Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States

CONTEXT: *Abortion availability and accessibility vary by state. Especially in areas where services are restricted or limited, some women travel to obtain abortion services in other states. Little is known about the experience of travel to obtain abortion.*

METHODS: *In January and February 2015, in-depth interviews were conducted with 29 patients seeking abortion services at six facilities in Michigan and New Mexico. Eligible women were 18 or older, spoke English, and had traveled either across state lines or more than 100 miles within the state. Respondents were asked to describe their experience from pregnancy discovery to the day of the abortion procedure. Barriers to accessing abortion care and consequences of these barriers were identified through inductive and deductive analysis.*

RESULTS: *Respondents described 15 barriers to abortion care while traveling to obtain services, and three major consequences of experiencing those barriers. Barriers were grouped into five categories: travel-related logistical issues, system navigation issues, limited clinic options, financial issues, and state or clinic restrictions. Consequences were delays in care, negative mental health impacts and considering self-induction. The experience of barriers complicated the process of obtaining an abortion, but the effect of any individual barrier was unclear. Instead, the experience of multiple barriers appeared to have a compounding effect, resulting in negative consequences for women traveling for abortion.*

CONCLUSION: *The amalgamation of barriers to abortion care experienced simultaneously can have significant consequences for patients.*

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Although abortion is a common procedure[1] and a critical component of reproductive health care,[2] abortion access and service availability are not uniform within or across states. In 2014, some 90% of U.S. counties lacked an abortion clinic, and five states had only one.[3] Seven percent of individuals who obtained an abortion at a clinic in 2014 reported living in a state other than the one in which they had the abortion.[4] In 2008 (the most recent year for which data are available), abortion patients traveled a mean one-way distance of 30 miles to obtain care; 6% traveled more than 100 miles.[5] Those who lived in a state with a waiting period, who were in their second trimester or who resided in rural areas had increased likelihoods of traveling longer distances.

Given that 75% of abortion patients were poor or low-income in 2014,[6] any additional barriers to abortion care—including travel and its associated costs, such as lost wages and expenses for child care, transportation and accommodations—may be significant for many women. Individual financial and travel-based barriers, including difficulties in raising the funds for the procedure and for travel, in using insurance to pay for services, in locating a provider and in arranging travel, have been well documented.[7–11] These barriers may become more pronounced as a pregnancy advances, because procedure costs increase and the number of available providers decreases. In 2012, whereas 95% of abortion facilities offered abortions at eight weeks' gestation, only 34% did so at 20 weeks.[12] This decrease in service availability with increasing gestations may create an insurmountable financial barrier for women who cannot travel. For example, among a group of women denied an abortion because of gestational age limits, 85% reported procedure and travel costs as the primary reason for not obtaining an abortion elsewhere.[11]

State abortion laws and regulations may also have a negative impact on patients' ability to obtain care.[13–16] In 2014, some 57% of women of reproductive age lived in one of the 27 states considered hostile to abortion rights (defined as those that had enacted at least four antiabortion provisions across 10 categories of major restrictions); by contrast, 31% of women had lived in 13 such states in 2000.[17] Increasingly restrictive policies regarding access to abortion services likely play a role in availability.[18] The number of nonhospital abortion clinics, which provide 95% of abortions,[3,19] declined 6% between 2011 and 2014; some of this decline may be attributable to restrictive laws aimed at closing clinics, which in turn might force patients to travel.[3]

Texas and Ohio are considered hostile to abortion rights,[17] and provide examples of how abortion restrictions and landscapes can impact how and where women obtain

services. In 2013, Texas passed HB 2, which encompassed several types of targeted regulation of abortion provider (TRAP) restrictions, including requirements that providers have hospital admitting privileges and that facilities meet the physical standards of ambulatory surgery centers; the number of abortion-providing facilities in the state dropped from 41 to 22 in the six months after the law was passed[20] and may have declined further since that time. The reduced number of providers has translated to limited appointment availability among the remaining providers. Wait times of 2–3 weeks for an abortion have been documented at some facilities, and the average one-way distance to the nearest abortion provider has increased from 17 to 70 miles, which is especially significant if women must make the trip more than once.[14] Women seeking abortions in Texas have reported that the closure of so many clinics has led to confusion about where to obtain care, increased costs and travel for care, and sometimes forced them to delay or forgo getting care.[13,21]

Ohio, which has many of the same restrictions in place as Texas, saw the closure of at least six of its 18 abortion clinics from 2011 to 2014, following the implementation of a stringent hospital transfer agreement TRAP law* similar to the Texas hospital admitting privilege requirement.[3,22,23] Combined with gestational age limit restrictions and an in-person waiting period of 24 hours, the law may have driven women to travel to neighboring Michigan to obtain abortion services, as anecdotal reports suggest.[24]

Individually, restrictions such as those in Texas and Ohio may not demonstrably violate women's fundamental right to abortion. However, in June 2016, the U.S. Supreme Court overturned two provisions of Texas law HB 2 in *Whole Woman's Health v. Hellerstedt*,[25] ruling that the hospital admitting privilege and ambulatory surgical center requirements together created a constitutionally impermissible undue burden by placing substantial obstacles in the path of women seeking an abortion. The Court subsequently denied judicial review to pending appeals from Mississippi and Wisconsin to reinstate admitting privilege laws similar to those in Texas;[26] the Mississippi law would have closed the only abortion clinic in the state. By declining to hear these cases, the Court reinforced its support for the idea that the confluence of restrictions that force women to travel to obtain an abortion can be an unconstitutional impediment to women's right to access safe and legal abortion care. Still, despite the ruling, many clinics in Texas have remained closed.[27]

In areas where abortion services are becoming increasingly difficult to access (including Texas and Ohio), media reports document that women travel elsewhere to obtain services.[24,28] Previous research has taken state abortion policy under consideration and focused on the negative impact of specific, individual restrictions.[13–16] However, little is known about the experiences of women who travel for abortion care. We undertook this study to examine the breadth of barriers, beyond those related to individual state-level abortion restrictions, that such women encounter and any associated consequences.

METHODS

Sample and Data Collection

In January–February 2015, we conducted in-depth interviews with 29 women seeking abortion services at six sites in Michigan and New Mexico. Data collection lasted approximately five days at each site. We selected these states because they had fewer and less severe abortion restrictions in place than at least one nearby state (including Ohio and Texas).[29] For example, Michigan and New Mexico allow abortion later into pregnancy than Ohio and Texas, and do not require hospital admitting privileges for physicians providing abortion. Additionally, New Mexico does not have a waiting period, allows Medicaid funds to pay for abortion and does not single out abortion clinics for regulation. Michigan has regulations specific to abortion clinics and has a 24-hour waiting period; however, the state's TRAP laws have not had the effect of closing a significant number of clinics, and the waiting period does not necessitate two clinic visits, because the consent forms can be signed in advance online. Consequently, we anticipated the potential to capture women traveling to Michigan and New Mexico from more restrictive, nearby states. Eligible women were 18 or older and had traveled from outside of the interview state or from more than 100 miles within the state to access abortion services.

During clinic intake, eligible patients were identified by clinic staff and informed of the opportunity to participate; interested patients (almost all of those eligible) were referred to the research team for more information. Our sample of 29 therefore reflects almost all eligible patients who visited the sites during the study. Of note, most interviews were conducted at a time during the appointment when patients would otherwise have been sitting in the waiting room, so the burden on participants was minimal. The four-person interview team, all of whom are authors, conducted the interviews individually. Interviews were conducted only in English in private rooms at the site; most lasted about one hour. All participants provided verbal and written consent. At the end of the interview, participants completed a short questionnaire on sociodemographic characteristics and received $50 cash as compensation.

We used an in-depth interview guide that we had developed and then piloted with six women seeking abortions in a New York City clinic; the pilot resulted in minor changes to the guide for improved flow and clarity of questions. We began the interviews by asking the women to describe

*Transfer agreements mandate a contractual arrangement with a local hospital to transfer patients in the event of a complication even though no hospital may refuse emergency care. In Ohio, public hospitals are legally prohibited from entering into a transfer agreement with an abortion provider even if they are the closest hospital. (Source: LAWriter, Ohio laws and rules, chapter 3702: Hospital Care Assurance Program, 2014, http://codes.ohio.gov/orc/3702.)

in detail the time from when they first found out about the pregnancy through when they arrived at the clinic. Respondents were then asked specific questions about how they chose the clinic, the process by which they made the appointment, steps taken toward arranging and undertaking travel and the associated costs, involvement of others in any of these steps, reasons for any delays in obtaining care, and their knowledge or perception of state laws or restrictions regarding abortion. We also asked participants if they had any personal or anecdotal stories regarding attempting (or succeeding) to terminate a pregnancy outside of a clinic setting.

Study protocols and interview guides were approved by our organization's federally registered institutional review board.

Data Management and Analysis

Interviews were digitally recorded and transcribed verbatim, and identifying information was stripped during the cleaning phase. We developed initial coding schemes based on the interview guides and existing literature, and we adapted and updated them throughout the coding process. Members of the research team independently double-coded 16 transcripts and then met to resolve code differences through discussion and development of new codes. After further double-coding and discussion, remaining transcripts were coded by at least one member of the research team. We used NVivo 10 to organize the data, code transcripts and generate code reports.

For this analysis, we focused on barriers to getting timely abortion care and consequences of experiencing these barriers. We conceptualized barriers as either the specific issues that led women to travel outside of their home communities for care or the obstacles they encountered while traveling. After reading all of the transcripts, we conducted content analysis across respondents' narratives to identify barriers and consequences that women had described. As a preliminary step to identify the most prevalent barriers and consequences, we counted the number of transcripts in which each barrier and consequence appeared. We created a matrix to track these counts, and to examine patterns between barriers and consequences. Since no clear patterns emerged between women's characteristics and any of the barriers or consequences identified, our matrix instead guided our analysis toward a focus on the interrelated nature of the barriers described. As a final step, we conducted narrative analysis of barriers and consequences within the transcripts of a selected group of participants who were identified in the matrix as having encountered multiple barriers and consequences.

TABLE 1. Number of women in a study of barriers to abortion care and their consequences for women who traveled to receive services, by selected characteristics, Michigan and New Mexico, 2015

Characteristic	No.
Total	**29**
Age	
18–19	2
20–24	11
25–29	8
30–34	4
35–39	3
40–44	1
Race/ethnicity	
Hispanic	10
White	10
Black	7
Other	2
Family income as % of federal poverty level	
<100	14
100–199	8
≥200	7
Educational attainment	
<high school	1
High school graduate/GED	9
Some college/associate's degree	14
≥college	5
No. of prior births	
0	9
1	6
≥2	14
Gestational age (weeks)*	
0–7	11
8–12	7
13–19	5
20–23	4
24–25	2
One-way distance (miles)	
0–59	4
60–119	10
120–179	3
180–239	2
240–299	5
≥300	5
One-way travel time (hours and minutes)	
<2:00	11
2:00–3:59	6
4:00–5:59	9
≥6:00	3
State of residence	
Ohio	14
Texas	12
Nebraska	1
Indiana	1
New Mexico†	1†

*Self-reported. †Participant traveled more than 100 miles within New Mexico.

RESULTS

Sample Characteristics

Study participants varied by demographic characteristics (Table 1). The greatest numbers were in their 20s (19 of the 29), were Hispanic or white (10 each), were poor or low-income (22), had at least some college education (19), had had at least one birth (20), were no more than 12 weeks pregnant (18), and had traveled less than 120 miles (14) or at least two hours (18) one way to receive care. Participants were split evenly between the two interview states, and resided in Ohio (14), Texas (12), Indiana (one), Nebraska (one) and New Mexico (one).

The Role of Travel

Although we did not conceptualize travel itself as a barrier to care, it emerged in women's narratives as a factor that exacerbated the negative impact of barriers they faced. In some cases, the distance itself was not what made traveling burdensome; external factors (e.g., inclement weather, limited access to safe and reliable transportation, or the need to use multiple means of transport) significantly increased the time it took women to travel even relatively short distances to care. For example, one woman, who traveled 85 miles from Indiana to Michigan, said that the experience of having to cross state lines itself was distressing and further stigmatized the experience. In her words:

"I feel like it's just really nerve-racking. … It just makes you feel like you're doing something bad. You know, like you're going out of state because where you live doesn't allow it. It just makes you feel kind of guilty for no reason."—*22-year-old at 17 weeks' gestation*

Traveling did not always have simple or homogeneous effects on women's experiences; some participants identified positive aspects of traveling to receive services (e.g., it provided an opportunity to see a new place or gave them a greater sense of privacy). But overall, women described the experience negatively. A woman who traveled 320 miles from Texas to New Mexico said:

"I mean, it made me go through so much extra stress and money and everything for no reason. … It didn't hinder me from doing it; I didn't say, 'Oh, I'm just going to keep it now.' I just had to go all the way out of my way. It made it so much worse for me."—*22-year-old at 11 weeks' gestation*

For many, having to travel long distances or over state lines to obtain abortion care intensified the effects of multiple barriers.

TABLE 2. Barriers to obtaining abortion reported by women who traveled to receive services, and number of women reporting each, by barrier group

Group	No. of women reporting
Travel-related logistical issues	**27**
Making arrangements after appointment was scheduled (e.g., for transportation, accommodations, child care and work schedule changes)	27
Involving unwanted persons in abortion decision or travel arrangements	12
Requiring multiple means of transport to get to appointment	3
System navigation issues	**27**
Hoop-jumping (logistics involved in securing an appointment)	23
Lack of information, resources or referrals, including lack of transparency	15
Need to make multiple visits to the procedure clinic	10
Encountering crisis pregnancy centers that delayed abortion care	4
Limited clinic options	**25**
Limited or no options near home	24
Clinic closures in home state*	14
Unavailable appointment times at other clinics (e.g., because of overbooking or excessive demand)	8
Financial issues	**25**
Need to raise money for procedure and related costs (e.g., travel, logistics)	20
Lack of insurance coverage	13
Difference in procedure costs between clinics	8
State or clinic restrictions	**18**
Gestational limits (state- or clinic-imposed)†	12
Waiting periods (state-imposed)	10

*This barrier signifies that women explicitly mentioned clinic closures as the reason for travel, rather than simply indicating a lack of clinics near their home. †Includes limits on medication abortion. *Note:* The total for each group reflects the number of women who experienced at least one barrier within the group, not the number of times barriers were reported.

Barriers and Their Consequences

Participants described 15 barriers they encountered while traveling to obtain care. We grouped like barriers into five groups: travel-related logistical issues, system navigation issues, limited clinic options, financial issues, and state or clinic restrictions (Table 2). All of the women (including one who was unable to obtain the abortion) encountered barriers; 24 experienced a barrier in four of the five barrier groups. The most frequently described barriers were not concentrated within any one barrier group. The most common barrier, making travel and related arrangements, was experienced by 27 women. For example, when asked if she would have preferred to have an abortion closer to home, a participant who had traveled 275 miles from Texas to New Mexico said yes, and described the difficulty of travel logistics and arrangements this way:

"I have other kids, and then I had to arrange to, you know, to leave them with someone. Well, my daughter is taking care of them right now, but she had to miss school, 'cause my boyfriend is at work. And then my friend had to come and miss a day from work, and then we'll have to drive back, like, another four hours, and then we have to stay at a hotel."—*34-year-old at nine weeks' gestation*

Three consequences of encountering barriers to abortion care emerged in participants' narratives: Women obtained abortions at later gestations than desired because of delays in seeking care (reported by 19 women); experienced negative mental health outcomes (17); and considered ending the pregnancy on their own, either with medications (misoprostol, herbs or home remedies) or by blunt-force physical trauma (six). Of the six women who reported the third consequence, one had considered and one had attempted to obtain misoprostol to end their pregnancies; one had considered and three had attempted using other methods. In all, 27 of the 29 women experienced at least one of these consequences; 13 experienced at least two. More than half described delays resulting in later gestation at abortion and mental health effects.

Amalgamation of Barriers And Consequences

Each barrier complicated women's processes of obtaining an abortion, though it was not possible to discern the particular effect of any one barrier on any given consequence. Instead, it appears that the experience of multiple barriers may have a cumulative effect: The impacts of individual barriers were compounded when encountered simultaneously. This compounding effect also manifested in the often circular and sometimes overlapping nature of barriers. For example, encountering a lack of information

may have resulted in the need to jump through hoops to receive care, which in turn may have generated further gaps in information and more hoops. A woman who had traveled 155 miles from Ohio to Michigan described one such situation:

"I was only given two … options. The other clinic was in the opposite direction, and they weren't very—I don't know what the word I am looking for is, like they were giving me the runaround. Like, there was a general number for the clinic. I called that number, and they were like, 'No, you have to call this number.' So I called another number for scheduling, and they were like, 'You have to call this number, and you have to call the social worker, and you have to. ...' I am like, you gave me six numbers, and all I am trying to do is talk to somebody, and so I didn't get that [appointment] there."*—23-year-old at 22 weeks' gestation*

Another woman, who had traveled 65 miles from Ohio to Michigan, similarly outlined the way that the barriers of a lack of information and clinic closures overlapped to make obtaining an abortion difficult:

"I looked up [abortion clinics in] Ohio, but nothing popped up. … [Everything I found] said closed, closed, closed. So I kind of figured like, 'Were there not any?' … They don't have any clinics. So … pretty much it's banned."*—25-year-old at six weeks' gestation*

Though each participant clearly described the barriers and consequences she faced when seeking care, it is not possible to tease out any individual barrier as a cause of the consequences women experienced. For example, a woman who had traveled 50 miles to obtain services in New Mexico reported seven barriers to care and described two consequences: negative mental health outcomes and attempting to end the pregnancy on her own. She recounted:

"I didn't know what to do. I would throw myself on the bed, or I would throw myself down the stairs. I would hit my stomach in the shower. I've considered trying to pull it out of myself. I don't know. I was just going crazy. I haven't slept. I have no energy. I don't know if I'm depressed. I don't know if it's a depression, but I've never been like this."*—21-year-old at 12 weeks' gestation*

Case Studies

Two women's narratives further illustrate the cumulative effects of barriers.

•***Julia.*** At the time of the study, Julia, 38 years old, was 22 weeks pregnant and had traveled 880 miles from Nebraska to New Mexico. She had been 20 weeks pregnant when she discovered her pregnancy. Julia had been visiting her main health care provider and related specialists regularly in an effort to diagnose and treat unrelated health concerns, but because she had been using an IUD, none of her providers had thought to administer a pregnancy test. Concerned about how a pregnancy and giving birth would impact her role as caregiver for a sick family member, her own health and her job, Julia had decided to terminate the pregnancy. But Julia's home state prohibited abortion after 20 weeks; she would need to travel to receive care. She found it exceedingly difficult to get a referral or find information on abortion, in part because each health care professional she encountered in the course of her care assumed she would want to carry the pregnancy to term. When Julia tried to seek out information on abortion, she "had to poke, had to prod" to get it. She explained:

"In Nebraska, you know, I was too far along for anyone to perform the procedure. Legally. … You're telling me I have the right to choose, but you also tell me I'm going to be trapped because of law. So what do I really have? I have the right—I have the right to research and have to fight for it. Why do you have to fight for it so bad? It's already a horrible decision. Why do you have to fight to make such a horrible choice? ... Why do I have to fight and travel and put all this money on credit cards and beg for all this help? Why can that hospital [in my town] not be able to help me? … I can't afford this battle. If I didn't tell my family, I couldn't have done this. Period."

Faced with at least one barrier to abortion care from each barrier group, Julia experienced all three consequences identified in our study. She related:

"I was within a week of barely being able to get into [another clinic] because of the late term. … There's only a handful of places nationwide that would take me at this point. … And there my doors shut, or get extraordinarily small. … Next option, are you going to throw yourself down the stairs? Do you want to run me over? Do you want to hurt me bad enough that I got to go to the hospital and force them to do this? Because this is not the best option for anyone."

Julia had been able to find an abortion provider that performed abortions past 20 weeks in a neighboring state, and had borrowed money to buy the plane ticket needed, but upon arriving, she had been turned away for being "too high risk." From there, Julia had had to scramble to obtain an abortion in New Mexico, where she was ultimately able to obtain an abortion at 22 weeks. Julia found the entire experience stressful and isolating; she reported that she did not get the care and guidance that she needed from her doctors, and remarked, "Nobody should ever have to be slammed up against a door this quickly and [told] 'Ha! Okay. Figure it out.'"

•***Carla.*** When we interviewed Carla, she was 33 years old and seven weeks pregnant; she had traveled 600 miles from Texas to New Mexico. Carla had become pregnant with a new partner while separated from her husband. Although she and her husband reconciled and were initially excited about the prospect of raising a baby together, they ultimately decided that it was not in the best interest of their family; they had two children already. Carla described feeling unsafe around the man with whom she had become pregnant and said she did not want him in their lives. For this and other reasons, obtaining an early abortion had been important to Carla. She also had been determined to end her pregnancy by medication rather than aspiration or surgery, as she explained:

"I wasn't sure how far along I was; if they would have told me I was 10 weeks today, I wouldn't have done it. … It seems like at 10 weeks, it doesn't look like a little blob

anymore, and it looks more, I don't know. … So that's another thing I'm struggling with. I'm going to be lying, saying I had a miscarriage. Which, in my mind, I'm doing the pill, and it's a medically induced miscarriage. I have to do that to have sanity in my life."

Because Carla had discovered her pregnancy at about five weeks, she had thought she would be able to obtain the abortion she needed. The closest clinics to Carla were in major cities, 60 and 120 miles from her home. However, once she began investigating what she would have to do, she discovered that both the 24-hour waiting period in Texas and long waits for appointments would prevent her from getting her abortion within the time frame that she needed in either city. She recounted:

"I Googled 'abortion clinics in Texas' and was so just put out because there's this waiting period, and [I could get into one clinic in about a week]. But then there's a chance that after I get in and have the ultrasound that I may not be able to get back in for two weeks. They can't guarantee me. They only do procedures on Wednesday, Thursday, Fridays, and they're so booked. So I called several different ones. This one girl at [a nearby clinic] said, 'Well I probably shouldn't tell you this, but a lot of girls have been driving to this place in New Mexico.' So she gave me the number [of this clinic]."

Carla knew that the reason that clinics closer to her were experiencing such high volumes and long wait times for appointments was that many clinics in the state had closed, and that as a result, "there's some limited amount of clinics left in Texas, and they're jam-packed booked." After more phone calls and Internet investigation, she was relieved to finally get connected to a clinic in New Mexico. The 600-mile trip was "a nightmare"; dangerous winter conditions on the roads extended what would have been an eight-hour drive to 12, and she had trouble finding lodging. Although Carla considered these conditions "a sign from God," she felt she could not turn back and wait another two weeks to obtain an abortion closer to home; for her, every minute counted. Carla's story illustrates that the experience of multiple barriers can prevent a woman from obtaining not only timely abortion access, but the kind of abortion she wants.

DISCUSSION

Women travel to obtain abortion care for a variety of reasons, often related to limited service availability in a given area. Our study participants' narratives reveal how individual barriers can compound and exacerbate the experience of traveling for abortion, and may have significant consequences.

Previous studies have documented individual barriers that delay access to abortion—difficulty in raising the funds to cover the costs of the procedure and travel, late pregnancy recognition, lack of insurance coverage, difficulty locating a provider, and distance and arranging travel.[7–11,13,15,30,31] Many of these barriers were evident in our respondents' narratives, as they are not unique to the experience of travel, but interact with it in onerous ways. We found no direct link between any one barrier and any one consequence (or any minimum number of barriers that will have consequences), and no clear patterns of barriers and consequences according to women's demographic characteristics. Instead, we uncovered a compounding relationship: The intersection of multiple barriers to abortion care creates consequences for women who travel for abortion, and the effects may be greater than those of individual barriers previously identified.

While other studies have focused on evaluating the impact of one restriction of abortion care (or a group of restrictions in one local context),[15,32–34] ours sought to capture the impact of restrictive environments more generally. For example, we did not measure the incidence or impact of traveling to obtain abortion care in order to avoid a waiting period law in a given state, but instead documented the effects of waiting periods in the context of the many other barriers that women face. In Carla's story, the effect of clinic closures in her home state was captured as a component of her motivation to travel to New Mexico to obtain the early abortion she wanted. This finding echoes the results of a study of abortion patients in Alabama who traveled more than 30 miles to receive services; many reported that the state-required 48-hour waiting period often translated to much longer waiting periods—sometimes a week or more.[30] This is longer than would have been acceptable to Carla. Julia's narrative highlighted the effect of hardships of traveling, including at least one barrier from each of the five groups and all three consequences we identified. If not for the restrictive abortion laws in their given states, Carla and Julia—and other women in this study—may not have experienced the barriers and consequences they did.

The mechanism by which any one barrier—or any combination of barriers—triggers the judgment of an unconstitutional undue burden is unclear. Our findings demonstrate that the burdens of traveling for care may not always be plain. They support the conclusion of the Supreme Court in *Hellerstedt v. Whole Woman's Health*[25] that the health benefits of abortion restrictions must conclusively outweigh the burdens they impose on women, and should be considered in the context of all available scientific evidence and other existing restrictions.

Of the consequences of barriers to abortion care that participants faced, the most commonly described was being delayed in obtaining care. This finding is in line with previous research.[7–11,15] In a study of women seeking abortions at or after 20 weeks, many attributed their delay in seeking care to logistical issues, such as difficulty finding a provider or raising the funds for the abortion.[35] The many women who cite financial difficulty as a reason for delay[36] may find themselves experiencing a negative feedback loop: Because the cost of an abortion may rise with increasing gestation, a delay in raising the necessary funds may lead to a higher cost of the procedure; that, in turn, could lead to further delay if a woman needs to then raise additional funds.

Women also described experiencing negative mental health outcomes as a result of the barriers to care they

encountered. Rigorous, scientific evidence supports the conclusion that abortion does not cause mental health problems;[37,38] studies to the contrary have been thoroughly debunked.[39] In research comparing mental health outcomes of women who obtained a wanted abortion with those of women denied one, the latter had worse outcomes for anxiety, self-esteem, life satisfaction and emotions one week after seeking abortion.[40] The predominant emotion women expressed after obtaining a wanted abortion was relief.[40] Because women often cite reasons for abortion such as an inability to afford a child, the desire to better care for existing children, and the wish to maintain their job or finish school, it stands to reason that being prevented from having a wanted abortion could adversely affect mental health and well-being.[41] Our findings support this idea.

Although only four women in our study described attempting to end their own pregnancies and two described considering this option, they represent a nonnegligible proportion of our sample. Consideration of a behavior can be predictive of the likelihood of engaging in that behavior,[42] so these women's willingness to disclose considering this stigmatized behavior is worthy of scrutiny, especially as most of them mentioned methods that would not be effective and would not be considered safe. This pattern underscores the level of desperation women felt as a result of encountering barriers to abortion care. Nationally, only 2% of abortion patients in 2014 reported having attempted to end the pregnancy on their own (1% with misoprostol and 1% with some other substance),[6] but a study of Texas women seeking abortions in 2012 found that 7% had attempted to end their current pregnancy on their own.[43] A follow-up study in Texas found that most women who had made attempts would have preferred to obtain an abortion in a clinic setting, but felt precluded from doing so because of limited resources and local facility closures.[43] Future research should attempt to distinguish among the methods women use when they consider ending their own pregnancies, as doing so will allow for a better estimation of the overall risks and consequences of this phenomenon according to the effectiveness and safety of the method used.

Strengths and Limitations

Key strengths of our study are that it captured women's full stories of their experiences in traveling to seek abortion care and it highlighted these experiences in two states. Still, our study is not without limitations. It captured only English-speaking women who were able to travel to obtain services during the time interviewers were present in the clinic; women whose predominant language is Spanish—including undocumented immigrants—and women who were unable to travel to obtain a wanted abortion were not represented. These women may have experienced barriers to care and consequences, including unwanted births, to a much greater degree and in wholly different ways than our study participants.[11,44] Similarly, women who would have liked an abortion earlier, but could not travel and instead waited to have the procedure at a clinic closer to their home, were not captured here, and their experiences may differ as well. That there were few differences in barriers and consequences described in the two interview states lends credence to the idea that the amalgamation of barriers, rather than state-specific restrictions, drives the felt impact for women. However, these findings cannot be generalized to the experiences of women traveling for abortion care in other states, given the varying restrictive environments across settings. Finally, some of the barriers identified here may be the direct result of sample selection; because we designed the study to capture women traveling for services, the barriers and consequences we identified may be inherently linked with travel.

Conclusion

Results from this study may help inform researchers assessing the impact of barriers to abortion access and their consequences; our findings highlight the importance of taking a holistic and broad view of the many barriers that women may encounter in seeking abortion services, and how they add up. While examinations of the impact of individual barriers on women's access to abortion care represent valuable research endeavors, future studies should take into account these findings on the multiplying effect of barriers in order to more fully measure their outcomes. Indeed, the *Whole Women's Health v. Hellerstedt* ruling affirms that the cumulative effects of multiple abortion restrictions result in a violation of a woman's constitutional rights: "Increased driving distances do not always constitute an 'undue burden,' but they are an additional burden, which, when taken together with others caused by the closings … help support the District Court's 'undue burden' conclusion."[25] Future research attempting to establish that state restrictions on abortion access represent an undue burden for women and focusing on individual barriers may not produce sufficient evidence; highlighting the concept of compounding barriers may be especially salient. Because abortion is a critical component of reproductive health care and a human right, it is imperative that policymakers work toward reducing all obstacles to abortion services.

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