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“Unmet Need for Abortion”: Conceptualization, Relevance, and Utility as a Tool for Meeting
Abortion Needs in the United States

By

Ariana H. Bennett

A dissertation submitted in partial satisfaction of the
requirements for the degree of
Doctor of Public Health
and the Designated Emphasis
in
Women, Gender, and Sexuality
in the
Graduate Division
of the
University of California, Berkeley

Committee in charge:

Professor Anu Manchikanti Gómez, Co-chair
Professor Julianna Deardorff, Co-chair
Professor Cassandra Marshall
Professor Katrina Kimport

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Abstract

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Abortion is a fundamental component of people’s ability to decide if, when, and under what circumstances to have a child. The ability to obtain an abortion is critical to both reproductive autonomy and public health. Despite this, a large body of evidence demonstrates that it is often difficult to obtain an abortion in the United States (U.S.). State-level policies restrict abortion availability and create logistical, financial, and emotional barriers. Difficulty accessing abortion disproportionately and inequitably burdens those who have been historically and systematically marginalized—low-income people, Black, Brown, and other people of color, young people, and those who live in rural or non-metropolitan areas. The existing body of literature demonstrates that the current political climate and service delivery landscape create a gap in which some people who want an abortion are not able to obtain one at all or in a manner that is acceptable to them. This amounts to an urgent public health and health equity problem—in the U.S., people’s abortion needs are not being met.

In public health, medicine, and the field of family planning, lack of access to critical services is commonly framed and documented as “unmet need,” such as with the longstanding measure of “unmet need for family planning” as a tool to understand population-level contraceptive access. Documenting “unmet need for abortion” could be one potential tool those working in abortion access could use to direct advocacy efforts, service delivery, and resource allocation to meet abortion need(s). However, it is not clear whether conceptualizing problems in abortion access as unmet need would be valuable and, if it is, how to define or measure that need.

This dissertation uses multiple methods to explore the concept of unmet need for abortion in the U.S. My first aim is to present a nuanced and critical analysis of unmet need for abortion, including its conceptualization and utility as both a concept and a tool for the abortion rights

movement. My second aim is to quantitatively describe the prevalence of not obtaining a wanted abortion among a nationally representative sample.

Chapters 2 and 3 present findings from in-depth qualitative interviews with 30 stakeholders in abortion access from around the U.S. about their perspectives on unmet need for abortion. Stakeholders included people working in direct service settings, research, advocacy, grassroots abortion funds, reproductive justice organizations, and philanthropy. Chapter 2 explores the potential benefits and harms of using unmet need for abortion as a tool to frame and measure problems with abortion access in the U.S. Findings from this study point to the complexity of the concept of unmet need for abortion. As a tool for advocates, researchers, policymakers, and others working for abortion access, unmet need for abortion could draw necessary attention to and broaden public dialogue about crises in abortion access. However, participants' hopes for positive shifts in public discourse and resource allocation for abortion were counterbalanced by their concerns—that the tool could be misused, that the limits of quantification come at too great a cost, and that by centering abortion alone it would serve to further disconnect abortion from the broader fight for reproductive justice.

Chapter 3 describes how stakeholders understood unmet need for abortion. I identified two distinct conceptualizations: outcome-based unmet need for abortion, in which need is defined as obtaining an abortion; and process-based unmet need for abortion, in which need is additionally defined in terms of the experience of getting an abortion, including navigating obstacles, preferences in method and setting, and quality of care. While some participants primarily leaned toward one conceptualization, most utilized both. Participants debated the relative importance of these conceptualizations based on which they projected could be useful for mobilizing support and resources for abortion access.

Chapter 4 describes the prevalence of not obtaining a wanted abortion in a nationally representative sample of adults (ages 18-44) who had ever been pregnant. Nearly 6% of respondents reported having wanted an abortion they did not obtain. In open-ended text describing why they did not obtain the wanted abortion, participants most frequently reported personal reasons for not getting an abortion (e.g., changing their mind; personal moral or religious opposition), though it was also common to report policy-related reasons (e.g., gestational limits set by state or facility policy). These findings suggest that people in a national sample will answer questions about whether and why they did not obtain a wanted abortion. In addition, these data provide some insight into the complexity of wanting an abortion. Rather than framing this experience as not getting a wanted abortion, for some people, it may be more accurate to describe this as not getting an abortion that was wanted at one point.

Unmet need for abortion is a complex concept that has potential benefits and potential harms as a tool to document and improve abortion access. In addition, it can be conceptualized in multiple ways that affect its utility. As threats to abortion access increase, people not getting abortions they want, either at all or in a manner that is acceptable to them, will only become of greater concern. This dissertation contributes to a growing and timely body of research about devising new ways to understand and meet abortion needs.

For all the local abortion funds, to which you should donate now.

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Chapter 1: Introduction

All people have the right to have children, not have children, parent their children in safe communities, and to have bodily autonomy. These rights are the fundamental principles of reproductive justice (1). Founded in 1994 by a group of Black women activists, the reproductive justice movement provides a framework to “reimagine what reproductive freedom could look like for all people” (2) (p.178). The ability to obtain an abortion is necessary to realizing this vision, and ensuring that people can obtain abortions when they want them is an important human rights and public health goal.

Despite this, a large body of evidence demonstrates that it is often difficult to obtain an abortion in the United States (U.S.). State-level policies restrict abortion availability and create logistical, financial, and emotional barriers. Difficulty accessing abortion disproportionately and inequitably burdens those who have been historically and systematically marginalized—low-income people, Black, Brown, and other people of color, young people, and those who live in rural or non-metropolitan areas (3–5). In addition, studies show that there are people who want abortions and are not able to obtain them (6–10). This amounts to an urgent public health and health equity problem—in the United States, people’s abortion needs are not being met.

In public health, medicine, and the field of family planning, lack of access to critical services is commonly framed and documented as “unmet need,” such as with the longstanding measure of “unmet need for family planning” as a tool to understand population-level contraceptive access (11). Given the crisis in abortion access, there is presumably an unmet need for abortion in the U.S. Existing data are not able to demonstrate the scope of, or fully characterize, this need. Nor are they able to evaluate whether or how the development of a tool like unmet need for abortion would serve to help ensure abortion needs are met.

At the time I am finishing this dissertation, the U.S. Supreme Court is deciding *Dobbs v. Jackson*, about a Mississippi law that bans abortion after 15 weeks’ gestation and directly challenges *Roe v. Wade*. Their decision is expected to overturn the constitutional right to abortion in the U.S. As a result, there will be a surge in state-level abortion prohibitions (12), that will only make it harder for people to obtain abortions. Researchers, policymakers, advocates, and others working for abortion access need tools to understand people’s abortion needs and effectively inform advocacy and resource distribution to ensure they are met. I investigate unmet need for abortion as one such tool.

Overview of the dissertation

This dissertation is a multi-method exploration of the concept of unmet need for abortion in the U.S. My overarching aim is to present a nuanced and critical analysis of unmet need for abortion, including describing how it is currently conceptualized by stakeholders in abortion access, understanding its utility as a tool to such stakeholders, and presenting descriptive quantitative data about the prevalence and context of not obtaining a wanted abortion in this country.

In Chapter 1, I first describe the state-level abortion restrictions that create barriers to abortion care, as these barriers indicate abortion needs are not met in the U.S. I also describe what is known about people who do not obtain wanted abortions and pose the question of whether this should be conceptualized as “unmet need for abortion.” Next, I present the history of unmet need for abortion, including past efforts to measure it and how it is currently used in the

literature. Given the close relationship to the existing metric of unmet need for family planning, I provide background on that measure, including critiques, as they inform whether and how unmet need for abortion could be understood and used.

In Chapter 2, I explore the potential benefits and harms of using unmet need for abortion as a tool to frame and measure problems with abortion access in the U.S. Using qualitative data from interviews with 30 stakeholders working in abortion access, I describe the complexity of the concept of unmet need for abortion. Participants' hopes for positive shifts in public discourse and resource allocation for abortion were counterbalanced by their concerns—that the tool could be misused, that the limits of quantification come at too great a cost, and that by centering abortion alone it would serve to further disconnect abortion from the broader fight for reproductive justice.

In Chapter 3, I describe how stakeholders conceptualized unmet need for abortion. Two distinct conceptualizations emerged from the data—outcome-based unmet need for abortion, in which need is defined as obtaining an abortion, and process-based unmet need for abortion, in which need is additionally defined in terms of the experience of getting an abortion, including navigating obstacles, preferences in method and setting, and quality of care. While some stakeholders leaned toward a single conceptualization, most endorsed both. Participants debated the relative importance of these conceptualizations based on which they believed would garner more support for or less pushback against abortion access.

In Chapter 4, I present data from a nationally representative survey, for which we adapted existing and developed original questions about considering, wanting, and not obtaining a wanted abortion. In the parlance of Chapter 3, these data represent an outcome-based unmet need for abortion. However, given the concerns surfaced in Chapter 2, findings are not described using this terminology. About a quarter (24.19%) of respondents who had ever been pregnant reported having had an abortion. An additional 14.51% had considered abortion and 5.17% had wanted an abortion at some point but did not report having one. Almost 6% of respondents had wanted an abortion they did not get. In addition, I present sociodemographic characteristics of those who report a history of not obtaining a wanted abortion, as well as the reasons they did not obtain them. To my knowledge, these are the first such data from a national sample.

Finally, in Chapter 5, I conclude with a summary and synthesis of the dissertation. I present the contributions and takeaways from each chapter and discuss implications and future directions.

State-level abortion restrictions

A large and growing body of literature demonstrates that there are multiple, and often insurmountable, barriers to obtaining an abortion in the U.S.. People seeking abortion report financial, logistical, informational, and social barriers to obtaining the care they want (13–15). Many barriers to abortion are caused by policies that regulate its provision. Recent years have seen an unprecedented increase in state policies that restrict abortion access (16–18). In 2021 alone, state legislatures enacted over 100 provisions restricting abortion (18).

There are various types of restrictive state-level policies. Some, such as mandatory counseling, waiting periods, or ultrasound policies, aim to deter individuals from getting abortions. Gestational duration bans limit abortion eligibility by setting a point in pregnancy after which abortion is prohibited. Forty-four states have these laws, such as those banning abortion at 22 weeks gestation (19). People seeking abortion after 20 weeks tend to be younger and have

limited financial resources, so these bans disproportionately affect them (20). The past few years have seen a proliferation of state bills that would ban abortion at six weeks (21). The first such bill to go into effect was Texas Senate Bill 8 in September 2021, and other states are poised to follow (22,23). Gestational bans can prevent people from obtaining abortion or force them to travel to seek care, further delaying care and increasing costs (7). Based on data collected between 2008-2010, researchers estimated that over 4,000 women in the U.S. are denied an abortion each year and go on to give birth as a result of gestational limits (7). The number is inevitably higher now, as additional bans have been enacted in the intervening years.

Targeted regulation of abortion provider (TRAP) laws impose arduous requirements on abortion providers and facilities that are non-commensurate with requirements for other comparable health care services. For example, laws requiring abortion providers to have hospital admitting privileges and requiring abortion facilities to meet ambulatory surgical center standards. These are often passed under the guise of improving patient safety, but data suggest that they do not (24,25). However, such laws are associated with decreased abortion provider availability (26) and can lead to clinic closures, which can cause delays in care and increase travel and financial costs. After clinic closures caused by such laws in Texas, one study found a 13% decrease in abortions state-wide and an increase in second trimester abortions (27).

Restrictive policies also include funding bans. Most notably, the Hyde Amendment, first implemented in 1977, prohibits the use of federal funds for abortion. Sixteen states use their own funds to cover abortion through Medicaid. The other 34 plus Washington, DC do not (28). Funding bans increase out-of-pocket expenses, which can make abortion difficult or impossible to access and intensify financial barriers for poor and low-income people (29–31). Funding bans pose particularly obvious and pernicious threats to equity. Due to economic, racial, and social inequality, women of color are disproportionately likely to be low income and insured by Medicaid, and are therefore disproportionately likely to be harmed by public funding bans. In 2014, 30% of Black and 24% of Hispanic women ages 15-44 were enrolled in Medicaid, compared to 14% of white women (32). Data indicate that prohibitions on the use of public funds to pay for abortion prevent an estimated one-quarter of Medicaid-eligible pregnant people from obtaining a wanted abortion (29,33).

Taken together, state-level restrictions create multiple and compounding barriers to abortion. By reducing provider availability and patient eligibility, policies force people to travel for abortion and increase the distance they need to travel, which can cause delays and increase financial and emotional costs (13,15). These burdens are often intensified for individuals at higher gestations and those who are young, low income, or live in rural areas (13,15,34,35). Financial burdens are not limited to the cost of the abortion itself, but include transportation and lodging, childcare costs, and/or lost wages from taking time off work (30). Though each logistical or financial barrier can jeopardize one's ability to obtain an abortion in and of itself, qualitative data indicate that people seeking abortion experience these barriers as cumulative (15). Barriers compound to negatively affect people's ability to obtain wanted abortion care and their experience seeking care.

Self-managed abortion

Increasing legal restrictions around the country have drawn increased attention to self-managed abortion—an abortion that a person completes on their own, without clinical supervision (36–40). Ralph and colleagues published the first population-based estimates of self-

managed abortion in the U.S. in December 2020. They found that 1.4% (95% CI, 1.0%-1.8%) of 18-49 year old women reported ever attempting self-managed abortion (40). Adjusting for abortion underreporting, they projected that 7% (95% CI, 5.5%-8.4%) of women will attempt self-managed abortion in their lifetime.

Researchers have explored the extent to which self-managed abortion reflects a preference versus lack of access to clinical care. In the national sample, respondents most commonly reported self-managing because it seemed faster or easier than clinical care (47%) and/or the clinic was too expensive (25%). Thirteen percent chose self-management because of concerns about parental consent, far distance to the clinic, and/or feeling that it was “more natural.” These findings support those of a study of requests to an online telemedicine abortion service, which found that most people (60%) were seeking medication abortion through the service due to a combination of barriers to clinical care (most commonly cost) and personal preference (most commonly privacy) (41).

People who want but do not obtain an abortion

The many challenges in accessing abortion suggest that there are people who want to obtain an abortion but are not able to. In the past decade, researchers have investigated the longitudinal health, social, and economic impacts of not receiving a wanted abortion and have found that being unable to obtain a wanted abortion is harmful to women and families. Most notably, the landmark Turnaway Study investigated the effects of receiving versus being denied a wanted abortion. Foster and colleagues enrolled nearly 1,000 women who sought an abortion at 30 clinics across the U.S. The research team followed participants for five years between 2008 and 2015, comparing people who were just under the gestational limit of the clinic they went to, and therefore received a wanted abortion, and those who were just over their clinic’s gestational limit and were therefore turned away (6,42). Over time, women who were denied an abortion had worse financial, health, and family outcomes than those who were not. Being turned away was associated with: increased household poverty and difficulty financing basic needs over 4-5 years (43,44); worse parental-infant bonding and poorer child development outcomes for existing children for up to 5 years (45,46); and higher likelihood of staying connected to a violent partner over 2.5 years (47).

The Turnaway Study provides critical insight into the experience of not receiving a wanted abortion. However, even those who were turned away still made it to a clinic, leaving the experiences of people who never reach a provider, and whose abortion needs may not be met, unexplored. To address this concern, several studies have used innovative approaches to understand the experiences of people who considered abortion but may not have presented at an abortion clinic (48–53). Fuentes et al. (2016) interviewed people unable to schedule or keep abortion appointments after Texas House Bill 2 closed many clinics in the state (48). They found that being unable to have these appointments created confusion and distress, led to increased costs and travel, and caused women to delay abortion and in some cases not get an abortion at all. In their study of pregnancy decision-making among women in rural Appalachia, O’Donnell and colleagues (2018) interviewed women recruited in a broad range of locations, including shopping centers, to overcome traditional sampling limitations and include those who may have considered, but not sought, an abortion (51). They found that for many participants with a pregnancy they deemed unacceptable, abortion seemed so unfeasible that it was not considered a viable choice. Roberts et al. (2018) conducted a mixed methods study among women in prenatal

clinics in Maryland and Louisiana and found approximately 30% percent had considered abortion for their current pregnancy (10). While most who considered abortion did not have one due to personal preference, for some, it was due to policy-related barriers. Upadhyay and colleagues (2021) used Google Ads to survey women searching Google for abortion who were currently pregnant and considering abortion (9,52). Four weeks after the initial survey, 32% reported they were still seeking an abortion; of these, 57% had tried to get an abortion, and 60% wished they had an abortion “at this point” (9). Most recently, Moseson and colleagues (2022) used three online platforms to recruit people who had considered but not obtained an abortion and who believed abortion could have been the best option for them for a recent pregnancy (15). All respondents reported that at least one barrier, such as financial cost, prevented them from obtaining an abortion; over half reported two or more barriers.

The existing body of literature demonstrates that the current political climate and service delivery landscape do not enable all people’s abortion needs to be met. The question of whether this should be understood and documented as “unmet need for abortion” remains open.

History and measurement of unmet need for abortion

After *Roe v. Wade* (1973), the Alan Guttmacher Institute (AGI) began regularly surveying abortion-providing medical facilities to monitor abortion incidence and provision trends in the U.S.; a process they continue to this day. Their first such survey was conducted in 1974 to measure the impact of *Roe* (54). Among the measures they used was an estimate of “unmet need for abortion;” an apparently corollary of the measure of “unmet need for family planning” which was by then a well-established indicator. AGI’s 1975 publication, “The Unmet Need for Legal Abortion Services in the U.S.” appears to be the first time unmet need for abortion is conceptualized in the scientific literature on family planning (54). Because AGI’s early work provides the first and only published estimates of unmet abortion need in the U.S., I provide detail here about how they initially conceptualized and calculated this need, as well as how it changed over the years it was estimated. In every report in the 1970s, AGI researchers noted serious concerns about unmet abortion need and health equity, as unmet abortion needs were consistently estimated to be disproportionately high among women who were young, low-income, or lived in non-metropolitan areas (54–58). They also found that abortion services remained geographically concentrated in metropolitan areas, unequally burdening some patients with travel and its accompanying costs.

To construct the first estimates of abortion need, AGI used existing data about “unwanted” and “mistimed” births, as well as abortion rates in New York City and California, where abortion was legal before *Roe* (54). AGI researchers assumed that, given equal access, abortion utilization would be relatively constant nationwide, with slight variations by demographic group. They based this assumption on U.S. fertility data indicating that “unwanted” and “mistimed” birth rates did not vary geographically, but varied based on age, race/ethnicity, and socioeconomic status. Polling data at the time indicated that support for legal abortion differed geographically, but it was unknown if this correlated to abortion seeking. To account for this, AGI estimated a high and low range of abortion need. The high end of the range was based on New York City, which had the highest abortion rates in the U.S. California’s abortion rate was taken as the low end of the estimate because their rates were lower than New York City but similar to other states where abortion had been legal prior to 1973. The range was intended to help public health officials plan for a range of service delivery needs in their jurisdictions.

Researchers compared these estimates of abortion need to the number of abortions actually provided, and the difference was considered unmet need for abortion (54).

Over the next six years, AGI continued to produce estimates of met and unmet abortion need in the U.S., occasionally revising their approach to calculating these numbers (55–58). In 1978 AGI updated their calculation of abortion need to be based on more recent data from a wider variety of states (55,56). The revised estimate used the average abortion rate of the six states with the highest 1976 resident abortion rates as an approximation of what abortion utilization would be by age and race if other areas improved service availability (55,56). The 1979 report offered the first explicit definition of those “in need of abortion services” as “women who wanted to terminate their pregnancies by abortion and would use abortion services if they were available” (55) (p. 333).

In 1981, AGI changed the criteria for calculating abortion need one last time (57). In this calculation, they assumed that abortion need was “substantially met” in states where over 80% of 15- to 44-year-old women lived in a county with at least one high volume abortion providing facility (p. 10). The five states that met that threshold in 1978 were used as the standard for establishing abortion need estimates by age and race. Further analyses of the particular impact of the Hyde amendment estimated that unmet need for abortion among Medicaid-eligible women skyrocketed after Hyde was implemented, with unmet need significantly higher where state funding was also restricted to mirror the federal restrictions imposed by Hyde (59).

After 1981, estimates of unmet need for abortion no longer appear in AGI reports, replaced by measures of the service delivery landscape found to be associated with unmet need in early reports, such as geographic distribution and types of providers, public funding, the need to travel for abortion services, and restrictive policies (60–62). The 1981 publication seems to represent a turning point after which reports focus on proxies for unmet need, such as the proportion of women living in a county with no provider, minors deterred by parental consent laws, and Medicaid-eligible women prevented from accessing abortion due to lack of funds (57,61), which have come to be among the bedrock measures of access that define abortion research today.

There was a subsequent attempt to measure unmet need for abortion in the U.S., undertaken for a master’s thesis in 2016 (63). Wollum (2016) defined unmet need for abortion as “abortions that took place in a non-home state or that did not occur at all” (p. 7). Using AGI and CDC abortion surveillance data, Wollum estimated state-specific abortion rates, accounting for demographic factors and the unintended pregnancy rate. She then constructed counterfactual scenarios in which she took four variables determined to influence abortion occurrence—public funding, private insurance restrictions, number of abortion providers per pregnancy, and percent of women living in a county with no abortion provider—and statistically modeled them to be the least restrictive possible. Wollum calculated total unmet need by subtracting her predicted abortion incidence from the counterfactual predictions. She estimated unmet need for abortion in 2012 as 70.5 abortions per 1000 live births. In her analyses, eliminating public funding restrictions had the largest impact reducing unmet need.

Current uses of unmet need for abortion

The phrase unmet need for abortion does still appear in the literature, usually in discussion sections of scientific papers or commentaries about barriers to abortion access. This invocation of the term could be an artifact of the early AGI estimates, though it is also likely due

to the familiarity with and cachet of unmet need for family planning as a global health indicator. When the phrase is used it is not always clear how it is being defined or whether scholars are using it to refer to the same phenomenon.

For example, Aiken and colleagues (2017) described the experience and characteristics of women seeking medication abortion via online telemedicine in Ireland and Northern Ireland, where abortion was illegal at the time. The authors found that many women sought these abortions and framed this in terms of unmet need: “This study provides evidence of the unmet need for TOP [abortion] services in Ireland and Northern Ireland, particularly among a population of women who lack the financial means to travel abroad to access services” (64) (p. 1214). Wollum et al. (2020) came to a similar conclusion after finding that requests received by an online medication abortion helpline in Brazil increased even after Zika ended, indicating an “unmet need for abortion” that was partly being accommodated by online services (65). Both studies invoked the concept of unmet need for abortion, presuming it would have meaning for their audience. However, in both cases it is not clear if the unmet need they identify is for a certain type of abortion (aspiration vs. medication), setting (in-clinic vs. remote), location (domestic vs. abroad), or something else.

In their qualitative study about pregnancy decision-making and pathways to abortion services among rural women, O'Donnell and colleagues (2018) found that when abortion services were not perceived as feasible, women faced with an unwanted pregnancy often responded by adjusting their perceived acceptability of pregnancy (51). The authors state that “at the population level, this may conceal potential unmet need for abortion services; this unmet need has negative implications for women’s health and well-being, and may be avoidable” (p. 111). Though they do not define unmet need for abortion, it seems they mean it to signify women with an unwanted pregnancy who would choose to have an abortion if those services seemed feasible to them, which is different from how Aiken and Wollum used it, above.

Others have discussed special cases of unmet abortion need, invoking the same terms but referring to different circumstances. For example, Akin et al. (2005) found an unmet need for abortion provided by the public health service in Turkey (66). Wenham and colleagues (2019) critiqued reproductive health care during the Zika crisis, including an “unmet need for abortion during health emergencies” (67) (p. 3). As these examples show, though unmet need for abortion comes up in the literature, the reader often has to infer what is meant in any given case, and the phrase appears to be taken for granted—as though there is a shared understanding, though none has been established.

Existing measure of unmet need for family planning: A cautionary tale

In considering the utility of re-conceptualizing unmet need for abortion, it is imperative to look to the history of the related measure of unmet need for family planning (i.e., contraception), which has been a core concept in the global family planning field for almost 50 years. According to global health entities such as the U.S. Agency for International Development (USAID), the unmet need for family planning measure aims to estimate the proportion of women who want to stop or delay childbearing but are not using a “modern” contraceptive method, which is taken to signify the amount that contraceptive use would increase if “fertility preferences were fully implemented” (11) (p. 8). As a population-level proxy for contraceptive access, the measure has been used to justify the creation and expansion of family planning programs, evaluate family planning programs, and assess contraceptive access around the world.

The longstanding use of the measure of unmet need for family planning provides insight into the utility as well as the potential pitfalls of defining and measuring unmet need for abortion.

History and development

Measurement of what is now called unmet need for family planning began in the first international fertility and family planning surveys in the 1960s (11,68). These surveys were launched in so-called “high fertility countries,” and grew out of the population control movement. The U.S. was a financial and intellectual leader of the population control movement, which prioritized curbing “excessive” population growth as an international development strategy (69,70). Family planning programs were a key tool to this end. Unmet need was measured to document the existence of a group of women who would presumably use family planning services if they existed, and therefore to justify investment in family planning programs (11). The current iteration of these global family planning surveys is the Demographic and Health Survey (DHS), run by USAID, which launched in 91 countries in 1984 (11). Since its inception, the DHS has prioritized unmet need for contraception as a key measure.

Unmet need for family planning has persisted as a measure despite population control at least nominally falling out of favor as an approach to reproduction. This can be partly attributed to the 1994 Cairo International Conference on Population and Development (ICPD). The ICPD marked a shift in the family planning discourse from one of population control to one of women’s sexual and reproductive health and rights (11,69). Unmet need for family planning served as a bridge between these two approaches (11,71). The Cairo Program of Action called on governments to assess unmet need in their countries and to redefine family planning goals in terms of unmet need as opposed to fertility reduction targets (11). Unmet need for contraception continues to be an international priority, as demonstrated by its inclusion in the United Nations’ 2006 Millennium Development Goals (11), and later as part of the Sustainable Development Goals (72).

Of note, the measure of unmet need for family planning has never included need for or use of abortion. In his seminal 1978 article comparing unmet need for birth control in five Asian countries, Westoff notes that the proportion of family planning users (and therefore the rate of unmet need) would have been different *if abortion had been included as a method of family planning*, particularly in Korea, where abortion was relatively accessible (73). He does not address why the decision was made to exclude abortion from these calculations.

Current measure of unmet need for family planning

The quantitative estimation of unmet need for family planning has evolved over time. The current version, revised in 2010-11, includes 15 survey questions (11,74). The denominator includes women who are currently married or in a union, as they are assumed to be sexually active. Women who are sterilized or report using a contraceptive method are considered to have “met needs” for limiting (the desire to have no more children) or spacing (the desire to delay pregnancy for at least two years), respectively. For those not using contraception, a series of other questions are considered in the algorithm. Women who are pregnant or have post-partum amenorrhea are considered to have unmet contraceptive need if they reported that their current or most recent pregnancy was not wanted. Women are categorized as infecund, and therefore without contraceptive need, if they: 1) are married at least five years with no children, never having used contraception; 2) have not menstruated in the past five years; or 3) report that they

cannot become pregnant, are menopausal, or had a hysterectomy. The remaining women not using contraception are considered to have unmet need for limiting or spacing or to have no unmet need, based on their stated preferences for future pregnancy.

Critiques of the existing measure

Many researchers have critiqued the existing measure of unmet need for family planning as conceptually and methodologically flawed (71,75–80). Methodologically, researchers point to the arbitrary nature of the criteria and their definitions, which can result in mis-measurement (11,76,81). Bradley & Casterline (2014) show that making medically- and socially-reasonable changes to the length of post-partum amenorrhea, desired pregnancy delay, or infertility definitions yield meaningfully different estimates of unmet contraceptive need (11). The focus on married and partnered women obscures the contraceptive needs of others, and likely underestimates overall need. The sole inclusion of “modern” contraceptive methods disregards “traditional” methods, even if they are effective or preferred. The existing measure of unmet need for family planning does not account for the multiple reasons people choose not to use contraception outside of access, and therefore do not “need” contraception (68,71,82,83). Treating met and unmet need as a dichotomy, rather than a spectrum, obscures the fact that there are different dimensions of need that can be met or unmet at the same time (84,85).

There are even greater conceptual concerns. The most common of these concerns is that researchers, not women themselves, determine unmet need, as none of the survey questions assess a person’s desire for contraception or understanding of their own contraceptive need (76,78,79). The presumption that everyone who wants to stop or delay childbearing *should* use contraception betrays the measure’s population control roots. Feminist and women’s health critiques have been on the grounds that this measure provides justification to coerce women to use contraception and to expand family planning programs to limit fertility (69,76,79). This construction of unmet need for family planning is rooted in the pregnancy planning paradigm, which assumes that unintended pregnancy is uniformly negative and should be reduced (86). However, years of research demonstrate that pregnancy desire and “pregnancy intention” are complex, multi-dimensional, and fluid (86).

The existing measure of unmet need for family planning does not include abortion. This makes abortion invisible in women’s reproductive lives, as well as jeopardizes the integrity of estimates of contraceptive need. For example, if a woman reports she has been married at least five years, has never used contraception, and has no children, she is classified as infecund with no way to account for whether she had experienced pregnancy and had abortions (71). It is not possible to measure people’s ability to regulate fertility without accounting for abortion (87).

Part of the root of this problem is the dissociation of abortion from “family planning” more broadly. According to the World Health Organization, family planning “allows people to attain their desired number of children, if any, and to determine the spacing of their pregnancies” (88). Though this definition would encompass abortion, they further specify “...through use of contraceptive methods and the treatment of infertility.” In this vein, abortion is not among the family planning services recognized by the U.S. Department of Health and Human Services (89). Though it is not explicitly documented why early researchers did not include abortion as a method of family planning in these measures, historically, this exclusion of abortion has been largely strategic so that contraception would not be tarnished by abortion stigma, political controversy, or religious objection, though the separation is in contrast with people’s experience of abortion and contraception co-existing as family planning options (90,91).

The current measure of unmet need for family planning is also underpinned by the idea that abortion should be decreased—a reduction in abortion rates is commonly considered a potential benefit of reducing unmet contraceptive need, and abortion rates are sometimes framed as an indication of unmet need for family planning (92–95). This framing perpetuates an idea in public health and medicine that abortion is an adverse outcome that can and should be prevented, implying that reducing abortion is a legitimate family planning and public health goal and further stigmatizing abortion (96,97).

Unmet need for abortion in the U.S. today

The literature reviewed here indicates indicate there are pregnant people who want, but cannot obtain, abortions. However, it is not clear whether (re)conceptualizing this as unmet need for abortion would be valuable, or how to define or measure that need if so. AGI's initial conceptualizations of unmet abortion need are informative, but these estimates were constrained by a number of assumptions. In using abortion rates in states with good access as a proxy for total abortion need, AGI assumed that everyone who wanted or needed an abortion in those states was able to obtain one. These estimates also performed discursive work that rooted abortion need in discourses of pregnancy planning, medicalization, and the legal/illegal dichotomy. By using age- and race-based rates of unwanted and mistimed births as a basis for estimating abortion need (54), the early AGI estimates codified the entanglement of abortion and unintended pregnancy. The resulting age- and race-standardized rates of unmet need for abortion then obscured the way their conceptualization of unmet need was dependent on their conceptualization of unintended pregnancy. This connection between abortion and unintended pregnancy continues—despite compelling scholarship critiquing the concept and measurement of pregnancy intention (86,98,99), abortion is still frequently discussed primarily as an outcome of pregnancies that are unintended, unwanted, or mistimed. AGI's metrics of unmet abortion need also relied on the assumption that obtaining a legal, clinical abortion meant that one's abortion needs were met, regardless of the experience of seeking and receiving that abortion or the quality of care. Notably, the same proxies for abortion access that were derived from early trends in unmet abortion need are still the main ways we understand abortion access today. However, changes in the political, technological, and social context warrant a fresh look at these ideas. This dissertation contributes in two main ways: I investigate the conceptualization and utility of unmet need for abortion and describe the frequency and context of not obtaining a wanted abortion in a national sample.

Chapter 2: Benefits and Risks of Conceptualizing “Unmet Need for Abortion”: Stakeholder Perspectives

Introduction

Despite being legal, common, safe, and acceptable to those who obtain them, abortion remains a highly contested, politically controversial, and stigmatized reproductive experience, and is severely regulated at the state level. In the past decade, there has been an unprecedented rise in state-level policies restricting abortion (16,17). These policies are varied and include tactics such as regulating abortion providers and facilities, imposing gestational limits, prohibiting the use of public funds for abortion, requiring parental consent and notification for minors, and mandating waiting periods, counseling, and ultrasound viewing, among others (100). Restrictive policies have numerous consequences, including clinic closures, delays in timely care, and increased costs (26,101–104). A large body of evidence indicates these restrictions create serious, often insurmountable, barriers to obtaining an abortion in the U.S. (48,103,105). Patients who are able to make it to an abortion clinic share stories of logistical, informational, and financial burdens in addition to experiences and/or fear of judgment and harassment (13–15). Data indicate that restrictions on abortion disproportionately and inequitably burden low-income people, Black, Brown, and other people of color, young people, and those who live in rural or non-metropolitan areas (3–5). That is, those who have been historically and systematically marginalized. Therefore, issues of abortion access are not only matters of reproductive rights and health, but also of health equity and reproductive justice.

Given the barriers to obtaining an abortion, there are people who are unable to obtain the abortions they want. For example, researchers estimate that approximately one-quarter of Medicaid-eligible people are prevented from getting a wanted abortion due to prohibitions on the use of public funds to pay for abortion (29,33), and that at least 4,000 people are denied wanted abortions each year due to gestational limits (7). Being denied a wanted abortion is associated with negative effects on physical and mental health, financial wellbeing, existing children, and relationships (6,43,45,47).

In the face of increasing barriers to abortion care, researchers have sought to understand the experiences of people who consider abortion but may not present at an abortion clinic, either because they obtain an abortion outside the clinical setting or do not obtain one at all (48–53). In a recent national survey, 1.4% of U.S. women ages 18–49 reported ever attempting to self-manage an abortion outside the formal healthcare system (40). Studies indicate that people self-manage abortion for a range of reasons, including personal preferences and barriers to clinical care (40,41). Other studies have used innovative approaches to understand the experiences of those who consider but do not obtain an abortion (8,49,51,52). A national survey of pregnant women searching Google for an abortion found that four weeks after their initial search, 32% were still seeking an abortion; of these, 60% wished they had an abortion “at this point” (9). In a study among prenatal care patients in Maryland and Louisiana, approximately 30% had considered abortion for their current pregnancy (10). While most did not have an abortion due to personal preference, for some, it was due to policy-related barriers. In further qualitative analyses from that same study, Kimport (2021) found that for some, abortion was “unchooseable” due to structural or cultural constraints and/or past health care experiences (106). This supports findings among women in rural Appalachia who had experienced a pregnancy they deemed

unacceptable—for many, abortion seemed so unfeasible that it was not considered a viable choice (51).

The existing body of literature demonstrates that the current political climate and service delivery landscape create a gap in which some people who want an abortion are not able to obtain one at all or in a manner that is acceptable to them. This gap could be understood as an “unmet need” for abortion (107). Studies to date are not able to demonstrate the scope of or fully characterize this potential unmet need. Researchers have called for better ways to understand and measure abortion access, as ability to obtain an abortion is critical to both public health and reproductive autonomy (108). A better understanding of unmet need for abortion could contribute to answering this call. However, there is a need to first conceptualize the issue well, including investigating its utility as tool for those working in abortion advocacy.

Background: “Unmet need” in sexual and reproductive health

Unmet need for abortion: History and current uses

Soon after *Roe v. Wade* (1973) legalized abortion in the U.S., the Guttmacher Institute began regularly surveying abortion-providing medical facilities to monitor abortion incidence and provision. Reports from their first several surveys include estimates of the “total” and “unmet” need for abortion services (54–58). Researchers estimated the total need for abortion services using methods adapted from those used to plan for family planning services (54). The gap between total abortion need and the number of abortions actually provided constituted “unmet need.” The purpose of these estimates was to help government and public health officials understand the need for abortion services and public funding in their areas in order to plan for service delivery (54).

Guttmacher’s estimates of unmet abortion need were not ahistorical in sexual and reproductive health. “Unmet need for family planning,” also called “unmet need for contraception,” has been a key metric in global family planning for almost 50 years (11). Defined as the proportion of women not using contraception among those who can become pregnant and are not seeking pregnancy (11), unmet need for family planning functions as a population-level proxy for contraceptive access. The measure has been a tool to successfully advocate for the creation and expansion of family planning programs, evaluate family planning programs, and assess contraceptive access around the world. Many researchers have critiqued this measure as conceptually and methodologically flawed (71,75–80). The most common concern is that researchers, not women themselves, determine contraceptive need (76,78,79). Scholars have also pointed to the historic used of this measure to justify the expansion of programs to limit fertility and coerce women to use contraception (69,76,79).

While there is a long and troublesome history conceptualizing and measuring unmet need for family planning, there is less precedent for or understanding of unmet need for abortion, which has a limited and inconsistent presence in the extant literature. Between 1975–1981, the Guttmacher Institute estimated that unmet abortion need was consistently disproportionately high among women who were young, low-income, or lived in non-metropolitan areas, raising health equity concerns (54–58). After 1981, estimates of unmet need for abortion no longer appear in Guttmacher reports, replaced by measures of access and availability such as geographic distribution and types of providers, public funding, and restrictive policies (60–62), which remain bedrock measures of abortion access.

The phrase “unmet need for abortion” still appears in the literature, usually referenced in passing in research articles or commentaries (51,64,65,109–112). When used, it is not always clear how the phrase is being defined or whether scholars who use it are referring to the same phenomenon. For example, Aiken and colleagues (2017) described the experience and characteristics of women seeking medication abortion via online telemedicine in Ireland and Northern Ireland, where abortion was illegal at the time. The fact that so many women sought these abortions led the authors to conclude that, “This study provides evidence of the unmet need for TOP [abortion] services in Ireland and Northern Ireland, particularly among a population of women who lack the financial means to travel abroad to access services” (64) (p. 1214). Wollum et al. (2020) found that requests received by an online medication abortion helpline in Brazil persisted even after the Zika crisis ended, indicating “a large unmet need for abortion services that is being covered in part by online services” (65) (p. 9). O’Donnell and colleagues (2018) found that, when abortion services were not perceived as feasible, some women faced with an unwanted pregnancy in rural Appalachia responded by adjusting their perceived acceptability of pregnancy (51). The authors state that “at the population level, this may conceal potential unmet need for abortion services; this unmet need has negative implications for women’s health and well-being, and may be avoidable” (p. 111). In each example, “unmet need for abortion” seems to serve as a call to improve abortion access. However, between the three examples, unmet need for abortion could signify a need for a certain abortion method or setting, domestic abortion services, more affordable abortion, or could refer to people who continue a pregnancy but would choose an abortion if it seemed feasible to them.

(Re)conceptualizing unmet need for abortion in the U.S. today

While studies and current barriers to abortion indicate there are pregnant people who want, but cannot obtain, abortions, it is not clear whether (re)conceptualizing this as “unmet need for abortion” would be valuable, or how to define or measure that need if so. Guttmacher’s early definition of unmet need was constrained by numerous assumptions that limit its utility in today’s context. For example, early estimates defined abortion need as being the need for legal, clinical abortion services (54). However, safe and effective abortion modalities are now available outside of a clinic (e.g., medication abortion by mail, home abortion provision). In addition, researchers used abortion rates in states they deemed to have good access as a proxy for what abortion utilization would look like if everyone had access to legal abortion. This approach assumed that everyone who wanted an abortion in those states obtained one. Guttmacher’s metrics also relied on the assumption that obtaining an abortion meant that one’s abortion needs were met, regardless of the experience of seeking and receiving care. Even as the measure was created, deployed, and then retired, there has been little scholarly discussion of its design and, perhaps more importantly, the conceptualization of unmet need for abortion and its utility to as a tool for abortion advocates.

The present study

Advocates, service providers, researchers, and others working for abortion access need tools to understand people’s abortion needs and effectively inform advocacy and resource distribution to ensure they are met. Unmet need for abortion has a history as a tool for service delivery planning and is familiar parlance that is still being used in limited circumstances. However, its utility as a tool to understand and improve abortion access is not known. In part,

this is because it is not clear how those who would use it—people working for abortion access today—conceptualize unmet need for abortion, whether they believe it can be useful for their work, how they understand its potential benefits and harms, and what they think about measuring it. To address this gap, this study explored the concept and value of unmet need for abortion by drawing on the observations and experiences of stakeholders working in abortion access across the U.S.

Methods

Recruitment and study procedures

I conducted 30 in-depth interviews between May and October 2021 with stakeholders working for abortion access. Stakeholders included: 1) people working in direct service settings (e.g., clinicians, abortion clinic staff and administrators), 2) abortion researchers (e.g., sociologists, demographers, epidemiologists), 3) people working in grassroots abortion funds (i.e., mutual aid organizations that provide financial and logistical support to those seeking abortions) (113), 4) reproductive justice activists, 5) abortion advocacy organization staff, and 6) staff in philanthropic foundations that fund abortion-related programs and research. Membership in these groups is not mutually exclusive, so these groupings functioned primarily as a recruitment strategy to ensure variation and representation across this set of stakeholder types.

I recruited participants through purposive and snowball sampling. I initially identified potential participants through professional networks, which included members from each stakeholder group. In addition, I asked each interviewee, as well as individuals who were recruited but declined to be interviewed, to recommend others who they thought should be interviewed. I recruited these referrals on a rolling basis, prioritizing representation across stakeholder groups, as well as participants from organizations that serve all four U.S. Census regions (West, Midwest, South, and Northeast).

I invited potential participants to be interviewed via an email explaining the study, which included a link to schedule an interview time. Those who did not respond to the initial email were sent one follow-up email one to three weeks later. Prior to their interview, I sent participants a link to a secure Qualtrics platform that included a consent form and a brief demographic survey.

Interviews took place in English over video or phone call, per participants' preference, and lasted an average of approximately 75 minutes (range 50 to 105). I offered participants a \$50 gift card via email as remuneration for their time and participation. The Committee for Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

Interview Guide

I developed a semi-structured interview guide to elicit participants' perspectives about unmet need for abortion. I began by creating a list of potential interview topics relevant to unmet need for abortion based on my research aims and informed by review of literature about people who do not obtain wanted abortions, past uses of unmet need for abortion, and the existing metric of unmet need for family planning. I then organized these topics into categories, which would become the domains of the final interview guide. I expanded each topic into open ended questions and added probes and prompts as appropriate. I referred to semi-structured interview

guides from other studies conducted with stakeholders and people in their professional capacities for guidance. Two researchers with extensive experience conducting qualitative studies on abortion and contraception reviewed and provided feedback on the content and flow of the interview guide. The final interview guide included questions in four broad domains: 1) history in abortion and reproductive justice work, 2) fully meeting abortion needs in the U.S., 3) “unmet need for abortion” as a concept, 4) measuring and documenting unmet need for abortion.

To build rapport and learn more about how participants were oriented in abortion work, I opened interviews by asking participants to share a bit about their history in the field, what brought them to the work, and an accomplishment they were proud of. Interviews focused on how participants conceptualized abortion need in the U.S. in general and sought to explore understandings, definitions, conceptions, and opinions of the concept of “unmet need for abortion.” In some conversations, participants brought up the issue of measurement/quantification without being prompted, and I followed up with clarifying and probing questions. When they did not, I directly asked about the idea of trying to measure “unmet need for abortion.”

Analysis

I audio recorded interviews and sent them to a professional transcription agency to be transcribed verbatim. I reviewed each transcript alongside the audio recording to check for accuracy and de-identify the text as needed. I took notes during each interview and used them to create a memo after each interview with a summary and my reflections about the interview content and process.

Using Dedoose, I thematically coded each transcript using an iterative approach. The present analysis focuses on data that give insight into whether defining and measuring “unmet need for abortion” would be valuable to the field of sexual and reproductive health. In the first round of coding, I broadly coded for any discussion of unmet need for abortion. I then sub-coded these excerpts using codes that emerged from the data as well as a priori codes developed from the interview guide to capture: the benefits and harms participants identified related to defining and/or measuring unmet need for abortion; reflections on the terminology itself; the complexity of the concept; and the social, economic, and political factors participants identified as contextualizing and shaping unmet need for abortion. I continued iteratively sub-coding transcripts until no new codes emerged. Throughout the coding process, I maintained a data analysis memo, in which I examined particular codes and emerging themes across transcripts. As I progressed through this analysis, I began to see that “benefits” and “harms” of unmet need for abortion were threads throughout the sub-coded data. I then organized the coded data to try to disentangle the benefits and harms of how unmet need for abortion could be used (e.g., quantification, documentation, conceptualization writ large) and the benefits and harms of such a concept being defined at all (e.g., the potential effects of such documentation and conceptualization). Participants’ hopes and worries about unmet need for abortion coalesced around a few salient themes: uses of measurement and documentation, implications for issue framing, and broader questions about the connection of abortion to other issues, which is how the results are organized below.

Throughout the results, participants are identified by their years of experience in abortion or reproductive justice work. This identifier contextualizes their insights and perspectives, while being general enough to maintain confidentiality. I also include a participant ID number to show

the breadth of responses. When relevant to the data being presented, I include other participant characteristics, such as their professional role or geographic region.

Sample Characteristics

The sample included 30 stakeholders (see Table 1). On average, participants had worked in abortion or reproductive justice for approximately 17 years (range 3 to 45). Most (n=23) had worked in the field for at least 10 years. Stakeholders were between 29 and 72 years old (average age 43 years). Most (n=24) identified as cisgender women and as white (n=18). Eleven participants lived in the South, seven in the West, six in the Northeast, and six in the Midwest. Many stakeholders worked in more than one state and/or nationally. Nine worked in the South, nine in the Midwest, seven in the West, and four in the Northeast. Ten worked in organizations that had a national focus, and an additional nine did work with a national reach, such as service provision to individuals from around the U.S. and/or national policy initiatives, research, or programming.

Given individuals' long histories in abortion-related work, some had experience in more than one stakeholder group. For example, at the time of the interview, six participants worked in a direct service setting, including clinicians (e.g., physicians, midwives) and administrators providing abortion in various settings (e.g., in clinics, via telemedicine, at home), however 11 had worked in direct service at some point in their career. Table 1 details the various stakeholder groups participants belonged to throughout their careers.

Results

While participants had diverse perspectives about the meaning and value of the concept of “unmet need for abortion,” throughout the interviews it was clear that all participants believed there were people who could not obtain wanted abortions and felt this was an important problem. Participant 6 (9 years' experience), who works in a national advocacy organization, called unmet need for abortion “100 out of 10, very extremely important.” Similarly, Participant 10 (22 years' experience), a researcher in the Northeast, identified it as “kind of the million dollar question—how many people want abortions but don't get them?”

While recognizing the importance of abortion need(s) not being met, stakeholders saw both potential benefits and harms to conceptualizing “unmet need for abortion.” Some of these related to the potential quantitative measurement and documentation of unmet need for abortion, some to the overall framing of abortion access as a social issue, and still others to the broader implications for the abortion rights movement. Table 2 presents a summary of results.

Documenting unmet need for abortion and uses of data

Participants highlighted the value of measuring unmet need for abortion, ways it could be measured, and the benefits and harms of trying to quantify and document this information. Throughout conversations about documentation, participants' responses highlight that unmet need for abortion can be thought of as a tool—one that could be useful or concerning depending on how it is used and by whom.

Benefits of using unmet need for abortion as a tool

Stakeholders who saw benefits to documenting unmet need for abortion saw it as a tool that could be used to increase awareness and mobilize resources and support, both within and outside of the abortion rights movement. Participants expressed the need for improved understanding within the abortion rights movement of the extent to which abortion-related needs are not being met, and some thought measuring unmet need for abortion would serve that aim. A new metric could be a useful tool because the changing abortion landscape has made some existing metrics of abortion access less reliable and relevant. For example, Participant 28 (37 years' experience), referenced how common measures of abortion access revolve around the geographic distribution of clinics:

These access measures made sense when you thought geography was necessary for access, right? So like, how close is the clinic to you [?] ... But now that we have telemedicine, now that we have sort of a lower distribution of clinics, and therefore, we don't actually know how far someone is away from the service that they need ... I could be five miles away from the first trimester clinic, but if I am 22 weeks pregnant, that clinic is useless to me, right? ... I think we've got to move to an unmet need [measure], because geography no longer determines availability, and if self-managed abortion is increasing and sort of potentially filling some of that need.

In addition to the increase in non-clinical abortion options, in her view, measuring abortion access in terms of proximity to an abortion clinic is no longer sufficient because increases in law- and facility-imposed gestational limits mean that more and more pregnant people, particularly those at increased gestations, will not be eligible for abortions at their nearest clinic.

An unmet need measure could also be used to shed light on how shifts in service delivery modalities impact abortion access, which seemed to be of particular interest to those working in or adjacent to philanthropic funding. For example, Participant 18 (19 years' experience) noted that it would be helpful to know whether options such as telemedicine or abortion pills by mail “are meeting what we would consider an existing need or ... putting [abortion] within reach for folks that might not have imagined that would be possible for them.” Some participants pointed out that in the current funding environment, data like these are a tool used to direct grant-making:

[I]f there was a way to quantify that [unmet need for abortion], it'd be amazing. ... I think that's the argument I keep trying to make in the grant applications—just like, there is need here. And how do you talk about that? How do you say I'm not taking patients from other places and actually creating opportunities for abortion care where there isn't? (Participant 14, 20 years' experience)

Among many participants, there was a sense that documenting unmet need for abortion could help those working in abortion access know how and where to direct resources more effectively, from building clinics and developing innovative care models, to directing funding, and even grassroots mutual aid. Participant 11 (5 years' experience), who works in an abortion fund in the Midwest, discussed the potential utility of using data about unmet needs to create visual maps to guide practical support networks, to “work with folks in those areas [with highest need] to build up these survival networks that we've been creating over the years to ensure that people in those areas are, in fact, getting to the care that they need.”

Beyond the abortion rights movement, participants shared the sentiment that the general public does not grasp the current “crisis in the access to [abortion] care” (Participant 7, 20 years’ experience), and hoped that quantitatively documenting unmet need for abortion could be used to help people see that.

I do think that there's not a good understanding of how hard it is to get an abortion in the United States. ... But if there were quantitative measures that we could point to and say, the unmet need for abortion has risen dramatically in the years since the Supreme Court made this decision, that might be useful in helping people who basically think abortion should be available but just don't really think about it all the time. And helping them understand the degree of crisis that we're in. (Participant 16, 30 years’ experience)

Ideally, participants believed increased awareness could lead to an increase in public and private resources directed toward abortion access, and could help garner political, philanthropic, and legal support, especially given the resonance of unmet need as a concept in public health, medicine, and government, and as seen with the widespread and long-term use of the existing metric of “unmet need for family planning” in global sexual and reproductive health work. Participant 18 (19 years’ experience) called unmet need “a really well-trod construct in health care utilization and infrastructure conversations,” noting “There’s a reason why people use it.” Participant 27 (12 years’ experience) added that unmet need for abortion could be useful in articulating problems in abortion access to the broader medical community because it puts “abortion access in the same terms that they're thinking about other types of health care access.” In this way, participants hoped unmet need for abortion could be used as a tool to make their priorities legible to people and institutions with power and resources.

In theory, stakeholders believed a quantitative measure could be a tool for lobbying legislators, particularly those who already support abortion rights. Participants noted that empirical evidence provides legitimacy and credibility that is necessary for elected officials to take claims seriously. When asked about quantitatively measuring unmet need for abortion, Participant 23 (3 years’ experience), reflected on her experience in national policy advocacy, saying, “I think that could be useful, especially when talking with policymakers. They're always looking for data. No matter how many times I tell them, your district is with you. ... Your people, they want abortion to be accessible. We always have to have data.”

Concerns about using unmet need for abortion as a tool

In discussing a measure of unmet need for abortion, participants also identified several concerns related to how the tool could be used, whether it was necessary, and fear of oversimplifying a complicated phenomenon. In terms of data use, participants frequently expressed concern that a documented measure of unmet need could give fodder to abortion opponents. Echoing others, Participant 25 (9 years’ experience) considered this “a glaring risk,” saying: “[I]s that then fuel for people who are trying to limit access to abortion services?” Participant 11 (5 years’ experience) could foresee abortion opponents using the information to try to shut down grassroots efforts to fund abortion and practical support, like that provided by her organization. They worried that if abortion funds used data about unmet need to build mutual aid networks, abortion opponents:

... could swarm an area that they see us building solutions around to try to shut that down. ... Yeah, so that's always the trade-off of getting more information about the state

of abortion access and creating solutions to it, knowing that it's possible we're still just playing a cat-and-mouse game with the antis.

A few participants noted that unmet need for abortion could be seen as a victory for the anti-abortion movement. Participant 20 (15 years' experience) thought tracking how many people carried unwanted pregnancies to term because they could not access abortion made hypothetical sense but also expressed concern that people could use it "on the anti[-abortion] side to be like super excited. That's something they'd love to say, 'We saved this many lives.'" While many shared these concerns, some felt they did not warrant *not* collecting and disseminating such data. Participant 1 (39 years' experience) explained: "The trick has always been, in our field, to not supply the antis with data that they can use. But in reality, they use any data they want and twist it. So in some ways, we all have to drop that worry."

In addition to concerns about abortion opponents, a few participants were wary of how the data would be used by abortion rights proponents as well. For example, Participant 8 (7 years' experience) expressed concern that data would not be used to benefit the communities it came from, a concern rooted in the history of research being extractive, as opposed to community-centered, especially in communities of color. She said, "Yeah, you want to assess these unmet needs, but to what end? What will happen when you've done that assessment? What then is going to go back into the community? How is this reported back to the community? What changes are being suggested or tried out in order to make sure that those needs are actually then being met?" Participant 23 (3 years' experience) emphasized the importance of making sure there was a clear utility to such a tool to "people on the ground," such as abortion funds, and not just for those doing policy work, "to make sure that there isn't any harm caused" to communities.

While some concerns were about the use of a new tool going forward, others were motivated by concerns about how similar tools have been used in the past. For example, some participants referenced the ways unmet need for family planning metrics have been used to justify population control and have therefore impeded reproductive autonomy (69,76,79). This led to concerns that these problems could be replicated in how unmet need for abortion is used:

[U]nmet need for contraception has been used for ill by people who are trying to limit the reproduction and fertility of certain groups of folks. ... I don't know if we run as much of a risk of ill use of abortion unmet need in that way. But certainly, racism and classism undergird everything. So, I think a risk would be, to what extent do those things lead to a policy emphasis on reducing unmet need in a way that is really more about fertility control than reproductive autonomy. (Participant 9, 25 years' experience)

Participant 13 (25 years' experience) expressed doubt that unmet need for abortion could be used as a tool without being "pulled back into the same old problems" associated with unmet need for family planning.

Participants also questioned whether, as a tool, a measure of unmet need for abortion was worth the resources it could take to create. Existing data about abortion access have been resource intensive to obtain, in terms of both people and money, and the investment required to measure unmet need for abortion might be better spent elsewhere. For Participant 13 (25 years' experience), a measure of unmet need for abortion, while theoretically interesting, would come with clear opportunity costs:

I think if someone has a cool idea about how you can do that without spending all the resources of the movement, like cool. Like let's try it out and see if we can do it. But I

don't see that advance on the horizon. And again, I don't want us to get stuck in our research mentality so deeply that we use resources that would be better used getting people an actual service.

The question of whether such a tool was worth the investment of resources should be considered alongside participants' uncertainty about whether it would have the desired impact. Speaking about its utility as a lobbying tool, one stakeholder pointed out that if estimates of unmet need are perceived as small by elected officials, it could backfire (Participant 26, 18 years' experience). Participant 17 (12 years' experience) expressed skepticism about quantitative data impacting state policymakers, who, in her experience in the South, are not often swayed by reproductive autonomy, making such lobbying difficult:

But unfortunately, it's very hard to get them [policymakers] to say, look, it's really important to meet people's needs. Instead, it's more like, well, just as long as everybody has the bare minimum. If we're avoiding harm to people, that's enough. And how do we actually get the legislative folks and the policy folks to be able to see beyond that, to really understand that autonomy in any aspect of reproduction is just so central.

Given what is already known about extreme barriers to abortion access, some participants felt more data are not needed to know that the status quo is unacceptable. Participant 18 (19 years' experience) described "arguing with herself" during the interview—first thinking a measure of unmet need for abortion could be used to "solve so many things," and then wondering if it really would. Given how much is already known about the barriers experienced by people who make it to clinics, she then changed her mind about the utility of unmet need, saying, "I think we know enough about it frankly ... I can't see [a measure being] that expedient, to be honest." Participant 5 (10+ years' experience) echoed this, asking, "[W]hat do we find with the [measure of unmet] need that we don't already know? No, we're not reaching the people in rural Wyoming." They continued that they "don't see anything wrong with incorporating data from patients that providers see. But I think for me as somebody who actively thinks about how white supremacy informs bureaucracy, I don't believe that we need additional data to say that we need more clinics."

Other concerns were rooted in broader critiques about measurement, rather than specific to "unmet need for abortion" as a quantity to be measured. As opposed to concerns presented above about whether unmet need for abortion can be used appropriately and by whom, these concerns highlight the question of whether unmet need for abortion can be a useful tool at all, given the inherent limitations of quantification. Quantification implies that *quantity* matters, which was not always the priority to participants. Participant 22 (10 years' experience) shared, "I guess in my view, even one person that doesn't have an abortion because they felt like they will be stigmatized because of it is too many. I mean, it doesn't matter if it's 1 or 100 or 10,000 I don't need a specific number to be able to know that it needs to be destigmatized." Emphasizing quantity could be counter to centering the most marginalized. Participant 14 (20 years' experience) shared her approach, which is "don't just focus on the numbers, focus on the people that have the hardest time."

Participants' most prominent concerns about the value of a measure of unmet need for abortion were about the loss of richness and complexity they felt were an inevitable consequence of quantification. Many participants, including those who supported developing a measure, mentioned the risks of over-simplifying people's experiences. Participant 15 (45 years' experience) noted that quantification "gets rid of the nuance, and, to me, nuance is everything

when it comes to this.” Part of this loss of nuance is due to the nature of cross-sectional data. Participants discussed that people’s feelings and desires about pregnancy and abortion can fluctuate even within a pregnancy, blurring the lines between “met” and “unmet” need for abortion. For example, a pregnant person could have a quote-unquote “unmet need” for abortion at seven weeks, but then not at 10 weeks either because they obtained the abortion, had a miscarriage, or no longer wanted an abortion. Numerous participants noted that, at best, unmet need for abortion could provide a “snapshot,” which could limit its utility as a tool.

For some, their hesitation seemed to stem from frustration with what they saw as a larger desire in the abortion rights movement for things to be “neater.” Some participants questioned whether there could or should be a clear dichotomy between “met” and “unmet” abortion need. The lack of allowance for complexity was frustrating to some participants.

I have kind of an issue with the rigidity around some of these ways that we want data about this stuff. I think people are human beings who change their minds and weigh all kinds of things and decide, make different decisions. ... [A]n issue that I have with research sometimes, it’s like we want to fit—we want everything to fit into nice little boxes that supports a certain narrative. And I think it is actually far more complicated than we [as a movement] allow it to be, or have the tolerance for. (Participant 22, 10 years’ experience)

Defining unmet need quantitatively would entail delineating cutoffs between what makes a need “unmet” or not. For participants, this raised the concern of leaving groups out.

[L]et’s just say there’s particular communities where unmet need looks really different than it does in the majority of this country. That experience of unmet need might be hard to include in a measure because it’s a smaller community, and then you’d be missing something if you were using that measure to design a program or design an intervention or design a campaign to change things. You could do harm to a community whose needs get left out. (Participant 16, 30 years’ experience)

Concerns about who is left out related to deeper concerns about the process of developing a measure, and who designs it. Participant 6 (9 years’ experience), couched her concerns by saying, “I think I have a lot of fears around like who’s creating a tool, like who are they developed by? Are they just white men developing tools?” Participants worried that groups left out of a measure of unmet need would be the same groups historically marginalized and excluded, which could reinforce existing lines of stratification by rendering needs of certain groups invisible. Participant 30 (6 years’ experience) named these concerns, asking “[A] fear that I hold would be, who’s having their voice heard?” She worried that multiply marginalized groups, such as trans youth, would have their experiences of unmet need for abortion obscured.

Framing abortion in terms of “unmet need”

In addition to how a measure of unmet need for abortion could be used as a tool, participants provided insight into the value of conceptualizing the issue of unmet need for abortion as a broader idea—that is, the value of the presence of such a tool beyond the specific uses of data. Participants shared benefits and concerns about framing issues of abortion access in terms of unmet need for abortion, including how this framing could change public discourse about abortion and the implications of using the term “need.”

Shifting the conversation

Participants saw several benefits to adding the concept of “unmet need for abortion” to the public discourse. Among these was the potential to broaden the conversation about abortion access problems. Participant 4 (24 years’ experience) reflected on how conversations about state-level abortion restrictions, both within the abortion rights movement and in the general public, have focused on the burdens for people obtaining abortion care, with less attention to how restrictions cause some people not to get abortions at all. She considered this issue “huge,” adding, “We need to acknowledge that people are not getting care that they want now, so we should be discussing it, we should be considering that people are unable to get their wanted abortions.”

Participants thought the existence of a tool such as unmet need for abortion could provide the opportunity to engage in an important conversation that has been difficult to have—the possibility that there should be more abortion in the U.S., which is counter to mainstream messages that frame abortion as negative. Participant 24 (12 years’ experience), identified this potential benefit:

[Unmet need for abortion] might be helpful in a way that—I’m always frustrated at how much I feel like abortion advocates are just always on the defensive. And I’m like, no, we need to write our own narrative and our own needs, and our need is actually not that abortion just should exist at all, but that it should exist in a much higher volume than it does right now, and that we’re actually really struggling on a basic level.

Participants hoped that the concept of unmet need for abortion could help facilitate this burgeoning conversation both within and outside the abortion rights movement in the U.S.

I do think that idea of conceptualizing this is super important. The idea that there are people who are not getting abortions because of a variety of reasons should suggest to us that the abortion rate in the United States is suppressed. And just offering that up as a construct, as a social construct, I think is super important. (Participant 28, 37 years’ experience)

Discussion of the conceptualization of unmet need for abortion connected to longstanding debates about public messaging around abortion. For example, participants referenced the historical reluctance within the abortion rights movement to admit that abortion opponents had succeeded in reducing abortion, which made it difficult to suggest there should be more abortion in the U.S. Participant 28 (37 years’ experience) also pointed to concerns about political controversy and fear of backlash that she saw as hindering support for efforts to improve abortion access if those efforts might also increase the abortion rate:

[W]e as a field are deathly afraid of a rise in the abortion rate. We don’t view the rise in an abortion rate as positive. So, when the abortion pill was introduced in 2000, they interviewed a number of scholars about what was going to happen to the abortion rate. And everybody was like, “No, it’s just going to be substitution. People who were going to have abortion are now going to have medication. You don’t have to worry. The abortion rate is not going to increase.” And so nobody even dared to think that you might get a rise because they were so afraid that it would lead to a backlash against the abortion pill. ... But I thought it was stupid. I was like, well, then why are we bringing the abortion pill?

The whole point of this is to increase the number of people that can have an abortion. But people were so deathly afraid.

Not all participants thought the concept of unmet need for abortion would shift the public discourse about abortion in a helpful way, and a few expressed concerns that, instead, it could misdirect conversations about improving abortion access. These participants, including one in direct service and one from an abortion fund, worried that even just framing problems with access as “unmet need” could be taken to indicate that clinics and abortion funds were not doing enough to meet abortion needs. This could direct blame for access problems toward service providers, instead of toward the larger forces that contribute to people being unable to get abortion care.

The question of “need”

Participants had varied opinions about the effect of framing abortion in terms of the concept of “need.” For some, discussing abortion as a need legitimized it. In particular, considering all abortions as “needs,” regardless of reason or circumstance, pushed back against the stratified legitimacy of abortions, in which certain abortions are viewed as acceptable and others are not (114).

There is so much I like about the phrase, “unmet need for abortion.” I like it when people attribute abortion and “need.” Because I think it cuts against this false notion of frivolity that people just, oh, they just kind of want to get rid of a pregnancy. They don't actually need to. So I like that. (Participant 26, 18 years’ experience)

Some participants saw a “need” framework as an opportunity to center the pregnant person in abortion access narratives, as opposed to centering policies, barriers, or service availability. They hoped focusing on a person’s self-defined needs could center reproductive autonomy by being fundamentally about “what a person wants” (Participant 17, 12 years’ experience) and whether they “get what they need” (Participant 7, 20 years’ experience).

Others were skeptical about whether the term “need” would have this impact, partially due to uncertainty about its resonance with pregnant people themselves, versus a “desire” or “preference” for abortion. Participant 25 (9 years’ experience) added that “not everyone might feel that it [abortion] is a need to them, it might be something that they've decided on out of [the] options that they have.” The term “need” could be too limiting to capture people’s experiences. Participant 18 (19 years’ experience) shared an example of this problem:

[I]t’s not sensitive enough to some of the internal conflict that people might be feeling. And it puts pressure on folks to vocalize a need. And I think that people are disinclined. People are really disinclined to say that they lack.”

Participants who voiced these concerns thought framing abortion as a need if that does not resonate with people’s experiences would undermine unmet need for abortion as a person-centered tool. Participants contextualized this concern using examples of other reproductive health priorities that have been decided by people other than potential service users themselves, such as efforts to increase uptake of long-acting reversible contraception or to advocate for self-managed medication abortion as a solution to abortion access problems. After sharing such an example from her own work, Participant 8 (7 years’ experience) asked, “So I feel like, when

talking about unmet need, the question is who is saying [it]—who’s determining what those needs are?”

Participants also differed in their opinions about whether the using the term “need” would foster a sense of social responsibility for ensuring abortion access. Participant 4 (24 years’ experience) felt it had this potential. Referencing the success of the existing measure of unmet need for family planning, she said, “You feel like, ‘Oh, someone has an unmet need, let’s help them.’ They use those words because they’re very good words like, ‘Oh let’s meet people’s needs.’” Others saw it differently, understanding the existence of needs as a neutral state, with no inherent accompanying obligation to meet them. This was voiced by Participant 12 (5 years’ experience) when she said, “[A]n unmet need is just kind of like, ‘Oh, this person didn’t have this.’ Whether or not someone needs an abortion today, the obligation is that they should be able to have one. Period. So you need that structure in place.”

Bigger picture concerns: What unmet need for abortion misses

Throughout the interviews, most participants discussed abortion as deeply contextual and connected to other aspects of people’s reproductive and social lives. This raised questions about whether a tool like unmet need for abortion risks over-emphasizing the abortion itself and disconnecting it from the conditions of people’s lives.

Over-emphasizing the abortion itself

For various participants, unmet need for abortion implied a focus on whether an abortion was *obtained*. For some, it was equally important to focus on whether abortion was a meaningful possibility for people. Participant 3 (25 years’ experience) critiqued this focus on outcomes, saying, “[P]art of the problem is that how we usually measure stuff is like, did this happen or not? It’s like we’re very focused on the outcome.” Participants 3 and 12 both shared stories in which their organizations helped someone travel for an abortion that they then decided they did not want. For both, it was the ability to have the option that mattered most:

I was like, yeah, that’s why we pay for you to come. That’s what we want. Like we don’t care if you have the abortion or not. We want you to be able to do what you want.
(Participant 3, 25 years’ experience)

[T]hat’s OK. We’re not going to charge you for your hotel room. We’re not going to take back your gas money. We want it to be truly “pro-choice.” (Participant 12, 5 years’ experience)

Abortion being *possible* for people mattered, whether or not they sought or obtained one. Participant 3 continued:

[Y]ou just don’t know how many people like never see abortion as an option and like therefore don’t consider it. And what would it mean for them to be able to consider it? How would that influence their path regardless of whether they had an abortion or not? But it was like actually an option.

Participants’ focus on the importance of ensuring abortion is “within the realm of possibilities” for people (Participant 2, 12 years’ experience) segued into discussions about how the current state of abortion access in the U.S. could constrain any conceptualization of unmet

need for abortion. Given abortion stigma, access barriers, and lack of geographic availability, some people may not consider abortion even if they might otherwise want one:

Starting from [abortion] need where we are now just ignores the fact that because of information and access barriers, a lot of people wouldn't even identify themselves as potentially interested in this possibility [of abortion]. (Participant 13, 25 years' experience)

Taking a current level of abortion need at face value might identify people who are unable to obtain a wanted abortion, but it does not account for those who might consider or seek abortion under other circumstances.

(De)contextualizing and (dis)connecting abortion

Across various interviews, participants discussed the connection between abortion needs and needs related to parenting, sexual and reproductive health, and the social and economic contexts that shape people's lives. Given its focus on abortion need alone, participants questioned the utility and adequacy of unmet need for abortion as a tool. While some stakeholders noted the importance of maintaining an explicit focus on abortion given urgent crises in abortion access, others expressed concern about disconnecting abortion from reproductive well-being more broadly. These concerns were related, for some, to a sense that abortion has historically been too siloed in reproductive health and rights movements.

In almost every interview, participants discussed the fact that some people have abortions because parenting is foreclosed to them. Participant 16 (30 years' experience) articulated how this demonstrates some of the conceptual limitations of unmet need for abortion, as it obscures the connection between abortion and parenting:

Because we don't know what the real need for abortion is, in part, because we don't make it fully possible for people to have the families they want to have. So some abortion need is being driven by things that we should also be working to eliminate. Like there's some abortion need that comes out of pregnancies that people probably would like to bring to term but just don't see a way in the world as it exists. But that is still abortion need as the world exists today. ... So we shouldn't be focused exclusively on meeting the need as it exists today, but we should be focused on meeting the need as it exists today. It just shouldn't be the only thing we think about when we think about the needs of people who are pregnant.

Participants often credited the reproductive justice movement with expanding the sexual and reproductive health field's—and sometimes their own—thinking about the interdependency between the ability to parent and the ability to obtain an abortion.

[A]s abortion researchers, we're focusing on unmet need and the people who don't have this [abortion] as an option, or don't consider it an option or can't obtain it. But again, and I think the reproductive justice perspective is increasingly making us realize that's just one side of the coin. But if we're not providing people the resources to raise a child, to raise a family, then that's a big, huge unmet need for people who have them and/or people who want to but have abortions. (Participant 10, 22 years' experience)

In addition to concerns that it prioritizes abortion over other pregnancy outcomes, some participants expressed concerns that unmet need for abortion implies a false separation between abortion needs and other needs. Participants pointed out that when people have abortions because oppressive social or economic conditions do not allow them to have a baby, meeting their abortion need does not resolve these larger issues. Instead of abortion needs specifically, some participants thought there may be other needs, further upstream, that could be more central in people's lives. Participant 16 (30 years' experience) expressed concern that conceptualizing "unmet need for abortion" could preclude consideration of these other needs, obscuring the social and economic contexts that shape abortion need.

So if the path we go down [in conceptualizing unmet need for abortion] is, "Do you want to be pregnant right now, Yes/No?" And the answer is "No," therefore, you have a need for abortion. But maybe what you needed was something different. That's what I was thinking. What you needed was an apartment so that you could have a baby not living with your six siblings.

Some of these participants underscored that having unmet basic needs could not be disentangled from abortion needs. Toward the end of our interview, Participant 26 (18 years' experience) said, "So, we're talking about the unmet need for abortion. But if undergirding that are people's unmet needs for secure housing, and food, and jobs with living wages, and resources for their living children, then those unmet needs also have to be addressed." In highlighting the relationship between abortion and other needs, these participants drew attention to the limitations of an individual-level conceptualization of unmet need for abortion, and pointed to the community-level, systemic, and structural needs that undergird it.

I just wonder how it [unmet need for abortion] lines up with the other needs people are having in these communities. Because access to abortion is not a single issue struggle. (Participant 20, 15 years' experience)

Discussion

This study explored how stakeholders understand the utility of unmet need for abortion as a potential tool to improve abortion access in the U.S. Stakeholders interviewed for this study raised complex issues to consider in conceptualizing or measuring unmet need for abortion. Participants all discussed vast and urgent problems with abortion access in the U.S.—the fact that people's abortion needs are not being met was a high priority. As a tool for advocates, researchers, policymakers, and others working for abortion access, unmet need for abortion offers potential benefits. It could attract and direct investment of resources and shift the discourse around abortion access. However, stakeholders also raised concerns about how such a tool could be used and highlighted the tradeoffs inherent in quantifying something complex and dynamic. Stakeholders emphasized that abortion cannot be singled out or separated from other aspects of people's lives and social conditions.

With increasing state-level restrictions on abortion and the U.S. Supreme Court seemingly on the brink of overturning *Roe v. Wade*, the need to talk about people who cannot obtain a wanted abortion will likely only increase. This, along with the resonance and durability of the "unmet need for family planning" metric internationally, indicates there could be a utility to a concept like "unmet need for abortion." However, the data presented here raise serious

concerns about such a tool and highlight the importance of intentional examination of such a metric that engages stakeholders at multiple levels and attends to structural inequalities to understand how it could operate as a tool for abortion advocates (and unintentionally opponents) and what discursive possibilities could be created or foreclosed through its deployment.

In interviews, the concept of unmet need for abortion was often inextricable from the possibility of measuring it, with pros and cons intertwined throughout conversations. In this way, conceptualizing unmet need presumes quantification and measurement are primary ways to understand abortion access. Measurement of constructs plays an important role in the fields of public health and sexual and reproductive health, including determining prevalence of issues (and selecting which issues), understanding “successes” and “failures,” and as a tool to establish funding and policy priorities. Though problematic, measuring unmet need for family planning helped legitimize contraceptive access as a health care and public health priority (11,71). At its best, a measure of unmet need for abortion could similarly legitimize abortion access as a necessary and appropriate public priority. However, due to abortion exceptionalism (i.e., the ways abortion is treated less favorably than seemingly comparable issues) (115,116), it may not be reasonable to expect a similar investment in abortion as compared to contraception.

At the same time, a measure of unmet need for abortion could be a tool used to better contextualize changes in the abortion rate, for example by enabling an interpretation in which an increase in the abortion rate could indicate a success in meeting people’s needs. This could enable stakeholders to support a welcome and necessary counter to a common idea in public health and medicine—that abortion is an adverse outcome that can and should be prevented, and therefore reducing abortion is a legitimate family planning and public health goal (96,97).

While measures are helpful tools for what they draw attention to, they risk obscuring issues outside their immediate focus and foreclosing other ways of understanding (117). Quantification necessitates simplification, which can be at odds with adequately capturing people’s lived experiences of reproduction. Stakeholders highlighted the myriad ways abortion needs are complex and can shift, even within a single pregnancy. To measure unmet need for abortion, however, there must be a threshold someone crosses into needing an abortion. This raises the question of what it means to want an abortion enough to count and who has the power to make that decision. In this way, while documenting unmet need for abortion has the potential to increase visibility of people who articulate a clear desire to have an abortion, it could also leave others invisible, such as those whose access is so limited they do not even get to have a need to be counted.

In addition to the uses of a measure, the data presented here indicate the importance of thinking more broadly about the conceptualization of unmet need for abortion itself and how such a concept could impact the framing of abortion in the public discourse. For example, narratives about abortion regret have become a mainstay of the antiabortion movement (118) and are often countered by data that people are certain about their abortion decisions (119,120). However, such demands for certainty can put pressure on people seeking abortion to justify their decisions and demonstrate their certainty, which can be difficult (121). If conceptualizing unmet need for abortion relies on the assumption that people experience abortion as a clear-cut need or prioritizes those who do, then it could further normalize the idea that it is not common or acceptable to have mixed or changing feelings about abortion, which could reify potentially harmful messages about abortion certainty and the specter of regret.

Conceptualizing unmet need for abortion is further complicated by questions of how it fits into larger conversations about health equity and reproductive justice. A comprehensive

understanding of abortion need must account for the ways that social and structural determinants of health shape abortion decisions, desires, and needs. Understanding abortion need requires consideration of the fact that some people have abortions because parenting is foreclosed to them by multiple structures of oppression, highlighting the connections between abortion need and the conditions of people's lives. Stakeholders problematized the disconnection of abortion need from these other issues that comprise reproductive well-being more holistically. This siloing of abortion has a long history in the reproductive health and rights movements. However, need for abortion is just one component of reproductive well-being, and must be understood alongside other needs, such as for contraception, fertility treatment, and birthing options. Such an approach could highlight patterns and connections, for example, there may be certain groups of people who are prevented from realizing their reproductive desires across the board. This is in line with the reproductive justice framework, which de-centers abortion and instead centers reproductive oppressions broadly (1). From a reproductive justice perspective, the right to *not* to have a child (whether by contraception, abortion, or abstinence) can only exist alongside equal rights to have a child and parent in safe and healthy communities.

While unmet need for abortion has potential utility as a tool to help those working in abortion access direct resources and broaden some conversations about abortion access, the potential pitfalls are considerable. In particular, the data presented here caution against further separating abortion from reproductive well-being broadly. Inasmuch as unmet need for abortion defines "success" as obtaining abortion, it risks detracting attention from other goals, such as the opportunity to see what abortion reveals about people's lives, including the social and structural conditions that enable or disable family building with joy and dignity.

Limitations

While I recruited a diverse and balanced sample in terms of stakeholder type and region, the stakeholders reflected in this sample are mostly white (18/30) and highly formally educated (22/30 held a graduate or professional degree). There could be multiple reasons for this. For some stakeholders, such as medical providers, researchers, and lawyers, formal education is required to hold their position. Due to longstanding patterns of exclusion and gatekeeping, fields like academia and medicine remain largely white (122,123). In addition, I recruited partially through my own professional networks. My position as a white graduate student may have influenced who comprises my network and/or influenced stakeholders' comfort participating or referring colleagues to me. Stakeholders from other social locations may have different perspectives related to their experiences as people of color and/or navigating abortion work with less formal education that provide insights into unmet abortion need that are thus not captured in this analysis. The data collected in this study can therefore only provide partial insight into the value of unmet need for abortion as a tool for abortion stakeholders. In addition, I used a priori stakeholder groups to create a sample that included people who work in abortion in various capacities. However, these groups do not represent an exhaustive list of types of stakeholders in abortion access, which means some perspectives that are relevant to fully understanding the utility of unmet need for abortion may be left out.

Conclusion

Previous research has not explored the value of conceptualizing unmet need for abortion as a tool to inform advocacy and resource distribution to ensure people's abortion needs are met.

This paper describes the benefits and potential harms of framing, defining, and documenting unmet need for abortion, based on the perspectives of a diverse group of stakeholders working in abortion in the U.S. Based on stakeholder concerns, unmet need for abortion may not be *the* tool needed in the movement for abortion access. But the data presented here indicate that some shifts in how these issues are examined and understood are warranted. Common indicators of abortion access and availability increasingly fall behind in light of the ever-evolving legal, political, technological, and social landscape. A broader conversation about fully meeting abortion needs is valuable and timely.

Tables

Table 1. Characteristics of participants in stakeholder interviews about unmet need for abortion in the U.S. (N = 30)

	N (%)
Stakeholder type(s) (in career)*	
Direct service	11 (37)
Advocacy	10 (33)
Research**	10 (33)
Abortion fund	7 (23)
Reproductive justice	7 (23)
Philanthropy/Funding	3 (10)
Region, current residence	
South	11 (37)
West	7 (23)
Midwest	6 (20)
Northeast	6 (20)
Region, focus of current job or role*	
South	9 (30)
West	7 (23)
Midwest	9 (30)
Northeast	4 (13)
National	19 (63)
Race/ ethnicity	
White	18 (60)
Black	7 (23)
South Asian	1 (3)
Multiracial	4 (13)
Gender	
Woman	24 (80)
Nonbinary	3 (10)
Queer/femme	2 (7)
Genderqueer	1 (3)
Education	
Graduate or professional degree	22 (73)
Bachelor's degree	4 (13)
Some graduate school	2 (7)
Some college	1 (3)
Decline to state	1 (3)
	Average (range)
Age	43 (29-72)
Years in abortion or reproductive justice work	17 (3-45)

* Not mutually exclusive, percentages do not sum to 100

** Researchers included individuals trained in public health, sociology, demography, and women's studies

Table 2. Summary of Chapter 2 results: Benefits and risks of conceptualizing unmet need for abortion

Documenting unmet need for abortion and uses of data

Benefits of using unmet need for abortion as a tool	• Increasing awareness inside and outside abortion rights movement • Measure of access that can account for non-clinical abortion • Direct resources within the abortion rights movement • Mobilize external resources and support
Concerns about using unmet need for abortion as a tool	• Supplying information to abortion opponents • Potential for data to be extractive and not community-focused • Replicating past harm of similar tools, such as unmet need for family planning • Resource intensive to create • Uncertainty of impact • More data not needed to know status quo is unacceptable • Concerns with quantification and measurement generally, such as oversimplification

Framing abortion in terms of “unmet need”

Shifting the conversation about abortion in public discourse	• Importance of highlighting people who cannot get wanted abortions • Discussing the possibility that the abortion rate should be higher in the U.S. • Concern that the framing could direct blame for access problems to providers and abortion funds for not “meeting needs”
The question of “need”	• “Need” as a potentially legitimizing framing for abortion • Debate about whether “need” is person-centered or not • Debate about whether “need” fosters a sense of obligation to meet it or not

Bigger picture concerns: What unmet need for abortion misses

Over-emphasizing the abortion itself	• Unmet need for abortion implies the outcome—obtaining an abortion—matters most • Abortion being a meaningful possibility for people matters just as much
(De)contextualizing and (dis)connecting abortion	• Abortion need cannot be separated from parenting, basic and community needs, and social and economic conditions • By focusing on abortion alone, unmet need for abortion could obscure these connections

Chapter 3: Process or Outcome? Stakeholder Conceptualizations of Unmet Need for Abortion

Introduction

Abortion is a fundamental component of people's ability to decide if, when, and under what circumstances to have a child. The ability to obtain an abortion is critical to both reproductive autonomy and public health. Longitudinal research indicates that being denied a wanted abortion is harmful for pregnant people and for families, as it is detrimental to mental and physical health, relationships, and financial wellbeing (6,43,45,47). Ensuring that people can obtain abortions when they need them—that is, meeting people's abortion needs—is an important public health and human rights goal.

Despite this, multiple indicators suggest that people's abortion needs are not being met in the U.S. Numerous barriers, such as state-level policies restricting abortion, as well as pervasive abortion stigma, make abortion difficult to obtain (16,17,124,125). Restrictive policies can lead to abortion clinic closures, delays in care, and increased costs (26,101–104), which in turn create significant obstacles to obtaining an abortion in the U.S. (48,103,105). Abortion clinic patients share stories of financial and logistical burdens, as well as experiences and/or fear of judgment and harassment (13–15). Data indicate that, some people never get a wanted abortion due to such burdens. For example, researchers estimate that at least 4,000 people each year are denied wanted abortions due to gestational limits (a point in pregnancy after which abortion is prohibited) (7). Additionally, prohibitions on the use of public funds to pay for abortion are estimated to prevent approximately one-quarter of Medicaid-eligible pregnant people from obtaining a wanted abortion (29,33).

As state-level restrictions on abortion continue to increase (18), and the U.S. Supreme Court considers the case of *Dobbs v. Jackson* (2021) (126), which is poised to overturn *Roe v. Wade*, the need for advocates, policymakers, researchers, and others working in abortion access to focus on people who cannot obtain a wanted abortion will likely only increase. One way this problem could be approached is as “unmet need for abortion,” which is a familiar concept in the field of family planning due to the longstanding measurement of “unmet need for contraception” as a tool to understand population-level contraceptive access (11). Documenting “unmet need for abortion” could be one potential tool those working in abortion access could use to direct advocacy efforts, service delivery, and resource allocation to meet abortion need(s).

Prior analyses from the current study identified the benefits and risks of conceptualizing and documenting unmet need for abortion from the perspectives of stakeholders working in abortion access across the U.S. (Chapter 2). As a tool for abortion advocates, unmet need for abortion could raise awareness about the urgency of access problems, garner resources and direct their investment, and shift the public conversation about abortion access. However, stakeholders also raised concerns about how such a tool would be constructed, how it could be (mis)used, and the risk of further separating abortion from other reproductive experiences and social contexts. In discussing the value of the concept of unmet need for abortion and its utility as a tool for those working for abortion access, the complex and dynamic nature of the concept became apparent. In the prior analysis, stakeholders voiced differing and flexible considerations of unmet need, suggesting there is potential discrepancy in how people understand unmet need for abortion.

The findings from Chapter 2 make clear that should unmet need be taken up as a tool, how that tool is conceptualized is important. This paper examines how stakeholders in the field

conceptualize unmet need for abortion with the goal of understanding the consistency and variations in how people think about the concept and identifying patterns in the content and use of their conceptualizations. A better understanding of how stakeholders are defining unmet need for abortion can provide insight into its utility and limitations, as different conceptualizations may have different implications for efforts to meet abortion needs.

Methods

Recruitment and study procedures

Between May and October 2021, I conducted 30 in-depth interviews with stakeholders working in abortion access. Stakeholders included: 1) people working in direct service (e.g., clinicians, abortion clinic staff and administrators), 2) people working in abortion funds (i.e., grassroots mutual aid organizations that provide financial and logistical support to those seeking abortions) (113), 3) abortion researchers (e.g., sociologists, demographers, epidemiologists), 4) abortion advocacy organization staff, 5) reproductive justice activists, and 6) people working in foundations that fund abortion-related programs and research. As membership in these groups is not mutually exclusive, they were used for recruitment purposes to enable variation and representation across these types of stakeholders.

I used purposive and snowball sampling to recruit participants. Initially, I identified potential participants through professional networks. I also asked those I recruited (whether they were interviewed or not) to recommend others who they thought should be interviewed. I recruited these recommendations on a rolling basis, prioritizing balancing representation across stakeholder groups as well as U.S. Census regions (West, Midwest, South, and Northeast).

I sent potential participants an email inviting them to be interviewed, which included an explanation of the study and a link to schedule an interview. If potential participants did not respond to the initial email, I sent one follow-up email one to three weeks later. In advance of each interview, I sent participants a link to a secure Qualtrics platform that included a consent form and a brief survey asking about demographics and other characteristics, such as years of experience in the field.

Interviews occurred over phone or video call, based on participants' preference. Interviews were semi-structured and lasted an average of 75 minutes (range 50 to 105). I asked participants questions that fell into four broad domains: 1) history in the field, 2) vision for fully meeting abortion need(s) in the U.S., 3) definitions and understandings of "unmet need for abortion," and 4) perspectives on measuring and documenting unmet need for abortion. Interviews focused on how participants conceptualized abortion need in the U.S. in general and sought to explore understandings, definitions, conceptions, and opinions of the concept of "unmet need for abortion." Each participant was offered a \$50 e-gift card as remuneration. The Committee for Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

Analysis

For this analysis, I focused on data that gave insight into the various ways stakeholders defined and conceptualized unmet need for abortion. I thematically coded each transcript using an iterative approach. First, I broadly coded each transcript for any discussion of "unmet need for abortion." I then subcoded these excerpts using both a priori codes developed from the interview

guide and codes that emerged from the data to capture how participants defined unmet need for abortion, including its components and why they defined it as they did, with the aim of identifying patterns in how people talked about it. I continued subcoding in an iterative manner until no new codes emerged. Throughout the coding period, I maintained an ongoing data analysis memo, in which I noted emerging patterns and themes across transcripts. As I progressed through this analytic process of iteratively coding and memoing, I began to see an emerging distinction between two conceptualizations of unmet need for abortion—one focused on outcomes and the other on processes. I reviewed the data again with this lens to see how and when participants discussed unmet need in each of the two ways I identified and to look for any additional emergent conceptualization(s). I did not find additional conceptualizations, but did find that, although they were distinct, the same person could use both conceptualizations. I then organized the coded data to develop a more robust description of each conceptualization of unmet need (outcome- and process-based), including how participants explained their reasons for understanding unmet need a certain way and the utility of each conceptualization. As I developed these results, I noted places where there were potential tensions between the two conceptualizations, as well as how and when participants used each, which are reflected in the results below.

Throughout the results, participants are identified by their self-reported number of years in abortion or reproductive justice work. Their tenure in the field contextualizes their experience and perspectives, while still maintaining confidentiality. Additionally, a participant ID number is included to demonstrate the breadth of responses. I include additional participant characteristics, such as their geographic region or professional role, as relevant to the data presented.

Sample Characteristics

The sample included 30 stakeholders (see Table 3). Participants reported an average of 17 years of experience in abortion or reproductive justice work (range 3 to 45), and most (n=23) had worked in the field for 10 years or more. Stakeholders worked across the U.S., and many worked in multiple states and/or nationally, either independently or because their organization had staff or services in various locations. Among those whose work included state or regional focus, nine participants worked in the South, seven in the West, nine in the Midwest, and four in the Northeast. Ten participants worked in national organizations, and an additional nine did work that had a national presence, such as providing services to clients from around the country, policy initiatives, national research, or programs. Six participants lived in the Midwest, six in the Northeast, 11 in the South, and seven in the West. Stakeholders ranged in age from 29 to 72 years old (average 43 years). Most identified as white (n=18) and as cisgender women (n=24).

Some participants had experience in more than one stakeholder group over the course of their histories in abortion-related work. For example, six participants worked in a direct service setting at the time of the interview, however an additional five had worked in direct service provision at some point in their career. Table 3 includes the various stakeholder groups participants belonged to throughout their careers, not just their primary affiliation at the time of the interview.

Results

Throughout the interviews, stakeholders described how they understood and conceptualized “unmet need for abortion.” Participants talked about unmet need for abortion in

two distinct ways—in terms of the *outcome* of a pregnancy and/or in terms of the *process* of obtaining an abortion (see Figure 1). The two conceptualizations were not mutually exclusive. All participants discussed an outcome-based conceptualization, while many additionally described a process-based approach. While some participants leaned toward one conceptualization over another, most acknowledged the importance of both. In the sections below, I describe how participants discussed unmet need for abortion in terms of outcomes and processes, as well as how they thought about these different conceptualizations in relation to each other.

Outcome-based conceptualizations of unmet need for abortion

Not obtaining a wanted abortion

In the outcome-based conceptualization, participants defined unmet need for abortion as not obtaining an abortion, despite not wanting to be pregnant. For most participants, the most straightforward example of outcome-based unmet need involved someone who explicitly wants an abortion and does not obtain one. Discussions of why these outcome-based examples comprised unmet need tended to be brief and straightforward; this lack of elaboration suggested that participants presumed a shared understanding of this type of unmet need. Stakeholders regularly defined unmet need in terms of obtaining an abortion as the outcome, saying things like:

It refers to people who need abortions who can't get them (Participant 9, 25 years' experience)

People who want to be in a state of not being pregnant aren't able to get into that state (Participant 16, 30 years' experience)

People who want abortions and they aren't able to get them for one reason or another (Participant 10, 22 years' experience)

Further demonstrating how straightforward this seemed to many participants, when asked to define unmet need for abortion, Participant 4 (24 years' experience) provided examples of studies that had tried to measure people's experiences of not obtaining wanted abortions. To clarify her definition, I asked if unmet need for abortion is "something more than someone who wanted an abortion and didn't get it?" To which she responded succinctly, "No, I think that is it."

When they did offer further explanation of outcome-based unmet need for abortion, stakeholders discussed the factors that stop someone from getting an abortion they know they want. Often, this included restrictive policies that created insurmountable barriers to abortion care. Notably, in discussing these barriers in terms of outcomes, participants did not focus on *how* people experienced these barriers, but on the *end result* of not getting an abortion. In the example below, Participant 16 (30 years' experience) referenced the many hurdles people face seeking abortion and specified that the unmet need for abortion is not about the hurdle itself but about the people who do not surmount it:

[T]here are just so many dead ends that people trying to get abortions end up going down. ... [I]f you assume that at each hurdle, some percentage of people who wanted an abortion don't make it over—they represent the unmet need.

Not being able to fully consider abortion

Some participants extended their outcome-based understanding of unmet need for abortion to include some people who were not able to fully consider abortion as an option. Participants noted that due to factors such as perceived lack of feasibility, stigma, or lack of information, some people do not obtain (or seek) abortions they might otherwise choose. Participant 27 (12 years' experience) reflected this view, asking, "Is [unmet need just] the people who made it to the clinic and got turned away? I would say no. It's the people who contemplated abortion but didn't know that they could get one." Furthermore, when discussing unmet need in terms of not obtaining an abortion, some stakeholders also discussed those who do not want to be pregnant but do not consider abortion at all, either because they do not know it is an option or just because they cannot conceptualize it as within the realm of possibility.

Stakeholders who discussed unmet need in these ways qualified it as being a more hypothetical unmet need. Participant 3 (25 years' experience) commented that "probably not everybody, but certainly some of those people, if they did perceive abortion as an option, would have maybe done that, and be happier for it. But it's also that sort of unanswerable question." While these examples of unmet need for abortion are not as straightforward as not obtaining a clearly wanted abortion, participants raised them in the context of discussing unmet need from an outcome-based perspective in terms of who does not obtain an abortion they might otherwise want. Because in these examples participants continued to be oriented around someone getting or not getting an abortion, these support an outcome-based definition.

Process-based conceptualizations of unmet need for abortion

The other way participants conceptualized unmet need for abortion focused on the process of obtaining one. These participants defined unmet need in terms of the experience of obtaining an abortion and described three distinct process areas: navigation of obstacles to access, preferences in abortion options, and the quality of abortion care. Notably, stakeholders highlighted that it is possible to experience a process-based form of unmet need even if an abortion was ultimately obtained.

Navigating obstacles to abortion

In describing process-based unmet need, participants highlighted the burdens caused by barriers to abortion access, such as by gestational limits, traveling long distances, or lacking funding or insurance coverage—what Joffe and Cohen (2020) term the "obstacle course" (127). While stakeholders referenced these barriers in outcome-based conceptualizations because of their role in preventing people from obtaining abortions, the way barriers were relevant to a process-based approach were different. In this conceptualization, participants focused on the *experience* of barriers in and of itself as indicating unmet need, even when someone surmounts these barriers and ultimately obtains an abortion. Participant 11 (5 years' experience) described this type of unmet need as the things "people have to get past in order to get their abortion care." Participant 6 (9 years' experience) echoed this, considering the "hoops" someone has to jump through to comprise unmet need, independent from the end result of the pregnancy outcome:

I'm thinking about a young person who couldn't afford an abortion. And then had to fundraise and had to fundraise, and then had to fundraise. And then finally got in for an abortion, but it was much more expensive and then continue to have to fundraise and

figure out—and then like that process is pushed back. *And just that even being a part of the process, I think that that indicates unmet need.* [Emphasis added.]

Participant 15 (45 years' experience) expressed a similar sentiment when discussing having to travel for abortion care:

I think somebody who is one of those stories of road trips who defied all odds, and over a period of four weeks finally became unpregnant with this crazy story behind it—that should be an *unmet* need story. That's not a great story for, ah, we met their need for abortion. That's bullshit.

Preferences in abortion

When participants talked about unmet need in terms of process, another piece they discussed was people's preferences in abortion, such as method or setting. Participant 24, a home abortion provider with 12 years of experience, reflected on her experience supporting someone close to her in having an abortion at home:

We had clinical abortion at our fingertips, and she desperately didn't want it. And to her, she had unmet needs in accessing abortion care, even though we had medicine all around us. But I think it's good to remind ourselves that feeling like our needs are not being met can look a lot of different ways, including people who are looking for a specific kind of abortion care, a specific kind of provider, or a specific method that's not available to them in their area.

As part of a process-based conceptualization, multiple participants echoed examples of unmet need that involved being unable to have an abortion in someone's preferred setting, such as in a clinic or at home.

There's so many people who don't get to have the abortion they actually want and need. ... They don't get to do it in a setting they'd like. They don't get to be surrounded by the loved ones they'd like, especially for people who would maybe prefer a non-clinical abortion but end up needing to do a clinical abortion. ... And then I think the same is true in reverse, right? That some people are having self-managed abortions, but that's not the abortion they wanted either. (Participant 26, 18 years' experience)

In addition, numerous participants considered it an unmet need for abortion if someone was unable to get the type of abortion they wanted, for example if they wanted a procedural abortion but went to a clinic that only offered medication abortion, or vice versa:

I think it's still unmet need if ... they weren't able to access the abortion care that they were seeking. ... So maybe they wanted a medication abortion, but they couldn't [and so had to have a procedure]. ... you still got an abortion, but it wasn't the abortion that you envisioned. (Participant 17, 12 years' experience)

A few participants also brought up the lack of attendant services, such as pain management options, as comprising unmet need for abortion because it did not allow people to receive preferred services. Participant 8 (7 years' experience) described the impact of this on clients of her abortion fund, some of whom “literally cross state lines” to have the sedation they desire during their abortion.

Quality of care

Participants discussed quality of care as part of their process-based conceptualizations of unmet need for abortion. Often, this was brought up by direct service providers and those with experience in abortion funds. Participants mentioned common quality of care metrics, such as wait times, appointment availability, patient satisfaction, clear communication, respectful treatment, and bedside manner, as part of unmet need for abortion. For example, participants shared anecdotes of clinics booking weeks in advance, preventing people from getting abortions in a timely manner, which was particularly concerning because abortion care is often time sensitive. Given this, Participant 14 (20 years' experience), who works in direct service, noted, "you can have clinics and still have unmet need." Participant 15 (45 years' experience) reflected on how the difficulty scheduling appointments creates unmet need even in states with relatively good access to abortion:

... in [Western state], where we pride ourselves for being the most liberal state in the United States, the most advanced at making sure that there is no obstacle in terms of cost, service access, et cetera, et cetera here, right? We think that's us. [But,] It takes six calls to different clinics to finally land an appointment, because everybody's too filled up. ... [That is] unmet need.

The lack of information and services for marginalized groups comprised another dimension of unmet need that participants related to quality of care. In particular, participants discussed the ways that non-English speakers, young people, Black and Brown people, and patients who are LGBTQ, disabled, and/or fat are frequently excluded from or harmed by clinical care.

The unmet need for abortion? I think there's a lot. I think that our LGBTQIA-identified folk, trans and non-binary folks are really left out of the conversation. ... So there's an unmet need there. Folks are going places and being harmed trying to access care. ... The other unmet needs, like I mentioned, folks with varying abilities. I can remember someone with a hearing or visual impairment that we had funded at [my organization] showing up at the clinic and the clinic calling us like, we don't know how to support them. (Participant 20, 15 years)

Participants also identified lack of emotional support as a process-based unmet need for abortion that reflected poor quality of care. Participant 21 (10 years' experience) explained why she saw care and support as pivotal pieces of unmet need:

[B]ecause, even if somebody is going through—they've had to travel so far during their abortions and all this shit, right? They can be like, all of that fucking sucked, and it was awful. But that nurse I had was really nice. Or that volunteer that I had was really nice, and it made all the difference. ... And if that need, that very basic need of feeling loved and supported through a tough time cannot be met, then that's where we are sort of failing at our job.

Most often, quality of care came up in the context of concerns about clinical abortion care. Interestingly, all three home abortion providers in the sample discussed working outside a clinical setting specifically to focus on quality of care and person-centered abortion, thereby meeting clients' process-based abortion needs.

Critique of a process-based conceptualization of unmet need

Not all participants agreed that the process-based needs discussed here actually represented “unmet need for abortion.” Some participants thought that while preferences and quality of care in abortion mattered, they did not represent unmet need *for abortion* because an abortion was ultimately obtained. For these participants, these process-based needs represented some other kinds of unmet needs, such as for patient-centered care, which were important but separate from unmet need for abortion. Regarding abortion method and setting preference, Participant 16 (30 years’ experience) said,

I think of those as being unmet need, but not unmet need for abortion. It's sort of like I know a lot of people who had hospital births that they were really unhappy with, like just devastatingly unhappy. And they clearly had unmet needs. But it wasn't unmet need for an Ob-Gyn or for a birth, they had a birth. And I think the same would be true. I would say like people who have an abortion in clinic and don't have a good experience with that, either because of not getting good quality care or not getting patient-centered care or just because that's really not the place they will ever feel comfortable, do have unmet needs. ... But I wouldn't include that in unmet abortion need.

Participant 4 (24 years’ experience) shared a similar sentiment that quality and choice were separate from need, saying “That's unmet need for getting care the way you want it, but they actually did get the abortion, so it's not unmet need for abortion.” To her, unmet need was not necessarily about getting the specific abortion you want, but getting a safe abortion, full stop.

Instead of unmet need, some participants considered unfulfilled abortion preferences as within the realm of decisions and tradeoffs that are often required in other areas of health care, or even life in general. Participant 18 (19 years’ experience) discussed the difficulty she had conceptualizing preferences as part of unmet need for abortion. She commented that among people working in abortion access, abortion is often held to an “idealized standard of healthcare,” which she saw as unrealistic:

And oftentimes, in that, we try to create a world in which there aren't tradeoffs in decision making. Like, if you think about the doctor visit that you're going to go to, like, well, I'd really like to see my normal nurse practitioner, but the satellite clinic has better parking so I'm going to go here because I can fit it in my day. That's just a very typical health care experience. And for some reason, we—some subset of the field doesn't feel comfortable with that being people's stories around [abortion] method selection. And I think that just is setting an unrealistic standard. And frankly, is infantilizing people who are seeking abortions because they can navigate those particular tradeoffs and are doing it.

For some, these decisions could be seen as common parts of health care, in which individuals must weigh options and decide what is “good enough.” Participant 1 (39 years’ experience) described this, and how it may differ for different people:

[I]f you don't want to be pregnant, and you would prefer to have a procedure, [but] you go to a place and they can't do a procedure, but they can give you pills, and you take them, and you become unpregnant, is that good enough? And was your particular need met?

Participants acknowledged that while people will sometimes forego their abortion preferences to be able to end a pregnancy, this may not inherently mean they had unmet need. Participant 1 continued, that “in reality, we know that people accept some abortions that are not [ideal], because it meets their needs to become unpregnant ... But they ... made a decision that the most important thing was to get unpregnant as soon as possible. And this is what was available.” However, for other participants, the urgency and uniqueness of abortion made it incomparable to other health care decisions. For example, Participant 5 (10+ years’ experience) shared stories from working in direct service that caution against understanding process-based unmet needs for abortion as within the realm of usual health care. While they agreed that people would often accept compromises to get an abortion, in their experience, the desperation people felt to end pregnancies meant they did not have a true opportunity to decide what was “good enough,” and instead felt they had to “take whatever is available,” even if it was detrimental.

Strategic deployment of outcome- and process-based conceptualizations

Every participant talked about unmet need for abortion in terms of outcomes, and many, but not all, also talked about it in terms of process. When participants discussed unmet need in both ways, they talked about how certain conceptualizations were useful for some settings, demonstrating intentionality and strategy in how and when each conceptualization could be deployed.

Throughout the interviews, participants provided insight into the potential utility of each conceptualization of unmet need as a tool for abortion advocacy. Their explanations of unmet need for abortion in terms of outcomes and process revealed a range of considerations when thinking about how, when, and whether to engage an outcome- vs. process-based understanding. In thinking about what components of unmet need would be most important to document, participants strategically considered which conceptualization would be most likely to garner support or prevent backlash. For some participants, this was outcome-based unmet need. Participant 26 (18 years’ experience) felt that for policymakers, it would be most impactful to document people’s experiences not being able to obtain a wanted abortion, “Because you’re going to have to just get your five-minute conversation in with that person and see what you can leave in a leave behind packet.” While her reasoning was partly for simplicity in lobbying, it was also due to real concern that a process-based definition of unmet need would not seem like a compelling problem to many people, due to abortion stigma. She added:

I think we’re just a long way from many people and many members of the public and the press and our representatives caring enough about people who have abortions to want them to have a really positive experience of it. ... I think [there are] a lot of even pro-choice people who think that, yeah, people should kind of have to run the gauntlet on this. Like, it shouldn’t be too easy. It shouldn’t be too pleasant.

Others felt differently, seeing process-based unmet needs as the most politically feasible to document. In her interview, Participant 24 (12 years’ experience) generally focused on process-based unmet need, which she viewed as aligned with the mission of her work as a home abortion provider. In addition, though, she saw process-based unmet need as a more strategic tool, because she did not think it was politically tenable to discuss outcome-based unmet need:

[I]t’s hard. Like, as much as most of us in the abortion community will secretly admit that we think that’s a problem, that we shouldn’t be having babies that we don’t want to have,

it is hard to publicly admit that. So like none of these babies should have been born? That paints us in a not so nice light.

Some participants felt that prioritizing between outcome- and process-based unmet need was less about a proactive strategy and more about the restrictions imposed by the current state of healthcare and abortion policy. For these stakeholders, in an ideal world, process-based unmet needs, like preferences, could be addressed, but in the current reality, dealing with outcome-based need may be all that can be done. Participant 27 (12 years' experience) talked about this as "the dream versus reality scenario" as it related to people being able to obtain their preferred method of abortion (medication vs. procedural). She anticipated procedural abortion, which requires trained providers and is most commonly provided in abortion clinics, becoming less available in the current political climate:

I absolutely wish that people could get the kind of abortion they want where and when they want it. But I think just the realities of everything that is happening in this country right now, everything from malpractice [insurance] providers wanting to drop abortion providers to all the legal lawsuits that are going to be launched in Texas, I think the reality of it is that medication abortion is just going to start to become more of a standard.

Participant 18 (19 years' experience) expressed the sentiment that outcome-based needs must be addressed first and that addressing process-based needs may not be realistic, given the state of health care in the U.S. She said, "I want to get to that conversation about how people want to shape their abortion experience. But if we jump there immediately, I feel like we lose the fact that that's not on par with healthcare delivery in this country."

In addition to the state of healthcare delivery in the U.S., this sense that outcome-based need had to come first was largely a product of an increasingly restrictive policy landscape and decreasing abortion availability. Even participants who strongly prioritized process-based needs expressed that they sometimes seemed like a "luxury" in today's climate. Participant 3 (25 years' experience) discussed what it is like to help clients get an abortion today compared to when she started working in abortion:

... [20 years ago] was also when we had 10 clinics [in our area]. You could be like, this clinic's like a dentist office ... And then this clinic's playing Ani DiFranco and selling speculums. Like, what do you like in an abortion provider? And now it's just like, do you want your abortion? Here's where you go. Which is sad.

She went on to discuss additional process-based needs related to quality of care, such as being able to direct clients to a clinic with "Black people working there if they're Black, or that has their language reflected, or is culturally competent and like community-based in different ways," all of which she viewed as "a huge piece of unmet need." And yet she noted, "We're just in such a situation now that you don't have the luxuries of that kind of stuff."

Despite the grim state of abortion access today, participants who conceptualized unmet need in both ways felt that it was philosophically important not to give up on meeting people's process-based needs. Participant 30 (6 years' experience) thought that a sole focus on outcomes was partly to blame for the dire circumstances around abortion access today, saying:

I feel like if all you do is care, at the end of the day, if somebody is pregnant or not, and that's considered success or all needs met, I feel like that's probably how we got to where we are today. That doesn't really address where everybody is coming from.

Asked what direction she thought the abortion rights movement should be going, Participant 26's (18 years' experience) response reflected a need to push against the factors that constrain a more expansive vision of fully meeting people's abortion needs, saying, "I think we need to stop dreaming in moderation."

A few participants noted the importance of just engaging in a conversation about unmet need for abortion as being valuable to maintaining a forward looking, hopeful vision. For Participant 13 (25 years' experience), this was to make sure "we're not losing sight of what we mean by true access or what it would mean for everyone's needs to be met." Participant 5 (10+ years' experience) similarly felt that "the vision just needs to be talked about more ... [to see] if we're all envisioning the same thing. So that we know that we're working together properly and with the same hope."

Discussion

The data presented here provide insight into how stakeholders in abortion access understand and define unmet need for abortion. I identified two main ways participants conceptualized unmet need for abortion. One conceptualization is outcome-based, in which unmet need for abortion is understood as those who never get the abortion. The second, in contrast, is a process-based conceptualization, in which unmet need for abortion accounts for what it takes to get an abortion. While some participants primarily employed one conceptualization or the other, most utilized both. Participants debated the relative importance of these conceptualizations based on which they projected could be useful for mobilizing support and resources for abortion access. These interview data make clear that there is no single or shared conceptualization of unmet need for abortion. In fact, not even individual stakeholders meant the same thing every time they talked about unmet need, demonstrating they could simultaneously deploy multiple conceptualizations of unmet need for abortion. Participants had diverse views on when and how to employ outcome- vs. process-based definitions of unmet need, with compelling reasons to prioritize each.

Each conceptualization of unmet need for abortion points to a different prioritization, and therefore has different consequences. Recent research about the impact of a 2021 law restricting abortion in Texas offers a timely example. Texas Senate Bill 8 (SB 8) banned abortion once cardiac activity is detected in a pregnancy (128), which usually happens around 6 weeks gestation (129). SB 8 went into effect on September 1, 2021. Initial data and early media coverage indicated that the number of abortions in Texas decreased by half in the first 30 days after the implementation of the law (130,131). This reflected a decidedly outcome-based approach to both understanding the issue at hand and mobilizing public outrage and support. More recent studies suggest that the total decrease in abortions was actually less due to large increases in the number of Texans who obtained abortions out of state and ordered abortion pills online (132,133), prompting a *New York Times* headline declaring, "Most Women Denied Abortions by Texas Law Got Them Another Way" (134). From an outcome-based approach, the message is that the policy was not as effective as abortion opponents hoped, and that fewer abortion needs are unmet in Texas than abortion advocates feared. This, of course, obscures the wide range of process-based unmet needs and how the law impacts the experience of finding an abortion and people's ability to have an abortion in a way they find acceptable and upholds their reproductive autonomy. Interestingly, the research brief in which the University of Texas at Austin released these findings, and which was cited in the *New York Times* article, did include

qualitative reports of process-based unmet needs, including difficulties finding and scheduling care in Texas, challenges getting appointments out of state due to high demand, and the burdens associated with travel (133). However, this framing is largely absent from the accompanying media coverage in the *New York Times* (134). Notably, data collection for this study occurred prior to SB 8's passage; the media framing and recent research on the impacts of SB 8 would be important to explore in future research, particularly to understand the adequacy of an outcome-based approach in the wake of these abortion restrictions, which may mirror the experiences in more states should *Roe v. Wade* be further weakened or overturned, as is anticipated in the upcoming *Dobbs v. Jackson* decision.

In abortion, as in all health care, outcomes are important. A large body of research demonstrates that outcome-based unmet need for abortion matters—not getting a wanted abortion is harmful for people's physical and emotional health, relationships, and finances (6,43,45,47). Whether they supported this approach or not, many participants felt that in the face of urgent and escalating threats to abortion access, the abortion rights movement can only afford to focus on outcomes—with decreasing availability and increasing restrictions, getting an abortion at all must be good enough. There was a divide between what some participants felt *could* be done or felt was possible in the context of the current U.S. healthcare system (addressing outcome-based needs) and what they *wished* could be done (addressing process-based needs). This question takes on new meaning in the face of the potential overturn of *Roe v. Wade*. Such a crisis could make it feel even more necessary to just focus on meeting outcome-based needs, as advocates and service providers defend *any* ability for people to obtain an abortion.

However, an approach only focused on outcomes is in line with a narrow, limited understanding of abortion access. In fact, process-based abortion needs, such as abortion preferences and quality of care, are integral components of patient-centered health care access. Levesque and colleagues' (2018) framework of patient-centered access defines it as “the possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care” (135) (p. 4). In their conceptualization, access comprises the “fit” between people and systems, and includes supply, demand, and process factors. Such a broad understanding of access includes all the outcome- and process-based abortion needs conceptualized by stakeholders in this study.

Others have pointed to the need for broad and nuanced conceptualizations of abortion access (136). A broader approach offers a counter to concerns that process-based needs cannot be prioritized until outcome-based needs are met. In addition, a focus on more than just outcomes provides opportunities for innovative ways to improve abortion access in domains where stakeholders may have more direct influence, which may be elusive in spheres as large and intractable as policy, stigma, and structural inequities. Recent qualitative work with women forced to travel for third-trimester abortion care found that there were ways to mitigate the burdens of this travel even in the absence of policy change (137). This is in line with a process-based approach to meeting abortion needs—even while working to meet outcome-based needs, there are strategies that can improve the process of obtaining an abortion. Maintaining focus on process-based needs seems especially prudent given how successful the anti-abortion movement has been in not only targeting outcomes (e.g., the number of abortions provided), but also in targeting aspects of the process and making it increasingly burdensome to obtain care.

Above all, participants' discussions of the contours and components of outcome- and process-based unmet need make clear that the two conceptualizations have different implications for what it takes to *meet* abortion needs. In an outcome-based conceptualization, abortion needs are met if someone is no longer pregnant because they obtained an abortion. An outcome-based approach only requires doing what is necessary to bring people who are not able to get an abortion "up to" the current status quo—to the same level of access as those who currently manage to get abortions, no matter the hardship. In this view, abortion needs are still largely met in Texas under SB 8. However, a process-based conceptualization of unmet need for abortion requires something different. A process-based understanding requires those in abortion research, advocacy, and direct service to investigate people's abortion preferences and how they fit into movement priorities. This invites the question of what it could look like to re-imagine abortion-related care. Prioritizing between these conceptualizations raises a philosophical question about which and whose needs the abortion movement is oriented to try to meet, and whether (and when) it is "good enough" to simply become unpregnant. Even participants who more strongly endorsed an outcome-based view of unmet need still thought the components of process-based need mattered, just that they were separate from *abortion* need. Viewing outcome- and process-based needs as separate has potential implications for advocacy and research. Issue framing impacts what is researched, advocacy efforts, and policy and funding priorities. For example, research about abortion method preference is more likely to be undertaken if what it takes to meet abortion need is conceptualized in a process-based way. Conceptualizing unmet need for abortion in terms of both outcomes and process indicates that individuals and society can have met and unmet abortion needs at the same time. This allows a broader understanding of what it will take to meet abortion need(s) in the U.S.

Limitations and implications for future research

While I recruited a diverse sample in terms of stakeholder type and region, the stakeholders reflected in this sample are mostly white and highly formally educated. Stakeholders from other social locations may have different perspectives that are thus not captured in this analysis. The data collected in this study can therefore only provide partial insight into how stakeholders in abortion access understand unmet need for abortion. In addition, I used a priori stakeholder groups to create a sample that included people who work in abortion in various capacities. However, these groups do not represent an exhaustive list of types of stakeholders in abortion access, which means some perspectives that are relevant to fully understanding the definition and complexity of unmet need for abortion were inevitably left out.

Stakeholders' discussions about prioritizing outcomes over process may reflect the limitations of the term "unmet need for abortion." Given the term's history as a metric in contraceptive access, the term itself may limit people's imaginations or direct them towards a certain line of thinking. However, distinctions and potential trade-offs between an outcome- and process-based approach to meeting abortion needs is valuable independently of the concept of "unmet need." In addition, these findings are not limited to abortion, as many health issues have process vs. outcome implications for how resources, time, and attention are directed.

Future research could investigate whether there are patterns in which types of stakeholders subscribe to what kind of conceptualization of unmet need for abortion. For example, in my analysis, those working in abortion funds and direct service provision were likely to discuss quality of care related process-based unmet needs. This study was not equipped to investigate meaningful differences between groups or why different stakeholders conceptualized

unmet need for abortion in different ways. There could be other trends among stakeholders working in different areas that could shed light on ways in which people are having different conversations about abortion needs, and therefore may be talking past each other.

Conclusion

This analysis presents an understanding of what stakeholders working in abortion access are grappling with and thinking about when they think about unmet need for abortion. The data presented here provide further insight into concerns about the utility of unmet need for abortion as a concept (see Chapter 2), given wide variations in how unmet need is conceptualized by those who might use it as a tool to advance their work. These data also provide insight into where the abortion rights movement stands in considering what matters in abortion access. Outcome and process reflect orientations to care provision and advocacy—the need to obtain an abortion and the needs of people while they seek and have abortions. They represent complexities and potential tensions among those working for abortion access. Understanding that there is variation in how people think about the concept of unmet need for abortion, and the contours of that variation, offers insight into the implications of prioritization in efforts to meet abortion needs that stems from different conceptualizations.

Tables and Figures

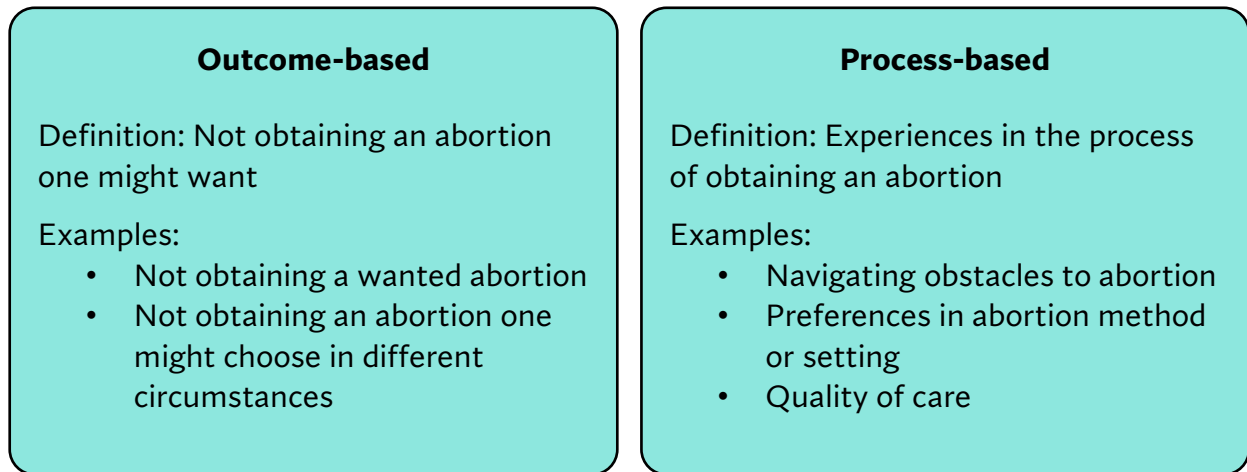
Table 3. Characteristics of participants in stakeholder interviews about unmet need for abortion in the U.S. (N = 30)

	N (%)
Stakeholder type(s) (in career)*	
Direct service	11 (37)
Advocacy	10 (33)
Research**	10 (33)
Abortion fund	7 (23)
Reproductive justice	7 (23)
Philanthropy/Funding	3 (10)
Region, current residence	
South	11 (37)
West	7 (23)
Midwest	6 (20)
Northeast	6 (20)
Region, focus of current job or role*	
South	9 (30)
West	7 (23)
Midwest	9 (30)
Northeast	4 (13)
National	19 (63)
Race/ ethnicity	
White	18 (60)
Black	7 (23)
South Asian	1 (3)
Multiracial	4 (13)
Gender	
Woman	24 (80)
Nonbinary	3 (10)
Queer/femme	2 (7)
Genderqueer	1 (3)
Education	
Graduate or professional degree	22 (73)
Bachelor's degree	4 (13)
Some graduate school	2 (7)
Some college	1 (3)
Decline to state	1 (3)
	Average (range)
Age	43 (29-72)
Years in abortion or reproductive justice work	17 (3-45)

* Not mutually exclusive, percentages do not sum to 100

** Researchers included individuals trained in public health, sociology, demography, and women's studies

Figure 1. Stakeholder Conceptualizations of Unmet Need for Abortion



Chapter 4: “Have you ever wanted or needed an abortion you did not get?” Data from a nationally representative survey

Introduction

A large body of evidence demonstrates that obtaining an abortion in the United States is often difficult. Recent years have seen unprecedented increases in state-level policies restricting abortion (16–18), and the first quarter of 2022 alone indicates this year could set a record on policies that restrict or ban abortion (138). These policies are varied and include tactics such as imposing gestational limits, prohibiting the use of public funds for abortion, requiring parental consent and notification for minors, and, increasingly, outright bans based on abortion method or reason (18,100,138). Such restrictions create considerable and potentially insurmountable barriers to obtaining an abortion in the U.S. (48,103,105). People who make it to an abortion clinic often have to travel long distances and incur high costs to receive care, as well as deal with misinformation and experiences and/or fear of judgment and harassment (13–15).

Given these barriers, there are people who want abortions who are unable to obtain them. Data indicate that over 4,000 people per year who seek abortions at clinics are denied those abortions due to gestational limits (7). However, less is known about people who may want an abortion but never make it to a clinic. To address this gap, recent studies have aimed to understand the experiences of people who considered abortion but did not obtain one and may not have sought one. A mixed methods study of people seeking prenatal care in Louisiana and Maryland found that approximately 30% percent had considered abortion for their current pregnancy (10). Most did not obtain one due to personal preference, and for some, it was due to policy-related barriers. Another study used Google Ads to survey pregnant people searching Google for abortion, and found that 32% were still seeking an abortion four weeks later; of these, most had tried to get an abortion (57%) and wished they had already had one (60%) (9). Most recently, Moseson and colleagues (2022) used three online platforms to recruit people who had considered but not obtained an abortion, specifically focusing on those who had not visited an abortion clinic and who had at least one pregnancy in the five years prior for which they believed abortion could have been the best option for them (8). All respondents reported at least one barrier to abortion, such as cost, as having prevented them from obtaining one, and over half reported two or more barriers.

These studies provide critical insight about people who consider, but do not obtain, abortions, including the reasons they do not obtain them as well as innovative study design and recruitment approaches to reach them. However, they have also used small or non-representative samples, which limit their ability to demonstrate the full extent or scope of the experience of not obtaining a wanted abortion. There is no precedent for understanding the national prevalence of not getting a wanted abortion by asking individuals about their own experiences. The present study adapted questions that had been used in prior studies and piloted new questions in a nationally representative survey with the primary aim of describing prevalence and trends in reporting a history of not obtaining a wanted abortion. As that this was the first time these questions were asked in a population-based survey panel, a secondary aim of this study was to assess whether this population would respond to these questions. Given that being unable to obtain a wanted abortion is harmful to people (6,43,45,47), this study contributes to a growing understanding of the nature and extent of not getting a wanted abortion in order to gain information that can help direct future research and resources toward improving access.

Methods

Data Source

Data for this study came from a study to develop a metric of person-centered contraceptive need conducted by the UC Berkeley School of Social Welfare. The aim of the parent study was to use this new metric to establish the national level of contraceptive need in the U.S. to improve contraceptive access. The present analysis focuses on questions related to considering or wanting an abortion that was not obtained.

Between January and March 2022, an independent research organization, NORC at the University of Chicago (139), collected these data using their probability-based, nationally representative AmeriSpeak panel. AmeriSpeak's sampling frame is the NORC National Frame, which is estimated to cover 97% of U.S. households. As of January 26, 2021, the AmeriSpeak panel included 48,900 members ages 13 and older from over 40,000 English- and Spanish-speaking households (140). In addition to its wide coverage, the research team selected the AmeriSpeak panel due to its successful use in prior reproductive health research (141).

Sampling, Recruitment, and Data Collection

To be eligible for the parent study, panel members were between the ages of 15 and 44, assigned female sex at birth, not known to be sterile, and able to complete the survey in English or Spanish. Participants of all gender identities and with sexual partners of any gender were eligible for inclusion. NORC created a study-specific sampling frame of active AmeriSpeak panelists who were eligible for the study. From that, they generated a stratified random sample based on age, race/ethnicity, gender, state, and key benchmark variables from the NSFG and the Current Population Survey (142).

NORC recruited potential participants via email, which contained a link to the online survey and information about remuneration for survey completion. NORC sent additional email reminders throughout the survey field period. The survey invitation was also available in panelists' AmeriSpeak online account or mobile app. Participants accessed the self-administered survey via web browser by clicking the link in their recruitment email, online account, or app. Clicking the link led potential participants to an online informed consent form. Those who provided consent proceeded to a series of eligibility screening questions, and eligible participants continued to the survey. The entire survey took an average of approximately 21 minutes to complete. NORC provided participant remuneration after survey completion in the form of their cash-equivalent "AmeriPoints" system, with the amount of points determined based on factors such as survey length (142). NORC offered all participants a cash equivalent of \$8 for completing the survey. The study protocol was approved by the Committee for Protection of Human Subjects at the University of California, Berkeley and the NORC Institutional Review Board.

The larger survey consisted primarily of items related to contraceptive access to address the main research aim of the parent study. Sociodemographic items included age, race/ethnicity, pregnancy history, relationship and parenting status, educational attainment, insurance type, employment, financial strain (difficulty living on household income, experiences of financial hardship, largest affordable emergency expense), state, and urbanicity.

Development of Abortion Need Survey Items

The analyses presented here focus on responses to a subset of questions about abortion that aimed to capture the frequency and context of considering or wanting an abortion and not getting one. The research team developed, selected, and refined these abortion questions based on a review of the literature and previous survey items, stakeholder interviews, and feedback from abortion and contraception researchers. To identify existing survey questions that could be used or adapted for this national panel, I reviewed prior studies that investigated the experience of considering but not obtaining an abortion. Through professional networks, I also reached out to abortion researchers I knew to be conducting related studies and asked if they would share their survey instruments with our team. From these surveys, I created a list of existing questions that were broadly related to the aims of this study. To incorporate the perspectives and priorities of various stakeholders in determining the survey questions, I used data from qualitative interviews with 30 stakeholders in abortion access described in Chapters 2 and 3. As part of these interviews, I asked stakeholders what questions they would ask people who could get pregnant to better understand if they had not obtained a wanted abortion or if they ever had abortion needs that were not met. During each interview, I took notes on stakeholder suggestions, which I then compiled into a list. After all interviews were complete, I reviewed the list of suggested survey questions and identified those that would be appropriate and relevant to the sample in this study. In addition to the specific questions they suggested, we also took stakeholders' broader perspectives on abortion access (see Chapters 2 and 3) into account when developing survey questions.

From the lists of prior survey questions, stakeholder suggested questions, and the research team's understanding of stakeholder perspectives and the gaps in the literature, we created a preliminary list of questions for the current study. The number of questions that could be added was limited to around five, given that abortion was not the focus of the parent study. Once we developed a preliminary list of potential questions, we asked three experts in quantitative abortion research who were not involved in the study to review them. Two were unable to review them in the allotted time frame, but one provided feedback that we used to further refine the questions. Abortion and contraception researchers on the research team refined and finalized the questions through discussion until consensus was reached.

In interviews, several stakeholders referred to questions used in the Abortion Prenatal Study as questions that were relevant, successful, and would be useful in a national setting. Researchers asked people seeking prenatal care in Louisiana and Maryland, "Have you considered having an abortion for this pregnancy even for just one second?" (yes, no), and, if so, why they had not had an abortion at that point (10). We adapted these questions for the current survey. Adaptation was necessary to ensure the questions were relevant to a national sample with participants included regardless of pregnancy history. In the current survey, we asked participants who reported having ever been pregnant but did not report ever having an abortion, "Have you ever considered having an abortion for any current or past pregnancy, even for just one second?" (yes, no, I'm not sure). Considering an abortion and wanting an abortion are not the same, as supported by the findings from the Abortion Prenatal Study that many people who had considered abortion did not have one because they decided they did not want one (10). Some stakeholders suggested it could be informative to differentiate between considering and wanting abortion in surveys. Given this, we added a second question for these same participants to identify those who had at one point decided an abortion may be right for them: "Have you ever wanted or needed an abortion?" (yes, no, I'm not sure). Stakeholders discussed that considering

and wanting an abortion are not inherently clear, distinct, or static states, and that people's thoughts about abortion could change during or after pregnancy (Chapter 2). Based on these interviews, and in consultation with abortion and contraception researchers, we therefore included "I'm not sure" as an answer choice in both questions.

For participants who responded "yes," "I'm not sure," or did not respond to having ever wanted or needed an abortion, we then asked, "Have you ever wanted or needed an abortion that you did not get?" (yes, no, I'm not sure). In addition to participants who reported histories of pregnancy and not abortion, we asked this of participants whose total number of pregnancies was higher than the number of abortions they reported, as they may have wanted an abortion for other pregnancies. Those who responded "yes" were asked an open-ended follow-up question: "What was the reason(s) you did not get the abortion(s)?" Figure 2 presents a flowchart with a list of questions about considering, wanting, and not obtaining a wanted abortion and which participants received them.

Given that participants were included regardless of pregnancy history, we thought it was possible there may be few respondents who had personally wanted an abortion they did not obtain, and that those who had may not be willing to report the experience, as abortion is generally underreported in surveys (143–145). Given this, we also included two questions related to participants' perception of the feasibility of obtaining an abortion in their area that could be answered by everyone in the sample, regardless of pregnancy or abortion history. Both of these questions were suggested by stakeholders in interviews, and both have precedent in the literature. The first, "How easy or hard do you think it is for someone to get an abortion in the area where you live?" (very hard, somewhat hard, somewhat easy, very easy, I'm not sure) was used in the Google Ads study of people seeking abortion online (52). The second, "Based on what you know or have heard, is it legal to get an abortion in your state?" (yes, no, I'm not sure) was used in the Ohio Survey of Women, an annual population-based survey about pregnancy, contraception, and reproductive health care (146).

In the survey, we used the phrase "wanted or needed" to capture a range of ways people might think about their history with abortion. This language was intended to provide multiple entry points for respondents to answer based on their experience, without making a value distinction between "wanting" or "needing" an abortion. When presenting results, I use the phrase "wanted or needed" to accurately describe the data as they were collected. Throughout the rest of manuscript, I only use the term "wanted" to encompass participants' responses because I do not want to assert that "wanted" and "needed" abortions are different or suggest a hierarchy of abortions.

Data Analysis

This study aims to describe the prevalence and context of not obtaining a wanted abortion, therefore, the analytic sample includes only respondents who reported ever being pregnant (inclusive of all pregnancy outcomes). First, I conducted univariate analyses to tabulate the prevalence of considering, wanting, and not getting a wanted abortion among adults who had ever been pregnant. To better understand the group of respondents who reported not getting a wanted abortion, I then ran descriptive analyses on just this group to describe their sociodemographic characteristics and perceptions of abortion accessibility. Most respondents (91.17%) who reported not getting a wanted abortion provided the reason(s) in an open-ended follow-up question. I reviewed the open-ended responses and categorized them by theme. I then quantitatively coded these into a series of dummy variables, as responses were not mutually

exclusive. In the results below, I present the prevalence of each reason quantitatively, along with representative examples of the written responses.

I then conducted bivariate analyses using chi-square tests to examine associations between not getting a wanted abortion and sociodemographic characteristics, including: race/ethnicity, age, region, urbanicity, socioeconomic factors (e.g., educational attainment, insurance type, financial strain), and relationship and parenting status. In addition, I used chi-square tests to examine the relationship between having a past experience of not getting a wanted abortion and current perceptions of abortion accessibility (perceived ease or difficulty getting an abortion in their area; belief that abortion is legal in their state). Though usually a Fisher's exact test would be used in cases of small cell size, this test cannot be used for weighted survey data. Therefore, I used Pearson chi-square statistics for all bivariate analyses (147–149).

All analyses used survey weights, which NORC constructed using the NSFG for benchmarks, with the following raking dimensions for adults: age, education, race/ethnicity, marital status, number of children in household, and age by race. Survey weights account for differences between the U.S. population and the sample on these key characteristics. I conducted all analyses in STATA (version 17.0), using *svy* commands to account for weighting and complex survey design. In all analyses, I present weighted percentages and unweighted sample sizes and use a significance level of $p < 0.05$.

Results

Sample characteristics

A total of 2,857 eligible adults ages 18-44 completed the survey. Of these, 50.5% reported ever being pregnant, for an unweighted analytic sample of 1,783. Slightly more than half (54.06%) of adults who had ever been pregnant identified as white, 21.31% as Hispanic, and 15.56% as Black. Most commonly, these respondents (45.75%) were between ages 30-39. Most (82.45%) were parents, including of biological, adopted, and stepchildren. Nearly 80% of respondents were in a serious relationship. Nearly half were working fulltime (48.18%) and most had private health insurance (59.21%), such as through an employer or health insurance exchange. Table 4 presents sociodemographic characteristics of the analytic sample of adults who had ever been pregnant (referred to as the sample, going forward).

Prevalence of considering, wanting, and (not) obtaining an abortion

Table 5 presents the prevalence of obtaining a past abortion, considering abortion, and wanting or needing an abortion among the full sample of respondents who had ever been pregnant (unweighted $n = 1,783$). About a quarter (24.19%) of respondents who had ever been pregnant reported having had an abortion. An additional 14.51% had considered abortion and 5.17% had wanted or needed an abortion for a current or past pregnancy but did not report having one. A small proportion of respondents who did not report prior abortions were not sure whether they had ever considered (2.68%) or wanted/needed an abortion (3.13%) for a pregnancy. In the full sample of those who had been pregnant, including those who reported a prior abortion(s), 5.84% of respondents had wanted or needed an abortion at some point in their lives that they did not get, and 1.24% were not sure (see Table 6).

Table 6 presents the prevalence of not obtaining a wanted or needed abortion among the sample and three subgroups. The first subgroup represents respondents who may have wanted or

needed an abortion but did not obtain one. An unweighted 451 respondents (25.73% of the sample) fell into this category, either because they had wanted or needed an abortion in the past but reported no abortions or because they had more pregnancies than abortions (see Figure 2). Of these respondents, 22.70% reported wanting or needing an abortion they did not get and 4.83% were not sure.

The second subgroup in Table 6 includes those who considered abortion but did not report any abortions (unweighted $n = 253$). Among this subgroup, about one-quarter (26.34%) reported not obtaining a wanted or needed abortion. Of note, not everyone who reported considering abortion also reported wanting or needing an abortion. Of this subgroup, 34.27% reported also having wanted or needed an abortion, and 8.25% were unsure if they had ever wanted or needed an abortion (not shown).

The third subgroup in Table 6 includes respondents who reported ever wanting or needing an abortion but did not report having had one (unweighted $n = 85$). Among this subgroup, 62.59% reported having wanted or needed an abortion they did not get.

Respondents who reported not getting a wanted or needed abortion

Table 7 presents characteristics of respondents who reported ever not getting a wanted or needed abortion. Among this subset, 39.39% of respondents identified as white, 33.20% as Hispanic, and 15.68% as Black. Around 45% each were between 18-29 and 30-39. The majority were parents (90.48%). Over a quarter (27.60%) reported having had at least one abortion, in addition to the abortion(s) they wanted or needed but did not get. At the time of the survey, almost half (45.11%) lived in the South, a quarter (26.84%) in the West, 18.29% in the Midwest, and 9.76% in the Northeast. At the time of data collection, about half had public insurance, 38.28% had private or commercial insurance, and 11.31% were uninsured. Most reported some current financial strain, with over two-thirds (69.61%) indicating it was somewhat (32.04%) or very (37.57%) difficult to live on their household income. Three-quarters experienced some kind of financial hardship in the past year.

In terms of perceptions of abortion accessibility generally, 39.81% of those who reported not getting a wanted or needed abortion in the past thought it was hard or somewhat hard to get an abortion in the area where they lived at the time of the survey, and 11.40% were not sure how easy or hard it was. 17.44% believed it was not legal to get an abortion in their current state of residence, and over one-quarter (28.58%) were not sure if it was legal or not.

The majority of respondents (91.17%) who reported not getting a wanted or needed abortion provided the reason(s), and most (80.09%) provided reasons that could be coded as a single response category. Of note, 11.43% reported that their pregnancy ended another way, such as by miscarriage. Table 8 lists all reasons and their frequency. Most commonly, respondents reported a personal or individual reason for not getting the abortion(s), such as not being able to “go through with it” (17.86%). Some who responded this way specified they worried about experiencing difficult emotions if they had an abortion, such as guilt or regret. For example, one shared “I didn't think I'd have the emotional capability of dealing with the aftermath of an abortion.” A second common personal reason was that participants had changed their minds or decided to continue the pregnancy (16.41%), such as the respondent who said, “I decided to have my children. I did consider it in the beginning of both, but ended up getting attached and kept them.” Nearly 10% of respondents did not get the abortion due to personal moral or religious opposition, for example, “Because I don't believe in abortions” and “I'm Catholic. It would be murder in my eyes.”

Participants also reported financial or logistical barriers that were likely policy-related had stopped them from obtaining an abortion. Nearly 10% said they did not get the abortion because the pregnancy was “too far along” for reasons including gestational duration bans, facility duration limits, and personal assessment of a limit. For example, one shared, “Didn't know I was pregnant until 3-4 months by then it was too late,” and another that she was “Past [the] legal timeframe.” High out-of-pocket financial costs contributed for 9.65% of respondents, such as for those who said they had “No money to cover the cost” or “Couldn't afford it at the time.”

Additionally, some participants reported interactions with others as preventing them from obtaining an abortion. For 9.27%, this was due to influence, pressure, or threats from their partner at the time. These responses ranged from being about their partner's desire to have a baby (e.g., “Father wanted it”) to manipulation by a partner (e.g., “Ex manipulated me into not getting it”) and, in some cases, coercion and abuse (e.g., “My partner at the time threatened to harm me if I did”).

Bivariate analyses of characteristics related to not getting a wanted or needed abortion

Bivariate analyses considered whether there was an association between current characteristics and not getting a wanted or needed abortion. Sociodemographic characteristics such as age, race, parenting status, income, insurance, and geographic location are known to be related to obtaining abortions as well as experiencing barriers to abortion (3–5,150). As there are no existing national data about the sociodemographic context of not obtaining a wanted abortion, I present these as exploratory analyses to identify potential patterns and areas for future investigation. Importantly, the sociodemographic characteristics reflect the respondents' status at the time of data collection, not at the time they did not obtain an abortion, so these results can only indicate relationships between past and present experiences, without directionality.

In bivariate analyses, there was no association between respondents' race, age, parenting status, relationship status, geographic region, or urbanicity and past experience of wanting or needing an abortion not obtained (see Table 9). However, there was a significant association between some current socioeconomic factors and not getting a wanted abortion in the past. For example, those working full time at the time of the survey less commonly reported a history of not getting an abortion (20.89%) compared to those not working full time (26.90%; $p < 0.05$). There was also an association between both current educational attainment and insurance type and not getting a wanted abortion in the past. Nearly 30% of those with a high school education or less reported a history of not getting a wanted abortion, compared to closer to 20% among those with some college or above ($p < 0.05$). Among those privately insured, 16.71% reported not getting a wanted abortion, with a proportion nearly double that among those with public insurance and the uninsured (32.49% and 37.52%, respectively; $p < 0.001$). In terms of current financial strain, there was an association between a history of not getting a wanted abortion and reporting current difficulty living on household income ($p < 0.001$): 29.15% of those who currently found it very or somewhat difficult to live on their household income reported a history of not getting a wanted or needed abortion, compared to 15.01% of those who found it very or somewhat easy.

In terms of current perceptions of abortion accessibility, there was an association between not getting a wanted or needed abortion and respondents' current perceptions of how easy or hard it is to get an abortion where they live. Among those who were unsure about the ease of abortion access in their area, it was also more common to report being unsure if they had ever

wanted or needed an abortion they did not get (18.95%). Comparatively, only 1.64% of those who thought it was hard to get an abortion where they live and 1.46% of those who thought it was easy were unsure if they had ever not gotten a wanted abortion ($p < 0.001$). In terms of knowledge about abortion legality, reporting a history of not getting a wanted abortion was more common among those who believed abortion was not legal in their state (27.22%) or were not sure if it was legal (29.15%) than among those who knew it was legal (20.92%; $p < 0.001$).

Discussion

This study described the prevalence of considering, wanting, and not obtaining a wanted abortion in a national sample of adults who had ever been pregnant. Nearly 6% of respondents reported having wanted an abortion they did not get. I describe their current characteristics, perceptions, and experiences, along with which of those factors were associated in bivariate analyses. To my knowledge, no similar data exist from a national population-based sample.

In previous studies, researchers have asked currently or recently pregnant people if they considered abortion to better understand those who consider, but do not obtain, abortions (8,10). In addition to asking participants who reported no history of abortion if they had ever *considered* abortion, in this study, we also asked whether they had ever *wanted* an abortion. While we found overlap between respondents who had considered an abortion and had wanted an abortion, there was also notable divergence. Only about one-third of those who reported having considered abortion also said they had wanted one, and 8% were not sure whether they had. These data indicate that people who have been pregnant understand and experience *considering* abortion as different than *wanting* one. To the extent that scholars do not see this distinction, they may misunderstand the role of abortion in people's lives as well as barriers and facilitators to ensuring people's abortion needs are met.

Participants' responses provide some insight into the complexity of wanting an abortion. For example, a small proportion of respondents were not sure whether they had ever wanted abortion they did not get. Additionally, in open-ended responses, participants' most common reasons for not getting a wanted abortion were feeling they could not go through with it (17.86%) or changing their minds (16.41%). Rather than framing this experience as not getting a wanted abortion, for some people, it may be more accurate to describe this as not getting an abortion that was wanted at one point. These data support the idea that, just as with other life and reproductive experiences, it is normal for people to change their minds about abortion. Data indicating that people are certain about their abortion decisions (119,120) are often used to counter anti-abortion narratives about regret (118,121). However, certainty narratives can also imply that it is not common or acceptable to have mixed or changing feelings about abortion. Demonstrating certainty to justify an abortion can be difficult for some people (121), and may be an unreasonable bar. At the same time, participants' responses must be understood in context. Many said they could not go through with the abortion or changed their minds. People live in contexts and structures that can make abortion unfeasible, unobtainable, or unchooseable (106,151,152). It is possible that these were responses to real assessments of how possible abortion was for them—geographically, logistically, financially, and socially.

In this study, personal reasons were most commonly why participants did not obtain an abortion they had wanted. However, participants also reported not getting abortions due to gestational duration and financial cost, which can at least partially be attributed to policies setting gestational limits and limiting insurance coverage of abortion. These findings are similar

to those among prenatal patients who did not get an abortion they considered (10). In addition to cost, another recent study found that fear of judgment and not being able to find a nearby provider were common reasons for not getting a considered abortion (8).

In bivariate analyses, there were associations between not getting a wanted abortion in the past and some current socioeconomic characteristics, such as educational attainment, health insurance type, and difficulty living on household income. In each of these examples, reporting a history of not getting a wanted abortion was more common among respondents who reported current experiences that are often considered indicative of socioeconomic disadvantage—having a high school diploma or less (compared to a college degree or more), having public insurance or no insurance (compared to being privately insured), and finding it difficult to live on household income (compared to easy). A health equity approach prioritizes ensuring that “everyone has a fair and just opportunity to be as healthy as possible” regardless of social or economic position (153), and requires consideration of patterns in who is able and unable to obtain abortions. The associations found here raise health equity concerns, and mirror known injustices in abortion access, as abortion restrictions have been found to disproportionately burden low-income people, those with public insurance, and lower educational attainment (3,5). It is important to note that these analyses reflect the respondents’ socioeconomic status at the time of data collection, and not at the time they did not obtain a wanted abortion, and therefore these associations cannot be taken to imply directionality or temporality in either direction. However, in light of the stark lack of class and wealth mobility in the U.S., it is plausible that current socioeconomic status could be similar to past circumstances (154,155).

In addition to the research findings, this study also makes methodological contributions. We asked participants two original questions, developed specifically for this study and which can be used and adapted for future research: whether they had ever wanted or needed an abortion and whether they had ever wanted or needed an abortion they did not get. In addition, when asked, the vast majority of respondents who reported not getting a wanted abortion responded to an open-ended question asking why this was the case. This indicates that, despite being a potentially stigmatizing question, at least some people are willing to disclose information about abortions they wanted at one point but did not obtain.

Limitations

There are limitations that should be mentioned. There was limited space for additional questions in the extant survey, therefore, we added only six items, without follow-up items that could shed light on the circumstances of not getting a wanted abortion. As a result, we asked questions about considering, wanting, and not obtaining an abortion in terms of lifetime history, as opposed to about a current or a recent pregnancy. We therefore do not know when respondents did not get their wanted abortion(s), or their age, where they lived, or other information to contextualize their lives at the time. We also did not ask about each pregnancy respondents had, so we do not know for how many of their pregnancies they considered, wanted, or did not obtain a wanted abortion. We also do not know if those who reported not getting a wanted abortion took steps to seek an abortion, such as calling a clinic, making an appointment, or ordering pills, which could shed light components of the process of seeking abortion that were particularly difficult to navigate or overcome.

In this survey, we used adapted and new questions. While these questions were reviewed by experts in abortion and contraception research, I did not conduct cognitive interviews or pilot testing. This means we do not have confirmation that respondents understood the questions as

intended. Given the complexity of considering, wanting, or needing an abortion, future research should investigate how people understand each of these terms and whether, how, and why they identify their lived experience with them.

Another limitation is the potential for bias due to recall or retrospective reporting. When asked about lifetime experience with and/or need for abortion, the quality of respondents' recollection may decline with the passage of time. Research among people denied an abortion shows that as time passes, people's reports of the intendedness of the pregnancy shifts (156); in the same way, their assessment of wanting an abortion for a past pregnancy could also change. People may also be reluctant to report that they had wanted an abortion for a past pregnancy if they went on to continue that pregnancy and parent the resulting child. Notably, even when denied wanted abortions, women can go on to love their children and be glad to have them in their lives (6).

In addition, abortion is highly stigmatized and is often underreported in research (143–145). This could mean these data underestimate how many people in the study had a history of abortion, had considered or wanted an abortion, or had not obtained a wanted abortion. We were encouraged that 24.19% of those who had ever been pregnant (12.21% of all adult respondents in the parent study) reported having had an abortion, which indicated many people were willing to disclose this history.

Conclusion

These data provide the first known estimates of the prevalence of lifetime history of not getting a wanted abortion among a national sample. The adapted and original questions from this study can be used for further research to better understand the frequency and context of not obtaining a wanted abortion. With the pending U.S. Supreme Court decision in *Dobbs v. Jackson*, which is poised to overturn *Roe v. Wade*, and the flurry of state-level restrictions and prohibitions on abortion that are anticipated in response, it may become increasingly common that people do not obtain abortions they want. This study contributes to a growing and timely body of research about the frequency and context of not getting a wanted abortion in the United States.

Tables and Figures

Figure 2. Survey questions and flow for items related to considering, wanting, and not obtaining a wanted abortion

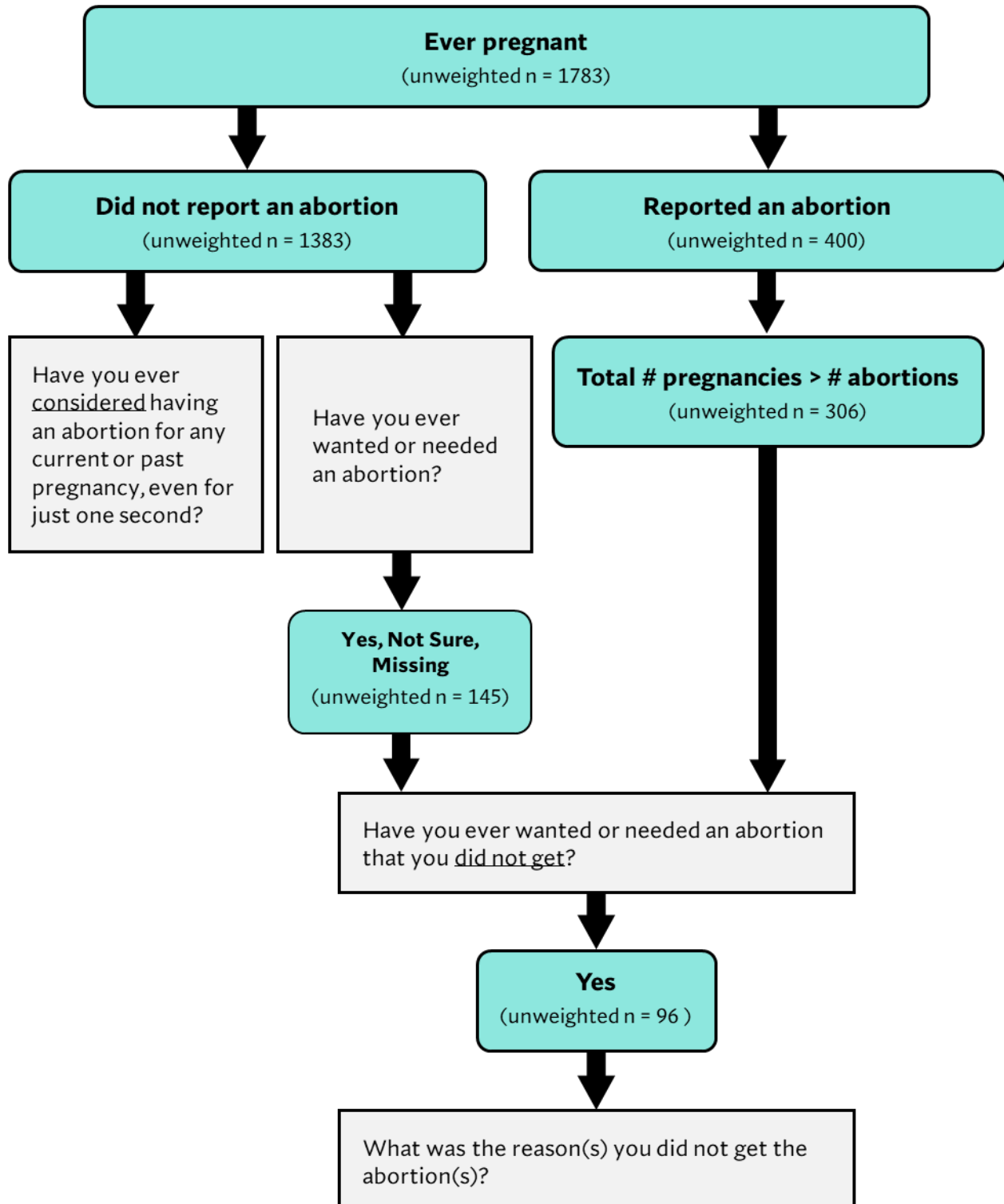


Table 4. Characteristics of a national sample of adults who had ever been pregnant in the U.S. (N = 1783)

	Weighted %	Unweighted n
Race/Ethnicity		
White	54.06	1045
Black	15.56	233
Hispanic/Latinx	21.31	318
Asian	4.34	64
Multiracial	4.06	100
Other	0.67	23
Age		
18-29	38.09	405
30-39	45.75	994
40-44	16.16	384
Parent		
No	16.92	200
Yes	82.45	1577
Missing	0.62	6
In a serious relationship		
No	20.94	292
Yes	79.06	1491
Census region		
Northeast	12.04	214
Midwest	24.08	546
South	38.43	612
West	25.45	411
Urbanicity		
Urban	36.56	716
Suburban	44.32	760
Rural	19.12	307
Born in the United States		
Yes	85.05	1547
No	12.15	203
Prefer not to say	2.34	25
Missing	0.47	8
Current employment status		
Working full time	48.18	914
Working part time	15.93	310
Not working for pay	34.82	546
Other	0.41	5
Missing	0.66	8

Table 4, continued

	Weighted %	Unweighted n
Highest education completed		
High school equivalent or less	32.94	313
Vocational or technical school, some college, or associates degree	35.82	706
Bachelor's degree, post graduate study, or professional degree	31.24	764
Insurance type		
None	8.06	129
Public (Medicaid, CHIP, Medicare)	29.23	403
Private or employer-based (including military & health insurance exchanges)	59.21	1204
Don't know	2.53	35
Missing	0.97	12
Difficulty living on total household income		
Very or somewhat difficult	45.56	709
Very or somewhat easy	48.56	1003
Not sure	4.05	59
Missing	1.83	12
Any financial hardship(s) in past year		
No	30.97	635
Yes	55.06	915
Missing	13.96	233
Largest affordable emergency expense		
I could not pay for any emergency expense	23.35	309
\$1-99	12.69	192
\$100-399	20.20	341
Over \$400	42.16	915
Missing	1.60	26

Table 5. Obtaining, considering, and wanting or needing an abortion among a national sample of adults who had ever been pregnant in the U.S. (N = 1783)

	Adults who had ever been pregnant	
	Weighted %	Unweighted n
Ever had an abortion		
Yes	24.19	400
No	74.94	1368
Missing	0.87	15
Did not report a past abortion, but had considered abortion for a past or current pregnancy		
Yes	14.51	253
No	57.41	1078
Not sure	2.68	32
Missing	0.34	5
Not asked*	25.06	415
Did not report a past abortion, but had wanted or needed an abortion at some point		
Yes	5.17	85
No	66.29	1238
Not sure	3.13	38
Missing	0.34	7
Not asked*	25.06	415

* Only respondents who did not report a prior abortion were asked if they had ever considered abortion or had ever wanted or needed an abortion. See Figure 2.

Table 6. Not obtaining a wanted or needed abortion among a national sample and subgroups of adults who had ever been pregnant in the U.S.

	Main sample		Subgroup					
	Adults who had ever been pregnant (n = 1783)		*Had a past pregnancy for which they may have wanted or needed an abortion and not obtained one (n = 451)		**Did not report a past abortion, but had considered abortion for a past or current pregnancy (n = 253)		***Did not report a past abortion, but had wanted or needed an abortion at some point (n = 85)	
	Weighted %	Un-weighted n	Weighted %	Un-weighted n	Weighted %	Un-weighted n	Weighted %	Un-weighted n
Have you ever wanted or needed an abortion that you did not get?								
Yes	5.84	96	22.70	96	26.34	65	62.59	57
No	17.46	321	67.85	321	15.32	30	35.86	26
Not sure	1.24	16	4.83	16	0.67	3	1.55	2
Missing	1.19	18	4.63	18	0.19	1	0	0
Not asked****	74.27	1332	0	0	57.48	154	0	0
Total		1783		451		253		85

* Subgroup includes respondents who reported more pregnancies than past abortions, as they could have wanted an abortion for a different pregnancy and not obtained one. It also includes respondents who answered yes, not sure, or skipped the question asking if they had ever wanted or needed an abortion.

** Subgroup includes respondents who reported considering abortion for a past or current pregnancy, but did not report ever having an abortion

*** Subgroup includes respondents who reported ever wanting or needing an abortion, but did not report ever having an abortion

**** See Figure 2 for a full depiction of which respondents were asked which questions

Table 7. Characteristics of respondents who reported not obtaining a wanted or needed abortion among a national sample in the U.S. (N = 96)

	Weighted %	Unweighted n
Race/Ethnicity		
White	39.39	36
Black	15.68	19
Hispanic/Latinx	33.20	24
Asian	3.50	3
Multiracial	7.09	11
Other	1.13	3
Age		
18-29	44.07	30
30-39	44.91	49
40-44	11.02	17
Parent		
No	9.52	7
Yes	90.48	89
Ever had an abortion		
No	72.40	67
Yes	27.60	29
Among those not reporting a past abortion, ever considered abortion		
Yes	90.39	65
No	1.33	1
Not sure	8.28	1
Among those not reporting a past abortion, ever wanted or needed an abortion		
Yes	76.59	57
No	0	0
Not sure	23.41	10
In a serious relationship		
No	27.36	27
Yes	72.64	69
Census region		
Northeast	9.76	11
Midwest	18.29	26
South	45.11	38
West	26.84	21
Urbanicity		
Urban	35.87	38
Suburban	42.54	42
Rural	21.59	16
Born in the United States		
Yes	90.81	86
No	9.19	10
Prefer not to say	0	0

Table 7, continued

	Weighted %	Unweighted n
Current employment status		
Working full time	45.29	42
Working part time	17.23	18
Not working for pay	37.49	36
Highest education completed		
High school equivalent or less	39.67	24
Vocational or technical school, some college, or associates degree	39.98	47
Bachelor's degree, post graduate study, or professional degree	20.35	25
Insurance type		
None	11.31	13
Public (Medicaid, CHIP, Medicare)	49.26	42
Private or employer-based (including military & health insurance exchanges)	38.28	39
Don't know	1.16	2
Difficulty living on total household income		
Very or somewhat difficult	69.61	64
Very or somewhat easy	25.33	28
Not sure	5.06	3
Any financial hardship(s) in past year		
No	21.43	22
Yes	64.65	67
Missing	13.91	7
Largest affordable emergency expense		
I could not pay for any emergency expense	35.71	34
\$1-99	19.62	13
\$100-399	17.81	19
over \$400	26.86	30
How easy or hard do you think it is for someone to get an abortion in the area where you live?		
Hard or somewhat hard	39.81	39
Easy or somewhat easy	48.79	43
Not sure	11.40	14
Based on what you know or have heard, is it legal to get an abortion in your state?		
Yes	53.98	59
No	17.44	14
Not sure	28.58	23

Table 8. Reasons respondents reported not getting a wanted or needed abortion among a national sample in the U.S. (N = 96)

	Weighted %	Unweighted n
Personal or individual		
Couldn't go through with it	17.86	13
Changed mind or decided to continue pregnancy	16.41	17
Difficulty making the decision	2.55	2
Personal moral or religious opposition	9.69	13
Interactions with others		
Partner influence or pressure	9.27	10
Family influence or pressure	4.43	2
Policy-related financial or logistical barriers		
Too far in pregnancy	9.90	10
Financial cost	9.65	10
Lack of transportation (including for necessary travel)	3.90	3
Young age	2.49	3
No identifiable provider	1.35	2
Informational barriers		
Did not know where or how to obtain an abortion	1.80	2
Another reason	1.91	3
Pregnancy ended another way	11.43	8
Did not provide reason	8.83	9

* Responses were not mutually exclusive

Table 9. Bivariate analyses of characteristics related to history of not getting a wanted or needed abortion among a national sample in the U.S.

Have you ever wanted or needed an abortion you did not get?										
	Yes		No		Not sure		Total		<i>F</i> statistic	<i>p</i> value
	Weighted %	Un-weighted n	Weighted %	Un-weighted n	Weighted %	Un-weighted n	Weighted %	Un-weighted n		
Race/Ethnicity									0.69	0.70
White	22.47	36	73.80	149	3.73	5	100	190		
Black	19.56	19	70.97	60	9.47	4	100	83		
Hispanic/Latinx	26.70	24	68.95	73	4.35	4	100	101		
Asian	28.63	3	59.62	9	11.75	2	100	14		
Multiracial	30.85	11	67.86	22	1.28	1	100	34		
Other	21.75	3	78.25	8	0	0	100	11		
Age									1.40	0.23
18-29	30.90	30	62.63	69	6.47	5	100	104		
30-39	22.04	49	74.23	173	3.73	8	100	230		
40-44	14.93	17	79.05	79	6.02	3	100	99		
Parent									1.04	0.35
No	19.14	7	80.86	31	0	0	100	38		
Yes	24.42	89	69.84	290	5.74	16	100	395		
In a serious relationship									0.17	0.84
No	23.13	27	73.06	82	3.81	3	100	112		
Yes	24.06	69	70.39	239	5.55	13	100	321		
Census Region									0.42	0.86
Northeast	18.36	11	78.14	48	3.50	1	100	60		
Midwest	19.63	26	74.38	89	5.99	5	100	120		
South	27.43	38	66.88	111	5.69	5	100	154		
West	24.54	21	71.38	73	4.09	5	100	99		

Table 9, continued

Have you ever wanted or needed an abortion you did not get?										
	Yes		No		Not sure		Total		<i>F</i> statistic	<i>p</i> value
	Weighted %	Un- weighted n	Weighted %	Un- weighted n	Weighted %	Un- weighted n	Weighted %	Un- weighted n		
Urbanicity									1.62	0.17
Urban	17.96	38	74.97	157	7.07	11	100	206		
Suburban	26.59	42	71.20	124	2.22	4	100	170		
Rural	35.74	16	58.32	40	5.95	1	100	57		
Working full time									3.47	0.03*
No	26.90	54	64.93	145	8.17	12	100	211		
Yes	20.89	42	76.97	176	2.14	4	100	222		
Working part time									0.75	0.47
No	23.42	78	72.22	264	4.35	13	100	355		
Yes	25.79	18	65.41	57	8.80	3	100	78		
Not working for pay									0.88	0.42
No	21.53	60	73.60	236	4.86	8	100	304		
Yes	29.01	36	65.97	85	5.01	7	100	128		
Highest education completed									2.55	0.04*
High school equivalent or less	29.53	24	60.60	50	9.87	6	100	80		
Vocational or technical school, some college, or associates degree	21.41	47	76.21	165	2.38	6	100	218		
Bachelor's degree, post graduate study, or professional degree	20.53	25	75.88	106	3.58	4	100	135		

Table 9, continued

Have you ever wanted or needed an abortion you did not get?										
	Yes		No		Not sure		Total		<i>F</i> statistic	<i>p</i> value
	Weighted %	Un- weighted n	Weighted %	Un- weighted n	Weighted %	Un- weighted n	Weighted %	Un- weighted n		
Insurance type									5.54	0.000***
None	37.52	13	55.49	20	6.99	2	100	35		
Public (Medicaid, CHIP, Medicare)	32.49	42	62.37	95	5.15	5	100	142		
Private or employer-based (including military & health insurance exchanges)	16.71	39	80.10	199	3.19	7	100	245		
Don't know	12.64	2	43.14	6	44.23	2	100	10		
Difficulty living on total household income									5.28	0.0006***
Very or somewhat difficult	29.15	64	66.77	154	4.08	6	100	224		
Very or somewhat easy	15.01	28	82.16	152	2.83	6	100	186		
Not sure	16.12	3	58.06	14	25.82	4	100	21		
Any financial hardship(s) in past year									0.55	0.58
No	18.41	22	76.30	100	5.30	5	100	127		
Yes	24.92	67	69.81	191	5.27	9	100	267		
Largest affordable emergency expense									1.20	0.30
I could not pay for any emergency expense	30.39	34	65.32	70	4.29	3	100	107		
\$1-99	30.51	13	61.13	41	8.36	4	100	58		
\$100-399	20.88	19	77.27	75	1.85	2	100	96		
over \$400	17.64	30	76.28	134	6.09	7	100	171		

Table 9, continued

Have you ever wanted or needed an abortion you did not get?										
	Yes		No		Not sure		Total			
	Weighted %	Un-weighted n	Weighted %	Un-weighted n	Weighted %	Un-weighted n	Weighted %	Un-weighted n	<i>F</i> statistic	<i>p</i> value
How easy or hard do you think it is for someone to get an abortion in the area where you live?									8.01	0.000***
Hard or somewhat hard	28.56	39	69.80	87	1.64	2	100	128		
Easy or somewhat easy	24.92	43	73.62	167	1.46	5	100	215		
Not sure	13.41	14	67.64	67	18.95	9	100	90		
Based on what you know or have heard, is it legal to get an abortion in your state?									8.73	0.000***
Yes	20.92	59	78.08	224	1.01	5	100	288		
No	27.22	14	72.78	46	0.00	0	100	60		
Not sure	29.15	23	51.81	51	19.04	11	100	85		

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Note: I present the corrected F statistics, based on Pearson chi-square tests, to account for complex survey design and weighting (Rao and Scott, 1984)

Chapter 5: Conclusion

In this dissertation, I set out to investigate the concept of unmet need for abortion, including what it means to stakeholders working in abortion access and whether researchers, funders, and advocates should pursue its development as a tool to understand and meet abortion need(s). Relatedly, I set out to quantitatively describe one component of unmet need for abortion—the prevalence of ever not getting a wanted abortion among a nationally representative sample.

In Chapter 2, I describe the potential value of using unmet need for abortion as a tool, including the ways it could be advantageous as well as its pitfalls and potential harms. Stakeholders' perspectives speak to the interplay of concept and measurement. They saw benefits and drawbacks of the tool itself, related to quantification, measurement, and documentation. In addition, there were benefits and drawbacks to the broader concept, related to how it could impact public discourse about abortion and what it misses from a reproductive justice perspective. Overall, I identified more concerns than benefits. These findings challenge a core principle in public health, that the way to know and understand health issues—to (literally) make them count—is to measure them. Given that all stakeholders agreed that people not obtaining wanted abortions is an important and pressing problem, these findings encourage those working in abortion access to identify and invest in alternate ways of understanding and addressing this. In the abortion rights movement, these findings may provide a particular caution to researchers (who create measures and collect and disseminate data) and funders (who fund these efforts and/or use the data to direct resources).

Some of the complexity and limitations of unmet need for abortion that surfaced in Chapter 2 come into better focus in Chapter 3, where I demonstrate that there was not one unified or fixed conceptualization of unmet need for abortion. Instead, stakeholders held two distinct conceptualizations: outcome-based and process-based unmet need. While this enables stakeholders to intentionally and strategically deploy one conceptualization or another in order to attract support or avoid opposition, the lack of shared understanding also contributes to why the tool may be problematic. However, findings about how and why stakeholders use outcome vs. process approaches provide useful insight into how the abortion rights movement is oriented to direct resources. As the example of Texas Senate Bill 8 shows, understanding abortion needs in terms of outcome vs. process is relevant to current events and policy. As additional states (e.g. Idaho, Oklahoma) mirror Texas's six-week ban, other states (e.g., California, Connecticut) move to bolster abortion protections to accommodate those who need to travel out of state (22,23,157,158). While this may go a long way in meeting outcome-based needs, process-based unmet needs may increase. Inasmuch as stakeholders valued both types of need, these findings encourage those working for abortion access and the media covering these issues to not lose sight of either form of unmet need, even when one is not expedient.

In Chapter 4, I present the first data about not obtaining a wanted abortion among a national sample. This study contributes to the larger understanding of unmet need for abortion in terms of findings and methods. Methodologically, we demonstrated that people will answer questions about whether and why they did not obtain a wanted abortion. The questions we adapted and developed for this study can be tested and used in further research. In addition, the findings highlight the importance of distinguishing between *considering* and *wanting* an abortion. If researchers, advocates, and others concerned about abortion access do not recognize this distinction, they risk misunderstanding people's experiences and misdirecting attention and resources. This is particularly important given that respondents most commonly reported not

getting abortions they once wanted because they made a different decision. These data provide an opportunity to acknowledge that, while many people have high levels of certainty about abortion decisions, it is also normal and acceptable for people to change their minds about abortion. Proactively supporting this idea would enable the abortion rights movement to push back against narratives of abortion regret without simultaneously replicating normative ideas about certainty.

The stakeholders interviewed for this study were diverse—their distinct roles as researchers, direct service providers, funders, advocates, activists give them different vantage points and different priorities. This is one of the strengths of the study, but also means that these results may have different implications for various stakeholders and sectors in the abortion rights movement. While charged with different goals, these stakeholders are interdependent. For example, researchers typically decide what gets measured and design the measures that become tools for funders, advocates, policymakers, and others.

All three studies demonstrate that issue framing matters. In Chapter 2, some of the biggest benefits and concerns related to how the framing of “unmet need for abortion” could impact the public discourse about abortion. Ultimately, the framing being exclusively about abortion revealed the greatest potential risks—obscuring the connection between abortion need, parenting, and the conditions of people’s lives. In Chapter 3, too, issue framing matters, as approaching abortion need as being about an outcome versus a process can yield very different priorities and investments. In Chapter 4 I tried to take the lessons from Chapter 2 and put them into practice. It would have been expedient to be able to refer to what I was documenting as (outcome-based) unmet need for abortion. But, given the concerns raised in Chapters 2 and 3, I decided to instead describe the specific experience I was investigating (not getting a wanted abortion), instead of framing it as unmet need.

Whether called unmet need for abortion or not, the issues discussed in this dissertation—people not getting wanted abortions, not being able to fully consider abortion, and not getting abortions in acceptable ways—are poised to increase as threats to abortion access and availability increase. The ability to obtain an abortion is a fundamental component of reproductive well-being, health equity, and reproductive justice. This dissertation contributes to a growing and timely body of research about devising new ways to understand and meet abortion needs.

References

1. Ross LJ, Solinger R. Reproductive Justice: An Introduction. Oakland: Univ California Press; 2017.
2. Ross LJ. Conceptualizing Reproductive Justice Theory: A Manifesto for Activism. In: Ross LJ, Roberts L, Derkas E, Peoples W, Bridgewater Toure P, editors. Radical Reproductive Justice: Foundations, Theory, Practice, Critique. First Feminist Press edition. New York, NY: Feminist Press at the City University of New York; 2017.
3. Upadhyay UD, Johns NE, Cartwright AF, Franklin TE. Sociodemographic Characteristics of Women Able to Obtain Medication Abortion Before and After Ohio's Law Requiring Use of the Food and Drug Administration Protocol. *Health Equity*. 2018 Jul 1;2(1):122–30.
4. Roberts SCM, Fuentes L, Kriz R, Williams V, Upadhyay UD. Implications for women of Louisiana's law requiring abortion providers to have hospital admitting privileges. *Contraception*. 2015 May;91(5):368–72.
5. Salganicoff A, Sobel L, Ramaswamy A. The Hyde Amendment and Coverage for Abortion Services [Internet]. Kaiser Family Foundation; 2020 [cited 2020 Apr 30]. Available from: <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>
6. Foster DG. The turnaway study : ten years, a thousand women, and the consequences of having--or being denied--an abortion [Internet]. First edition. Scribner; 2020 [cited 2021 Mar 10]. Available from: <https://libproxy.berkeley.edu/login?qurl=https%3a%2f%2fsearch.ebscohost.com%2flogin.aspx%3fdirect%3dtrue%26db%3dcab04202a%26AN%3ducbb25739521%26site%3dedslive>
7. Upadhyay UD, Weitz TA, Jones RK, Barar RE, Foster DG. Denial of abortion because of provider gestational age limits in the United States. *Am J Public Health*. 2014 Sep;104(9):1687–94.
8. Moseson H, Seymour JW, Zuniga C, Wollum A, Katz A, Thompson TA, et al. “It just seemed like a perfect storm”: A multi-methods feasibility study on the use of Facebook, Google Ads, and Reddit to collect data on abortion-seeking experiences from people who considered but did not obtain abortion care in the United States. *PLOS ONE* [Internet]. 2022 Mar 3 [cited 2022 Mar 10];17(3). Available from: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0264748>
9. Upadhyay UD, McCook AA, Bennett AH, Cartwright AF, Roberts SCM. State abortion policies and Medicaid coverage for abortion are associated with pregnancy outcomes among individuals seeking abortion recruited using Google Ads: A national cohort study. *Soc Sci Med*. 2021 Feb 6;113747.

10. Roberts SCM, Kimport K, Kriz R, Holl J, Mark K, Williams V. Consideration of and Reasons for Not Obtaining Abortion Among Women Entering Prenatal Care in Southern Louisiana and Baltimore, Maryland. *Sex Res Soc Policy* [Internet]. 2018 Oct 11 [cited 2019 Jul 23]; Available from: <https://doi.org/10.1007/s13178-018-0359-4>
11. Bradley SEK, Casterline JB. Understanding Unmet Need: History, Theory, and Measurement. *Stud Fam Plann*. 2014 Jun;45(2):123–50.
12. Guttmacher Institute. Abortion Policy in the Absence of Roe [Internet]. State Laws and Policies. 2022 [cited 2022 May 1]. Available from: <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>
13. Barr-Walker J, Jayaweera RT, Ramirez AM, Gerdtz C. Experiences of women who travel for abortion: A mixed methods systematic review. *PloS One*. 2019;14(4):e0209991.
14. Doran F, Nancarrow S. Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. *J Fam Plann Reprod Health Care*. 2015 Jul;41(3):170–80.
15. Jerman J, Frohwirth L, Kavanaugh ML, Blades N. Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States. *Perspect Sex Reprod Health*. 2017 Jun;49(2):95–102.
16. Nash E, Cappello O, Naide S, Mohammed L, Ansari-Thomas Z. Radical Attempts to Ban Abortion Dominate State Policy Trends in the First Quarter of 2019 [Internet]. Guttmacher Institute. 2019 [cited 2019 Apr 24]. Available from: <https://www.guttmacher.org/article/2019/04/radical-attempts-ban-abortion-dominate-state-policy-trends-first-quarter-2019>
17. Guttmacher Institute. Last Five Years Account for More Than One-quarter of All Abortion Restrictions Enacted Since Roe [Internet]. Guttmacher Institute. 2016 [cited 2019 Apr 24]. Available from: <https://www.guttmacher.org/article/2016/01/last-five-years-account-more-one-quarter-all-abortion-restrictions-enacted-roe>
18. Nash E. State Policy Trends 2021: The Worst Year for Abortion Rights in Almost Half a Century [Internet]. Guttmacher Institute; 2021 Jan [cited 2022 Mar 13]. Available from: <https://www.guttmacher.org/article/2021/12/state-policy-trends-2021-worst-year-abortion-rights-almost-half-century>
19. Guttmacher Institute. State Bans on Abortion Throughout Pregnancy [Internet]. State Laws and Policies. 2022 [cited 2021 Mar 10]. Available from: <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions>
20. Foster DG, Kimport K. Who Seeks Abortions at or After 20 Weeks? *Perspect Sex Reprod Health*. 2013;45(4):210–8.
21. Guttmacher Institute. A Surge in Bans on Abortion as Early as Six Weeks, Before Most People Know They Are Pregnant [Internet]. Guttmacher Institute. 2019 [cited 2021 Mar

- 10]. Available from: <https://www.guttmacher.org/article/2019/03/surge-bans-abortion-early-six-weeks-most-people-know-they-are-pregnant>
22. Zernike K. Oklahoma Legislature Passes 6-Week Abortion Ban Modeled on Texas Law. *The New York Times* [Internet]. 2022 Apr 28 [cited 2022 May 1]; Available from: <https://www.nytimes.com/2022/04/28/us/oklahoma-abortion-legislature.html>
 23. Zernike K. Idaho Is First State to Pass Abortion Ban Based on Texas' Law. *The New York Times* [Internet]. 2022 Mar 14 [cited 2022 May 1]; Available from: <https://www.nytimes.com/2022/03/14/us/idaho-abortion-bill-texas.html>
 24. Upadhyay UD, Cartwright AF, Goyal V, Belusa E, Roberts SCM. Admitting privileges and hospital-based care after presenting for abortion: A retrospective case series. *Health Serv Res*. 2019;54(2):425–36.
 25. Roberts SCM, Upadhyay UD, Liu G, Kerns JL, Ba D, Beam N, et al. Association of Facility Type With Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions. *JAMA*. 2018 Jun 26;319(24):2497–506.
 26. Austin N, Harper S. Assessing the impact of TRAP laws on abortion and women's health in the USA: a systematic review. *BMJ Sex Reprod Health*. 2018 Apr;44(2):128–34.
 27. Grossman D, Baum S, Fuentes L, White K, Hopkins K, Stevenson A, et al. Change in abortion services after implementation of a restrictive law in Texas. *Contraception*. 2014 Nov;90(5):496–501.
 28. Guttmacher Institute. State Funding of Abortion Under Medicaid [Internet]. Guttmacher Institute. 2021 [cited 2021 Mar 10]. Available from: <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>
 29. Roberts SCM, Johns NE, Williams V, Wingo E, Upadhyay UD. Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion. *BMC Womens Health*. 2019 Jun 19;19(1):78.
 30. Jones RK, Upadhyay UD, Weitz TA. At What Cost? Payment for Abortion Care by U.S. Women. *Womens Health Issues*. 2013 May 1;23(3):e173–8.
 31. Roberts SCM, Gould H, Kimport K, Weitz TA, Foster DG. Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States. *Womens Health Issues*. 2014 Mar 1;24(2):e211–8.
 32. Boonstra HD. Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters. *Guttmacher Policy Rev*. 2016;19:46–52.
 33. Henshaw SK, Joyce TJ, Dennis A, Finer LB, Blanchard K. Restrictions on Medicaid Funding for Abortions: A Literature Review [Internet]. Guttmacher Institute; 2009 Jun [cited 2020 Aug 23]. Available from: <https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review>

34. Margo J, McCloskey L, Gupte G, Zurek M, Bhakta S, Feinberg E. Women's Pathways to Abortion Care in South Carolina: A Qualitative Study of Obstacles and Supports. *Perspect Sex Reprod Health*. 2016;48(4):199–207.
35. White K, deMartelly V, Grossman D, Turan JM. Experiences Accessing Abortion Care in Alabama among Women Traveling for Services. *Womens Health Issues Off Publ Jacobs Inst Womens Health*. 2016 Jun;26(3):298–304.
36. Moseson H, Herold S, Filippa S, Barr-Walker J, Baum SE, Gerdtts C. Self-managed abortion: A systematic scoping review. *Best Pract Res Clin Obstet Gynaecol*. 2020 Feb 1;63:87–110.
37. Grossman D, Hendrick E, Fuentes L, White K, Hopkins K, Stevenson A, et al. Knowledge, opinion and experience related to abortion self-induction in Texas. *Contraception*. 2015 Oct;92(4):360–1.
38. Jerman J, Onda T, Jones RK. What are people looking for when they Google “self-abortion”? *Contraception*. 2018 Jun;97(6):510–4.
39. Hellerstein E. The Rise of the DIY Abortion in Texas [Internet]. *The Atlantic*. 2014 [cited 2020 May 18]. Available from: <https://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/>
40. Ralph L, Foster DG, Raifman S, Biggs MA, Samari G, Upadhyay U, et al. Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States. *JAMA Netw Open*. 2020 Dec 1;3(12):e2029245.
41. Aiken ARA, Starling JE, van der Wal A, van der Vliet S, Broussard K, Johnson DM, et al. Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States. *Am J Public Health*. 2020 Jan;110(1):90–7.
42. Dobkin LM, Gould H, Barar RE, Ferrari M, Weiss EI, Foster DG. Implementing a Prospective Study of Women Seeking Abortion in the United States: Understanding and Overcoming Barriers to Recruitment. *Womens Health Issues*. 2014 Jan 1;24(1):e115–23.
43. Foster DG, Biggs MA, Ralph L, Gerdtts C, Roberts S, Glymour MM. Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. *Am J Public Health*. 2018;108(407–413).
44. Miller S, Wherry LR, Foster DG. The Economic Consequences of Being Denied an Abortion [Internet]. *National Bureau of Economic Research*; 2020 Jan [cited 2021 Mar 10]. Report No.: w26662. Available from: <https://www.nber.org/papers/w26662>
45. Foster DG, Raifman SE, Gipson JD, Rocca CH, Biggs MA. Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children. *J Pediatr*. 2019 Feb 1;205:183–189.e1.

46. Foster DG, Biggs MA, Raifman S, Gipson J, Kimport K, Rocca CH. Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion. *JAMA Pediatr*. 2018 Nov 1;172(11):1053–60.
47. Roberts SC, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med*. 2014 Sep 29;12(1):144.
48. Fuentes L, Lebenkoff S, White K, Gerdtts C, Hopkins K, Potter JE, et al. Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas. *Contraception*. 2016 Apr;93(4):292–7.
49. Roberts SCM, Kimport K, Kriz R, Holl J, Mark K, Williams V. Consideration of and Reasons for Not Obtaining Abortion Among Women Entering Prenatal Care in Southern Louisiana and Baltimore, Maryland. *Sex Res Soc Policy* [Internet]. [cited 2019 Jul 17]; Available from: <https://link.springer.com/article/10.1007/s13178-018-0359-4>
50. Berglas NF, Kimport K, Williams V, Mark K, Roberts SCM. The Health and Social Service Needs of Pregnant Women Who Consider but Do Not Have Abortions. *Womens Health Issues*. 2019 Sep 1;29(5):364–9.
51. O'Donnell J, Goldberg A, Lieberman E, Betancourt T. "I wouldn't even know where to start": unwanted pregnancy and abortion decision-making in Central Appalachia. *Reprod Health Matters*. 2018 Nov 8;26(54):98–113.
52. Upadhyay UD, Jovel IJ, McCuaig KD, Cartwright AF. Using Google Ads to recruit and retain a cohort considering abortion in the United States. *Contracept X*. 2020 Jan 1;2:100017.
53. Moseson H, Wollum A, Seymour JW, Zuniga C, Thompson TA, Gerdtts C. Comparison of Facebook, Google Ads, and Reddit for the Recruitment of People Who Considered but Did Not Obtain Abortion Care in the United States: Cross-sectional Survey. *JMIR Form Res*. 2021 Feb 24;5(2):e22854.
54. Alan Guttmacher Institute. The Unmet Need for Legal Abortion Services in the U.S. *Fam Plann Perspect*. 1975;7(5):224–30.
55. Forrest JD, Sullivan E, Tietze C. Abortion in the United States, 1977-1978. *Fam Plann Perspect*. 1979 Dec;11(6):329–41.
56. Forrest JD, Tietze C, Sullivan E. Abortion in the United States, 1976-1977. *Fam Plann Perspect*. 1978;10(5):271–9.
57. Henshaw S, Forrest JD, Sullivan E, Tietze C. Abortion in the United States, 1978-1979. *Fam Plann Perspect*. 1981;13(1):6.

58. Weinstock E, Tietze C, Jaffe FS, Dryfoos JG. Abortion Need and Services in the United States, 1974-1975. *Fam Plann Perspect.* 1976;8(2):58–69.
59. Gold RB. After the Hyde Amendment: Public Funding for Abortion in FY 1978. *Fam Plann Perspect.* 1980;12(3):131–4.
60. Henshaw SK, Forrest JD, Blaine E. Abortion Services in the United States, 1981 and 1982. *Fam Plann Perspect.* 1984;16(3):119–27.
61. Henshaw SK, Forrest JD, Sullivan E, Tietze C. Abortion services in the United States, 1979 and 1980. *Fam Plann Perspect.* 1982 Feb;14(1):5–8, 10–5.
62. Chor J, Dyer A, Harwood B. Access to Family Planning and Induced Abortion. In: *Reducing Racial/Ethnic Disparities in Reproductive and Perinatal Outcomes.* Springer; 2011. p. 39–63.
63. Wollum A. Abortion in the United States: Occurrence, trends, cross-state care-seeking and unmet need [PhD Thesis]. 2016.
64. Aiken A, Gomperts R, Trussell J. Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis. *BJOG Int J Obstet Gynaecol.* 2017 Jul;124(8):1208–15.
65. Wollum A, Larrea S, Gerds C, Jelinska K. Requests for medication abortion support in Brazil during and after the Zika epidemic. *Glob Public Health.* 2020;1–12.
66. Akin A, Kocoglu GO, Akin L. Study supports the introduction of early medical abortion in Turkey. *Reprod Health Matters.* 2005 Nov;13(26):101–9.
67. Wenham C, Arevalo A, Coast E, Corrêa S, Cuellar K, Leone T, et al. Zika, abortion and health emergencies: a review of contemporary debates. *Glob Health.* 2019 Jul 24;15(1):49.
68. Casterline JB, Sinding SW. Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. *Popul Dev Rev.* 2000;26(4):691–723.
69. McIntosh CA, Finkle JL. The Cairo Conference on Population and Development: A New Paradigm? *Popul Dev Rev.* 1995 Jun;21(2):223–60.
70. Hartmann B. Population control I: Birth of an ideology. *Int J Health Serv Plan Adm Eval.* 1997;27(3):523–40.
71. Cleland J, Harbison S, Shah IH. Unmet Need for Contraception: Issues and Challenges. *Stud Fam Plann.* 2014;45(2):105.
72. United Nations Department of Economic and Social Affairs. Tracking Global Progress in Family Planning [Internet]. United Nations; 2017 Dec. (Population Facts). Report No.: 2017/11. Available from:

www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2017-11.pdf

73. Westoff CF. The unmet need for birth control in five Asian countries. *Fam Plann Perspect*. 1978 Jun;10(3):173–81.
74. Bradley SEK, Croft TN, Fishel JD, Westoff CF. Revising Unmet Need for Family Planning [Internet]. Calverton, Maryland, USA: ICF International; 2012 Jan [cited 2020 Jun 13]. (DHS Analytical Studies No. 25). Report No.: DHS Analytical Studies No. 25. Available from: <https://dhsprogram.com/publications/publication-as25-analytical-studies.cfm>
75. Senderowicz L. Contraceptive Autonomy: Conceptions and Measurement of a Novel Family Planning Indicator. *Stud Fam Plann*. 2020 May 1;51(2):161–76.
76. Dixon-Mueller R, Germain A. Stalking the elusive “unmet need” for family planning. *Stud Fam Plann*. 1992 Oct;23(5):330–5.
77. Pritchett LH. Desired Fertility and the Impact of Population Policies. *Popul Dev Rev*. 1994;20(1):1–55.
78. Pritchett L. No Need for Unmet Need. Hopkins Population Center Seminar Series; 1996 Feb 12; Johns Hopkins School of Hygiene and Public Health.
79. Dixon-Mueller R, Germain A. Unmet need from a woman’s health perspective. *Plan Parent Chall*. 1994;(1):9–12.
80. Bankole A, Ekeh AC. Unmet need for couples: An analytical framework and evaluation with DHS data. *Popul Res Policy Rev*. 1999 Dec 1;18(6):579–605.
81. Institute of Medicine. The Need and Demand for New Contraceptive Methods. In: Harrison PF, Rosenfield A, editors. *Contraceptive Research and Development: Looking to the Future* [Internet]. Washington, DC: National Academies Press (US); 1996 [cited 2020 Jun 13]. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK232755/>
82. Foster DG. Unmet need for abortion and woman-centered contraceptive care. *Lancet Lond Engl*. 2016 Jul 16;388(10041):216–7.
83. Wulifan JK, Brenner S, Jahn A, De Allegri M. A scoping review on determinants of unmet need for family planning among women of reproductive age in low and middle income countries. *BMC Womens Health*. 2016 Jan 15;16:2.
84. Jain AK, Obare F, RamaRao S, Askew I. Reducing Unmet Need by Supporting Women With Met Need. *Int Perspect Sex Reprod Health*. 2013;39(3):133–41.
85. Khalil I, Richardson EZ. “When you least expect, this happens, it’s already growing”: Problematizing the definition of unmet need for family planning. *Open Access J Contracept*. 2019 May 29;10:7–18.

86. Aiken ARA, Borrero S, Callegari LS, Dehlendorf C. Rethinking the Pregnancy Planning Paradigm: Unintended Conceptions or Unrepresentative Concepts? *Perspect Sex Reprod Health*. 2016;48(3):147–51.
87. Dixon-Mueller R, Germain A. Fertility regulation and reproductive health in the millennium development goals: The search for a perfect indicator. *Am J Public Health*. 2007 Jan;97(1):45–51.
88. World Health Organization. Contraception: Overview [Internet]. [cited 2021 Mar 10]. Available from: <https://www.who.int/westernpacific/health-topics/contraception>
89. Gavin L, Moskosky S, Carter M, Curtis K, Glass E, Godfrey E, et al. Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. *MMWR Recomm Rep Morb Mortal Wkly Rep Recomm Rep*. 2014 Apr 25;63(RR-04):1–54.
90. Winikoff B. Is one of these things a not just like the other? Why abortion can't be separated from contraception. *Conscience*. 2014 Sep 22;35(3):27.
91. Coeytaux F. Abortion: the ultimate unmet need. In: Senanayake P, Kleinman RL, editors. *Family Planning: Meeting Challenges, Promoting Choices: The Proceedings of the IPPF Family Planning Congress, New Delhi, October 1992*. New York, NY: Parthenon Publishing Group Ltd; 1993. p. 701–8.
92. Norman WV. Induced abortion in Canada 1974–2005: trends over the first generation with legal access. *Contraception*. 2012 Feb 1;85(2):185–91.
93. Klijzing E. Are there unmet family planning needs in Europe? *Fam Plann Perspect*. 2000 Apr;32(2):74–81, 88.
94. Amo-Adjei J, Darteh EKM. Unmet/met need for contraception and self-reported abortion in Ghana. *Sex Reprod Healthc*. 2017 Oct 1;13:118–24.
95. Malter J, Franca E. New Study Finds Little Progress in Meeting Demand for Contraception in the Developing World [Internet]. Guttmacher Institute. 2012 [cited 2020 Jun 13]. Available from: <https://www.guttmacher.org/news-release/2012/new-study-finds-little-progress-meeting-demand-contraception-developing-world>
96. Weitz TA. Rethinking the Mantra that Abortion Should be “Safe, Legal, and Rare.” *J Womens Hist*. 2010 Sep 16;22(3):161–72.
97. Potter JE, Stevenson AJ, Coleman-Minahan K, Hopkins K, White K, Baum SE, et al. Challenging unintended pregnancy as an indicator of reproductive autonomy. *Contraception*. 2019 Jul 1;100(1):1–4.
98. Gómez AM, Arteaga S, Villaseñor E, Arcara J, Freihart B. The Misclassification of Ambivalence in Pregnancy Intentions: A Mixed-Methods Analysis. *Perspect Sex Reprod Health*. 2019;51(1):7–15.

99. Barrett G, Wellings K. What is a 'planned' pregnancy? empirical data from a British study. *Soc Sci Med*. 2002 Aug 1;55(4):545–57.
100. Guttmacher Institute. An Overview of Abortion Laws [Internet]. Guttmacher Institute. 2020 [cited 2020 Jun 14]. Available from: <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>
101. Baum SE, White K, Hopkins K, Potter JE, Grossman D. Women's Experience Obtaining Abortion Care in Texas after Implementation of Restrictive Abortion Laws: A Qualitative Study. *PloS One*. 2016;11(10):e0165048.
102. Karasek D, Roberts SCM, Weitz TA. Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before Arizona's Two-visit 24-hour Mandatory Waiting Period Law. *Womens Health Issues Off Publ Jacobs Inst Womens Health*. 2016 Feb;26(1):60–6.
103. Gerdtz C, Fuentes L, Grossman D, White K, Keefe-Oates B, Baum SE, et al. Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas. *Am J Public Health*. 2016 May;106(5):857–64.
104. Jones RK, Ingerick M, Jerman J. Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014. *Womens Health Issues Off Publ Jacobs Inst Womens Health*. 2018 Jun;28(3):212–8.
105. Roberts SCM, Turok DK, Belusa E, Combellick S, Upadhyay UD. Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women. *Perspect Sex Reprod Health*. 2016;48(4):179–87.
106. Kimport K. No Real Choice: How Culture and Politics Matter for Reproductive Autonomy. New Brunswick: Rutgers University Press; 2021.
107. Foster DG. Unmet need for abortion and woman-centered contraceptive care. *The Lancet*. 2016;10041(388):216–7.
108. Potter JE, Stevenson AJ, Coleman-Minahan K, Hopkins K, White K, Baum SE, et al. Challenging unintended pregnancy as an Indicator of reproductive autonomy. *Contraception* [Internet]. 2019 Mar 6 [cited 2019 Mar 6];0(0). Available from: [https://www.contraceptionjournal.org/article/S0010-7824\(19\)30039-3/abstract](https://www.contraceptionjournal.org/article/S0010-7824(19)30039-3/abstract)
109. Black AY, Guilbert E, Hassan F, Chatziheofilou I, Lowin J, Jeddi M, et al. The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives. *J Obstet Gynaecol Can*. 2015 Dec 1;37(12):1086–97.
110. Dickson KE, Jewkes RK, Brown H, Levin J, Rees H, Mavuya L. Abortion service provision in South Africa three years after liberalization of the law. *Stud Fam Plann*. 2003;34(4):277–84.

111. Patil TA. Manual Vacuum Aspiration (MVA) versus Electric Vacuum Aspiration (EVA) in first trimester medical termination of pregnancy (MTP). *J Res Med Dent Sci*. 2016 Sep;4(3):278–82.
112. Zuniga C, Thompson TA, Blanchard K. Abortion as a Catastrophic Health Expenditure in the United States. *Womens Health Issues*. 2020 Nov 1;30(6):416–25.
113. National Network of Abortion Funds. Common Questions About Abortion Funds [Internet]. Available from: <https://abortionfunds.org/common-questions/>
114. Kimport K, Weitz TA, Freedman L. The Stratified Legitimacy of Abortions. *J Health Soc Behav*. 2016 Dec;57(4):503–16.
115. Borgmann C. Abortion Exceptionalism and Undue Burden Preemption. *Wash Lee Law Rev*. 2014 Mar 1;71(2):1047.
116. Joffe C, Schroeder R. COVID-19, health care, and abortion exceptionalism in the United States. *Perspect Sex Reprod Health*. 2021 Mar;53(1–2):5–12.
117. Brunson J, Suh S. Behind the measures of maternal and reproductive health: Ethnographic accounts of inventory and intervention. *Soc Sci Med*. 2020 Jun 1;254:112730.
118. Ehrlich JS. Abortion regret: the new attack on reproductive freedom. Santa Barbara, California: Praeger, an imprint of ABC-CLIO, LLC; 2019. (Gale virtual reference library).
119. Ralph LJ, Foster DG, Kimport K, Turok D, Roberts SCM. Measuring decisional certainty among women seeking abortion. *Contraception*. 2017 Mar;95(3):269–78.
120. Rowland BB, Rocca CH, Ralph LJ. Certainty and intention in pregnancy decision-making: An exploratory study. *Contraception*. 2021 Feb 1;103(2):80–5.
121. Beynon-Jones SM. Untroubling abortion: A discourse analysis of women’s accounts. *Fem Psychol*. 2017 May 1;27(2):225–42.
122. National Center for Educational Statistics. Race/ethnicity of college faculty [Internet]. National Center for Education Statistics; 2018 [cited 2022 May 1]. Available from: <https://nces.ed.gov/fastfacts/display.asp?id=61>
123. Association of American Medical Colleges. Diversity in Medicine: Facts and Figures 2019 [Internet]. 2019 [cited 2022 May 1]. Available from: <https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019>
124. Biggs MA, Brown K, Foster DG. Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. *PLOS ONE*. 2020 Jan 29;15(1):e0226417.
125. Hanschmidt F, Linde K, Hilbert A, Riedel- Heller SG, Kersting A. Abortion Stigma: A Systematic Review. *Perspect Sex Reprod Health*. 2016 Dec;48(4):169–77.

126. Sobel L, Ramaswamy A, Salganicoff A. Abortion at SCOTUS: Dobbs v. Jackson Women's Health [Internet]. Kaiser Family Foundation Issue Brief. 2021 [cited 2022 Mar 13]. Available from: <https://www.kff.org/womens-health-policy/issue-brief/abortion-at-scotus-dobbs-v-jackson-womens-health/>
127. Cohen DS, Joffe C. Obstacle Course : The Everyday Struggle to Get an Abortion in America. Oakland, California: University of California Press; 2020.
128. Astor M. Here's What the Texas Abortion Law Says. The New York Times [Internet]. 2021 Sep 9 [cited 2022 Mar 15]; Available from: <https://www.nytimes.com/article/abortion-law-texas.html>
129. Murugan VA, Murphy BO, Dupuis C, Goldstein A, Kim YH. Role of ultrasound in the evaluation of first-trimester pregnancies in the acute setting. *Ultrasonography*. 2020 Apr;39(2):178–89.
130. White K, Vizcarra E, Palomares L, Dane'el A, Beasley A, Ogburn T, et al. Initial Impacts of Texas' Senate Bill 8 on Abortions in Texas and at Out-of-State Facilities. 2021;6.
131. Miller CC, Bui Q, Sanger-Katz M. Abortions Fell by Half in Month After New Texas Law. The New York Times [Internet]. 2021 Oct 29 [cited 2022 Mar 15]; Available from: <https://www.nytimes.com/interactive/2021/10/29/upshot/texas-abortion-data.html>
132. Aiken ARA, Starling JE, Scott JG, Gomperts R. Association of Texas Senate Bill 8 With Requests for Self-managed Medication Abortion. *JAMA Netw Open*. 2022 Feb 25;5(2):e221122.
133. White K, Dane'el A, Vizcarra E, Dixon L, Lerma K, Beasley A, et al. Out-of-State Travel for Abortion Following Implementation of Texas Senate Bill 8. Texas Policy Evaluation Project: The University of Texas at Austin; 2022 Mar p. 8. (Research Brief).
134. Sanger-Katz M, Miller CC, Bui Q. Most Women Denied Abortions by Texas Law Got Them Another Way. The New York Times [Internet]. 2022 Mar 6 [cited 2022 Mar 14]; Available from: <https://www.nytimes.com/2022/03/06/upshot/texas-abortion-women-data.html>
135. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013 Mar 11;12(1):18.
136. McGowan ML, Norris AH, Bessett D. Care Churn - Why Keeping Clinic Doors Open Isn't Enough to Ensure Access to Abortion. *N Engl J Med*. 2020 Aug 6;383(6):508–10.
137. Kimport K. Reducing the burdens of forced abortion travel: Referrals, financial and emotional support, and opportunities for positive experiences in traveling for third-trimester abortion care. *Soc Sci Med*. 2021 Dec 18;114667.

138. Nash E, Cross L, Dreweke J. 2022 State Legislative Sessions: Abortion Bans and Restrictions on Medication Abortion Dominate [Internet]. Guttmacher Institute; 2022 Mar [cited 2022 Apr 1]. Available from: <https://www.guttmacher.org/article/2022/03/2022-state-legislative-sessions-abortion-bans-and-restrictions-medication-abortion>
139. NORC at the University of Chicago [Internet]. [cited 2021 Mar 20]. Available from: <https://www.norc.org/>
140. NORC. Technical overview of the AmeriSpeak panel, NORC's probability-based household panel [Internet]. Chicago, IL: NORC at the University of Chicago; 2021 Jan. Available from: <https://amerispeak.norc.org/Documents/Research/AmeriSpeak%20Technical%20Overview%202019%2002%2018.pdf>
141. Shartz A, Johnston E. The Survey of Family Planning and Women's Lives: Methodology. Wash DC Urban Inst. 2016;
142. NORC. AmeriSpeak ESOMAR 28: 28 Questions to Help Research Buyers of Online Sample [Internet]. Chicago, IL: NORC at the University of Chicago; Available from: https://amerispeak.norc.org/Documents/FeatureDocuments/NORC_AmeriSpeak_ESOMAR_28.pdf
143. Jones RK, Kost K. Underreporting of Induced and Spontaneous Abortion in the United States: An Analysis of the 2002 National Survey of Family Growth. *Stud Fam Plann*. 2007;38(3):187–97.
144. Jagannathan R. Relying on Surveys to Understand Abortion Behavior: Some Cautionary Evidence. *Am J Public Health*. 2001 Nov 1;91(11):1825–31.
145. Lindberg L, Kost K, Maddow-Zimet I, Desai S, Zolna M. Abortion Reporting in the United States: An Assessment of Three National Fertility Surveys. *Demography*. 2020 Jun 1;57(3):899–925.
146. Gallo MF, Casterline JB, Chakraborty P, Norris A, Bessett D, Turner AN. Passage of abortion ban and women's accurate understanding of abortion legality. *Am J Obstet Gynecol*. 2021 Feb;S000293782100096X.
147. Stata Press. Stata Survey Data Reference Manual: Release 17. 2021.
148. Rao JNK, Scott AJ. The Analysis of Categorical Data from Complex Sample Surveys: Chi-Squared Tests for Goodness of Fit and Independence in Two-Way Tables. *J Am Stat Assoc*. 1981 Jun 1;76(374):221–30.
149. Rao JNK, Scott AJ. On Chi-Squared Tests for Multiway Contingency Tables with Cell Proportions Estimated from Survey Data. *Ann Stat*. 1984 Mar;12(1):46–60.
150. Jerman J, Jones RK, Onda T. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008 [Internet]. Guttmacher Institute; 2016 May [cited 2019 Apr 24].

Available from: <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>

151. O'Donnell J, Goldberg A, Lieberman E, Betancourt T. "I wouldn't even know where to start": unwanted pregnancy and abortion decision-making in Central Appalachia. *Reprod Health Matters*. 2018;26(54):98–113.
152. Kimport K, Littlejohn K. Abortion as Obtainable: Insights into how Pregnant People in the United States Who Considered Abortion Understand Abortion Availability. *Contraception* [Internet]. 2021 Sep 26 [cited 2021 Oct 13]; Available from: <https://www.sciencedirect.com/science/article/pii/S0010782421004054>
153. Braveman P, Arkin E, Orleans T, Proctor D, Plough A. What Is Health Equity? And What Difference Does a Definition Make? [Internet]. Princeton, NJ: Robert Wood Johnson Foundation; 2017 [cited 2021 Feb 21]. Available from: <https://nccdh.ca/resources/entry/what-is-health-equity-and-what-difference-does-a-definition-make>
154. The Pew Charitable Trusts Economic Mobility Project. Pursuing the American Dream: Economic Mobility Across Generations. The Pew Charitable Trusts; 2012 Jul.
155. Laurison D, Dow D, Chernoff C. Class Mobility and Reproduction for Black and White Adults in the United States: A Visualization. *Socius*. 2020 Jan 1;6:2378023120960959.
156. Rocca CH, Wilson MR, Jeon M, Foster DG. Stability of Retrospective Pregnancy Intention Reporting Among Women with Unwanted Pregnancies in the United States. *Matern Child Health J*. 2019 Nov;23(11):1547–55.
157. Fuller T. California Positions Itself as a 'Refuge' of Abortion Rights. *The New York Times* [Internet]. 2021 Dec 8 [cited 2022 May 1]; Available from: <https://www.nytimes.com/2021/12/08/us/california-abortion-sanctuary-state.html>
158. Kasakove S. What's Happening With Abortion Legislation in States Across the Country. *The New York Times* [Internet]. 2022 Apr 14 [cited 2022 May 1]; Available from: <https://www.nytimes.com/article/abortion-laws-us.html>