and left me vulnerable to an anti-choice organization.

The deceptive practices of many CPCs are well understood by members of the reproductive health community, but may be less known to women, or even to the agency staff referring to them. This points to another problem: lack of adequate training. It is possible that many of the staff that referred to CPCs were unaware of their intentions. If there were more comprehensive training regarding abortion referrals, staff would be informed of the deceptive tactics used by Crisis Pregnancy Centers and the threat they pose to pregnant patients that are undecided or seeking abortion services.

### **Refusals**

While CPC referrals are a problem, and certainly significant, the large number of Title X grantees that denied information regarding abortion services

persists in every state, with the exception of Vermont. The majority of Title X clinics in West Virginia, Kentucky, Oklahoma and North Dakota were not able or refused to give me information on where I could find an abortion clinic. Wyoming followed close behind with 46.6 percent refusals.

The number of Title X grantees that refused to refer for abortion services did so directly or by referring to another provider or an information source. When clinic staff directly refused they usually told me that they didn't know, they didn't do "that" (provide abortion services) there, they aren't allowed to give out information about abortion, or they would try to get me to come into their clinic claiming that in order to get that information I would need to speak to a nurse or counselor.

In Oklahoma, many of the "direct refusals" referred to when a clinic staff told me that they had the information and resources on a prepared sheet but that I had to pick it up in person because they weren't allowed to give out that information when it was over the phone.

When referring to another provider, many clinic staff referred to health centers, Planned Parenthood, or local gynecologists. However, referring to another provider did not guarantee that I would be able to get a referral. In many cases this meant that I would need to repeat my story and undergo a similar process only to end up with an information referral.

Information referrals were those that directed me towards a phone book, 411, Google or the Internet in general. Information referrals taken on face value don't seem to be harmful. However with a growing amount of hostility towards

abortion services reliable unbiased information on abortion becomes more difficult to find. Information referrals leave it to women to find an abortion provider. Again, CPC websites are deceptive and can easily be mistaken for clinics or a counseling center with medical information.

Information sources like the phonebook cannot always be trusted either. Louisville, Kentucky's new phonebook lists only abortion alternatives in the area; it fails to include the one abortion clinic in Louisville, the only full time abortion provider in the state.

The number of refusals, or referrals to information which are overwhelmingly the majority of Title X clinic responses, will most likely lead to searching the Internet or the phone book. This is problematic because finding accurate information about abortion and abortion clinics on the Internet is very difficult for people that are unaware of how CPCs frame themselves as counseling centers. They are often located in small towns and advertize free pregnancy tests and ultrasounds, making them appealing to young or low-income women (NARAL 2013), and they usually come up in the top three results of a Google search for abortion clinics.

While refusals, information referrals or referrals to another provider are not as harmful as CPC referrals, they leave pregnant women on their own and many of them will have to turn to the internet or phone book. It is difficult to find information for legitimate abortion clinics online, and very easy to mistake a CPC for an abortion provider or counseling center that could refer to one. CPCs advertise themselves as "abortion providers", "abortion alternatives", "family

planning information centers” or “women’s organizations” (NARAL 2013). There are now over 4000 CPCs in the U.S., and only 724 abortion clinics (Daily Beast 2013).

Regardless of whether I am being referred directly to a CPC or being forced to turn to Google to find an abortion clinic, I am much more likely to end up at the mercy of a CPC that I would be if the title X clinic had given me the information I requested.

**Figure 12**

<b>State</b>	<b>Direct Refusals (% of total)</b>	<b>Referrals to another provider (%)</b>	<b>Referrals to an information source (%)</b>	<b>Total: Refusal of information (%)</b>
West Virginia	24%	21%	11%	56%
Kentucky	21%	16%	24%	61%
Iowa	9%	5%	9%	23%
Maine	14%	4%	7%	25%
Oklahoma	36.4%	5.2%	9%	50.6%
North Dakota	27.3%	9%	18%	54.3%
Wyoming	13.3%	20%	13.3%	46.6%
Vermont	0%	0%	0%	0%

The overwhelming numbers of refusals in these states illustrate that there is a clear disconnect between the Title X guidelines policy on referrals and the reality of what is actually going on. In West Virginia, 56% of clinics directly refused, gave me an information referral or a referral to another provider. In Kentucky, that number was 61 percent. When you include CPCs in that number Kentucky had 90 percent refusals; just over half of North Dakota and Oklahoma’s responses were refusals; and just under 50 percent in Wyoming. In Maine and Iowa these percentages were much lower but still significant with 25 percent

refusals in Maine and 23 percent in Iowa. Vermont's title X clinics were all Planned Parenthoods. All of those that I engaged with referred me to their scheduling line (Planned Parenthood of Northern New England).

Refusals are problematic because they leave pregnant women without adequate medical information. Title X grantees that refused to refer denied me medical information that Title X guidelines entitles me to and does so on the basis that abortion is different from any other medical procedure that a medical provider would refer for. This serves to further isolate abortion from mainstream medicine and stigmatize it.

While the referrals received in Maine were better than the other states, there were still twenty five percent of Title X grantees that referred to an information source, another provider or directly refused. Many of the information referrals given in Maine were to the phonebook or "411". While this number may seem low in comparison to the results of the other states, it is reflective of the lack of referrals training.

This discrepancy can be attributed to a lack of a clear clinic policy and referrals training. It was common for me to receive two very different responses from different employees from the same Title X grantee. The referral was largely dependent upon who answered the phone.

A receptionist at a clinic in Maine told me "We don't support that option here". I called back and asked her again she told me "we do not participate in that option". I said but this is a family planning clinic right? She said yes but not an abortion clinic. I asked again if she knew where the closest abortion clinic was

and she said “we do not.” However, when I called that same clinic back a couple of weeks later I asked to be directed to family planning and was given the referral that I asked for right away.

The abortion referral practices in Maine have the power to teach us an important lesson: that even when abortion services are more legally accessible, information and adequate training surrounding abortion referrals is necessary.

### **Inconsistency of referrals**

The one trend that persists between the states’ Title X abortion referrals, is inconsistency. Inconsistent referral practices are illustrated between and within the states. Refusals and CPC referrals were not random or marginal results. The wide discrepancy between states shows that each state has unique factors that influence referral practice. But even in the states that had more referrals to abortion providers upon request, like Maine, I still had refusals. The fact that the only state with consistent referral practices was Vermont, due to the fact that all of their grantees are Planned Parenthood affiliates, demonstrates the need for referrals training.

These inconsistent referral practices are reflective of a lack of referrals training and misinformation given during training. The inconsistent referral practices demonstrate that there is confusion regarding referral policy, leaving the staff without adequate information or with misinformation to give a referral. When clinic staff is uninformed or misinformed on abortion referral practices they are more likely to refuse information on abortion services or refer to a Crisis Pregnancy Center.



Lack of information regarding abortion referral practices allows for individual clinic staff members to determine whether or not pregnant women will have access to accurate information on abortion providers. It allows for clinic staff to ask personal questions to determine whether or not pregnant women are worthy of medical information. Lack of information and training on abortion referrals also means that abortion stigma will likely influence the staff member's referral; clinic staff that aren't trained to give referrals will likely feel they are doing something wrong by referring for abortion services.

Some Title X grantees indicated that they had referral policies regarding abortion referrals policies that didn't involve referring to providers. These policies were either to refer to CPCs or adherence to an outdated gag rule when clinic staff refused to give information on abortion. Both CPC referrals and refusals can be attributed to Title X staff being uninformed or misinformed regarding abortion referral practices.

When Title X clinic staff are uninformed of the danger that CPCs present to women's health they may see CPCs as a resource they can refer pregnant women. If clinic staff lacked training or information on where to refer, they are more likely to bring in their personal opinions on abortion and refer to CPCs. Through my CPC follow up calls I found that some clinic staff were unaware of the practices of CPCs, while other staff intentionally referred to CPCs because they aligned with their personal opinions on abortion.

On my CPC follow up calls some clinic staff apologized when I expressed that the CPC had tried to talk me out of my decision and admitted that they thought that the CPC could give me information on abortion.

CPC follow up call—Spoke to a nurse, she told me that she usually give out the number to a local doctor, and ob/gyn or Hope Pregnancy Center. I told her that I had talked to her a couple of weeks ago and said that when I called the pregnancy center they tried to convince me not to get an abortion and **she said she was sorry she didn't know they would do that.** She said that the doctor she referred me to should be able to help me and not be biased. She said if not to call back again and she'd try to get another number for me.

Many title X clinics **that referred to a CPC told me on the follow up call that the CPC is the only place that they refer to.** Staffers told me that the CPC was where they “usually” or “always” refer.

(Hope pregnancy center) **I think that's the only place we refer to** but offered to have me talk to a nurse. I talked to the nurse and she said they don't have a list of places or anything. She asked me if I had internet access and I said no. She said that maybe I could go to the public library

One clinic staff member admitted that they usually refer to “life house” after a patient gets a pregnancy test

There were 3 state health departments in the same area of Kentucky that referred to the local CPC. They all had the number ready right away and told me that was where they directed all “abortion questions”. One receptionist did not even know the name of the facility she was referring me to when I asked her she told me that she wasn't sure “all I have here is abortions questions”. The fact that this set of clinics referred to a CPC right away, and clearly had the number listed right near the phone indicates there is a real problem with referrals training.

On CPC follow up calls I made I told the grantees that they had referred me to a CPC the last time that I had called and that they had tried to change my decision, that I was looking for an abortion provider. Many of the Title X staff

that had originally referred to a CPC didn't know where else to refer me or refused to give me information when I called back, and told me I would have to check the phone book. They usually said that the CPC is the only place they refer, or that they didn't know the CPC would try to change my mind, or did not comment.

### **Refusal Policies**

In West Virginia county health departments claimed that they could not give out that information because they receive Title X funding, which is in complete contradiction to the guidelines. The fact that employees believe they are not allowed to give out information regarding abortion services suggests that there is confusion about Title X referral guidelines.

Many of the direct refusals in Oklahoma were because of the large number of clinic staff that was adamant that they had a policy that patients must come in to get information on pregnancy options. The staff at multiple grantees told me they could not give me the information over the phone, but that they had a reference sheet if I could come in to pick it up they would leave it at the front desk. Again, this shows that there is confusion about what the policy is exactly regarding referrals.

The wide range of responses to a simple question indicates that Title X grantees may not be training their staff to give abortion referrals upon request. No training means that staff lacks the information about a medical procedure that is integral to their work as women's health providers. When there is not adequate training, the information that patients receive will be dependent upon who answers the phone. It also allows for speculation and questioning of the pregnant

woman.

### **Examples from my call logs:**

She asked if I had income I said not really. She asked me if my parents knew, I said no, she scuffed and said “bless your heart” and that abortions are expensive. She asked me if my boyfriend knew I said yes, and asked if he agreed with the abortion and I said yes, but we were still thinking about it. She told me I should think long and hard about it because it's a big decision

Nurse told me that she has seen many women who have made the rash decision to get an abortion and feel emptiness and so much regret after. She suggested that I think about adoption because so many people want kids that can't have them and it is so much better than abortion because its all about love. She told me I could have an open adoption and still see the baby from time to time. I told her I didn't think I could afford the medical bills, and she told me not to worry about it, if I came in and got a pregnancy test I could get a medical card that would pay for everything. She tried to have me schedule an appointment even though I said that I would need to get a ride, so I had to hang up.

Clinic staff felt entitled to bring in their personal opinions regarding abortion. I was told that abortion was murder, prayed for and warned of regret and guilt.

### **I was Prayed for by a nurse:**

Told me she would rather give me the number to pregnancy resource center that is open 24 hours than to an abortion provider. She said they had trained counselors that would make sure I wouldn't make a decision I would regret. She told me that because I'm only 19, state insurance will cover the pregnancy and all the appointments and care. She said that through WIC I could get free formula. She asked me if I minded if I said a prayer before we got off the phone, I said no and she prayed for me, my boyfriend and the health of the unborn child. These are some of the phrases I got down: give her guidance courage they need he pray for unborn child, that its healthy. She said I could call back or come see her anytime.

“I certainly hope you wouldn't do that. but if you have to..”

One receptionist told me that she considered it murder, but that she didn't want to talk me out of it.

Receptionist asked me if its really what I wanted to do. She asked me how old I was and I said 19. She told me she had her first at 21, I thought she meant abortion but she was talking about her daughter. She told me her baby weighed

5.3 oz—and how tiny she was. She asked me if my boyfriend was pressuring me to do it and I said no, I think he will be ok with whatever I decide. She said that her boyfriend wanted her to get an abortion but she was totally against them. She thought that by 10 weeks they had a heart and brain, hands and feet and she considered it murder. She said that her parents help her take care of her. She said she didn't want to talk me out of it, and to think about what I really wanted and not what my boyfriend wanted. She told me if I needed someone to talk about it she would be happy to talk to me about it.. Then she told me she would pray for me.

**“I’m probably not supposed to be saying this but I hope you don’t do it, you’ll regret it the rest of your life.”**

I spent my summer waiting. Holding on by a thread of hope that the clinic staff member I was speaking to would know where the closest abortion clinic was. Hoping they would understand me, or my situation. Hoping that I would answer their questions correctly so they felt I was “worthy” of the information.

It shouldn't be this difficult. Pregnant women shouldn't have to feel guilty or ashamed to ask for information, and when they do ask for it, it should be readily available. The information I am able to receive should not be dependent upon the beliefs that the clinic staff member has about abortion. I should be given the information simply because I requested it and because I'm entitled to it under the Title X guidelines.

This personal information is irrelevant to whether or not a woman should be able to obtain a referral. The lack of training puts pregnant women seeking medical information on abortion at the mercy of individual clinic staff members.

Refusals and CPC referrals leave pregnant women seeking abortion services without information or with misinformation. Title X clinics are dedicated solely to serving women's health care needs but in order to honor women's health care abortion cannot be isolated and treated as a special procedure for it is a

fundamental component of Women's health. If the grantee does not offer abortion services, and very few do, then referring to an abortion provider is critical to offer the full range of pregnancy options.

When clinic staff is left in doubt, so are their patients. In order to follow Title X guidelines and give comprehensive abortion referrals upon request, training is necessary. It has the power to inform staff about CPCs and what they do as well as the importance of their referral and their role in providing information on the full range of Women's health care services and pregnancy options.

## **Chapter Four: The Impact of State Legislation on**

### **Abortion Access**

Ever since the Supreme Court decision of Casey v. Planned Parenthood, when the court ruled that states could place limitations on second trimester abortions, state restrictions have become commonplace. This restrictive state legislation typically comes in the form of parental notification or consent laws, waiting periods, mandatory state directed counseling and the newest tactic of banning of telemedicine for the use of medical abortion.

In this section I will compare the results of my Title X clinic calls to the state legislation. I ranked the eight states in respect to restrictive state legislation passed regulating abortion access. These rankings took into account laws that directly limited access through legislation. I will assess the extent to which restrictive state legislation impacts abortion access and abortion referral practices at Title X clinics.

Figure 13

State	Parental consent or notification required for minors	Ban on Telemedicine abortion	Waiting Periods	Mandatory Counseling
Oklahoma	Consent	Yes	Yes, 24 hours	Yes
North Dakota	Consent	Yes	Yes, 24 hours	Yes
West Virginia	Notification	No	Yes, 24 hours	Yes
Kentucky	Consent	No	Yes, 24 hours	Yes
Wyoming	Consent	No	No	No

Iowa	Notification	No	No	Yes
Vermont	No	No	No	No
Maine	No	No	No	No

Parental notification laws require that a pregnant woman, if under the age of 18, notify her parent(s) or legal guardian(s) that she is having an abortion.

Parental consent laws require that minors gain their parent or guardians approval before obtaining an abortion. However, if a parent does not consent to the minor having an abortion, the minor has to get a judicial bypass, a very slow and drawn out process, making it less likely that the minor will be able to obtain an abortion because of time restrictions or increase in cost. These laws allow parents and judges to determine whether or not a minor will have access to an abortion. These restrictions come at a time when sex education is severely limited and many teenagers never receive adequate information about contraceptives and sex. If we aren't preparing minors to have safe sex, how can we expect them not to get pregnant? Minors are capable of making difficult decisions, and if they decide abortion is the best option for them, the minor's parents or the state should not be able to challenge that decision. No one should be forced to carry a pregnancy to term against her will simply because she is young.

Mandatory counseling is typically designed in order to provide women with information that will persuade them away from having an abortion. Many states give women false information regarding abortion: whether warning it is a dangerous procedure, that it could put them at a higher risk of breast cancer, depression or suicide.



Virginia mandates that women have an ultrasound before obtaining an abortion. The state health department listed only Crisis Pregnancy Centers on their website as health centers where women seeking abortion services could go to have an ultrasound free of charge (Bahr 2012).

South Dakota passed a law that requires doctors to warn of a suicide risk during mandatory counseling, and the court upheld it in July 2012 (Bassett 2012). There is no evidence that shows abortion causes mental health problems or a greater risk of suicide (John Hopkins Review 2008).

In contrast, a recent study found that women that wanted an abortion but were forced to carry their pregnancies to term felt more anxiety after being turned away. 90 percent of women that had abortions felt relieved after the procedure, often accompanied by feelings of guilt but not clinical depression. A year after their abortion or attempted abortion the two groups of women showed no significant differences in mental health. The study found that “turnaways” were more likely to be in poverty and exposed to domestic violence in their relationships and therefore had higher levels of stress and anxiety (ANSIRH). However these emotional responses indicate that abortion does not have any causal relationship with clinical depression (ANSIRH).

This biased and blatantly false information that is administered by the state is designed to inflict guilt in pregnant women seeking abortion, and by doing so, manipulate the decision they make about their bodies. The decision to have an abortion is already an extremely difficult one, and by requiring biased counseling, the state is pursuing an anti-choice agenda.

Not only does this counseling manipulate feelings and inflict guilt, but it also it treats women as if they are incapable of making decisions about their own bodies. It thereby reinforces the idea that women are objects to be regulated. If women are truly free subjects in the United States, then why are we constantly questioned scrutinized and subjected to regulation of what we wish to do with our lives and our bodies? Mandatory counseling is a tool used to manipulate and control; it perpetuates inequality and normalizes the policing of women's bodies.

Waiting periods have been passed in 35 states as of March 2013 (Guttmacher 2013). Waiting periods usually last 24 hours and restrict access in a multitude of ways. On a basic level they are restrictive because they mandate that women wait longer and think about their decision more than they already have. This is problematic because it assumes that pregnant woman seeking abortion services have not already thought through their decision; it assumes that women need the state to ensure that they are considering all options, and again treats women as incapable of rational decision making.

Waiting periods not only institutionalize the sexist notion that women are incapable of making their own decisions, but also disproportionately impact low-income women and women living in rural areas. As abortion providers decrease, many women have to travel farther and farther away to access this basic health care procedure. Ten states require in person counseling and a 24-hour waiting period (Guttmacher 2013). In practicality this means that if a pregnant woman is traveling a long distance to obtain an abortion, she will have to save enough money to pay for a hotel room in addition to securing transportation and the cost

of the procedure. This is no small cost for low-income women that are most likely struggling to come up with the means to obtain an abortion and get to the clinic; the cost of staying overnight at a hotel could mean waiting another two weeks for her next paycheck or having to miss work to stay overnight. Women that already have children also need to arrange for child care while they are away. Waiting periods are a detrimental threat to access.

Parental notification/consent laws, State mandated counseling and waiting periods have become commonplace restrictions and state legislation continues to get more and more extreme. Many of these laws used to fail in the state house or senate, but are now passing with larger margins. As restrictive laws regulating abortion become normalized, more extreme laws are being introduced that threaten to challenge *Roe v. Wade*.

### **ND and Oklahoma: Extremely Restrictive**

North Dakota and Oklahoma have some of the most restrictive laws surrounding abortion including a parental consent law, a 24-hour waiting period, a ban on telemedicine abortion and required state directed counseling that includes information designed to discourage her from obtaining an abortion (Guttmacher 2013).

If *Roe v. Wade* were ever to be overturned, abortion would be banned in North Dakota (Guttmacher 2013). North Dakota has some of the most conservative laws regarding abortion and their legislature is considering six extreme bills this session. In March 2013 North Dakota's legislature passed

legislation that will make it illegal to obtain an abortion after 6 weeks, or as soon as a heartbeat is detected (Kathryn Smith 2013). The only exception is if the life of the mother is in danger (Kathryn Smith 2013). The passage of this bill came just after Arkansas' 12-week ban on abortion, which is already threatening to challenge Roe (Kathryn Smith 2013).

The other bills the legislature is considering include a personhood initiative and a law requiring abortion doctors to be Ob-Gyns with "hospital admitting privileges" (Nick Smith 2013). This could cause the one clinic left in Fargo, The Red River Women's Clinic, to shut down because abortion providers will not be able to practice without these privileges and local hospitals are refusing to approve them.

North Dakota's house and senate passed a personhood initiative intending to challenge Roe v. Wade by amending the constitution to grant legal rights to human embryos (Inforum 2013). North Dakota voters will decide on adding it to the constitution during the 2014 elections (Inforum 2013).

Oklahoma, like North Dakota, has extremely strict laws on abortion. While North Dakota's legislature has threatened extreme measures to regulate abortion and threaten Roe, Oklahoma has taken a different approach. Oklahoma's recent laws have threatened abortion access and women's health care access more generally through financial means.

In the fall of 2012, Oklahoma ended their contract with Planned Parenthood as a provider of Women, infants and Children (WIC) program (Farber 2012). The WIC program provides low-income women who are pregnant, have

recently given birth, or have children under 5 with food vouchers to help offset some of the costs (Farber 2012).

Because Planned Parenthood does not provide abortion services at any of their locations in Oklahoma, they are largely dependent upon WIC funding as a source of revenue. The end of this 18 year contract means that three of the four Planned Parenthood clinics in the Tulsa area will be forced to shut down, which leaves nearly 20 percent of WIC participants in the Tulsa area unable to access the resources that WIC provides them (Cusp-Ressler 2012).

One WIC participant, Tiffany Rosales, tried calling other local clinics after she found out about Planned Parenthood closing and found out that the wait for an appointment at one of these clinics was 3-4 months (Cusp-Ressler 2012).

In addition to loss of access to programs like WIC, Planned Parenthood closing means the loss of access to basic women’s health services and information for low-income women that depend on those resources.

Percentage of referrals

Type of Referral	North Dakota	Oklahoma
Abortion Clinic Referrals	45.4%	41.6%
Clinic & CPC referrals	0%	1.3%
CPC referrals only	0%	6.5%
Direct Refusals	27.3%	36.4%
Information Referrals	18%	9%
Referrals to another Provider	9%	2.6%
Planned Parenthood (non provider) referrals	0%	2.6%
Unavailable	3	8

North Dakota and Oklahoma Title X grantee referrals had similar referral practices. The number of referrals to an abortion provider was under 50 percent in both states: 41.6 percent in Oklahoma and 45.4 percent in North Dakota.

One difference was the number of CPC referrals: Oklahoma had 6.5 percent of Title X grantees refer to CPCs, while North Dakota didn't have any. The Northwestern states did not seem to have a problem with CPCs.

Refusals:	ND	OK
Direct Refusals	27.3%	36.4%
Information Referrals	18%	9%
Referrals to another Provider	9%	2.6%

The majority of North Dakota's Title X grantees refused to give the information I requested as a pregnant patient by either directly refusing or referring to another provider or information source. (54%) In Oklahoma 48 percent refused directly, gave an information referral or referred to another provider; that number jumps to 58.4 percent if you include CPC referrals and referrals to Planned Parenthood non-providers.

The extreme legislation for women seeking abortion care in North Dakota and Oklahoma is growing. The fact that over half of all clinic staff at Title X grantees directly refused to give me the information I requested is an indication that restrictive legislation may have a significant impact on abortion referral practices. When abortion is highly stigmatized, through isolation and restrictive legislation, it is likely to cause silence around abortion services. The reason many

clinic staff may deny this information is out of fear that they are doing something wrong or jeopardizing their jobs.

Restrictive legislation and conservative religious and cultural norms produce a stigma around abortion services. Religion plays a significant role in influencing attitudes towards abortion, sex education and sexual health. These expectations and values often have an impact on the passage of conservative legislation but also shape the cultural attitude toward sexual health and abortion. If the culture is generally resistant to sex education, most people will be less willing to discuss abortion. This includes Title X workers, especially if they have not received referrals training.

North Dakota and Oklahoma both have a large religious population. 70.6 percent of North Dakotans identify as either very or moderately religious (Newport 2013). Oklahoma has a slightly higher religious population with 78% identifying as very or moderately religious (Newport 2013). Oklahoma's rate of 48 percent extremely religious population, compared to North Dakota's 42 percent, could account for the difference in CPC referrals.

North Dakotan and Oklahoman women already face a multitude of policies limiting their access to abortion services, yet the majority of Title X clinics refused to give information regarding abortion services upon request. Title X clinics are a critical resource for reproductive health services and information, especially for low-income women. If Title X grantees will not provide pregnant women with basic health care information, who will? The denial of this information leaves pregnant women seeking abortion services on their own.

## Moderately restrictive: WV and KY

Kentucky and West Virginia both have moderately restrictive policies regarding access to abortion services in relation to the other states. West Virginia has a parental notification law, a 24-hour waiting period and mandatory counseling (Guttmacher 2013). Kentucky's only deviation from West Virginia's legislation is that it requires parental consent rather than notification (Guttmacher 2013).

West Virginia and Kentucky both have high poverty rates as well as large religious populations. The poverty rate in rural West Virginia is extremely high at 20.2 percent; Kentucky's rural poverty rate is slightly higher at 22.9 percent (U.S. Census 2010), nearly seven percentage points higher than the 16% poverty rate in urban areas of Kentucky.

Although Kentucky and West Virginia have similar legislation regarding abortion, the results of my phone calls in the two states were very different. I think the large discrepancy in abortion referrals can be attributed to the incorporation of abortion services to Medicaid; West Virginia does not ban Medicaid from funding abortion.

Figure 14

Type of Referral	West Virginia	Kentucky
Abortion Provider	37%	10%
Provider and Planned Parenthood non provider referrals	0	2%
Provider and CPC referrals	.7%	4%
CPC referrals	4%	19%



CPC and Planned Parenthood non provider referrals	0	2%
Direct Refusals	24%	21%
Information referrals	11%	24%
Referrals to another Provider	21%	16%
Planned parenthood (non provider) referrals	.7%	2%
Wrong number	.7%	0

Kentucky had the lowest percentage of referrals to abortion providers in comparison with the other states. Only 17 grantees of the 169 I engaged with gave me the referral to an abortion provider that I requested, amounting to ten percent of responses in the state. 32 of the Kentucky grantees referred me to Crisis Pregnancy Centers, or nineteen percent, nearly twice the number of Title X grantees that referred to abortion providers.

37 percent of West Virginia’s Title X clinics gave referrals to abortion providers upon request. While that number may seem insignificant, and the state as a whole has a long way to go before meeting Title X guideline requirement of referring for abortion services upon request; in comparison to neighboring Kentucky, West Virginia’s Title X clinics had a relatively high number of Title X clinics that referred for abortion services.

In large part these results can be attributed to the fact that in West Virginia, Medicaid funding is available to fund abortion. Therefore, health providers generally have a more accepting attitude towards abortion services. They treat it as any other medical procedure. Due to the high poverty rates in West Virginia, Medicaid covers a large percentage of the population. Medicaid coverage is less stigmatized when more people use it, and because abortion

services aren't excluded from coverage abortion is not as stigmatized as we may expect it to be in a southern state. I think that the incorporation of abortion services under Medicaid funding played a large role in the referrals I got from Title X clinics in West Virginia.

There are other factors that point to West Virginia as a more progressive state in terms of abortion access: 11.8 percent of abortions performed in West Virginia were for out of state residents (Kaiser 2008). West Virginia is a southern state, and many of the surrounding states have very restrictive laws regarding abortion access. Because of the restrictive laws in nearby states, West Virginia is a desirable destination for pregnant women seeking abortion services in the South.

Although West Virginia is a Southern State and religion has a strong influence over West Virginian culture, only 4 percent of grantees referred to Crisis Pregnancy Centers (CPCs). Again, this is most likely due to the fact that abortion is not excluded from Medicaid funding.

Kentucky had the highest rate of CPC referrals of all eight states: 19 percent of all grantees referred to a CPC. This figure is disturbing as it depicts the heavy influence that religion has in the South, but also what happens when there is not comprehensive referrals training.

Because abortion services in Kentucky have become isolated from other health care services through state legislation, and even further by religion and southern culture, it is likely that employees feel uncomfortable, or even fear they are doing something wrong or putting their job in jeopardy by giving out information regarding abortion.

The majority of responses in both West Virginia and Kentucky were refusals. 56 percent of West Virginia's Title X clinics gave information referrals, referrals to other providers or direct refusals. All of these clinics refused to give the medical information I requested. In Kentucky 63 percent refused directly, referred to an information source or another provider; 86% if you include CPC referrals and Planned Parenthood non-providers.

These numbers are extremely problematic. The high poverty rates in West Virginia and Kentucky mean that many low-income women depend on Title X grantees for information regarding their health care, including abortion services. If Title X grantees cannot provide that information for them they are left on their own to find it. Women looking for abortion services online or in the phone book could easily end up at a Crisis Pregnancy Center, especially in states like West Virginia or Kentucky. Louisville's new phone book does not even list the one abortion provider in the state, yet provides five phone numbers under "Abortion Alternatives" (Nash 2012).

While West Virginia and Kentucky had very different results, with a discrepancy of 27 percent they both still have a long way to go to meet the Title X guidelines on referrals. The large majority of responses from Title grantees in both states were some type of refusal.

Kentucky and West Virginia had lower referral rates to abortion providers than the most restrictive states, Oklahoma and North Dakota. Much of this is due to the fact that West Virginia and Kentucky are southern states. The South tends

to be more religious. 75.4 percent of Kentucky residents identify as moderately or very religious; 74.9 percent in West Virginia (Newport 2013), similar rates to Oklahoma and North Dakota.

However, the South is not just heavily religious, it is where Christian evangelicalism is most popular. This is where the “Pro-Life” movement took root. 45.4 percent of Kentuckians are very religious, compared to West Virginia’s 42 percent (Gallup poll). This also could have had an impact on the number of CPC referrals, although it doesn’t account for the large gap.

West Virginia’s health insurance system corrects for the differences slightly but does not make up for it. Religion has a huge influence on Southern culture. A combination of both restrictive policies and extremely religious populations influence the high number of refusals.

### **Wyoming and Iowa --Some restrictions**

Wyoming and Iowa have relatively less restrictive policies on abortion. Wyoming’s only law is a parental consent law. Iowa has a parental notification law and requires counseling. However Iowa’s counseling is different than the other states in that it does not include information designed to discourage a woman from obtaining an abortion. These restrictions are different but comparable; Wyoming’s parental consent law is more extreme than Iowa’s notification law but Iowa requires counseling while Wyoming doesn’t (Guttmacher 2013).

Figure 15

Type of Referral	Iowa	Wyoming
Abortion Provider Referral	64%	53.3%
Provider and CPC referrals	5%	0
CPC referrals	9%	0
Direct refusals	9%	13.3%
Information referrals	9%	13.3%
Referrals to another Provider	5%	20%

Wyoming and Iowa had similar results as well. In both states the majority of grantees referred to an abortion provider. Iowa had a higher percentage of grantees that referred to an abortion provider at 64 percent. I think this could be attributed to the fact that there is only one abortion clinic in Wyoming, and it is the state with the lowest number of abortions performed per year. In contrast, Iowa has 4 abortion clinics.

Wyoming didn't have any CPC referrals while Iowa had 9 percent of grantees refer to CPCs. While this CPC referral rate is lower than Kentucky's it is still significant.

**Maine and Vermont:** No legal restrictions

Maine and Vermont have the least restrictive policies regarding access to abortion services. They also had the highest rates of referrals to abortion providers upon request.

Figure 16

Type of referral	Maine	Vermont
Abortion Provider Referrals	75%	100%
Direct Refusals	14%	0%
Information Referrals	7%	0%

Referrals to another Provider	4%	0%
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The higher number of abortion referrals could be attributed to a few different factors. These responses could be due to the more liberal climate of the Northeast; the culture of Vermont and Maine and the surrounding area decreases, to some degree, the stigma of abortion services.

Religion is another factor that may have had an influence. Vermont is the least religious state in the nation with only 19% of the population that identify as very religious, and for Maine that number is 24 percent (Newport 2013). Both states have significantly lower “very religious” identifying populations than the national average of 40 percent (Newport 2013).

Less religious influence and a more liberal culture undoubtedly play a role in attitudes towards abortion and Title X referrals to abortion providers. However higher rates of abortion clinic referrals is largely due to the fact that there are no legal restrictions on abortion access, which helps to de-stigmatize abortion services. Employees feel less afraid to give out this information because abortion services haven’t been targeted through state legislation, and therefore they are more inclined to treat abortion referrals as they would for any other health care service.

While both Maine and Vermont had generally higher rates of abortion referrals than the other states, there were still twenty five percent of Title X grantees in Maine that refused to give me a referral. This discrepancy illustrates

that since Vermont and Maine have very similar laws and demographics religion, culture and legislation are not the only factors influencing Title X referrals.

The difference between clinic staff in Vermont and clinic staff in Maine was clear: The Planned Parenthood staff in Vermont had referrals training. In Maine it was common for me to receive two very different responses from different employees from the same Title X grantee. The referral was largely dependent upon who answered the phone, and if they were willing to find the information for me.

The abortion referral practices in Maine have the power to teach us an important lesson: that even when abortion services are more legally accessible, information and adequate training surrounding abortion referrals is necessary.

Overall, states that had more restrictive legislation regarding abortion seemed to have a lower rate of referrals to abortion providers. Restrictive legislation isolates abortion as a medical procedure to be regulated; in doing so, this legislation not only decreases accessibility, it delegitimizes abortion as a medical procedure by treating it as unique and separating it from mainstream health care.

Kentucky and West Virginia proved to be exceptions of this rule, as the grantees in their states were less likely than the most restrictive states to refer for abortion services. This shows that religion and culture also play a large role in addition to restrictive legislation. And the large discrepancy between my Title X clinic calls in Kentucky and West Virginia, pointed to the importance of abortion being incorporated as a standard medical procedure. West Virginia, although

possessing similar demographic features of Kentucky, and heavily influenced by religion and conservative Southern culture, had much higher rates of abortion referrals. This can be attributed to the fact that abortion is not excluded from Medicaid funding in West Virginia.



## **Chapter Five: The Isolation of Abortion**

### **Services**

While restrictive legislation threatens abortion access, it is in large part possible to legislate abortion providers because of their isolation from mainstream health care services. Abortion is isolated physically from primary care facilities because the majority of abortions are obtained at abortion clinics. Its physical isolation allows for abortion providers to be targeted legally and by anti-choice activists. Not only is abortion regulated legally but also through financial means.

These policies treat abortion as if it is a separate or special service rather than what it is, a critical component of full health care for women. This isolation and legislative targeting of abortion services is made easier through the physical separation of abortion providers. The problem is exacerbated by restrictive legislation, funding laws, and previous legislation regarding the limit of information on abortion services. All of these factors further isolate abortion as a medical service for women and delegitimize abortion as a medical procedure. Its isolation results in a decrease in the number of abortion providers, high upfront cost, and ultimately inaccessibility. Isolation of abortion services has a detrimental impact on access for low-income and rural women in particular.

#### **Physical Isolation & Targeting of Abortion Providers**

The physical isolation of abortion doctors makes it easier to regulate abortion services. Most women go to abortion clinics to have abortions, because their primary care physicians do not provide abortion services. This isolation makes abortion providers easier to regulate and target through legislation. Targeted Regulation of Abortion Providers laws, usually referred to as TRAP laws, are designed to limit access to abortion. These laws regulate abortion providers often in the name of protecting women's health.

Michigan passed a law in December that will require all medical providers that surgically perform 120 or more abortions annually to obtain licensure as a "Freestanding Surgical Outpatient Facility" (Erb 2013). Providing outpatient services requires larger rooms for each patient, room for wheelchairs, etc. Many clinics don't have the means to renovate and expand by March, and will not be able to get licensed (Erb 2012). Ultimately this law will require many clinics to close their doors. This will be detrimental to women seeking abortion services and disproportionately impact women outside of Southeast Michigan, where Planned Parenthood has clinics. (Erb 2012) Laws like these are becoming increasingly more common; they indirectly target abortion access under the guise of protecting women's health.

Mississippi passed a law in April of 2012 that will require abortion doctors to have hospital admitting privileges at the nearest hospital in order to practice in the state (Robertson 2012). There is only one abortion clinic left in the state and all seven of the local hospitals refuse to grant the two doctors that practice in Jackson hospital admitting privileges (Quart 2013). If the law goes into effect, the

clinic will be forced to shut down and abortion will not be available in Mississippi (Quart 2013). North Dakota just passed similar law that could shut down The Red River Women's Clinic, the one abortion clinic left in the state.

Abortion clinics have become a political battleground, as they provide a physical space for anti-choice activists to occupy. Due to large protests, many women need to be escorted into clinics, but escorts cannot drown out the harassment. Extreme tactics including blockades, invasions, arson, chemical attacks, stalking, physical violence, gunfire, bomb threats, death threats and arson threats has increased at abortion clinics (Feminist Majority Foundation 2010). 23.5 percent of abortion providers surveyed experienced extreme violence in 2010, up from 18.5 percent in 2005 (Feminist Majority Foundation 2010). The number of abortion providers that reported 3 or more incidents of extreme violence increased from 9 percent in 2008 to just over 11 percent in 2010 (Feminist Majority Foundation 2010). This shows that these acts of violence are not random; they are strategic and increasingly more violent.

Nine out of ten abortion clinics had a harassment incident in 2008 (Guttmacher 2012). 87 percent of clinics reported picketing (Guttmacher 2012). Clinic staff has become the target of the violence; many clinic staffers have reported being stalked or harassed. Doctors in particular are the targets of extreme violence. Dr. George Tiller, one of the few providers who performed late term abortions, was shot and killed when attending his church in 2009.

Some "pro-life" websites label abortion doctors "baby-killers" and their clinics "Death Camps" and encourage attempts to murder abortion doctors. They

justify killing abortion doctors by claiming that it serves justice for the number of “lives” they have taken. There was a bill introduced in South Dakota in 2011 that would have allowed the homicide of abortion doctors (Sheppard, 2011). Although the bill is clearly unconstitutional because it violates the right to life, it demonstrates the hostile climate that abortion providers are subject to for their work. The increase in violence creates an atmosphere of fear. Clinic staffers that experience this violence regularly are twice as likely to quit.

There is an extreme shortage of trained abortion providers in the U.S (Medical Students for Choice). The number of abortion providers dropped by 38% between 1982 and 2005 (Jones RK and Kooistra K 2008)

Many abortion doctors are getting older but there are no young doctors to replace them. 57% of current abortion providers are over the age of 50 (Medical Students for Choice(MSFC), 2009). Medical schools refuse to address the need for abortion providers and “most physicians graduate with little more than circumstantial knowledge of abortion” (MSFC 2009). The Medical Students for Choice recognize that abortion is often left out of a medical education. Even in Ob/Gyn programs, 40 percent of Ob/Gyn programs exclude abortion from their rotations (MSFC 2009). Over 50 percent of abortions are performed by only 2% of American Ob/Gyns (MSFC 2009).

These laws are not only undermining the important role abortion doctors play every day by risking their lives to ensure access but they delegitimize their significance as medical providers. These doctors are being excluded from the medical community for providing a medical service that is necessary for women’s

health, to have the option to end their pregnancies. Many of these doctors started performing abortions later in their careers; they saw that the work needed to be done, and they did it. It was not a question of politics, but of providing health care.

One Doctor, William Parker, became an abortion provider mid-career. He was working as a gynecologist and saw first hand the struggles of women who could not access abortion and how it impacted their lives. He struggled with the issue on a personal level because he grew up in Alabama and was always taught that abortion was wrong (Parker 2012). He describes a realization he had upon hearing a speech by Dr. King on the Good Samaritan:

“Dr. King related the story of the Good Samaritan to encourage compassionate action on behalf of others. The story tells of an injured traveler who was ignored by passersby until one person, the Samaritan, stopped to help. According to Dr. King, what made the Good Samaritan "good" was his refusal to place himself first, asking instead, "What will happen to this person if I don't stop to help him?"

Similarly, I asked the simple question of myself, "What happens to women who seek abortion if I don't serve them?" **This radicalized me, leaving me more concerned about the unnecessary peril to women when safe abortion services are not available than about what would happen to me if I helped women in this way.** It was at that point—some eight years ago—that I began to perform abortions, compelled by women's situations and moved to action by their need, and by my respect for their moral agency to make such a decision.” –Will Parker (Parker 2012)

Edward Boas, an abortion provider in Idaho, has a similar perspective on his work. He emphasizes that abortion is only one small part of his work, but it is necessary health care service.

“I'm not gonna go marchin' ,” he said, “I have done surgery all my life and this is a minor little surgical procedure. ... It's part of the medical world and somebody's got to do it.” (Hammond 2008)

Doctor Brent Blue in Wyoming echoed a similar message:

“As far as I’m concerned, it’s part of a family practice,” Blue said. “It’s part of medicine. It’s no different from vasectomy services and no different than delivery services. ... It is not a political issue.” (Hammond 2008)

Despite the fact that Dr. Blue’s practice was bombed in 1995 he continues his work (Hammond 2008). Doctor Suzanne Poppema, a retired abortion doctor, began providing abortion services after facing an unintended pregnancy.

“Knowing personally what it felt like to be trapped by a pregnancy that I knew I could not continue—under any circumstances—made it very clear to me that providing abortions was a very important thing to do.” – Dr. Suzanne Poppema (Poppema 2007)

Poppema describes abortion providers as an endangered species because of both the physical violence and legislative attacks they face. Dr. Poppema’s reasons for becoming an abortion provider were different as a female doctor because they arose from personal experience but the sense of urgency is the same. She sees her work as necessary to help other women access abortion services. Abortion doctors face the threat of violence every day they go to work, but they continue to do it to ensure women have access to abortion.

Access to abortion is largely dependent on where you live. In 2005 18 % of women reported traveling over 300 miles to an abortion provider (Hammond 2008) The shortage of providers in Western states presents an extreme threat to access as many family practice doctors that provide abortion are retiring and no one is stepping up to replace them. Doctors Boas and Blue see abortion as just one component of women’s health. But they fear that when they retire no one will

take their place. Boas said when he started providing abortion services he was already 50 and had established himself in the medical community (Hammond 2008). He indicated that recent graduates are most likely “more worried about what people think” (Hammond 2008).

Another provider in the West attributed the lack of new doctors to the extreme regulations placed on abortion providers, for example the fear of having to present “insulting, patronizing and unscientific” information to their patients due to state legislation (Hammond 2008)). Because few doctors provide abortion services, new doctors are afraid of being restricted to only providing abortions rather than a range of services and ultimately be labeled “abortion doctors” and becoming isolated and stigmatized by the medical community (Hammond 2008).

Another reason abortion providers are not being replaced is because recent medical school graduates haven’t been trained. Abortion is largely excluded from medical schools. Between 1978 and 1995 the number of Ob/Gyn programs that provided routine training on first trimester abortion services dropped from 26 percent to only 12 percent (Almeling Tews & Dudley 1998).

Wyndi Anderson, a feminist and social justice activist, further emphasizes that access is a political problem,

“Without the ability to treat infections, virus and control bleeding many women and children died in those days (the 1940s), regardless of where they lived. We simply didn’t have the technology.

Today, we have the technology needed to fight infection and give women the choices they need when it comes to pregnancy. But the issue remains that for many women, where they live is the biggest indicator of their access to health care.

For rural women in America, this is especially true. The vast distances in the landscapes, physically and politically, leave women and their families in a situation where they may find no help available, no access to medical assistance when it comes to abortion, miscarriage and stillbirth. In many places, despite the expertise and technology that exists, there is simply no one around to help women and their families navigate pregnancy loss.

We know that providers who work in rural areas understand the needs of their community but are often limited by time, funds and lack of training. They can only do so much without the help of allies and partners who can fill in the gaps where needs are not being met.” (Anderson 2010)

--- Wyndi Anderson

Anderson argues that barriers to access are not because the technology isn't available, but because the resources aren't. The isolation of abortion services from medical training and the medical community leaves women in rural states without providers that offer access to a full range of health care services. Ms. Anderson points out a disturbing trend in the lack of health care access for women: in the 1940s was due to lack of technology, but now it is due to a lack of training and resources.

We have developed the technology that can make abortion safe and accessible through the advancement of telemedicine and medication abortion. Telemedicine has the power to expand access to health services regardless of location and medication abortion offers safe abortion services that can be done at home. The problem is no longer the lack of technology; it is restrictive legislation and the isolation of abortion services from mainstream health care. It is the isolation of abortion services that leads to the lack of training and resources and ultimately the inaccessibility of abortion services for low-income women in rural states.



**Technology**

Telemedicine is a fairly recent development in the medical field that allows doctors to treat their patients using the Internet. Telemedicine makes health care more widely accessible, especially to those residing in remote locations. Medication abortion is a procedure that can be done at home, and doctors can easily give directions without an on-site visit. The advancement of telemedicine could greatly benefit rural communities by making health care services more accessible.

Despite the fact that there is a great need for telemedicine, both for medication abortion and in general, five states have enacted laws that specifically prohibit the use of telemedicine for medication abortion in the past year (Deprez 2013). Nearly 3 out of 4 women that live in North Dakota do not live in a county with an abortion provider, yet the state has banned telemedicine for the use of medication abortion (Guttmacher 2013). Telemedicine offers the potential to expand health care access, especially where medical providers are difficult to come by. In the context of medication abortion, telemedicine would allow doctors to serve more women in rural areas. It could also cut down on travel costs for those women, making abortion more accessible.

A 2011 Obstetrics & Gynecology study compared the complication rate of medical abortion in person and via telemedicine and found that it was the same in both cases at 1.3 percent, proving that medication abortion is just as safe when telemedicine is used (Deprez 2013).

Both North Dakota and Oklahoma have placed a ban on telemedicine in the case of Medication Abortion. This legislation is a clear attempt at limiting access to abortion. It targets abortion services directly, isolating it from other health care procedures. This isolation perpetuates the stigma surrounding abortion. Treating abortion services as different than any other medical procedure further stigmatize and delegitimize its necessity for comprehensive health care for women.

### **Financial Isolation**

Abortion, like all medical procedures, is expensive. The difference between abortion and other medical procedures is that most health insurance companies don't cover abortion or only do so partially, which means that for many women the full cost must be paid at the time of the procedure. The average cost of an abortion is around \$500 but cost is largely dependent upon where you are and how far along you are; prices range greatly. The exclusion of abortion services from health insurance coverage both private and public has extreme consequences on women's lives, as abortion is expensive and time is an issue.

Funding laws regarding abortion, although often overlooked, can be the determining factor of whether or not a woman can obtain an abortion. Possessing the means to obtain an abortion is crucial, and paying for such an expensive medical procedure without insurance coverage is extremely difficult for many women. Restrictive policies regarding funding for abortion services have become commonplace. Attempts to limit access to abortion services financially began

following *Roe v. Wade*.

Congress passed the Hyde amendment in 1976 that prohibited Medicaid funding from covering abortion costs. By singling out abortion services from public funding the U.S. government made abortion extremely difficult for low-income women to access. The Hyde amendment does not stop there; its provisions have been adopted by 32 states (ACLU 2004).

Abortions are expensive and insurance coverage is hard to come by. In 2008, only a third of women accessing abortion services had health insurance that fully or partially covered the cost (Guttmacher 2010). \$470 was the median cost of obtaining a surgical abortion at 10 weeks in 2009. The median cost of a medication abortion was slightly more expensive at \$490 (Guttmacher 2010). For women working minimum wage jobs, at \$8 an hour and 40 hours a week, this is equivalent to 75% of their bi-weekly paycheck. Many minimum wage workers live paycheck to paycheck and depend on the income they make to pay for the essentials: rent and groceries. This complicates things further since many women do not have this kind of disposable income and in order to get it studies have shown that many women will forgo certain essentials like groceries in order to save up. This impacts not only the individual woman, but her family as well.

Abortion is time sensitive; the longer you wait, the more expensive the procedure is. Low-income women are usually not able to obtain an abortion until later when the cost is even higher. This means that or the time spent making the money to pay for it means that the abortion will take place later in the pregnancy. If that is the case, abortions are much more expensive the longer you must wait.

Limits on Public Funding have been extended to many state programs. Only sixteen states still allow for Medicaid funding to cover abortion (ACLU 2004). Fewer and fewer health insurance companies are offering abortion coverage. If they do cover abortion services, they may charge an additional fee to do so. Isolating abortion financially, and not including it in a “normal” health care coverage sends the message that it is a luxury or unnecessary medical procedure.

**Funding laws in each state**

**Figure 17**

State	Circumstances in which Public Funding is available	Public Insurance Policy regulations	Private Insurance Policies
KY	Only in cases of life endangerment, rape or incest.	Abortion is not covered in insurance policies for public employees.	Abortion is covered in private insurance policies only in cases of life endangerment, unless an optional rider is purchased at an additional cost.
IA	Only in cases of life endangerment, rape or incest.	None	None
ND	Only in cases of Life Endangerment	Abortion is covered in insurance policies for public employees only in cases of life endangerment.	Abortion is covered in private insurance policies only in cases of life endangerment, unless an optional rider is purchased at an additional cost.
OK	Only in cases of life endangerment, rape or incest.	None	Abortion is covered in private insurance policies only in cases of life endangerment, unless an optional

			rider is purchased at an additional cost.
WY	Only in cases of life endangerment, rape or incest.	None	None
WV	None	None	None
ME	Only in cases of life endangerment, rape or incest.	None	None
Vt	None	None	None

(Guttmacher Insurance Policies 2013)

The Hyde Amendment prohibits federal funding from going towards abortion, but state policy regarding funding of abortion varies (ACLU 2004). Like many states, Kentucky, Iowa, Oklahoma, Wyoming and Maine only provide funding for abortion in cases of rape, incest, or if the pregnancy threatens the woman’s life. North Dakota violates Hyde and only covers abortion in cases of life endangerment (Guttmacher Insurance 2013). What this means for low income women is that if they can’t come up with the money to obtain an abortion, they are forced to carry their pregnancies to term. Seventeen states have chosen not to restrict Medicaid funding from covering abortion, including Vermont and West Virginia.

Kentucky and North Dakota also exclude abortion coverage from their insurance policies for public employees (Guttmacher Insurance 2013). In North Dakota insurance policies for public employees, abortion coverage is only available if the mother’s life is endangered (Guttmacher Insurance 2013). North Dakota’s private insurance providers cover abortion only in the case of life endangerment; however, it is possible to obtain a rider but it costs more on a private plan.

These restrictive funding laws are reflective of a larger problem that health insurance does not guarantee access to abortion. This isolates abortion services even further from the medical system and serves to delegitimize them at the very same time. Most services that are not covered by health insurance plans are considered cosmetic. Abortion services are a critical part of full access to women's health care, but they aren't being treated as such.

Kansas banned private insurance companies from covering abortion in their general health plans unless the woman's life is in danger or a rider is purchased.

"The Act does nothing to inform a woman's choice; rather it obstructs it. It also does nothing to protect a woman's health; in fact, it endangers it. It does not reduce the cost of health insurance in any meaningful way. Nor does it have anything to do with ensuring that individuals are not forced to 'subsidize the cost' of another person's abortion or any of the other rationalizations Defendant has conjured up," –ACLU attorneys (Hegeman 2012)

The fact that funding is only provided in cases of rape, incest, or life endangerment in most states means that most low-income women are expected to pay for their abortion at the time of their procedure. Women that can't afford to get an abortion, or manage to come up with the money in time, will either be forced to carry their pregnancy to term or resort to other measures.

The Affordable Care Act extends Hyde restrictions to the state health policies: that abortion is only covered in cases of rape, incest and life endangerment (Executive order 13535). It mandates that all insurance plans have a separate fund for abortion that requires an additional monthly fee. This means that only those that pay into the "abortion fund" will have access to that coverage when needed.

Low-income people buy the bare minimum when it comes to insurance. If they are required to buy insurance, every dollar matters.

When pregnant women seeking abortion are unable to access these services due to the isolation of abortion, we deny their right to self-determination. The isolation of abortion services disproportionately impacts low-income women in particular. High cost and lack of insurance coverage is the largest barrier to access. The decrease in abortion providers, lack of information, and legislation targeting abortion services all amount to extreme barriers for access and threaten women's health.

The physical separation of abortion clinics causes a shortage of providers, high cost and longer distances to travel. It makes abortion services almost completely inaccessible to low-income women, especially those living in rural areas.

The truth is that it is impossible to fully understand barriers to access when examining each factor individually. In women's real life situations, all of these factors merge together and create a multitude of barriers.

Take Wyoming for example, the state with the fewest abortions in the country, with only 70 abortions reported in 2005. The lack of access is extremely high: ninety six percent of counties in Wyoming had no abortion provider in 2008, and 96 percent of women lived in those counties (Guttmacher 2011). In 2008, there were 3 abortion providers in Wyoming (Guttmacher 2011). Despite reports of there being three providers, Emerg-A-Care is the only one that is known for performing abortions in the state, it is likely that the other two only

provide abortion services for their current patients (Hammond 2008). The cost of an abortion at Emerg-A-Care in 2008 was \$1,045; the only payment method is cash, and insurance is not accepted (Hammond 2008).

Although Wyoming seems to have some of the most limited access to abortion services, the majority of Title X grantees referred me to an abortion clinic. While 53% of the Title X grantees gave me some type of information about where I could find the closest abortion clinic, many of these referrals were to clinics in Billings, Montana or Colorado. The shortest distance between a Title X grantee and the abortion provider they referred me to was 65 miles. The farthest was 245 miles, and the average distance between the title grantees and the abortion provider they referred me to was 145 miles.

Traveling long distances seems unavoidable for Wyoming residents seeking abortion services unless they live in Jackson and have the means to pay over \$1,000 for the procedure. But even if a pregnant patient from Wyoming had the time, transportation means and gas money to travel all the way to Billings, Montana they will be up against Montana's 24-hour mandatory waiting period (Guttmacher 2013). So a pregnant woman seeking an abortion in Wyoming that was referred to a clinic in Billings would have to pay for a hotel room in addition to the cost of the procedure.

Because there is only one known abortion provider in Wyoming, and the cost is extremely high to obtain abortion services, the number of women that obtain abortions in Wyoming is the lowest in the country (Hammond 2008). This is not because women don't need these services, but because access is extremely



limited. Providers decrease because of violence and exclusion of abortion from mainstream medical education.

When women do not have access to abortion, whether because they lack a provider, distance or they cannot afford the procedure, it does not mean they won't have one. Women that cannot access abortion legally will resort to other means. The problem is that these means may be unsafe. Google searches for how to give yourself an abortion return forums upon forums of ideas and methods women have used. It is not uncommon for women to seek information on inducing an abortion at home.

“Do it Yourself” abortion is nothing new, in fact there are a wide variety of methods that women use, some safer than others. Some “Do it Yourself” methods have included using certain herbs and vitamins, bleach or other chemicals, alcohol poisoning and falling down stairs.

Do it yourself methods used to be more dangerous, but with the introduction of medication abortion, and increased access to the internet, these methods have become safer.

When a doctor prescribes a medical abortion they administer both mifepristone and misoprostal. Together, they are 98 percent effective in terminating a pregnancy (Women on Waves). Cytotec, a generic brand of Misoprostal, is 90 percent effective when used without mifepristone (Women on Waves). While there is no way to track illegal abortions, the dramatic increase in websites that market Cytotec suggests that there is an increase in demand for the pill (Calhoun 2012). Cytotec is an ulcer medication in the U.S. The pill is sold

online for between \$45-\$75, much cheaper than if you were to visit a provider (Calhoun 2012).

Although these pills are safe when taken as directed, if women do not have the directions of a doctor it is possible for them to cause excessive bleeding or be unsuccessful in terminating the pregnancy (Women on Waves). The fact that women have to resort to these potentially harmful tactics in order to have an abortion is disturbing. It reminds us that there is little that can stop someone from ceasing control over their own body. Restrictive legislation, decrease in providers, and cost can stop women from accessing abortion through a legal and safe means but it won't stop them from attempting an abortion.

When women were not able to legally obtain abortions prior to Roe, they resorted to potentially harmful "Do it yourself" methods. We have the technology to provide safe and affordable abortions, but they remain inaccessible and expensive.

While medication abortion was originally intended to make abortion more widely accessible and affordable, heavy regulations on the pill have gotten in the way (Calhoun 2012). Medication abortion, which was originally intended to make abortion more affordable, costs as much or more than a surgical abortion when obtained through a provider. Part of the problem is the physical isolation of abortion services. When abortion services are isolated from mainstream health care, doctors at abortion clinics become dependent on income from abortion services as their only means to make a living. If they made medical abortion cheaper, most women would opt for medical abortion causing their revenue to

drastically decrease; they may not be able to sustain their practices. Abortion is a critical component to women's health care and there is no legitimate reason for its isolation from the medical community, it is purely political. The medical community doesn't want to deal with the political controversy surrounding abortion, and in order to avoid conflict has left low-income women seeking abortion services without adequate health care.

Political decision-making has caused the isolation of abortion services resulting in the inaccessibility of abortion to the vast majority of women. Whether through restrictive legislation, restrictions on health insurance coverage, or a decrease in the number of providers, abortion services have become out of reach for many American women.

The political decisions made to restrict access to abortion and isolate abortion services at the cost of women's health are inexcusable. Medical abortion and telemedicine provide the technology necessarily to make abortion safe, accessible and affordable. And yet abortion is becoming further and further isolated from mainstream health care. Banning telemedicine for the use of medical abortion directly prevents doctors from expanding access to abortion services, despite the fact that it has been proven to be just as safe when prescribed at on-site visits.

There are alternatives to our current medical system and the isolation of abortion services, and providing comprehensive health care to pregnant women is not as difficult as we seem to think it is. If abortion services were to be incorporated to the mainstream medical system as a routine procedure, one that

would be taught at all medical schools to doctors and nurses alike, providers would not be in short supply. The integration of abortion services into primary care would take away the physical target for anti choice protesters. If health insurance treated abortion as a medical procedure essential to women's health by covering it, they would actually save money. If medication abortion wasn't so heavily regulated, it would be cheaper.

We have the technology to make abortion accessible and affordable. Lack of access used to be limited because the technology was not available to provide health care services. Now, as telemedicine advances, doctors can provide medication abortion to rural women. So why does access to abortion become more and more inaccessible?

## **Chapter Six: The Role of Title X Grantees in Promoting Abortion Access**

The Goal of this project was to gain a better understanding of the barriers low-income women in rural states face in accessing information on abortion services from Title X grantees. I found that Title X grantees are not consistently referring for abortion services upon request. In addition to restrictive state legislation, isolation of abortion services, and abortion stigma low-income women in rural states face inaccessible information on abortion services. Refusals and referrals to Crisis Pregnancy Centers deny low-income women access to information on abortion providers, leaving them to find this information on their own. The inconsistency in referral practices indicates confusion about the Title X referral policy and a lack of adequate training or misinformation given in training. When Title X grantee staff is uninformed or misinformed on abortion referral practices, it is their pregnant patients seeking abortion services that suffer the consequences.

### **Summary of Findings**

While I received a number of comprehensive abortion referrals in my calls, it is no coincidence that the majority of grantees either referred to a CPC, another provider, an information source or directly refused to refer for abortion.

All of the states struggled with inconsistent referral practices, with the exception of Vermont. Vermont's consistent referral practices are due to the fact that all of their Title X grantees are Planned Parenthood sites. The fact that there are great inconsistencies between states and clinics within each state is reflective of the fact that there is a lack of information and training regarding abortion referral practices.

The responses I received from Title X grantees that did not give me a referral to an abortion provider can be divided into two categories: Crisis Pregnancy Center referrals and refusals (including information referrals, referrals to other providers and direct refusals). The fact that there were such a wide variety of responses to a single question illustrates that there is confusion about abortion referrals and compliance with Title X guidelines.

### **Abortion Stigma**

The combination of restrictive state legislation and the isolation of abortion services from mainstream health care perpetuate abortion stigma. This stigma results in a lack of training and clear policy at Title X clinics.

Stigma is defined as “ a mark of disgrace associated with a particular circumstance, quality or person”. Abortion stigma is produced locally, through relationships. In rural or smaller communities this has a very real impact(ANSIRH 2013). Abortion stigma manifests itself through shaming and silencing anyone associated with abortion, whether it be women that have had or

considered having an abortion, abortion doctors and their staff, and anyone that stands up to protect access to abortion (ANSIRH 2013).

Abortion stigma is prevalent throughout the U.S. because abortion challenges the cultural assumptions of women's roles. Abortion challenges the ideas that motherhood is inevitable, that feminine sexuality can be independent of procreation, the idea that all women are nurturers and that women are autonomous individuals (ANSIRH 2013).

Abortion is seen as deviant, and anyone that is associated with abortion are seen as tainted or discounted because they have engaged in "deviant" behavior and thereby challenged the "ideals of womanhood" (ANSIRH 2013). The most dangerous aspect of abortion stigma is the power it has to silence. This is why it is so powerful in silencing Title X clinic staff when it comes to abortion referrals practices.

### **What happens when there is not adequate referrals training or clear knowledge of the Title X guidelines regarding referrals?**

When Clinic staff are not given information or trained on what to do when someone asks for abortion services they will either refuse to give a referral or refer to a Crisis Pregnancy Center.

CPCs are extremely biased pro-life centers that intend to convince women considering abortion to have their babies through distributing false information and emotionally manipulating counseling. They advertise free pregnancy tests to reel low-income women in to their centers. They inaccurately link abortion to

depression, breast cancer, drug and alcohol abuse, future miscarriages and higher risks for abnormalities. None of these links have been proven. The medical community, including the World Health Organization declared that there is no causal link between abortion and breast cancer in the mid 1990s.

CPC referrals increase for two different reasons when there is no policy: either the clinic staff thinks that the CPC is an unbiased trustworthy source of medical information and counseling or the clinic staff refers to the CPC because of their personal feelings on abortion. These two situations are problematic for different reasons, but they both highlight the fact that Title X clinic employees are not receiving proper training regarding the referral guidelines; the staff is not given adequate information on how they should handle a request for abortion services including where an appropriate place to refer is.

While the refusals, information referrals or referrals to another provider were not as harmful as CPC referrals, they leave pregnant women on their own and many of them will have to turn to the internet or phone book. It is difficult to find information for legitimate abortion clinics online, and very easy to stumble across a CPC website and mistake them for an abortion provider or a counseling center that could refer to a provider.

Phone books are not always reliable for this information either, as we can see is the case in Kentucky. The newest Louisville phonebook has several CPCs and adoption agencies listed under abortion alternatives but under abortion providers only lists the Planned Parenthood national line, and Planned Parenthood does not provide abortion services in Kentucky. The EMW women's clinic, the



only abortion clinic in KY, is not listed. Some CPCs even advertise themselves as abortion providers in order to get women seeking abortion services into their clinics (NARAL 2013). Information referrals for abortion services are not sufficient because the information is not reliable or trustworthy.

When a clinic referred to another medical provider, about 18.5% of responses from Title X grantees in West Virginia, it was usually a health department but sometimes a hospital or a government agency such as the Department of Health and Human Resources (DHHR). This type of referral gave me another hoop to jump through in order to get the information I was seeking and there was no guarantee that it would be given by that provider either.

Title X clinics are supposed to be safe spaces where women can go for health care services and medical information. The fact that the clinic staff gave me a wide variety of referrals is reflective of the fact that the staff has not been trained or made aware of the referral policy, or they have been given incorrect information.

Some responses from clinic staff that refused or referred to CPCs indicated that there was a policy in place. Clinic staff that indicated they had policies on abortion referrals other than referring to abortion provider upon request either told me that they weren't allowed to give any information regarding abortion or referred me to a Crisis Pregnancy Center. Other grantee employees said that they that they weren't allowed to give information on abortion, some of them even used Title X as justification for their refusal.

Title X grantees referring to Crisis Pregnancy Centers is extremely problematic and disconcerting. So many low-income women rely on Title X for their health services and as a trusted source of medical information. Referring to a CPC when a pregnant woman directly requests information for an abortion provider directly contradicts the Title X guidelines. But it does more than that. A government funded clinic referring to a CPC, a counseling center that is designed to give inaccurate medical information and manipulate in order to “save the fetus” at any cost to the pregnant woman, means that Title X cannot be trusted to give objective medical information.

Some clinic staff told me they couldn’t give me information on abortion because they received Title X funding. This directly contradicts the guidelines and follows logic of the gag rule that expired in 1993. This was not a random occurrence, many grantees in both West Virginia and Oklahoma told me that they weren’t allowed to give out this information when they refused my request.

### **Why aren’t Title X grantees referring for abortion services?**

Health care professionals are responsible for providing medical information to facilitate informed consent. Low-income women need a reliable source of medical information. Why is it that when it comes to abortion Title X clinic staff aren’t consistently providing this information in the form of a referrals? If it were any other health service, referrals would be granted upon request.

Abortion stigma plays a large role in the inconsistency of referrals. Restrictive legislation and the isolation of abortion services perpetuate this stigma. Abortion

stigma silences; in the case of Title X, it leaves many grantee staff uninformed or misinformed about Title X guidelines on abortion referrals. It creates confusion around policy at all levels and makes clinic staff feel as though they are doing something wrong by referring for abortion services. Comprehensive referrals training would help to address these inconsistencies.

### **Lack of training**

When employees have not been trained on what to do in the case when asked for an abortion referral or given information on where the closest abortion provider is located they will not give a good referral. Instead, this lack of information results in direct refusals, information referrals, referrals to other providers, or CPC referrals.

If clinic staff have not been trained on how to respond to a pregnant woman seeking abortion they might not know where the closest abortion provider is, and so they may refuse to give information because they don't have any. If they did know where the closest abortion provider was, due to high legislative restrictions and the isolation of abortion they may have felt uncomfortable or even afraid to tell me where I could go because they don't know whether or not it is okay. Because abortion is politicized, they could have denied me information thinking they could be doing something wrong or that they could get in trouble for referring me.

When uninformed about policy clinic staff can easily end up referring to a CPC. Crisis Pregnancy Centers advertise themselves as pregnancy counseling centers and are usually located in small towns, much closer and more local than

abortion providers. The staff, if not given information about what Crisis Pregnancy Centers do, are likely not to be aware of their intentions.

Lastly, when there is no clear policy or training on what to do when asked for an abortion referral it is left up to individual staff member to decide how he or she will respond. This allowed for them to bring in their personal opinion on abortion. This came in the form of judgmental comments, warnings, and questioning.

The information I am able to receive should not be dependent upon the beliefs that the clinic staff member has about abortion. I should be given the information simply because I requested it, because I'm entitled to it under the Title X guidelines.

### **Isolation of Abortion Referrals**

It is the responsibility of Title X clinic managers to make sure that their staff is aware of title X guidelines and when a patient straightforwardly asks for a referral, she is given it. Title X clinic managers are choosing to ignore this issue or set their own policies even if they misinterpret or fail to meet the referral guidelines. Some of the reason for this is that abortion access has become extremely politicized in recent years, which makes abortion referral practices more controversial. These clinic managers are most likely afraid of being sued, so instead of training employees to refer, they don't tell them anything. The idea of "risk management" becomes more important to clinic managers than the patients that need medical information. But what about the risk their failure to refer

presents for pregnant women's health? It is possible that Title X managers don't know the Title X policy, hence the referral policies to CPCs and adherence to the outdated gag rule.

### **Why Title X Referrals are Fundamental to Abortion Access**

Unfortunately this step comes at a time when women desperately need a reliable source for abortion referrals. There is so much misinformation regarding abortion services coming from restrictive state legislation and Crisis Pregnancy Centers.

Title X clinics were intended to be health centers that women could trust for basic services as well as accurate medical information. The inconsistency in referrals means that Title X clinics cannot be considered a reliable source for obtaining medical information on all pregnancy options. The lack of information surrounding training on abortion referral practices at Title X leads to an increase in CPC referrals, information referrals and refusals; all of which leave women either with misinformation or no information. This lack of information makes it difficult to find an abortion provider and impedes access to abortion.

“The patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice” –  
American Medical Association (NARAL 2013)

The problem here with Title X clinics failing to give their clients, low-income women, information on where they can access an abortion, is that it means that low-income women are being denied access to medical information.

This denial of information and lack of a trustworthy source of medical information is another barrier to access, on top the barriers they already face: extremely restrictive legislation, a shortage of providers, distance and cost. Roe guaranteed American Women the right to have an abortion as protected under the 14<sup>th</sup> amendment.

But it doesn't matter if abortion is legal if it is inaccessible. I've spelled out the laws that make abortion extremely difficult to obtain, and many of them disproportionately impact low-income women, especially those living in rural areas. But the largest deterrent to abortion is lack of means and information.

Title X grantees are supposed to be a resource for medical information. They are funded solely to benefit women's health. And while they can't perform abortions with that funding, they can refer. And that referral can mean the difference between a woman ending up at an abortion provider where she asked to be referred or at a Crisis Pregnancy Center where she is made to feel guilty for making a personal decision about her health.

That referral allows a patient to make a decision by herself, not a decision coerced. These women need a reliable source of medical information, a small concession to make for the inaccessibility of abortion services. These women depend on Title X for health services and other information so why can't they consistently provide information on abortion?

## **Recommendations**

Abortion is a common medical procedure; 1 in 3 women will have an abortion in her lifetime. Women have abortions for many different reasons and have very different experiences. The abortion debate in the U.S. often centers on judging these circumstances and experiences, justifying or vilifying them. But abortion will happen whether its legal or not, whether its safe or not, and whether we agree with the reasons or not. Women have been having abortions in every society ever studied. We have the technology to make abortion affordable and accessible. The fact that abortion is inaccessible for so many American women is a direct result of political decision-making. The restrictive legislation and the isolation of abortion services perpetuate abortion stigma. Addressing inconsistent abortion referral practices will require challenging restrictive legislation, the isolation of abortion services and abortion stigma; tackling all three is necessary to increase access.

### **Recommendations for the Movement**

#### ***Shifting the Framework***

While the most fundamental barrier to abortion access is the cost and lack of insurance coverage, the mainstream debate continues to be centered on legality. Despite the clear message voters sent in November 2012, legal restrictions have only become more prevalent and extreme.

Dr. Parker believes that the anti-choice activists know that they will not be able to completely outlaw abortion and therefore strategically attempt to chip away at abortion access by proposing restrictive legislation on second trimester abortions. The anti-choice attacks on abortion access require resistance on behalf

of the pro-choice activists. Pro-choice activists participate in this dialogue with the antis and by doing so allow them to dictate the conversation around abortion.

“Apparently recognizing that termination of pregnancy won't be outlawed any time soon, abortion opponents are willing to engage in dialogues that— while appearing to progress towards a more civil exchange with abortion supporters—unwittingly enlist the energies of abortion rights activists for the restriction of those rights. These conversations subtly endorse the parsing away of this fundamental human right, ironically beginning with women in their second trimester, who often have the most compelling need to have an abortion in the first place. As is common in discussions of abortion, absent from these dialogues are the voices of the women and families that are affected—the very women who are and will be denied access to what is oftentimes a health-related decision.” – Dr. William Parker (Parker 2012)

The focus of protecting rights and constantly playing defense on the legal front causes the pro-choice movement to engage in a conservative framework. They adopt rhetoric that perpetuates abortion stigma and shame, such as the messaging that abortion should be “safe, legal and rare.” This legal framework leaves no room for Women’s real experiences with abortion, discussion of access beyond legality, or what abortion means for women’s health and status in society.

As legal restrictions on abortion increase and abortion services become more and more isolated from mainstream health care, abortion becomes inaccessible to many low-income women. Without access to abortion services, women turn to “Do it yourself” at-home abortions. They are forced to put their own health at risk.

The larger ideas of what abortion means for women’s health and place in society also get lost in a legal framework. The debate centers on when human life



begins, but misses out on what fetus rights mean for women's lives. What do the increased restrictions on abortion mean for women's status in our democracy? We seem to be missing out on the fact that the state is asserting control over and policing women's bodies.

Abortion is about the power to choose how we want to live our lives. Without access to abortion as a pregnancy option women are stripped of all agency; and when we are stripped of agency we are also stripped of equality. We can no longer be considered full subjects or equal participants in a democracy. We are rendered powerless to our biology.

Lynn Paltrow, the Executive Director of the National Advocates for Pregnant Women (NAPW) did an interview with Laura Flanders regarding the increase of restrictive state legislation and the increasing number of personhood amendments where she argued that

“Even progressive interviewers will talk about personhood measures as if their only impact is going to be on abortion”, says Paltrow. "We are talking about the status of women and whether you can add fertilized eggs, embryos and fetuses to the Constitution without subtracting pregnant women from it. You cannot."

(Paltrow 2013)

Abortion rights activists use real women's experiences and circumstances to justify certain experiences and vilify others in the fight to keep abortion “safe, legal and rare”. Playing into this rhetoric perpetuates abortion stigma, when we should be aiming to destabilize it. The movement needs to reevaluate their messaging and examine what their rhetoric is doing. Framing abortion access as fundamental for women's equality in a democracy would shift the debate. It

would allow abortion rights activists to shift their focus from struggling to defend legal rights to the larger picture of access.

### ***Challenging Abortion Stigma***

Abortion stigma both contributes to the restrictive legislation and isolation and is a product of it. Stigma silences; it silences the women that have abortions, the providers, and anyone associated with it. Abortion stigma undoubtedly played a role in the hesitancy of Title X staff to refer for abortion services. So how do we challenge abortion stigma?

A recent strategy for de-stigmatizing abortion is “coming out,” or encouraging women that have had abortions to share their stories. Abortion rights activists have attempted to adopt the “coming out” strategy after observing its success in the gay rights movement.

“I’ll never forget the day in 11<sup>th</sup> grade when our biology teacher went down the row asking each girl to say what she would do if she got pregnant. Would she have an abortion or have the baby? I knew what I would do. I would never give up my dream of escaping that town but I sat nervously waiting to see what everyone else said. When the most popular girl in our class, a straight-A student beloved by all teachers, said she’d have an abortion, I felt my fears fade. I knew I wasn’t alone. I knew it was okay for me to say my life mattered, too.”

—Paige Dawson, Vice President for Public Policy at Planned Parenthood in Central North Carolina (Johnson 2011)

Dawson’s story demonstrates how effective endorsing abortion is in combating stigma. Hearing someone else say she would have an abortion made her feel like she wasn’t alone, that other women felt just like she did. Sharing abortion stories helps normalize it.

Kai Gurley, Development Manager at Choice USA, argues that while the “coming out” strategy will likely be effective over time, abortion rights activists should not expect women to share their abortion stories. Gurley thinks that the movement needs to be conscious of what they are asking of women in conservative states and rural communities (Gurley 2012).

“The lived experience of violence and harassment for people associated with abortion services should give us pause. The thinking and direction of the abortion rights movement originates primarily from the coasts, but living life in Manhattan or San Francisco or Washington, DC is different than living life in Tulsa, Oklahoma or Greenville, South Carolina. It’s important to think carefully about the roles we are asking people to play. “Coming out” is a powerful contribution, but is not the only role one person can play to support progress around abortion access. If the abortion rights movement is going to ask women to be more visible and vocal about their experiences with abortion, we must do so with thoughtfulness about the potential impact on individual people – particularly people living in rural communities and conservative states. We must be working to address stigma in these communities.” —Kai Gurley (Gurley 2012)

Gurley argues that there are many different roles to play in de-stigmatizing abortion, “coming out” or making a public announcement is just one way to play a role to advancing abortion access. I agree with Gurley that although this strategy is important, we need more than that especially for women in rural communities that fear for their safety.

“We must support individual health care providers and social service workers to challenge the stigma around abortion in their clinics, agencies, and professional communities, a strategy we at the Abortion Access Project are currently pursuing. Everyone has a role to play, and these roles are as diverse as the people who play them.” (Gurley 2012)

I agree with Gurley’s argument that although “coming out” is effective, the abortion rights movements needs more than just abortion stories to challenge stigma. While every individual can help to de-stigmatize abortion by breaking the

silence, and should if they feel comfortable and safe doing so, abortion stories alone are not enough. We need anyone that believes women should be equal participants in our democracy to stand up for abortion access in whatever capacity they can. There are many ways to advance abortion access, and the medical community has the potential to pose an effective challenge to abortion stigma.

### **Isolation of Abortion services & the Importance of Medical Health Professionals in Fighting Abortion Stigma**

We have the technology to make abortion an affordable and accessible option for all American Women. It is the safest medical procedure with a very low rate of medical complications. Telemedicine abortion has been proven to be just as safe as on-site visits. Restrictive legislation and isolation of abortion become more and more extreme, making abortion inaccessible for the majority of American women.

We need health providers and the medical community to recognize abortion as a fundamental part of women's health care, and stand up to ensure abortion access. Abortion is politicized precisely because it is an essential component of women's health and autonomy. The attacks on abortion access are in resistance to women as full human beings.

In order to increase access to abortion we need to address stigma. Abortion has become so politicized and stigmatized, that health professionals don't want to deal with it. But we need medical providers now more than ever; we need providers that will stand up to protect women's health. Individual doctors can have a tremendous impact by recognizing the importance of providing women with the medical information they ask for and providing information for them to

make their own decisions about their pregnancies.

“I endeavor to move our world to a place where women have the space and power to make these tough decisions without judgment, coercion or restriction thrust upon them, and are able to do so in a setting of safety and uniform access to all possible reproductive options. It is in this context that I gladly provide first- and second-trimester abortion access for women in support of their humanity, dignity and health. I challenge my peers to do the same.” – William J. Parker (Parker 2012)

We need more doctors like Will Parker who sees it as his responsibility as a medical provider to make sure his patients have access to accurate information and services. For Parker, addressing access meant providing abortion services; but even committing to giving accurate referrals is a step in the right direction.

Doctors, nurses and clinic staff should be giving referrals for abortion services regardless of their personal opinion on abortion because the patient has the right to medical information.

Healthcare professionals at Title X clinics have the power to ensure that low-income women have access to accurate medical information on abortion by setting a standard for an effective and informative abortion referral. Everyone has a role in promoting abortion access, and women all around the country are depending on Title X clinics to step up and do their part.

### **Policy Recommendations**

Making abortion accessible will require the incorporation of abortion services into the mainstream medical system. Politically this will involve repealing laws that isolate and target abortion physically, legally, and financially. We need to repeal the Hyde Amendment and the same restrictions that have been applied to the Affordable Care Act so that women have insurance coverage for

abortion services regardless of their class status. We need Medical Schools to include abortion in their Ob/Gyn programs so that all medical providers know how to perform abortion services. We need medical providers everywhere to start providing abortion services as a routine medical procedure. We need to repeal the bans on telemedicine abortion so that medication abortion is accessible regardless of where you live.

While Title X referral practices alone cannot solve barriers to abortion access, they are a critical starting point. Addressing abortion referral practices at Title X clinics is a necessary first step in recognizing the responsibility of the medical community to provide abortion referrals as medical information. Title X is a resource for over 5 million women each year for health services. If Title X grantees and their staff won't stand up for women's health, who will?

### ***Comprehensive Referrals Training***

The only way to address the inconsistent referral practices is through comprehensive referrals training. Whether it be from a lack of clear guidelines, information, or referral training the Title X clinics I have called are more likely than not to fail to give the unbiased referrals that pregnant women are legally entitled to. The inconsistent referrals I received is a clear indication that a standard needs to be set and enforced for what an effective abortion referral looks like, and training for those referrals needs to be done at every Title X clinic.

### ***Repeal The Weldon amendment***

The Weldon Amendment, attached to Title X funding in 2005, does not punish Title X grantees that do not refer for abortion services (National Abortion

Federation 2012). It therefore allows grantees to choose whether or not they will refer for abortion services, making the Title X guidelines for referrals unenforceable. Referring for abortion services should not be optional, abortion is a fundamental component of women's health care. Low-income women need a reliable source of medical information, they need a health provider they can trust to refer them for abortion services. The Weldon Amendment represents the isolation of abortion services within Title X grantees. In order to increase access to abortion, we have to challenge isolation of abortion services, and the Weldon Amendment.

What I have found from calling these Title X clinics is just a small reminder of a more fundamental problem, the institutionalized resistance to women having full access to health care, one that cannot be corrected overnight. But it demonstrates the important role of healthcare professionals, and how their action or inaction will be a determining factor in whether women have access to information regarding all of their pregnancy options.

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