Women's Pathways to Abortion Care in South Carolina: A Qualitative Study of Obstacles and Supports

CONTEXT: *Women seeking timely and affordable abortion care may face myriad challenges, including high out-of-pocket costs, transportation demands, scheduling difficulties and stigma. State-level regulations may exacerbate these burdens and impede women's access to a full range of care. Women's reports of their experiences can inform efforts to improve pathways to abortion care.*

METHODS: *In 2014, semistructured qualitative interviews were conducted with 45 women obtaining abortions in South Carolina, which has a restrictive abortion environment. Interviews elicited information about women's pathways to abortion, including how they learned about and obtained care, whether they received professional referrals, and the supports and obstacles they experienced. Transcripts were examined using thematic analysis to identify key themes along the pathways, and a process map was constructed to depict women's experiences.*

RESULTS: *Twenty participants reported having had contact with a health professional or crisis pregnancy center staff for pregnancy confirmation, and seven of them received an abortion referral. Women located abortion clinics through online searches, previous experience, and friends or family. Financial strain was the most frequently cited obstacle, followed by transportation challenges. Women reported experiencing emotional strain, stress and stigma, and described the value of receiving social support. Because of financial pressures, the regulation with the greatest impact was the one prohibiting most insurance plans from covering abortion care.*

CONCLUSIONS: *Further research on experiences of women seeking abortion services, and how these individuals are affected by evolving state policy environments, will help shape initiatives to support timely, affordable and safe abortion care in a climate of increasing restrictions.*

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Although the right to abortion is federally protected in the United States,[1] women seeking timely, affordable, safe, legal abortion care may face myriad challenges. Financing may be a major consideration for women who are uninsured, have insurance that does not cover abortion, or have coverage but are reluctant to use it because of confidentiality concerns.[2] Women in the United States pay a median of $340 out of pocket for a first-trimester abortion—more than the median annual out-of-pocket health care costs among uninsured women aged 25–34.[3,4] In one U.S.-based study, half of the women paying out of pocket for abortion care found it financially difficult, and half required outside assistance.[2] Arrangements for transportation and child care represent additional costs and needs related to accessing abortion care. For example, in 2008, women traveled 30 miles, on average, to obtain abortion services;[5] in 2011, the average transportation expense was $44.[2] Both figures have likely increased owing to regulations that have led to closure of abortion clinics or mandated multiple visits, resulting in greater travel burden.[6,7]

Beyond financial concerns, the potential difficulty of obtaining accurate information on abortion care may affect access to the procedure. In some settings, it is relatively simple to consult a trusted medical provider;[8] in others, searching for information may be challenging and may yield inaccurate results.[9,10] Abortion stigma—anticipated, experienced or internalized—may be perpetuated by these pragmatic challenges to health care access.[11,12] Social support can help women navigate obstacles, and its absence may be an obstacle in itself.[13]

In addition, myriad state-level laws—such as mandatory counseling, waiting periods and gestational limits—regulate access to abortion services.[14] Provider-focused laws, including requirements regarding hospital admitting privileges, patient transfer agreements or facility standards, have contributed to a decrease in abortion providers across the country.[15,16] Between 2011 and the middle of 2016, some 334 state laws related to abortion services were passed.[17] These laws especially affect many Southern and Midwestern states, and disproportionately affect women of color, young women and women living in rural areas.[2,18]

Some barriers to abortion services are not well understood. Specifically, there is more to learn about women's experiences with health professionals prior to seeking abortion; whether and how abortion referrals are offered; and how women seek abortion care without professional referrals. To address these gaps, we conducted a qualitative study with women who successfully obtained abortion care

in South Carolina. By exploring how they sought information, communicated with professionals, received referrals (or did not) and prepared for their appointments, we sought to highlight supportive and hindering conditions along their various pathways. Women's reports of their experiences can inform public health practitioners, social services providers, medical professionals and advocates as they seek to assure clear pathways to abortion care.

METHODS

Setting

This study was conducted in South Carolina in September and October 2014 in conjunction with Provide, a national organization working to increase the capacity of health and social services personnel to support abortion access. Provide's Referrals for Unintended Pregnancy training initiative works in Southern and Midwestern states that have limited abortion access to improve the delivery of comprehensive pregnancy options care, including abortion referrals.[19]

South Carolina has steadily enacted increasingly restrictive abortion regulations.[20] Prior to May 2016, abortion was restricted after 24 weeks' gestation,[21] but as of that date, the procedure was prohibited at 20 weeks, with exceptions for endangerment to the woman's life or health.[22] For women younger than 18, the consent of a parent or adult relative or judicial permission is normally required.[23] Legislation enacted in 2010 requires women seeking an abortion to document that they received state-issued information online or in a clinic at least 24 hours prior to the scheduled abortion.[24,25] This information covers a number of topics, including the legal right to view ultrasounds taken before an abortion, the stages and risks of pregnancy, and the methods and risks of abortion, as well as a list of South Carolina sites offering free ultrasounds.[25] In addition to the long-standing prohibition against using federal funds for abortion,[26] South Carolina prohibits coverage of abortion by most public and private insurance plans.[21]

At the time of the study, most abortions in South Carolina were provided at three freestanding abortion clinics located in different regions.[27] There were more than 30 crisis pregnancy centers in the state,[28] some of which were located near the abortion clinics. These centers typically offer free pregnancy testing and related services, such as ultrasounds, but are not staffed by professional medical providers. They do not refer for or offer abortion services, and often provide misinformation regarding abortion.[29]

Study Design and Interviews

We conducted 45 in-depth, semistructured interviews with women during their abortion appointments in each of the three South Carolina clinics (13–16 per site). Participants were recruited through convenience sampling from the pool of women who came in for abortions on days when the interviewer was on-site, in September and October 2014. Participation was restricted to English-speaking women aged 18 or older who indicated interest in the study on a form included with registration paperwork. Sample size was based on a typical qualitative goal of obtaining a range of responses until interviews no longer revealed new themes.[30] Some 13–21% of eligible women agreed to participate in a given sampling session.

The interview guide focused on women's experience in finding information on abortion services, experience with health professionals en route to abortion care, and perceived barriers to and facilitators of accessing abortion services. The guide was informed by three theoretical frameworks. The first, domains of social support,[31] distinguishes emotional, instrumental and informational support; the second, health services utilization,[32,33] encompasses systemic and individual characteristics that may influence health care use; and the third, a conceptual model developed by Provide,[34] focuses on personal and systemic characteristics that may affect providers' abortion referral behavior. We used these frameworks to assess the variety of support that women reported, to examine the range of obstacles and facilitators they encountered, and to provide insight into the interactions between health professionals and women while the latter were confirming their pregnancy. We also collected information on participants' demographic characteristics and abortion history.

Interviews lasted 10–30 minutes and were conducted in private rooms in the clinics at a point in participants' appointments when they would have otherwise been waiting for counseling or lab work. The interviews were digitally recorded, and upon conclusion, participants received a $40 gift card. The study was approved by the Boston University Medical Campus institutional review board.

Analysis

Interviews were professionally transcribed verbatim and uploaded into NVivo version 10. The first and fifth authors read three interviews to identify themes and domains, and developed a codebook. Ten interviews were double-coded, after which NVivo was used to compare and evaluate intercoder reliability (kappa, 0.7). We employed a thematic analysis approach[35] using domains specified a priori from our conceptual models and the literature, while also allowing for unexpected themes to emerge. Coding conflicts were resolved through discussion and consensus. Data analysis was iterative; the emergence of new themes in later transcripts prompted review of earlier transcripts to ensure that themes were applied as appropriate. We used process mapping[36] to construct women's pathways to abortion services. This technique helps portray care processes, delineate common pathways and identify points for improvements. This visual representation of potential pathways provided the scaffolding for thematic analyses of the variety of barriers and facilitators that participants described.

RESULTS

Sample Characteristics

Regarding age, race and ethnicity, women who participated in the study were similar to women who have abortions in South Carolina.[37] About half of participants were black, a third were white and the rest identified themselves as multiracial; one individual was Hispanic (Table 1). Most partic-

TABLE 1. Number of women in a sample of patients at three freestanding abortion clinics in South Carolina, by selected characteristics, 2014

Characteristic	All	Clinic A	Clinic B	Clinic C
Total	**45**	**13**	**16**	**16**
Race/ethnicity				
Black	25	9	9	7
White	15	2	5	8
Multiracial*	5	2	2	1
Age				
18–25	20	5	11	4
26–35	17	4	4	9
≥36	8	4	1	3
Residence				
Urban	18	7	6	5
Rural	21	3	10	8
Suburban	6	3	0	3
Insurance				
Private, through employer	15	7	3	5
Private, through parent	4	1	2	1
Public†	13	4	6	3
None	13	1	5	7
Miles traveled to clinic				
<25	25	7	10	8
25–49	14	4	5	5
50–100	5	2	1	2
>100	1	0	0	1

*Including white, black, Asian, Puerto Rican and Native American. †Medicaid or Veterans Administration.

ipants were aged 18–35, and roughly equivalent numbers of women lived in urban and rural areas. Almost half had private insurance, and nearly a third had public insurance; however, none of the plans covered abortion. Roughly half of participants had traveled less than 25 miles to the clinic, and a third had traveled 25–49 miles; six women had traveled at least 50 miles for their appointments.

Process Mapping of Pathways to Care

Our process map (Supporting Information) shows variation in individual women's pathways to care, but five steps were common to nearly all: discovering and confirming the pregnancy; deciding to terminate the pregnancy; learning where to go for an abortion; calling an abortion clinic for information and an appointment; and preparing for the abortion appointment. The process map traces women's potential contact with a variety of providers, supporters, facilities and entities at each step along the pathway and reveals that while some steps were relatively direct, others often became complex and convoluted. For example, the limited number of clinics made clinic selection straightforward. In contrast, preparation for the appointment included multiple decision points; in this step, participants often had crisscrossing pathways across multiple contacts, some of which presented potential barriers.

Thematic Analysis

We found distinct areas where women confront challenges and receive support. These areas were loosely divided into intersecting pragmatic and emotional domains, and mapped especially well onto the domains of social support theory.[31] In the pragmatic domain, participants described the challenges of the practical tasks of preparing for the abortion appointment—securing finances, arranging transportation and negotiating time away from work. In the emotional domain, participants revealed the range of feelings they experienced related to obtaining an abortion, including their experiences or anticipation of stigma.

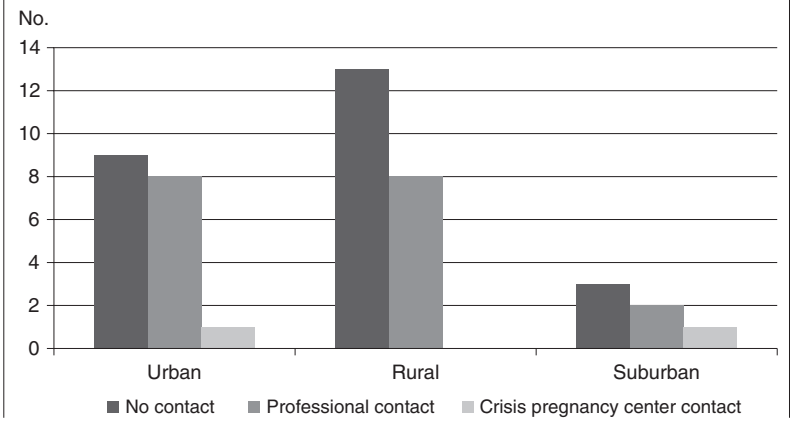
A major theme of judgment emerged throughout the process of seeking care and managing the pragmatic steps to obtain an abortion. Many women confronted (or feared confronting) the judgment of others, and many struggled with self-judgment. Some women indicated that the emotional aspect was their biggest challenge and that emotional support was the most helpful part of preparing for the appointment. Variations on the phrase "the hardest part is just knowing what I'm doing" were frequently used to describe the experience. Participants who expressed this feeling about the abortion also expressed confidence that it was the right decision. Especially noteworthy is how these feelings affected women's willingness and ability to seek needed support in advance of their appointment.

Women's descriptions of their experiences at each step en route to obtaining an abortion illustrate the complex emotional and pragmatic terrain they traveled along the pathway.

•***Discovering and confirming pregnancy.*** Twenty-five of the women had no contact with medical professionals or crisis pregnancy center staff to confirm their pregnancies prior to their abortion appointment (Figure 1). They described doing self-testing at home to confirm their suspected pregnancies. For example, a 27-year-old black woman who lived in a rural area reported, "I missed my period, and then I took a home pregnancy test."

Twenty women learned of or confirmed their pregnancy in an institutional setting prior to their abortion appointment—18 in a professional medical setting and two in a crisis pregnancy center. The professional contacts were in primary care or gynecology offices, urgent care clinics,

FIGURE 1. Number of women obtaining abortions who reported having had in-person contact with medical professionals or crisis pregnancy center staff for pregnancy confirmation prior to their abortion appointment, by residence



hospital emergency departments, Title X–funded family planning clinics or federally qualified health centers. The proportion of participants who had professional contact prior to the abortion was lower among rural participants than among those living in urban areas.

While most women visited institutional sites to confirm results of a home pregnancy test, five women had pregnancy tests only with a medical professional. Of these, three were surprised by the positive results during routine gynecologic or primary care exams, or an emergency department visit for an unrelated concern. Two women followed their home testing with visits to a crisis pregnancy center for confirmation. In these cases, one woman knew that the center's staff would actively counsel against abortion, but desired convenience and privacy; the other was surprised and angered by the center's antiabortion stance.

•Deciding to terminate the pregnancy. Though decision making was not a specific focus of the study, many women spontaneously described multifaceted reasons for their decision. Most described being unprepared to care for a new child in the manner they would like. Often their unreadiness was related to unstable finances, employment or housing, or to their relationship with the man involved in the pregnancy. A 28-year-old white woman who lived in a rural area noted that her boyfriend had three roommates and that she didn't "make enough to pay all of my bills [while living] at my grandmother's house, so there's no way that we would have been able to afford a little one at the moment." A 20-year-old multiracial woman who lived in an urban area shared similar concerns:

"[I'm] already struggling with my first child. In all reality, I got to look at the what-ifs and how things are going to be along down the line. Working a minimum-wage job and trying to take care of me and my child and [not having] my own place is already really hard. I know how it would be with two [children], so that's really it."

A few women focused on a desire to preserve the capacity to continue their education or career. Some women said that they either felt unready for or were finished with childbearing. A small number noted that continuing their pregnancy would increase the difficulty of separating from an abusive partner. Most women reported discussing their decision with the man involved in the pregnancy, friends or family; a small number said they had discussed their decision with no one.

•Learning about services. There was variation in whether health professionals discussed comprehensive pregnancy options with participants, whether they gave an abortion referral and how participants felt about their encounters. Of the 20 women who reported contact with a medical professional or crisis pregnancy center staff, seven were given a referral for abortion services. Of those who did not receive a referral, only four explicitly wished one had been offered, including one woman whose overtly antiabortion doctor recommended a crisis pregnancy center for "unbiased" counseling. Among those who saw a professional and did not request or receive a referral, most had already decided to seek an abortion.

Not all participants wanted to receive abortion information in these encounters. Some already had the information they needed, and others felt uncomfortable requesting this information, fearing judgment. When a 24-year-old black participant who lived in a rural area got her positive test results at a community health center, she reported not receiving information on her pregnancy options and interpreted this as a positive reflection on her character, commenting that it was "kind of a good thing they didn't assume the worst." A 32-year-old white woman living in a rural area described protecting herself by lying about her pregnancy plans to the nurse at a family planning clinic:

"They [asked] me if I [would continue the pregnancy], and I just said yeah, 'cause some people will judge you automatically.… I didn't tell them that I had already pretty much decided…. She seemed like she might be kind of judgmental, just the way she asked me.... I just got that vibe from her, like she'll probably treat me like crap, so I went ahead and lied."

Of the seven participants who were given referrals for abortion services, four reported feeling they were well treated and received nonjudgmental, thorough information. These women were seen in a family planning clinic, in an urgent care clinic, and by their usual gynecologist or primary care doctor. The interactions were characterized by direct communication and lack of judgment. One participant described her experience this way:

"We discussed all of the options, and he told me, 'If you choose not to go forward with the pregnancy, you can go here,' and explained what would be done [and] how the procedure would take place…. I've been with him for nine years, so the conversation was very easy."—*Black woman aged 37, urban*

The three women who described a negative or neutral referral experience received the requested information, but felt judged or were treated indifferently. An 18-year-old black woman who lived in an urban area told how an urgent care clinic doctor provided the requested abortion referral handwritten on a diabetes pamphlet, after which his demeanor changed from friendly to curt:

"After I said, 'Well, maybe I don't want to keep it,' he was like, 'Wait,' and walked out of the room. And then he gave me a brochure that somebody had written on 'Planned Parenthood,' and then he just left. I thought it was rude. You're a doctor, you're a professional."

A 31-year-old white woman who lived in a rural area received a referral from a family planning clinic nurse. She got the information she needed and described the interaction as neutral: "It was more or less, 'Good luck with your pregnancy. Here's some information.' They didn't go into detail as far as what I was gonna pursue. It was cut and dry. There was no conversation. They didn't discuss options."

Women who had no contact with a professional or a crisis pregnancy center, or had contact that did not provide

helpful information regarding abortion, used other means to learn where abortions were available. Many looked for information online, typically searching on the phrase "abortion South Carolina." Most participants said that finding the websites for the three clinics was easy, and that the sites provided accurate, comprehensive information.

In the search for a clinic, some participants reported accidental encounters with crisis pregnancy centers. A few reported finding these centers' websites and calling them, thinking they were "the same as Planned Parenthood." The resulting conversations, in which centers' workers discussed religious and antiabortion themes, were reported as frustrating or upsetting. A 37-year-old black woman who lived in an urban area said, "I accidentally called [a crisis pregnancy center], trying to look for a clinic, and [the woman who answered] was at one of the anti groups.… It was kind of a difficult conversation. She was really nice, but I just felt this kind of judging [of] people." Another participant reported the following interaction:

"I thought it was going to be a place similar to Planned Parenthood, but it wasn't. They were very into the religious aspect of it,… like you're sinning, you're going to be punished for this if you do it, and trying to talk you out of it.… They said you have other options—there's abortion or adoption or raising it, but they mainly talked about raising it yourself or adoption.… I left kind of angry."—*White woman aged 24, urban*

In addition to online searching, women reported knowledge of the clinics because of their own previous abortion or that of a friend or family member. Of the 21 patients who had had a previous abortion, only one-third had contact with a professional or a crisis pregnancy center prior to the current appointment. Of the 24 participants with no abortion history, more than half reported such contact. Some of these 24 women had previously accompanied someone to an appointment or had heard about the clinic, and others got information from a friend or family member. A few said they knew where the clinic was because in the past they had seen protestors outside.

•Contacting the clinic. Women described clinic staff as thoughtful and thorough. Some spoke of feeling nervous about clinic treatment, but uniformly reported feeling reassured once phone contact was made. A 25-year-old black and Native American woman who lived in a rural area described her experience:

"That lady on the phone was so sweet, so nice and kind-hearted. She gave me courage, just like it's OK to come in here. Those protestors out there say things that make you really think.... She was like, 'Well, you know, that's their opinion.' They don't know my situation."

Participant experience varied regarding appointment scheduling and timing. In two clinics, abortions could be booked only on certain days because of the rotating schedules of doctors. Limited availability made scheduling more difficult and sometimes resulted in delays in care. As one 24-year-old white woman from an urban area described her situation, "I made an appointment, which was for three weeks later, which was just nerve-wracking and horrible." In the third clinic, two local doctors provided abortion services six days a week; their availability allowed women greater flexibility in scheduling. Participants reported that the staff described their appointments as "penciled in," giving them a sense of unhurried reassurance. If women wanted more time to think or prepare, they were reassured that rescheduling would not cause significant delay.

Some women noted that their appointments at two clinics were delayed because of unexpected scheduling challenges. For example, one clinic introduced an electronic medical record system and scheduled fewer patients during the transition period. One participant reported that her appointment was postponed as a result of physician scheduling problems. Such delays could be caused by situations that commonly occur in many medical settings, but they highlight the precarious nature of abortion access in states with few providers.

•Preparing for the appointment. The greatest logistical barriers occurred as women prepared for their abortion appointments. They described the financial burden of paying for the abortion, arranging transportation and negotiating time off work for the appointment and aftercare. Though the interviewer asked participants about child-care arrangements, they did not consider this aspect of preparation to be a major challenge.

The majority of women reported difficulty paying out of pocket for the abortion. Many described making adjustments to assemble the funds, including putting off other payments, such as a car loan; refraining from "extras," such as meals in restaurants; and dipping into a "Christmas gift fund." Multiple women said the abortion expense was a temporary setback or onetime expense, in contrast to the long-term financial commitment of raising a child. For example, one woman related the following:

"I'm emptying my bank account today.… There are some things that are not going to get paid that probably should have been paid today. But in the long run, [having the abortion is] going to actually benefit us because we're not going to be taking away from our earnings continuously. We're just taking away this time so that we can continue to build further."—*Black woman aged 34, suburban*

For some women, the fee required their whole paycheck, meaning they would be "short" or "tight" on money for a few weeks. Others said they could afford to make the payment, but "just barely." Several participants noted that they had had less money in general lately because of lost wages resulting from pregnancy-related symptoms. Some women borrowed from or were given money by friends, family or the man involved in the pregnancy. A 31-year-old white woman living in a rural area described how she covered the cost:

"I actually had to get a loan for some of it. And a dear friend … sold some of his stuff and helped me pay for half.… If it wasn't for him, and me having a little bit of credit to fall back on, I don't know what I would have done."

Some women described the need for financial help as frustrating and embarrassing, regardless of whether they disclosed the reason for the request, and expressed concern about others' being short on money as a result of helping them. A few feared that asking for help made them appear irresponsible, while others described receiving needed support from a loved one as affirming. Some participants received financial assistance from clinics (e.g., military or student discounts) or need-based grants from local or national abortion funds. A 23-year-old white woman who lived in a rural area characterized such assistance in this way: "The [clinic's] financial assistance really did help.... That's an extra 200 to 300 dollars that's just not there, and insurance doesn't cover."

A number of women reported that it was difficult to reach organizations that provide abortion funding because of high demand on both the organizations' dollars and their phone lines. According to a 24-year-old white woman from an urban area, "I never did speak to anyone [at the fund], because the phone line is always busy because it's national."

Several participants expressed bitterness over the fact that their abortion was not covered by insurance. One woman pondered why her primary care doctor could not simply give her the pills for a medication abortion. Another said she felt the state's refusal to enable Medicaid expansion was directly responsible for people's being unable to afford raising children, and so may influence childbearing decisions. (Notably, Medicaid does not pay for abortion in South Carolina.)

Respondents noted one positive aspect of the finances for abortion—the transparency of costs. Participants reported that direct communication from clinics regarding all possible costs was reassuring and clarified financial needs. For participants who had received past medical care without such clarity about the exact pricing, this was a great relief.

Employed participants reported diverse experiences regarding taking time off for the appointment, the time needed for having a medication abortion at home and the suggested postabortion recovery period. Some participants managed their own schedules, and their concern was primarily over lost work time. Others needed supervisor approval for time off. Some had supervisors with whom they felt comfortable explaining why they needed the time, and so anticipated a compassionate response; however, many participants feared judgment if their supervisor knew of the abortion. For example, a 26-year-old white woman from an urban area said, "I just want to go to work afterwards, but I don't know if I'm going to be able to. And then if I have to call out, I don't know what to say. I don't feel like I should have to tell them what happened or what I'm doing."

Some participants anticipated stigmatizing reactions from others, which led to self-protective secretive behavior. One woman compared such reactions to mental health care stigma, saying that she would readily explain her work absence to a colleague if abortion were viewed like any other medical procedure, but as the situation stands, it felt risky to do so:

"With appointments like this, it's more hush-hush.... You don't really want to go into detail, because you don't know how some people might react. It's kind of the same way with mental health care, and everyone's hush-hush about that.... You don't want people to know you were here." —*White woman aged 24, urban*

Several participants reported that their work schedules prevented them from scheduling the abortion as they truly wished. One woman had an aspiration abortion rather than the desired medication abortion because of work-related scheduling delays; another woman experienced delays that led to her having the abortion at a clinic that was not her first choice.

Because of the scarcity of clinics, transportation was another obstacle. At all three clinics, oral or intravenous sedation is recommended as standard care for women receiving aspiration abortions, and many women agreed to this. These women required a ride home following their procedures. For some, securing a ride from their partner, friends or family was simple, but for others, this requirement presented a major challenge and may have necessitated unwanted disclosure.

Getting a ride required an additional element of organization and planning. The driver had to be able to come at the scheduled time and then often wait for hours, possibly rearranging his or her own work schedule to do so. For patients traveling from a distance, this meant a longer time commitment by the driver, as well as increased fuel costs. As a 21-year-old black woman who lived in an urban area explained, "I don't have my own car, so I had to get a friend to drop me off. It was a challenge, because I didn't really tell too many people about [the abortion], and the people who knew were busy or out of town." In some cases, women received unanticipated support, as did a 37-year-old white participant living in a rural area, who related: "One friend committed to doing it and then backed out, [so] I had to ask my stepmom. It was difficult. She was understanding, though." Some women, however, received the negative response they had anticipated, as did a 38-year-old black woman from an urban area, who encountered antiabortion beliefs: "My sisters wouldn't give me a ride,... so I had to ask an outsider.... I wish they could have understood this [and been] supportive."

Because one clinic was located next to a crisis pregnancy center and shared a driveway and similar signage, several participants described accidentally going into the center for their appointment. They were not aware of being in the wrong place, and staff did not point this out. Rather, staff attempted to dissuade them from having an abortion. These participants eventually went to the clinic for their appointments, but the experience was unnerving. A 32-year-old white patient who lived in a rural area described her interaction with a crisis pregnancy center worker:

"I walked in and was telling the lady that I was there for the abortion pill, and she [said], 'All right, come in this room.' [I said,] 'Oh gosh, I'm at the wrong place,' and she [replied], 'No honey, you're at the right place.' … I just wanted to hurry up and get out of there 'cause I felt like she was judging me. [Then the lady said], 'No, you came here for a reason,' and I [said], 'No!'"

None of the women interviewed expressed difficulty complying with state requirements prior to the abortion, such as accessing state-mandated information online or printing the required form to bring to the clinic.

DISCUSSION

Our study is one of few we are aware of to describe women's self-reported experiences along the pathway to obtaining abortion care. We focused on how women sought information, interacted with medical professionals and crisis pregnancy center staff, received referrals (or did not), and encountered support and barriers during the process of seeking care. Our study, conducted in South Carolina, offers a window into women's experiences in a restrictive setting. We identified a range of interrelated logistic and emotional challenges women faced on the path to receiving timely and affordable abortion care, reinforcing and expanding on prior studies.[2,3,13,38–40]

While the majority of abortion patients interviewed used home pregnancy tests, nearly half had subsequent contact with a health professional or crisis pregnancy center to confirm the result. Only seven out of 45 participants received abortion referrals, and one was given an inappropriate referral to a crisis pregnancy center. This low rate of referral is similar to that found in a Nebraska-based study,[38] in which nearly half of the 365 abortion patients surveyed had contact with a clinician prior to their abortion appointment, but only 31 received an appropriate referral. Similarly, a multistate study using simulated patients[39] found that fewer than half of calls to reproductive health centers that did not provide abortion resulted in a direct abortion referral.

Several participants who asked about abortion referrals felt judged by their clinician. Some indicated they did not ask for fear of judgment or said their clinician preemptively spoke dismissively of abortion. In addition, self-judgment was a common theme in women's descriptions of their biggest challenges regarding obtaining an abortion.

According to some study participants, scheduling their abortion promptly was challenging. As found elsewhere,[41] reasons noted for this delay included unavailability of appointments, work schedules and transportation challenges. Contrary to what has been found in other research,[2,3] though many participants in our study described the financial burden of obtaining an abortion, few named this as a reason for delaying their appointment. We do not know whether the results would have been the same if we had asked more direct questions about reasons for delays.

Nonetheless, paying for care was a significant challenge for most, but not all participants, regardless of insurance coverage. Though about three-quarters of our participants had health insurance, none were covered for abortion services, and procedure costs ranged from $400 to $1,000 (as determined via phone inquiries to clinics). The low end of this range is similar to the national average for a first-trimester abortion, and 2–4 times the average annual out-of-pocket health care spending for uninsured women aged 25–34.[4] Our findings are similar to those of another study on abortion costs and payment.[2] Many women reported receiving financial assistance from friends, family members or the man involved in the pregnancy, as well as using clinic discounts and abortion funds when possible; one woman took out a loan to pay for her procedure. Also mirroring related research, our findings revealed that for some participants, this expenditure would temporarily prevent payment of bills or the purchase of necessities or "extras." For a small number of women, asking for financial help was either a source of embarrassment or an opportunity for welcome support.

Our study complements other small studies examining women's self-reported experiences of seeking abortion care. Collectively, the findings point to the need for a wider net of medical professionals who are committed and trained to offer practical and emotional support to women as they navigate the sometimes difficult pathways to timely, affordable and nonjudgmental abortion care. Likewise, expansions of abortion funding for low-income women and clinic discounts based on income and student or veteran status would ease the financial difficulty of accessing abortion for many women, especially given the fragmented insurance coverage in the United States. Because of the uneven and constantly shifting legal and social environment regarding abortion care—and the wide variation across the country—such initiatives will be best served by state- or region-specific research to identify specific gaps and opportunities.

Limitations

The main limitation of this study is that we restricted our sample to women who had successfully obtained abortion care. Hence we did not include the perspectives of women who had considered abortion but could not locate services or overcome obstacles to care, or of those who did not attempt to seek abortion services despite their desire because they believed it would be impossible. The sample did not include women who traveled out of state for abortions, who were seen by a private doctor or in a hospital, or who performed a self-induced abortion outside of a professional setting.

The characteristics and experiences of this convenience sample may differ from those of eligible women who did not participate in the study. Participation might have increased if we had been able to conduct interviews off-site or on a different day, but logistical considerations precluded these options. Finally, we could not distinguish which obstacles that participants identified would have been the same in any state, regardless of its similarity to South Carolina.

Conclusions

Our study identifies a variety of challenges that women may encounter as they seek abortion care in South Carolina. Further research on women's experiences regarding abortion services, and how these individuals may be affected by evolving state policy environments, will help shape initiatives to support timely, affordable and safe abortion care in a climate of increasing restrictions.

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