Title

Distribution of abortion providers in los angeles county

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Results: More than half of our sample (53%) lived in a "blue" state (a state in which the majority voted for the democrat in the past three presidential elections), 26% lived in a "red" state and 20% lived in a "purple" state (a state in which the majority switched between republican and democratic candidates). Of all participants, 38% described themselves as liberal, 38% as "middle of the road" and 24% as conservative. A majority (59%) believed that abortion should not be restricted in most instances. Only 12% of the sample demonstrated high knowledge about abortion. In a multivariate logistic regression, participants' abortion knowledge was not associated with their state's political context. Participants own political leanings were predictive: Those with liberal political leanings (vs. conservative) were more likely to have high knowledge about abortion, as were participants who believe that abortion should be allowed in most circumstances.
Conclusions: Social science increasingly focuses on differences between red and blue states, but our findings suggest that there is considerable variation in abortion knowledge within these divergent political contexts.

P18

DISTRIBUTION OF ABORTION PROVIDERS IN LOS ANGELES COUNTY

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Objectives: To better comprehend the distribution of abortion providers in U.S. metropolitan areas for women of different racial, ethnic and income groups, to improve equitable service access.
Methods: Abortion providers and women of reproductive age by race/ethnicity were mapped in Los Angeles County and grouped according to service planning areas (SPA) using ArcGIS v10.1. The abortion provider ratio was calculated per 100,000 women of reproductive age in each SPA. Abortion provider locations were derived from the California Office of Statewide Health Planning and Development's database using *ICD-9* and CPT codes and an online yellow page search for "abortion services." Demographic data for age, gender, race and ethnicity were obtained from the 2010 U.S. Census.
Results: The West SPA had the lowest poverty rate and the highest provider ratio of 6.78 per 100,000 women. The SPAs with larger African-American and Latino populations had lower provider ratios of 1.0–3.1 providers per 100,000 women. The South SPA had the largest African-American population and highest poverty rate, with the lowest abortion provider ratio of 1.0 per 100,000 women. The East SPA had the largest Latino population and second lowest abortion provider ratio of 3.1 per 100,000 women.
Conclusions: The number of abortion providers per 100,000 women of reproductive age is highest in more affluent areas and lowest in areas with large minority and low-income populations. Although there are a large number of abortion providers in Los Angeles County, the distribution of these providers is unequal based on household income and race/ethnicity.

P19

LEGISLATION OF ABORTION PROVISION: A SURVEY OF WOMEN SEEKING REPRODUCTIVE HEALTH SERVICES

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Objectives: To describe patients' knowledge and attitudes towards abortion legislation.
Methods: Women presenting to an urban, university-based women's health clinic seeking reproductive health services were approached for participation at the completion of their visit. Participants completed a 44-question computerized survey evaluating their knowledge and attitudes towards abortion legislation in Illinois. Upon completion, participants received a fact sheet detailing current Illinois abortion legislation. The responses of participants seeking abortion services were compared with those seeking other reproductive health services.
Results: Of the 121 participants, 36% underwent abortion services. All participants had been pregnant at least once, 33.1% before age 18, and 60% had experienced abortion. The majority of participants were women of color (64.3% black and 22.9% Hispanic), were Medicaid recipients (61.9%), were affiliated as Democrats (65.0%) and were eligible to vote in Illinois (92.3%). More participants in the abortion services group paid out of pocket for care than the other services group (17.8% versus 4.1%, p= .008). Overall knowledge of Illinois abortion legislation was poor; however, the rate of correctly answered knowledge questions was higher in the abortion services group 50% of the time when compared with the other services group. The abortion services group exhibited less favorable attitudes toward restrictive abortion legislation than the other services group in nine out of 10 categories of legislation. Parental notification legislation was opposed by 69.2% of women who had experienced an adolescent pregnancy.
Conclusions: In this setting, experiencing abortion was associated with greater knowledge of and more negative attitude toward restrictive abortion legislation.

P20

THE PITFALLS AND PROMISES OF ADVOCATING FOR MEDICAID COVERAGE OF ABORTION IN CASES OF FETAL ANOMALY

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Objectives: We assessed the feasibility and acceptability of broadening Medicaid coverage of abortion exceptions to include cases of fetal anomaly, in addition to rape, incest and endangerment of the woman's life.
Methods: We interviewed 70 abortion providers about their experiences securing Medicaid coverage of abortion and 71 low-income women about their opinions of Medicaid coverage of abortion. Data were analyzed thematically in Atlas.ti.
Results: In states where fetal anomaly coverage was available, providers reported that compared with the other coverable exceptions of rape, incest and life endangerment, it is easier, though still somewhat challenging, to secure Medicaid coverage for abortion in cases of fetal anomaly. Providers working in states where Medicaid covered all (as opposed to some) abortions, reported the most streamlined experiences with Medicaid.
Though 82% of women supported Medicaid coverage of abortion in all cases, only 69% of women supported coverage in cases of fetal anomaly. Women expressed discomfort with terminating a pregnancy "just because" of an anomaly and with second-trimester terminations. However, many women recognized limited resources may impede a woman's ability to care for a child with disabilities.
Conclusions: These findings highlight potential opportunities and pitfalls of broadening the circumstances under which Medicaid covers abortion. Data highlight that any efforts to expand Medicaid coverage to include cases of fetal anomaly, instead of advocating for Medicaid coverage in all cases, should consider the burdens providers may encounter when working with Medicaid to obtain coverage for exceptions and how low-income women's level of support for coverage may change depending on pregnancy circumstances.