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ABORTION PATIENTS' PERCEPTIONS OF ABORTION REGULATION

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Purpose. **Most states regulate abortion differently than other health care services. Examples of these regulations include mandating waiting periods and the provision of state-authored information, and prohibiting private and public insurance coverage for abortion. The primary purpose of this paper is to explore abortion patients' perspectives on these regulations.**

Methods. **We recruited 20 participants from three abortion providing facilities located in two states in the U.S. South and Midwest. Using a survey and semistructured interview, we collected information about women's knowledge of abortion regulation and policy preferences. During the interviews, women weighed the pros and cons of abortion regulations. We used grounded theory analytical techniques and matrix analysis to organize and interpret the data.**

Results. **We discovered five themes in these women's considerations of regulation: responsibility, empathy, safe and accessible health care, privacy, and equity. Women in the study generally supported policies that they felt protected women or informed decisions. However, most women also opposed laws mandating two-day abortion appointments for women who were traveling long distances. Women tended to favor financial coverage of abortion, arguing that it could help poor women afford abortion or reduce state expenditures.**

Conclusions. **Overall the study participants' opinions on abortion policy reflect key values for advocates and policy makers to consider: responsibility, empathy, safe and accessible health care, privacy, and equity. Future work should examine abortion regulations in light of these shared values. Laws that promote misinformation or prohibit accommodations of unique circumstances are not consistent the positions articulated by the subjects in our study.**

Introduction and Background

Since *Planned Parenthood of Southeastern Pennsylvania v. Casey* [505 U.S. 833 1992], states have been granted increasing latitude to implement laws that regulate abortion by prohibiting public funding, mandating waiting periods, requiring state-mandated information, or compelling adolescents to obtain parental involvement in their abortion decision (Weitz, 2009). The antiabortion movement has embraced this strategy of incremental policy making at the state level to "protect women from the dangers inherent in abortion and to protect unborn victims from increasing levels of criminal violence" (Burke, 2008, 34) Abortion rights advocacy groups including the American Civil Liberties Union and the Center for Reproductive Rights have fought these policies arguing that they interfere with a woman's right to an abortion by placing an undue burden on both patients and providers (see www.aclu.org/reproductiverights and www.reproductiverights.org). Public health research supports the claim that *some* state laws interfere with women's access to a timely abortion (Dennis,

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Henshaw, Joyce, Finer, & Blanchard, 2009; Henshaw, Joyce, Dennis, Finer, & Blanchard, 2009; Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009) and reviews of the content of state-mandated information laws find many of these materials include significant scientific inaccuracies and false and misleading information (Gold & Nash, 2007). Due in large part to the tireless political efforts of abortion opponents, 33 states now have some law or policy specifically related to state-mandated information, 24 states require a waiting period, 32 states prohibit state Medicaid funds from paying for abortion, 4 states restrict private abortion insurance coverage, and 35 states require parental involvement (Guttmacher Institute, 2008).

Public opinion polls find that most Americans favor these laws (Gallup Poll News Service, 2007). There is no research, however, exploring the policy preferences of women who have or have had abortions. The purpose of this paper is to explore the perspectives of women who have abortion on the policies that are meant to govern their abortion experience. We investigate women's viewpoints on three different categories of abortion regulation: mandated information and mandatory waiting periods, Medicaid/insurance prohibitions, and parental involvement requirements.

Methods

The Heartland Abortion Regulation Project is a qualitative study exploring abortion patient's and abortion provider's opinions about abortion regulation. This paper focuses on the interviews we conducted with abortion patients; however, we refer to some of the provider interviews to provide context to the answers we received from patients. We used semistructured interviews with 20 women at the only three high-volume abortion facilities[1] in two states in the U.S. South and Midwest. Because of the incredibly small number of abortion providers in their region, the participating recruitment sites requested anonymity to protect them and their patients from becoming the targets of increased surveillance. Both states require the provision of state-mandated information and a waiting period, parental consent for minors, and restrict financial coverage of abortion. In addition to minor differences in state regulations, interpretations of the regulation differ among providers in each state so that women's experiences vary widely.

Potential interviewees were approached in the course of one of their abortion care appointments, consultation, procedure, or follow-up by a clinic staff member. Interested women were introduced to an interviewer who described the study and assessed their eligibility. All interviews took place within 2 days of participant recruitment, most taking place on the appointment day. To increase the richness of our data, we intentionally sampled participants from diverse age and race/ethnic groups. After our first several interviews, we asked clinic staff to help us recruit more African-American and Latina women to increase the ethnic diversity of our sample. Women's ethnicity was determined by staff through interactions with patients or a review of their medical records. Seventeen women were approached by a health worker, nurse, or clinician who gave them a study flyer and offered to introduce them to a field investigator. Two additional participants were referred by a physician without a flyer and one woman self-referred from a flyer she saw outside of the clinic. From these contacts, interviewers spoke to 32 women; of these, 30 women made interview appointments and 20 completed their interviews and surveys. Each participant received $30. Interviews were conducted in person by two female interviewers, the principal investigator, a doctoral-level sociologist, and a trained researcher with a Master's in Public Health and additional qualitative research training. We conducted interviews in four different trips to allow for ongoing data analysis. We stopped recruiting participants when we began to receive redundant answers to most of our questions. All study procedures were approved by the Institutional Review Board (IRB) at the University of California, San Francisco.

We surveyed interviewees for demographic information including age, race/ethnicity, years of education, and the number and outcomes of previous pregnancies. We also asked about the total cost of abortion, including abortion price, the cost of travel and child care, using pretested items from a study of out-of-pocket costs for abortion (Van Bebber, Phillips, Weitz, Gould, & Stewart, 2006). Finally, we collected information about various sociopolitical and cultural factors including religious and political affiliations.

The semistructured interview guide contained five sections: 1) Determining Pregnancy, Locating an Abortion Clinic and Having the Abortion 2) Abortion as Healthcare Service 3) Opinions about Abortion 4) Regulation of Abortion; and 5) About the Future. In this paper, we focus on Section 4, which explored women's opinions of the laws in their state including what they thought the laws were, how the laws affected their abortion, how they believed the laws were made, and who they thought benefited from the laws.

It is important to note that not all of our study participants were subject to the abortion laws in their states. For example, the women in our sample were over the age of 18 at the time of interview and therefore were not subject to the mandatory parental consent law. In the case of the insurance and Medicaid prohibitions, many women were not subject to these laws because

[1] "High-volume" abortion facility refers to clinics which provided more than 1,000 abortions per year. We selected these sites to ensure that there were sufficient numbers of patients available for recruitment on the days we visited the clinic.

Table 1. Study Subject Demographics

	Demographic Information					Pregnancy History	
Pseudonym	Recruited from	Age	Ethnicity	Educational Background	Monthly Income	No. of Children	No. of Abortions
Aisha	State A, Site 1	21	Native American	Some technical	0	1	2
Amanda	State A, Site 1	25	White	Some college	1,500	4	1
Angela	State B, Site 1	20	Black	Some college	0	1	2
Beth	State B, Site 1	39	White	Some college	0	2	1
Cassie	State A, Site 1	25	White	College graduate	2,666	0	1
Cheryl	State A, Site 1	43	White	GED	2,300	2	1
Deb	State A, Site 2	41	White	Graduate student	>2,500	1	1
Jackie	State B, Site 1	Unknown*	Black	Some college	Unknown*	3	2
Jennifer	State A, Site 1	27	White	College graduate	1,500	0	1
Jessie	State A, Site 1	18	Polynesian/ Native American	High school	0	0	1
Jordan	State B, Site 1	25	Black	High school	1,200	1	1
Joy	N/A	28	Native American	College graduate	1,500	0	3
Lisa	State A, Site 1	23	White	Some college	0	2	2
Lyndsay	State A, Site 1	18	White	High school	<2,500	0	1
Makayla	State A, Site 2	27	Black	Some graduate	1,800	2	1
Maricel	State A, Site 2	24	Hispanic	Some high school	1,500	1	2
Sonja	State B, Site 1	25	Black	College graduate	1,000	0	2
Tanya	State A, Site 2	25	Black	College graduate	2,000	4	1
Tricia	State B, Site 1	19	White	Some college	500	0	1
Vanessa	State B, Site 1	23	Black	College graduate	1,500	0	1

* Survey incomplete.

they "chose" to pay out of pocket rather than seek coverage through an insurance carrier. Additionally, in some states mandated information contains overtly misleading and erroneous information related to the physical and mental risks of abortion. However, in the states where we conducted our research the state-mandated information was intended to encourage motherhood or adoption by fostering a bond between the pregnant woman and her fetus (in the case of fetal pictures or ultrasound viewing) or to encourage her to consider alternatives like adoption or motherhood (by providing the names and numbers of crisis pregnancy centers and state agencies which provide information about welfare services).

Because the purpose of this study was to understand women's knowledge of and attitudes toward policy more generally, women's answers are meant to give us insight into the way that women who have abortions might think about the policies that affect their abortion care. We endeavored to adjust our interview to the participant's fluency in health care and policy. Some women were uninformed of the role of the government in health policy, whereas others had complex and informed opinions. Although our questions were not and could not be standardized, we did discuss the same three regulatory concepts with all of the women in the study: mandated information and waiting periods, parental involvement, and Medicaid and insurance coverage.

Transcriptions of audio recordings were compared the text to check for accuracy. We used fictitious names to label the transcripts and database our demographic information. We used the software program Atlas.ti 5.0 to code and memo interview transcripts. Using grounded theory analytical techniques, initial line-by-line coding led to the development of axial codes based on themes discovered in the text (Charmaz, 2006). The codes produced useful categories of behaviors, experiences, feelings, and beliefs. We conducted further analysis using a matrix technique (Ulin, Robinson, & Tolley, 2005). Based on the questions in our semistructured interview guide and some of our codes, this analysis allowed us to compare responses across participants. It also allowed us to explore the opinions of each participant across questions and themes.

Results

Participant characteristics

Participant's demographics are presented in Table 1. Among the women in our sample, the cost of the procedure ranged from $370 to $1,575. Six of the patients traveled more than 60 miles for their abortion appointment(s) and four traveled more than 100 miles. The cost of travel for the women depended on the distance traveled and ranged from $5 to $200. The reasons for choosing abortion among the women in our sample were diverse, but for most they matched the general categories identified in recent research "that having a child would interfere with a woman's education, work or ability to care for dependents; that she could not afford a baby now; and that she did not want to be a single mother or was having relationship problems" (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005).

General knowledge of abortion law

We began our regulation questions as follows: "Before you became pregnant were you aware of any rules or laws that might affect being able to get an abortion?" Overall, the women in our study did not have knowledge of state-level regulations on abortion. Only two women knew about parental consent laws; one had learned about it in a "women's studies" class in college and the other was subject to the law with her first pregnancy at age 17. One woman had better understanding of waiting periods because she had had a previous abortion in another state without a waiting period. Five women offered that regulations exist to limit the gestational age at which a pregnancy can be terminated. Although they were correct, gestational limits were not the focus of our study. Finally, one participant was unsure that abortion was legal before she became pregnant.

State-mandated information and waiting periods

Both of the states we studied had state-mandated information and waiting period laws. In State A, abortion providers must offer a booklet that details how an "unborn child grows" during each week of pregnancy, abortion methods, risks and emotional reactions, the medical risks of birth, women's rights with regard to abortion care and child support, and a list of state resources that help to pay for pregnancy. Providers must also offer women the opportunity to look at their sonogram picture before having an abortion. To comply with the state law, one clinic in State A offered one-day appointments to all clients by instituting a phone counseling script and offering to send the booklet by mail. Another clinic in State A scheduled all patients for two-day appointments unless they were traveling from a long distance. In these cases, a staff person read portions of the booklet to the client over the phone before their abortion appointment.

In State B, state law required that a woman may not obtain an abortion until at least 24 hours after a *physician* has discussed with the patient the risks associated with abortion including physical, psychological, and "situational." Our recruitment site in State B was able to maintain a one-day appointment schedule for out-of-town patients by having a doctor available for phone consultations on certain days.

One primary finding in this study is that having an abortion in a state with "state-mandated information" does not correlate with women either a) knowing that they are following a state mandate or b) being able to distinguish the state mandated information from other counseling provided by the clinic. Our discussions of "state mandated information" instead revealed the types of information that women felt were important to their own abortion decision and the types of information they felt other women needed to know before having an abortion.

Among women in our sample, there was a near consensus that certain types of mandatory information were a good thing.

> So that a woman can't turn around and say that it happened so fast that she didn't make an educated decision. I mean, I think that a lot of laws, regulations that are anything medical have to do with a lot of malpractice suits because I know that that's a very big issue right now. (Lisa, age 23)

Women suggested that such information could point out a woman's rights, answer questions, help women to make informed decision, and explain risks. These comments imply that women who have abortions support regulations which they believe they are designed to protect the rights and health of women or to protect clinics from lawsuits.

On the other hand, some women who supported the provision of information were suspicious of the state's role and feared that such information could be used to mislead women or influence a woman's abortion decision.

> I think it's always good to know what you're doing and to read information first. But again, it depends on what the state information says. If it's just, you know, fairly unbiased scientific facts I think that's fine. (Joy, age 28)

Women also commented on the mandated information that included images of fetal development and the law related to ultrasound viewing. Some women stated an explicit desire to see either the ultrasound picture or images of fetal development, whereas others expressed a suspicion that the state's laws were intended to coerce their decision.

> This to me is one of those things where they want you to look and see what it is. And they want you to, they want you to look, and, and see exactly what it is that you're doing. And they, it's almost, it's almost like they want, they want you to understand that this is, that they are right, this is murder, you are killing a living, breathing thing, and we're gonna tell you, you know, what's going on exactly. (Cassie, age 25)

We asked women to consider laws which mandate that women wait 24 hours after receiving state-mandated information before they have their abortion. A common criticism of such policies is that they will cause women (especially those traveling from out of town) to delay their abortion care. Yet, most of our patients had one-day abortion appointments. Of those who were traveling from out of town, only three were required to stay overnight. Of these three, two stayed overnight because of the nature of the care they were receiving rather than state regulation.

As was the case with state mandated information, most of the women in the study were unaware that the waiting period was a state-mandated policy. When asked to develop a hypothesis about why

a law requiring women to wait might exist, women were in agreement with one another. "Maybe because they think that people jump too quickly to hurry up and get it done" (Jackie, age unknown). Women who supported the law believed it existed to help women make good decisions and prevent regret. As one woman said, "You can't reverse it." Another woman guessed that the law might be of some assistance to clinics because it allowed them to schedule sonograms and get test results. This suggestion was supported by our interviews with providers who maintained two-day appointments for most patients for scheduling rather than regulatory reasons.

In an interesting contrast with their claims that state-mandated information and waiting period requirements may assist with decision making, most women said they made their personal decision before they made an appointment at the clinic.

> *Interviewer*: And do you think it mattered to talk to the doctor 24 hours before the abortion?
>
> *Jackie*: No, not for me because I already knew what I wanted to do.

In fact, responses to the question of whether a waiting period was a good law often included a caveat that while "for me" it was unnecessary, "other women" might benefit from the law.

> Like I said, where I got the first one it was just same day counseling, same day everything and I got it. But I'm okay with this because I realize also people need to go through education but it's just a little bit annoying if you already know the process, so, yeah. (Sonja, 25)

We asked our out-of-town participants to consider what it would be like if they had to stay overnight for their abortion appointment. One woman, put it this way: "stressful, a pain in the butt." Another woman who lived only 1 mile from her clinic considered the trip to the next closest clinic (300 miles away) and said simply, "I'd probably end up… just having the baby instead of going all the way up there." As one woman put it, waiting periods are a "good policy" but not a "good law."

Insurance and Medicaid

Although 10 of the 20 women in our sample had some type of public or private insurance, all of the women in our study paid the full out-of-pocket cost of their abortion. Of the women who were insured, only two women attempted to get coverage for their abortion. The remaining women did not attempt to get coverage because they already suspected their insurance would deny them coverage or because they did not want their insurance provider, employer, or parents to know about their abortion.

We asked women to consider why abortion was not covered by insurance. One woman suggested that the insurance companies may be owned by "religious" individuals who oppose abortion. Another woman explained that Medicaid did not cover abortion because it was "controversial" and thus taxpayers would be opposed to abortion coverage. Many women expressed surprise that *other* states provided Medicaid coverage for abortion services. This caused one woman, who opposed Medicaid coverage, to change her mind and express a desire for fairness across state boundaries.

Unlike the other regulations that women considered in this study, more women were opposed to restrictions on insurance and Medicaid coverage than were for them (13 opposed restrictions, 7 favored them). Women had both conservative and liberal arguments for supporting Medicaid coverage. On one side, women cited the fact that women who have abortions are less likely to draw money from tax-funded programs for mothers and children.

> Five hundred dollars versus thousands? That's incredibly idiotic…. The whole Medicaid thing, I think that should, it should definitely be paid for. Most definitely. Save us a lot of taxpayer money. (Beth, age 39)

Other women felt that Medicaid payment for abortion was important because some women needed support and would not be able to find it elsewhere.

> I know someone might not be as fortunate as I am…. so what does a person like that do? (Sonja, age 25)

One woman pointed out that because men are not required to pay for the abortion, Medicaid and insurance coverage provides equity for women who are responsible for the full cost of the abortion. Another woman supported insurance payment for abortion because it validated the women's need for abortion.

Still many of the women in our sample favored restrictions on Medicaid and insurance coverage. These women's concerns about insurance coverage of abortion included fear of women abusing the welfare system; fear that other health priorities would be ignored by reallocating resources; fear that abortion coverage would infringe on an insurance company's rights; and fear of lost privacy. In addition, some women felt that because pregnancy was "preventable" that Medicaid should not be responsible for paying for the abortion.

> *Interviewer*: Do you think insurance should pay for abortion?
>
> *Maricel*: No. Because something that you did, that you, mostly that you asked for it because when you're having sex you know what you're doing. So pretty much it's not something that, it's something that you can prevent. (Maricel, age 24)

Although these women were not supportive of insurance coverage of abortion in most circumstances, most supported exceptions for pregnancies that are the result of rape or incest or when the health of the fetus or woman are compromised.

Parental involvement

In both of the states that we studied, women under the age of 18 were required to obtain consent from at least one parent to have an abortion. Owing to our university IRB's requirements for obtaining informed consent, we were unable to interview women under the age of 18 in states where they could not independently consent to an abortion. However, many of our participants were able to draw on experiences with adolescent pregnancy as they considered our questions: six had experienced a previous adolescent pregnancy and three were under the age of 20 at the time of their interview.

Women in our study expressed strong ambivalence toward parental involvement. In their responses, women balanced competing rights: the rights of teens to make decisions for themselves and the rights of parents to make decisions for their children. Women's characterizations of teens ranged from careless and in need of direction to vulnerable and in need of protection; and characterization of parents ranged from compassionate and concerned to abusive or disinterested. Because the majority of women in our sample already had children, many women drew on their experiences as mothers. However, women also considered their own teen years in their appraisal of the abortion regulation. These issues often came up simultaneously in responses to questions about parental involvement:

> I understand [requiring parental consent for minors] because you're not your own guardian at that time and for whatever reason, for whatever might happen, you need somebody who's a parent or a guardian to support you. In that instance I will agree with that but I don't think it's more of the parent deciding for their child whether/if you have to have the baby. I think in that perspective it wouldn't be right because what if the child cannot handle it [the pregnancy]. But if it's for the support that they will need to go through the procedure, I would say yeah. (Sonja, age 25)

Negative characterizations of both teens and parents came into play in the discussions of the law. Women also drew on personal experiences. Lyndsay, who was 17 at the time of her first pregnancy, considered her experience an example of negative teen behavior:

> But, I think that it's a good law that you have to be 18 or older only because there are so many girls in high school that are just so careless about it…. Because I wasn't 18 [in my first pregnancy] it kind of like made me have to stop and think and. . . why . . . just I was being careless, you know just like "oh well, there's abortion out there." (Lyndsay, age 18)

Discussion

Most women in our study characterized their own abortion decisions as a good and thoughtful decision made in difficult circumstances. Yet their consideration of abortion regulation indicates that accepting their own reasons for abortion did not always translate into beliefs that other women had equally thought through their decisions. There was a consensus among our participants there are some circumstances or some women who need more regulation. Women were mostly unaware of the regulation of abortion before our discussions of abortion policy, yet their discussions of the merits and drawbacks of regulation offer important perspectives for consideration. There were five recurring themes in women's discussions of regulation: equality, informed decision making, responsibility, empathy, and privacy.

The concept of equality appeared mostly in discussions of insurance coverage for abortion. Some women argued that state laws should be universal so that women in one state would have the same benefits and restrictions as women in other states. In an alternative interpretation of equality, some women felt that poor women should be able to access Medicaid coverage so that they could get an abortion regardless of financial status. Overall, discussions of equality centered on women having equal access to abortion among themselves rather than women having equal parenting options in their relationships with men.

Because women did not feel well informed about abortion before their unplanned pregnancy, many expressed a desire to be informed and protected. Women in our study confused clinic policy with state regulations and it was often unclear whose responsibility it should be to provide information and protection. Nevertheless, women suggested that abortion regulation can "benefit women" by informing them about the risks of abortion and protecting them from bad health care experiences. Hearing about regulations like mandatory information and waiting periods seemed to enhance trust in the medical process. One surprising finding related to informed decision making was women's assertion that these types of regulation may prevent negative emotional consequences. Such answers showed both an acceptance of the concept that abortion can lead to negative emotional consequences and a willingness to be regulated in order for other women to be protected from such consequences. Because few women in our study considered their experience impaired by the existing regulations regulation, it is unknown whether their opinions about informed decision making would remain stable in the face of more restrictive legislation.

Making a responsible abortion decision was also of paramount concern for women in this study. Women felt that *information* leads to better decisions, which in turn protects women, fetuses, and clinics. Instead of interpreting the abortion right as an aspect of gender equality, our participants were more likely to argue that the abortion right should be earned through

information gathering and soul-searching. Relying on this interpretation, many women supported regulations that would, in their mind, reinforce a responsible decision-making process. Women in our study also expressed a concern that if abortion were too easily available then women would not take responsibility for the negative outcomes of their sexual and contraceptive behavior. Multiple abortions were a primary example of irresponsible behavior that might be prevented by regulation. Despite these opinions, several of the study participants were themselves obtaining a second abortion.

Women also argued for and against regulation out of empathy for women who find themselves in challenging circumstances. Concern for teens in distress led some women to support parental consent and others to oppose parental consent. Concern for women who travel long distances for abortion led some women to oppose the 24-hour waiting period and concern for women who may regret their hasty decisions led some women to support the waiting period. Many women suggested that the government does not have enough empathy for women who have abortions. One participant, Aisha, stated that she hoped her participation in the study would "get up there to the government and let real-life situations and everything be apparent to them."

Finally, many of the women suggested that abortion should be a *private* matter. Privacy, from the perspective of the patients in our study, was related to the ability to keep their abortion a secret from people who they do not want to tell. For example, some women were opposed to insurance coverage, fearing it would expose them to additional confidentiality risks. Women in our study did not take the concept of privacy to mean noninterference by the government. Instead, they saw it as a way to keep their lives and decisions personal.

Limitations

We would like to stress the point that our findings should be interpreted with caution. Many of the findings of our study seem to suggest that abortion regulation could benefit women or at the very least be innocuous with regard to access. However, one of the main limitations to our research is that we only interviewed women who successfully negotiated access issues like cost and distance. Second, although each of the women in our study obtained an abortion in a state where several regulations exist, provider responses to our interviews suggested that regulations increase the strain felt by providers. Providers are primarily responsible for carrying out regulations and documenting protocol. For example, clinics might offer the opportunity to receive state-mandated information over the phone for women traveling from out of town, which can add to their administrative burden. In this paper, we do not explore how the burden of regulations is felt by providers who reduce or discontinue services when unable to meet the requirements outlined in law. Working to design studies to uncover the voices that are absent from this study is an important next step to exploring the experience of abortion regulation from the patient's perspective. Likewise, research is needed on the relationship between regulations and the provision of care from the perspective of the clinician and the facility.

An additional challenge to conducting this research was identifying ways to discuss highly technical regulations with a group of relatively uninformed but important constituents. As researchers, our aim was not to influence our participants' opinions of policy. Although we as researchers have our own opinions about state regulations that are designed to reduce access to abortion, we were careful to avoid asking women to answer leading questions like, "How would you feel if your state provided you with misinformation about abortion?" By keeping the questions more general and open-ended, we believe we gathered richer information about women's true preferences for their own abortion care and abortion care for others. Thus, women's conclusions about the *potential* benefit of regulations should not be construed as support for the regulations as they are currently promulgated.

Conclusion

This study explored women's knowledge of and opinions about three types of regulations: mandated information and waiting periods, parental involvement, and Medicaid and insurance coverage. Women in our study were aware of a complex set of issues. First, they shared a concern expressed by the antiabortion movement that, without regulation, *some* women will make a hasty or uninformed abortion decisions. However, they also believed that regulations should be made to protect their health, safety, and right to make their own decision. Although women held high hopes for government regulation, many spoke knowingly of government antagonism toward abortion providers and abortion services. Women claimed that their personal abortion experiences opened their eyes to the challenges that other women might face owing to abortion cost and distance. Several women suggested that the government and antiabortion groups who want to restrict abortion further did a poor job of understanding and empathizing with women's reasons for abortion. Therefore, our findings suggest that women who have abortions do not have a uniform view of abortion policy. Rather, the women in our study considered each law and attempted to balance the rights of women to make decisions and be informed with the responsibility of women to make conscientious decisions for themselves and their families.

Overall the study participants' opinions on abortion policy reflect key values for advocates and policy makers to consider: responsibility, empathy, safe and accessible health care, privacy, and equity. Future work should examine abortion regulations, as they are actually promulgated in law, in light of these shared values. For example, laws that promote misinformation or prohibit accommodations of unique circumstances by mandating two visits in person at the clinic are not consistent with the positions articulated by the subjects in our study. Consequently, the findings of this study should not be used as justifications for abortion regulation writ large, but rather serve as a tool for evaluating existing and new laws. Such an approach might help to depoliticize the fight over abortion regulations as a zero-sum game and instead promote policies which are actually consistent with commonly held values.

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References

Burke, D. M. (Ed.). (2008). *Defending life 2008: Proven strategies for a pro-life America. A state-by-state legal guide to abortion, bioethics, and the end of life*. Chicago: Americans United for Life.

Charmaz, K. (2006). *Constructing grounded theory*. London: Sage.

Dennis, A., Henshaw, S. K., Joyce, T. J., Finer, L. B., & Blanchard, K. (2009). *The impact of laws requiring parental involvement for abortion: A literature review*. New York: Guttmacher Institution.

Finer, L. B., Frohwirth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2005). Reasons U.S. women have abortions: quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, 37, 110–118.

Gallup Poll News Service. (2007). Gallup's pulse of democracy: Abortion. Available: http://www.galluppoll.com. Accessed April 1, 2007.

Gold, R., & Nash, E. (2007). State abortion counseling policies and the fundamental principles of informed consent. *Guttmacher Institute Policy Review*, 10(4), 6–13.

Guttmacher Institute. (2008, November 1, 2008). State policies in brief: An overview of abortion laws. Available: http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf. Accessed November 11, 2008.

Henshaw, S. K., Joyce, T. J., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *Restrictions on Medicaid funding for abortions: A literature review*. New York: Guttmacher Institute.

Joyce, T. J., Henshaw, S. K., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *The impact of state mandatory counseling and waiting period laws on abortion: A literature review*. New York: Guttmacher Institute.

Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco: Jossey Bass.

Van Bebber, S. L., Phillips, K. A., Weitz, T. A., Gould, H., & Stewart, F. (2006). Patient costs for medication abortion: Results from a study of five clinical practices. *Women's Health Issues*, 16, 4–13.

Weitz, T. A. (2009). What physicians need to know about the legal status of abortion in the United States. *Clinical Obstetrics and Gynecology*, 52(2), 130–139.

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