Winter 2018

The Hyde Amendment: An Obstacle to Seeking Abortion Care in Maine?

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THE HYDE AMENDMENT: AN OBSTACLE TO SEEKING ABORTION CARE IN MAINE?

by

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A Thesis Submitted in Partial Fulfillment
of the Requirements for a Degree with Honors
(Sociology; Women's, Gender, & Sexuality Studies)

The Honors College

University of Maine

December 2018

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ABSTRACT

This thesis is an examination of the effects of the Hyde Amendment on lower-income people in the State of Maine seeking abortion care. The Hyde Amendment, passed in 1976, prohibits any federally funded insurance from covering abortion services unless the pregnancy results from sexual assault or incest, or if the pregnancy places the pregnant person's life in danger. This thesis aims to examine how not having an abortion covered by insurance exaggerates other financial obstacles to receiving abortion care. Through a literature review and survey data collected from a local sexual and reproductive health care center this paper explores how travel costs, food insecurity, childcare, and keeping an abortion secret affect lower-income people in the State of Maine who rely on Medicaid, a federally funded insurance. The survey data was collected from the Mabel Wadsworth Center in Bangor, Maine. Staff distributes an anonymous survey to each abortion client and the data have been compiled throughout the years. These data were last updated in 2015 and 158 patients responded to the survey. The data show keeping an abortion a secret, travelling more than 20 miles, and finding childcare were obstacles that made it more difficult to access an abortion. The data also demonstrate that the burden of financing the procedure affects some patients' ability to pay other monthly bills. This study provides a lens through which we can examine the ways that abortion is disproportionately difficult to access.

ACKNOWLEDGMENTS

For my mentor, and fellow Libra, Edie Pratt. Her unshakeable faith has taught me faith in myself. This is what women have always done.

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INTRODUCTION

Abortion has long been a hotly debated issue in American society. The procedure went from being completely legal in the year 1821 to being completely illegal in 1880. (Michigan Law Review, 1984). In fact, abortion was quite common in the mid-1800s up until the point of the quickening--when the pregnant person first feels movement. In the late 1850s, Dr. Horatio Robinson Storer began a campaign through the American Medical Association, founded about a decade prior, to lobby the legislature to pass laws that would completely outlaw abortions. There was no national consensus on abortion at the time. Some physicians regarded it as a violation of the Hippocratic Oath, while others saw it as a common medical procedure (Nossiff, 2001).

The movement to restrict access to abortion has its roots in capitalism and sexism. Doctors during the late 1800s began to worry that if midwives were able to provide care to patients it would detract from their business. When medical schools became more prominent male doctors believed that only they would be able to provide such complicated care to their patients. These newly trained men called their practice "midwifery," lifting the title from existing midwives. These men then began to preach that only they could provide any kind of pregnancy care, and that if a woman sought to provide such care she would be violating the rules of womanhood. This allowed these doctors to keep women from entering their practices and then through fear and positivism, men were able to corner the market (Wertz & Wertz, 1989). They feared that if midwives were legally allowed to perform abortions they would lose half their clientele. (Nossiff, 2001). Additionally, some doctors even argued that abortion was only

popular due to "women's too great love for 'fashion' and 'society'" (Wertz & Wertz p. 113). This suggests only that doctors considered there was a social belief that reproductive health should be only accessible to those who could afford to visit a physician as their patients. Drawing the association between a love of "fashion" which would only be something accessible to those able to afford it to a necessary medical procedure implies that abortion is just an accessory rather than a right of all people.

As time went on, the movement to legalize abortion picked up more and more momentum. It wasn't until the mid-1900s that the legalization of abortion began to gain support. One significant factor that contributed to this societal change of heart was a growing concern over children being born with rare birth defects or diseases. These defects and diseases included an outbreak of German Measles as well as an increasing number of "Thalidomide babies" being born (Michigan Law Review, 1984). During the 1950's and 1960's Thalidomide was a common drug used to treat leprosy and multiple myeloma. However, it was often prescribed to pregnant women to treat nausea. This resulted in thousands of babies being born with severe birth defects, including ocular issues and loss of limbs (Kim & Scialli, 2011). Additionally, the creation of the National Organization for Women (N.O.W) provided an organizational structure to the mid-century movement in support of the legalization of abortion (Michigan Law Review, 1984).

Thalidomide was invented in Germany and although it was illegal in the United States, it was widely used throughout England, Belgium and West Germany (Glendon, 1987). In 1962 a woman named Sherri Finkbine learned of the effects that the drug could have on a fetus after she had acquired the drug in another country. She was from Phoenix,

Arizona and tried in both New York and Arizona to obtain an abortion. She asked the Arizona superior court to authorize the Good Samaritan Hospital to perform an abortion and her request was denied (Kenney, 1963). Mrs. Finkbine eventually obtained her abortion in Sweden, but her case acted as a catalyst to the movement to legalize abortion.

A notable part of the history of the abortion debate is the makeup of the population on each side of the issue. It has been shown that those who were most opposed to abortion and most vocal about that opposition were quite removed from the culture of reproductive health. The crusade that was originally lead by male physicians throughout the country who had learned about the processes of birth and abortion in medical schools and who were removed from the community of women. They immediately alienated the midwives who had been experience in both births and abortions and who had been immersed in that culture. They were familiar with the real-life experiences of pregnant people rather than an academic understanding of how fetuses develop.

Furthermore, it is striking that the movement to legalize abortion was led largely by financially stable white women concerned about birth defects. The dominance of their rhetoric in the national discourse is troubling, for normalizing this one narrative fails to encompass the vastly different circumstances that surround the decision to carry to term or terminate. During this time period the movement to normalize and legalize abortion had the opportunity to radically overturn the way that abortion had previously been perceived in the United States, but instead the focus remained on those who were financially privileged. The focus remained on those like Sherri Finkbine who had the financial ability to travel to Sweden to obtain her abortion rather than the countless poor,

women of color, who were dying from illegal abortions and could not afford to raise children due to the systems of oppression that are so entrenched in American society, such as institutional misogyny and classism.

This paper aims to examine the ways that low-income people experience difficulty receiving abortion services. Each person experiences the world in a different manner depending on their different social identities. Multiple systems of oppression such as classism, racism, and misogyny can be felt in very different ways for each individual who might pertain to a marginalized group. This paper's focus will be on the ways that people experience both misogyny and classism by focusing on low-income people seeking abortion care. However, it is important to note that due to the combined impact of classism and racism, women of color are generally the most vulnerable in our society. This paper will touch on the topic of race when discussing the national framework however 94.7% of the population of Maine identifies as white (U.S Census Bureau, 2017) and therefore it will not be a focus of this paper. Additionally, this paper will aim to acknowledge that not only women need abortion care. Non-binary people and transgender men can also require access to abortion, however, much of the restrictions around abortion originate from sexist traditions aimed at restricting women's healthcare.

There is a great deal of legislation that disproportionately impacts lower income women (Lara, Holt, Pena, & Grossman, 2015). We have seen historically that those who have always had access to abortion were those like Sherri Finkbine, who could afford to travel long distances to have a safe procedure, while those who could not do so have been forced to either carry to term, face extreme financial distress, or result to unsafe self-induced methods.

In 1973 the landmark Supreme Court Case *Roe v. Wade* recognized a woman's legal right to terminate a pregnancy, though not without exceptions. The Court found that the decision to have an abortion is subject only to the medical judgment of the pregnant woman's attending physician during the first trimester. During the second trimester, the State may choose to regulate abortion procedures solely in the interest of promoting the mother's health. For "the stage subsequent to viability" the State may choose to regulate abortion in the interest of promoting the potentiality of human life. The point of viability is defined as the point when the fetus can survive outside of the womb, even if artificial aid is necessary (Roe v. Wade, 1973). Viability is difficult to determine, but it usually occurs around seven months or between the periods of 24 and 28 weeks.

Additionally, the case states that an abortion can only be performed by a physician. "Physician" in this case refers to a medical physician currently licensed by the State. The State has the right to prohibit abortions performed by any person who is not a licensed physician (Roe v. Wade, 1973). This stipulation is interesting because, as previously discussed, many physicians were worried that with the legalization of abortion they would lose a great deal of business to midwives. This is of particular concern for lower income women. Ability to access care from a licensed physician is not only expensive, but also often inconvenient. Many would have to travel, find childcare, or lose pay from missing work in order to visit such a professional. Thus, it may be more convenient for these women to see a midwife or take the medication abortion pill in the comfort of their own home. This provision therefore has an impact on who is able to access abortion care and is arguably the first restriction placed on abortion access.

In the thirty-five years since *Roe v. Wade,* copious amounts of abortion restrictions have been enacted, altering a person's ability to access the care to which they have a constitutional right. The first major restrictive legislation came in 1976 with the Hyde Amendment. The Hyde Amendment prohibits any federal funds from covering abortion care unless the pregnancy occurs as a result of rape or incest; or if a doctor certifies that a physical injury, illness, or disorder would endanger the mother's life.

This legislation primarily affects those who rely on federally funded insurance programs such as Medicaid, CHIP, or Indian Health Services. States have the option to either follow the federal regulations or provide coverage with state Medicaid funds. There are currently 17 states that have chosen to provide coverage, 32 states and the District of Columbia that have chosen to follow the federal regulations, and South Dakota only provides coverage when the pregnancy places the woman's life in danger (Dennis & Blanchard, 2013). Maine is one of the states that follow the federal standard.

The groundwork for the Hyde Amendment was laid in 1973 with the enactment of the Helms Amendment. This legislation restricts any funds from foreign aid from financing abortion care. Beyond that, federal funds can also not be used to "motivate or coerce any person to practice abortions" (Barot, 2013). This regulation came under the administration of President Richard Nixon and the U.S Agency for International Development (USAID), whose funding was the subject for discussion, clearly disagreed with the goals of the Helms Amendment. In fact, USAID responded by saying that this policy was in direct opposition to the philosophy of decolonization that they were attempting to practice at the time. USAID claimed this legislation had "seemingly imperialistic and hypocritical overtones" (Rosoff, 1973). The spokespeople representing

the USAID correctly identify this hypocrisy of refusing aid to abortion care when abortion care was legal in the United States. Both the Helms Amendment and the Hyde Amendment demonstrate to us the vehement opposition to abortion throughout the United States, especially when it comes to those who belong to more marginalized communities.

LITERATURE REVIEW

The Effects of the Hyde Amendment

The Hyde Amendment has been deeply affecting people since its conception. Abortion is a widely necessary procedure that many people rely on. Generally speaking, around 40-42% of all unintended pregnancies end in abortion (Jones & Jerman 2014). Additionally, 64% of all pregnancies among women below 100% of the federal poverty line are unintended (Dehlendorf, Harris, & Weitz, 2013). Therefore we can see that many women who rely on Medicaid would be forced to pay out of pocket for the procedure, which could be nearly impossible for a lot of women. Abortion restrictions continue to impact the ways that people are able to obtain the care they need, and often impose serious complications impeding the access. For low-income people the extra lengths they must go to could have a significant financial impact on their lives. When you only earn up to 138% of the federal poverty line, things like travelling, paying for food, losing pay from missing work, or paying for childcare can render receiving an abortion nearly impossible. According to the Guttmacher Institute, the average cost of an abortion at 10 weeks is about $370, $650 for a 14-week procedure, and $1042 for a procedure at 20 weeks gestation (Guttmacher Institute, 2007). The federal poverty line for a family of three is an income of $20,780 per year or approximately $1732 per month. Therefore for a family of three, a ten-week procedure would cost approximately 20% of the family's monthly income (Department of Health and Human Services, 2018).

In 2005 there were 7.5 million women of reproductive age (ages 15-44) that relied on Medicaid for health care services (Guttmacher Institute, 2007). Under the Hyde

Amendment regulations, these women would not be able to receive abortion care services unless the pregnancy resulted from rape or incest, or the pregnant person's life was in danger. Abortion care is an expensive procedure and without coverage from Medicaid it can be completely inaccessible to lower-income women. There are a number of factors affecting a woman's ability to access abortion care, and this paper aims to interrogate how the Hyde Amendment exaggerates the financial barriers blocking pregnant people from accessing the care that they need.

A study conducted in North Carolina examined the usage of public funding for abortion care. When the Hyde Amendment went into effect, North Carolina opted to create a separate abortion fund for low-income people needing abortion care. There were five times between 1978 and 1993 when this fund was completely depleted and therefore there was no remaining public assistance available to those who needed it. Cook, Parnell, Moore, & Pagini examined birth rates and abortion rates during times where there was an availability of public funding and when there was no funding. It is important to note that they found that there was no difference in pregnancy rates between the times when funding was available and funding was not available. However, using data collected for a period of 168 months between January 1980 and December 1993, the researchers found that for the months where funding was available, there were more abortions and fewer births. In 1989 there were 2,677 abortions per month, which is 127 more than there would have been had there been no funding for abortion available. The researchers found that in that year there were 345 state-funded abortions per month. Comparing these rates, the study found that 1 in 3 women who would have chosen to have an abortion instead carried the pregnancy to term. This is a startling statistic. If the regulations set forth by

the Hyde Amendment did not exist, and federal funding provided by these insurance programs were available these women would have been able to obtain the abortion that they needed. In fact, these researchers estimate that for every $527 reduction in funding during these years there was one additional birth (Cook, Parnell, Moore, & Pagnini, 1999).

One study, conducted in Oregon, investigated the financial obstacles that might affect a woman's experience seeking abortion care found that low-income women were more likely to report difficulty overcoming the obstacles they faced. Although Oregon has opted to use state Medicaid funding to pay for abortions in circumstances outside of those that are covered federally, low income women still reported financial difficulty due to complications in actually receiving Medicaid coverage. In an interview one participant described her experience by saying:

> "My sister had to take a day off work. We had to find somebody to drive us up there. It was just a mess. I was worried about gas money. I was even worried about how I was going to afford to eat while I was up there! I knew I'd get the Oregon Health Plan, but I had to wait for that too, because of paperwork" (Ostrach & Cheyney, 2014).

This quote illustrates the impact of childcare and transportation costs to the ability to receive care. It also demonstrates how women describing the obstacles they faced name the price of the procedure and the price of other factors in the same breath, showing that the combined impact of these financial burdens is significant to their lives. Another participant reported that her sister had to drive her to the appointment and was terminated from her place of employment for missing work on the day of her appointment. Losing

employment can be completely destructive to a person's life. It can be financially devastating to a person, especially if they are supporting a family.

Additionally, this study found that delays in Medicaid funding would often cause women to have abortions at a later gestational date (Ostrach & Cheyney, 2014). In fact, 67% of poor women having abortions in 2004 reported that they would have preferred having the procedure done earlier (Guttmacher, 2007). Often they had to wait longer due to an inability to get to the clinic or due to funding issues. This is relevant because as previously discussed, the price of abortions varies drastically at different stages of gestation. For example, in 2001 the average price of an abortion at 14 weeks gestation was $650 while the average price for 20 weeks gestation was $1,042 (Guttmacher, 2007). In six weeks time the price can augment by almost $400. This can be a significant difference for someone who has an income below 200% of the federal poverty line.

Paying for the medical procedure may limit a person's ability to pay for the other financial factors that often arise when seeking abortion care. These factors might include: being forced to skip a bill payment, travel, food, childcare, and getting time off work (among others). If there is no abortion clinic near where a pregnant person lives, they are forced to arrange for travel. If they are forced to travel far, missing pay from missing work may be a serious issue. Additionally, if the woman already has children, she may be unable to afford childcare for the day, or multiple days depending on the gestational age, and may not be able to find other arrangements. These factors coupled with the price of the procedure itself might adversely affect a woman's ability to afford her basic needs.

Poverty affects women at a higher rate than men, with poverty rates being twice as high amongst single-mother headed households as any other group (Brown & LaLumia 2014). This not only suggests that it would be harder for these women to pay for an abortion, it also suggests that seeking abortion care would require them to find childcare for the day. 58% of women over 16 participate in the workforce and 73% of them working full time which indicates that missing pay from missing work and paying for childcare could become enormous obstacles impeding access to care.

Moreover, in 2012 25% of Latina women and 22% of African-American had not visited a health care provider in the last year due to the cost. 36% of Latina women and 22% of African-American women reported that they had no insurance coverage. (Lara, Holt, Pena, & Grossman, 2015). With the financial burden of accessing health care already being so high amongst these populations it is likely that these women would be least able to access abortion and that other financial factors are most likely to affect these women. Between the years of 2001 and 2008, the rates of unintended pregnancies for women earning less than 100% of the federal poverty line increased from 120 to 137 per 1000 reproductive aged women while during the same time unintended pregnancy rates for those earning more than 200% of the federal poverty line decreased from 28 to 26 per 1000 reproductive aged women. In 2008 the rate of unexpected pregnancies for black women was 92 per 1000 reproductive aged women, 79 per 1000 reproductive aged Hispanic women compared to only 38 per 1000 white women. (Lara, Holt, Pena, & Grossman, 2015). Therefore, not only are these populations of women the least likely to be able to access abortion care, they are also the ones who are most likely to need abortion care.

Examining the role of publicly funded contraceptives in the lives of low-income women is important when discussing their ability to access abortion. Their ability to access effective forms of contraceptives may impact their need for abortion care or may indicate further financial struggles when an abortion is needed. According to the Guttmacher Institute, 77,520 women in Maine in the year 2010 relied on publicly funded contraceptives (Frost, Zolna, & Frohwirth, 2010). For these purposes, being in need of publicly funded contraceptives is defined as: "have a family income below 250% of the federal poverty level (FPL; estimated at $45,775 for a family of three in 2010). In addition, all women younger than 20 who need contraceptive services, regardless of their family income, are assumed to need publicly funded care because of their heightened need—for reasons of confidentiality—to obtain care without depending on their family's resources or private insurance." (Forrest & Samara, 1996). When discussing access to publicly funded abortion care it is important to consider that birth control must be publicly funded. One study reported that 18% of women using condoms experienced an unintended pregnancy, along with 24% who used the fertility awareness method, 28% who used spermicide only, and 14% of all women who used non-prescription birth control methods while .8% of those using IUDs experienced an unintended pregnancy, .05% of those using an implant, .6% of those using the Depo Shot, and 9% using the pill, patch, or ring (Forrest & Samara, 1996). Medicaid is mandated to cover birth control and due to this mandated coverage, the nation experienced a 3% drop in abortion rates which is the same declination rate that results from abortion restrictions. (Forrest & Samara, 1996). Therefore, we can observe that coverage of contraceptive services and supplies impacts the rate at which lower-income women would need to access an abortion.

Abortion Access & Travel Costs

This section aims to examine the ways that traveling may be an obstacle to receiving abortion care in a national framework. Previous studies have shown that between 2001 and 2002 it was estimated that one-quarter of women who obtained their abortions at a non-hospital health center traveled 50 miles or more in order to receive these services. In 2008 women traveled an average of 30 miles to receive an abortion, and 67% of patients traveled less than 25 miles while only 6% traveled over 100 miles (Jones & Jerman, 2013). This particular study conducted by Jones & Jerman also found that patients living in rural areas were more likely to travel greater distances.

There are areas of the United States where people have to travel extreme distances to obtain an abortion and these cases are often a result of restrictive laws surrounding abortion care. The passage of Texas' House Bill Two caused the number of women living 50 miles away to double, those living 100 miles away increased by 150%, those living 150 miles away increased by 350%, and most disturbingly the number of women living more than 200 miles away from the closest abortion provider increased by 2,800% (Whole Woman's Health et al. v. Hellerstedt, Commissioner, Texas Department of State Health Services, et al. , 2016).

The distance traveled can impact how soon a person is able to obtain an abortion. Previous studies have shown that the implementation of waiting periods and mandatory in-person consultation visits cause a delay in accessing abortion care (Jones & Jerman, 2016). This increase in delay could affect the type of procedure a person is able to obtain, or if the person is able to obtain the procedure at all. The most common delay to obtaining the procedure is the necessity to raise money to pay for the procedure

(Upadhyay, Weitz, Jones, & Foster, 2014) and of those who receive financial assistance for abortion traveled an average of 140 miles to access care (Ely, Hales, Jackson, Maguin, & Hamilton, 2017). One study found that from a sample of 231 abortion patients who had been turned away due to gestational age limits 58.3% of them cited travel and procedure costs as the reason for delay (Upadhyay, Weitz, Jones, & Foster, 2014). Additionally, those who are denied abortion access and forced to carry a pregnancy to term experience an increase in postpartum depression (Medoff, 2014). Another study found that mandatory in-personal consultation visits can have a severe impact on women's ability to access abortion care because they have to travel on two separate days. In this case, 12% of women returned for their abortion appointment after their consultation appointment after between 14 and 53 days. This added time of two to seven weeks could seriously change the abortion experience or availability for a patient. Different states have varying gestational age limits and the cost of an abortion augments significantly as the gestation progresses.

Abortion Access & Childcare

Another potential significant financial barrier to accessing abortion care is childcare. In 2014 59% of women obtaining abortions already had at least one other child (Jerman, Jones, & Onda, 2016). This would mean that in order to obtain an abortion the patient has to make a decision around where their children will be for the day. In my personal experiences working in reproductive health clinics I have certainly seen women obtaining abortions whose partner brought their child with them, or whose children played with a family member in the waiting room. However, this is obviously not always an option and it may not be the best option for the patient. If they must travel long

distances bringing a child on that trip is less than ideal. Additionally, there may not be space at the health center to accommodate a child, or the patient may not feel comfortable having their child present as they experience an emotional procedure.

Parents may need to find childcare for the day to have the procedure. For those who are low-income, this may be a challenge particularly if the patient is low-income, already has to pay for travel to the health center and has to finance the procedure as well. One study which conducted qualitative interviews with patients seeking abortion care in Michigan and New Mexico quoted one woman as saying

> "I have other kids, and then I had to arrange to, you know, to leave them with someone. Well, my daughter is taking care of them right now, but she had to miss school, 'cause my boyfriend is at work. And then my friend had to come and miss a day from work, and then we'll have to drive back, like, another four hours, and then we have to stay at a hotel." (Dennis & Blanchard, 2014).

This interview highlights how difficult it can be to arrange for care. It is not always as simple as dropping a child off at daycare and knowing they are safe for the day. Childcare can be extremely expensive and full-time professional care can cost $15,500 a year for a child or more than $21,000 a year for an infant (Weinraub, 2015). Parents with children under the age of six spend 8.8% of their income on childcare on average, however, parents living below the federal poverty line spend 20% of their income on childcare (Mattingly, Wimer, & Collyer, 2017). One study showed that for every additional $100 of supplemental funding that provided children with early education programs increased the enrollment of children in these programs by 1% (Magnuson, Meyers, Ruhm, & Waldfogel, 2005). This suggests that parents are not enrolling their

children in childcare programs because of the cost. While early childcare education programs are certainly different from center-based childcare and the two programs may differ in cost, this demonstrates that parents are not enrolling their children in programs because they cannot afford it.

Another indication that childcare may be a severe obstacle to obtaining an abortion is that the affordability of childcare can impact a parent's ability to work. Low-income parents often choose their job based around their ability to take care of their child. Many parents lose employment if they need to take time off to care for their child. In rural areas specifically it can be extremely difficult to access professional childcare, and therefore many parents rely on friend and family care (Berry, Katras, Sano, Lee, & Bauer, 2008). However, this access to care is then dependent on willing family members or friends who have the capability to watch a child. This capability may depend on financial, emotional, or even time related factors.

Abortion Access & Food Insecurity

Another serious concern that might serve as an obstacle to obtaining abortion care is food insecurity. If a person is low-income and has to pay out-of-pocket for abortion care, it might seriously impact their ability to afford food after the procedure. While ability to access food itself may not be a direct obstacle to obtaining abortion care, the compounding impact of paying for the procedure and paying for other obstacles may force a person to choose between food and the abortion. One qualitative study conducted throughout three different states found that the added financial burden of paying for the procedure often forces people to cut back on necessities, most commonly food (Dennis, Manski, & Blanchard, 2014).. Access to food is certainly something that may weigh on

the mind of a person as they evaluate whether or not they will be able to afford their procedure. Additionally, if a person already has a child, this may impact their ability to feed the child after the procedure. On the other hand, if they are unable to obtain an abortion they may not be able to provide healthy food to their child.

A SPECIFIC LOOK AT MAINE

There are many reasons why it is so important to examine abortion access in the State of Maine. First, Maine is one of the states that has elected to follow the federal regulations set forth by the Hyde Amendment. Furthermore, Maine is an incredibly unique state. Most of the population is spread out through a vast land mass. Often times the physical size of the state is underestimated, but Maine's landmass is large enough to fit all other New England States within it (Wolf, 2003). Much of the population is spread out throughout our sixteen counties and the ruralness of the State often means that health centers are quite far away from where people actually live. There is a strange cultural divide between Northern and Southern Maine. Speaking purely from personal experience, I once had a friend tell me I was not from "real Maine," I was from "tourist Maine." He was not entirely wrong. I grew up in Nobleboro, Maine, only an hour and a half from Portland. He grew up in Perry, Maine, two hours away from Bangor, and four hours from Portland.

This divide between "tourist Maine" and "real Maine" is arguably a reflection of the rates of poverty experienced by each area. In 2008 the counties with the highest poverty rates were Washington County with 20.1%, Somerset County with 18.7%, and Franklin county with 17.5% of the population living in poverty compared to York County with 9.4% and Sagadahoc County with 9.8% of the population living in poverty (Acheson, 2010). When we examine the percentage of income that comes not from earnings or investments but rather from transfer payments, which refers to financial assistance received through programs like Medicaid, Medicare, Social Security etc., we

see that this revenue is important in three specific counties: Aroostook, Piscataquis, and Washington. Respectively, these counties had averages of 31.9%, 30.9%, and 35.7% of an individual's personal income coming from transfer payments. This becomes incredibly important when we examine abortion access in the State of Maine (Acheson, 2010). The only abortion clinics are located in Cumberland County, Kennebec County, and Penobscot County.

The reliance on federally funded insurances is strong in Maine. 23.6% of reproductive aged women in Maine were enrolled in Medicaid between 2005 and 2006 and 12.1% of reproductive aged women in Maine were uninsured during the same time period (Guttmacher Institute, 2007). This means that between 2005 and 2006 35.7% of reproductive aged women in the State of Maine relied on insurance coverage that would not reimburse an abortion unless it was a Hyde-qualifying abortion. Additionally, 80% of transfer payments in Maine came from medical programs such as Medicare or Medicaid (Acheson, 2010). Previous studies have demonstrated that states which elect to use their own Medicaid funding to cover abortion care outside of the three exceptions made by the Hyde Amendment require fewer funds from abortion funding programs compared to the states that follow the federal regulation (Ely, Hales, Jackson, Maguin, & Hamilton, 2017). Maine follows the federal regulation set forth by the Hyde Amendment and therefore we can assume that there is a population of Maine women in need of supplemental aid from abortion funding programs, especially seeing as over an eleven-year period from 2000-2010 31.8% of new mothers lived in households earning less than $20,000 a year (Harris, Aboueissa, Baugh, Sarton, & Lichter, 2014).

The state of Maine has elected not to use state Medicaid funding to cover abortion in cases other than pregnancies resulting from rape or incest, or pregnancies that place the mother's life in danger. Additionally, Maine has a small number of reproductive health clinics where abortions are accessible. In 2014 81% of Maine counties had no clinics where abortions were available and 55% of Maine women lived in these counties. Between the years of 2011 and 2014 the number of clinics providing abortion care dropped by 20% (Jones & Jerman, 2017). In 2014, the median distance reproductive aged women lived from the closest abortion provider was 25.31 miles and the 80th percentile distance was 40.36 miles compared to a national average of 10.79 miles and an 80th percentile of 42.54 miles (Bearak, Burke, & Jones, 2017). Travelling appears to be one of the biggest obstacles faced by people seeking abortion care in the State of Maine. There are three organizations in the State which provide aspiration and medication abortion care. This is important to note because although there are 20 facilities in Maine which provide abortions, only three of them provide aspiration abortions, and only three of them are private centers (Jones, Robins, & Pankomera, 2018) and 95% of abortions are performed in health centers rather than physicians' offices or hospitals (Jones & Jerman, 2017), which suggests that most abortions in the State of Maine are happening at these three private centers. Medication abortions are only effective up until the eleventh week of pregnancy. Each organization only provides care at one of their offices and each organization only provides abortion care on weekdays.

Poverty & Travel Costs

It is important to consider the financial status of the population of Maine. Figure 1 demonstrates the State of Maine broken down by county to represent the percentage of the total county population in poverty. The data, collected by the U.S Census Bureau and presented on the United State Department of Agriculture Economic Research Service's website reveal an average of 12.3% of Mainers live in poverty. In comparing Figure 1 with the locations of the three full-service abortion providers in the state, which are the towns of Portland, Bangor, and Augusta, it is evident that the counties with the highest rates of poverty are those farthest away from the three abortion care providers in the state.

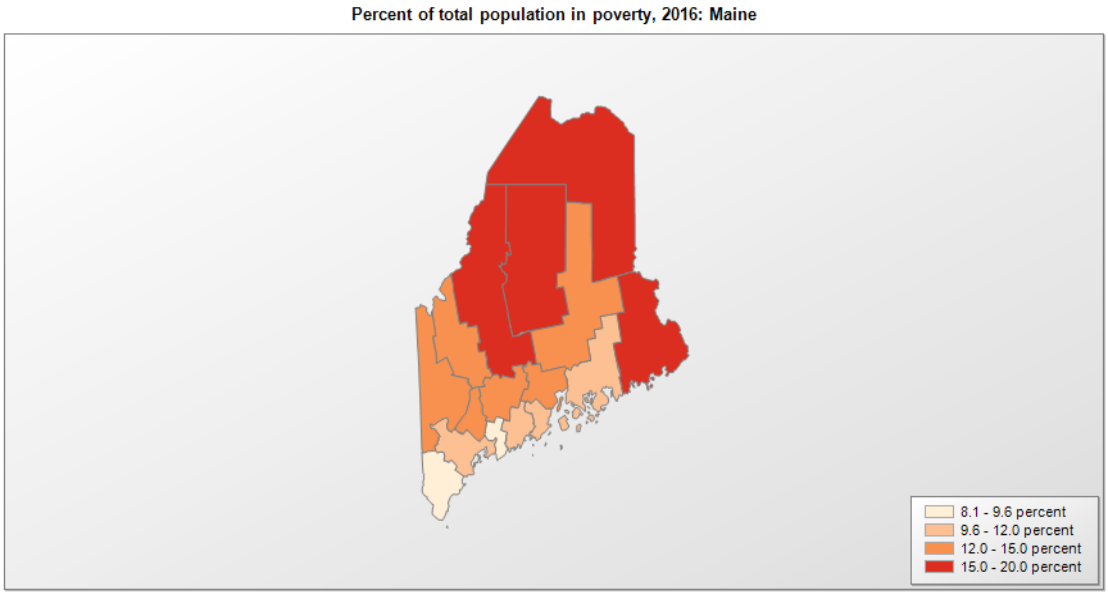

Figure 1

With the poverty rates in these locations being at the level they are, it is clear that there are many financial factors that limit people's ability to access abortion care. The purpose of this paper is to discover which financial factors impede access to abortion care and to what extent they do so. From these figures, I hypothesize that travel will be an

impediment to people's ability to access abortion care, with so much of the population that is living in poverty living in a location that requires travel to access an abortion.

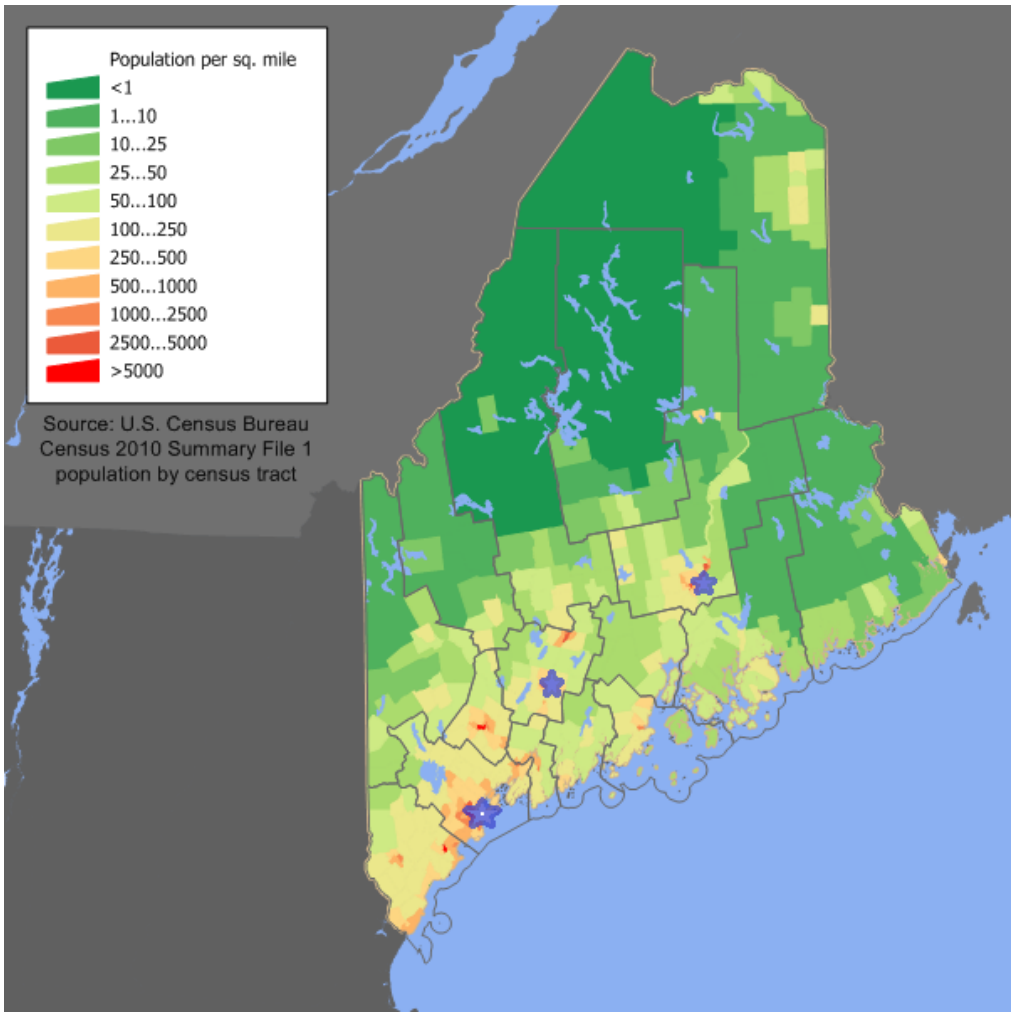

Figure 2

Figure 2 above shows Maine's average population per square mile. The three blue stars indicate where abortion providers are located. One can observe that there are pockets of people in Washington and Aroostook counties that are located quite far from the closest abortion provider. In fact, those living in Presque Isle are approximately 158 miles away from the closest abortion provider to them in the State of Maine. On July 31st

2014, the Morgentaler clinic in Fredericton, New Brunswick, which performed around 600 abortions per year, closed its doors. New Brunswick is the only Canadian province which refuses to provide Medicare funding for abortion access in private clinics. They will only cover abortion care if the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located. This closure left many Canadian residents with no choice but to travel to Bangor, Maine, approximately 172 miles away. With this, we can postulate that distance traveled is an obstacle to women being able to access abortion care.

One indication of the lack of access in the State of Maine is a new program being launched through a scientific study by a provider in Maine: Maine Family Planning. Maine Family Planning has 18 offices throughout the state but only provides abortion services at their office in Augusta. The organization is launching a program referred to as "telemedicine." Maine Law states that medication abortions must be provided by a licensed physician, however there is no specification that the doctor and patient have to be in the same physical space. For that reason, Maine Family Planning has begun providing medication abortion through telemedicine where the administration of the pill is supervised by a licensed physician. The program has been piloted in Aroostook and Washington counties where the population is the farthest from abortion providers and where some of the highest rates of poverty are. The necessity of this program indicates that women in these areas were unable to travel the necessary distance to a physical abortion provider.

Additionally, when examining the long trips that people are forced to make in order to obtain an abortion we must look not only at the financial impact that travelling

may have, but also at the time that it takes to complete such a journey. Time is especially important to note in these circumstances because if a pregnancy progresses to a certain gestational age, this can impact a person's ability to obtain an abortion. If a person has to save up the money to make a three-hundred-mile journey, their pregnancy may have progressed to a point where they are no longer able to obtain an abortion at the health center nearest to them and may have to travel even further. The Mabel Wadsworth Center in Bangor is only equipped to perform abortions up until a gestational age of 13 weeks 6 days while Maine Family Planning provides care up until 14 weeks and Planned Parenthood of Northern New England has a cutoff of 19 weeks 6 days. This means that the health center that provides the latest abortion care is located farthest away from some of the poorest populations. Presque Isle is located 286 miles away from Portland, Maine. This would make for 572-mile roundtrip journey to obtain an abortion if a person is past the gestational age that the Mabel Wadsworth Center is able to provide care.

This leads to a vicious cycle of time, finances, and access. If a person makes the long journey from Aroostook County to Bangor only to find that the Mabel Wadsworth Center is not able to provide care, they then have to save the money to make an even farther journey. On top of that, if it takes too long for that person to save up the money for a 572-mile trek they would be forced to save the money to travel all the way to Boston for an abortion, as that is the closest provider that provides abortion care past all gestational age limits in Maine. This could render obtaining the abortion completely impossible for a low-income person.

We must also examine time as a financial resource. Many low-income people rely on hourly employment. The following charts demonstrate the top employers in Aroostook

and Washington counties, the counties farthest removed from abortion providers and those with the highest rates of poverty.

Employment Range:
All

County:
- [ ] ANDROSCOGGIN
- [x] AROOSTOOK
- [ ] CUMBERLAND
- [ ] FRANKLIN
- [ ] HANCOCK
- [ ] KENNEBEC
- [ ] KNOX
- [ ] LINCOLN
- [ ] OXFORD
- [ ] PENOBSCOT
- [ ] PISCATAQUIS
- [ ] SAGADAHOC
- [ ] SOMERSET
- [ ] WALDO
- [ ] WASHINGTON
- [ ] YORK

Top 25 Private Employers in Maine by Average Monthly Employment by County
4th Quarter 2017

County	Name	Business Description	Employment Range
AROOSTOOK	AROOSTOOK MEDICAL CENTER, TH..	General medical and surgical hospitals	1,001 to 1,500
	TWIN RIVERS PAPER COMPANY LLC	Newsprint mills	1 to 500
	WAL MART / SAM'S CLUB	Warehouse Clubs and Supercenters	1 to 500
	NORTHERN MAINE MEDICAL CENTE..	General medical and surgical hospitals	1 to 500
	MCCAIN FOODS USA INC	Frozen fruit and vegetable manufacturing	1 to 500
	HOULTON REGIONAL HOSPITAL	General medical and surgical hospitals	1 to 500
	CARIBOU NURSING HOME INC	Nursing care facilities, skilled nursing	1 to 500
	SITEL OPERATING CORPORATION	Telemarketing and other contact centers	1 to 500
	COMMUNITY LIVING ASSOCIATION	Residential developmental disability homes	1 to 500
	PINELAND FARMS POTATO COMPA..	Perishable prepared food manufacturing	1 to 500
	AROOSTOOK MENTAL HEALTH SER..	Outpatient mental health centers	1 to 500
	MAINE MUTUAL FIRE INSURANCE CO	Direct property and casualty insurers	1 to 500
	MAPLE GROVE NURSING HOME INC	Nursing care facilities, skilled nursing	1 to 500
	NORTHERN MAINE GENERAL	Nursing care facilities, skilled nursing	1 to 500
	COLUMBIA FOREST PRODUCTS INC	Hardwood veneer and plywood manufacturing	1 to 500
	AROOSTOOK COUNTY ACTION	Other individual and family services	1 to 500
	PINES HEALTH SERVICES INC	Offices of physicians, except mental health	1 to 500
	LOUISIANA PACIFIC CORPORATION	Reconstituted wood product manufacturing	1 to 500
	HANNAFORD BROS CO	Supermarkets and other grocery stores	1 to 500
	MAIBEC LUMBER INC	Sawmills	1 to 500
	PARADIS SHOP 'N SAVE	Supermarkets and other grocery stores	1 to 500
	AROOSTOOK HOME HEALTH SERVI..	Home health care services	1 to 500
	HUBER ENGINEERED WOODS LLC	Reconstituted wood product manufacturing	1 to 500
	CIRCLE K	Gasoline stations with convenience stores	1 to 500
	DAIGLE OIL COMPANY	Fuel dealers	1 to 500

Maine Department of Labor, Center for Workforce, Research and Information, Quarterly Census of Employment and Wages survey.

Figure 3

Employment Range:
All

County:
- [ ] ANDROSCOGGIN
- [ ] AROOSTOOK
- [ ] CUMBERLAND
- [ ] FRANKLIN
- [ ] HANCOCK
- [ ] KENNEBEC
- [ ] KNOX
- [ ] LINCOLN
- [ ] OXFORD
- [ ] PENOBSCOT
- [ ] PISCATAQUIS
- [ ] SAGADAHOC
- [ ] SOMERSET
- [ ] WALDO
- [x] WASHINGTON
- [ ] YORK

Top 25 Private Employers in Maine by Average Monthly Employment by County
4th Quarter 2017

County	Name	Business Description	Employment Range
WASHINGTON	WOODLAND PULP LLC	Pulp mills	1 to 500
	DOWN EAST COMMUNITY HOSPITAL	General medical and surgical hospitals	1 to 500
	CALAIS REGIONAL HOSPITAL	General medical and surgical hospitals	1 to 500
	WHITNEY ORIGINALS INC	All other miscellaneous manufacturing	1 to 500
	WAL MART / SAM'S CLUB	Warehouse Clubs and Supercenters	1 to 500
	WORCESTER WREATH CO	All other miscellaneous manufacturing	1 to 500
	JASPER WYMAN & SON INC	Frozen fruit and vegetable manufacturing	1 to 500
	MACHIAS SAVINGS BANK	Savings institutions	1 to 500
	SUNRISE OPPORTUNITES	Residential developmental disability homes	1 to 500
	WASHINGTON ACADEMY	Elementary and secondary schools	1 to 500
	HANNAFORD BROS CO	Supermarkets and other grocery stores	1 to 500
	TRUE NORTH MAINE INC	Seafood product preparation and packaging	1 to 500
	CIRCLE K	Gasoline stations with convenience stores	1 to 500
	COOKE AQUACULTURE USA INC	Finfish farming and fish hatcheries	1 to 500
	ST CROIX TISSUE INC	Paper, except newsprint, mills	1 to 500
	AROOSTOOK MENTAL HEALTH SER..	Outpatient mental health centers	1 to 500
	NARRAGUAGUS BAY HEALTH CARE..	Nursing care facilities, skilled nursing	1 to 500
	DOWNEAST COMMUNITY PARTNERS	Child day care services	1 to 500
	DANFORTH HABILITATION ASSOCIA..	Residential developmental disability homes	1 to 500
	BELLS CALAIS IGA & BELLS ORONO..	Supermarkets and other grocery stores	1 to 500
	MARSHALL HEALTHCARE LLC	Nursing care facilities, skilled nursing	1 to 500
	LOVING CARE	Services for the elderly and disabled	1 to 500
	DUNKIN DONUTS	Snack and nonalcoholic beverage bars	1 to 500
	R H FOSTER ENERGY LLC	Petroleum bulk stations and terminals	1 to 500
	SUNRISE CARE FACILITY	Nursing care facilities, skilled nursing	1 to 500

Maine Department of Labor, Center for Workforce, Research and Information, Quarterly Census of Employment and Wages survey.

Figure 4

We can note from these charts that some of the largest employers in these two specific counties are industries where people are employed hourly rather than salaried, and therefore getting time off work could be a serious concern for someone seeking abortion care. They may not be able to afford to miss a shift, or several shifts, if they have to travel long distances. Regarding time as a resource is important in this sense because it illustrates yet another burden that must be taken into consideration when seeking abortion care. In 2015 39% of people over the age of 25 in Aroostook County reported a highest level of education of high school degree, while 20.9% reported having some college but no degree. In the same year 38.3% of people in Washington County reported their highest level of education as being a high school degree while 20.8% reported having some college but no degree. This would indicate that a high level of people living in these two counties rely on occupations where getting time off work could

be of serious concern. For those with a highest level of education being a high school degree, and with the largest employers being medical institutions or service industries, we can see that people in these counties likely are in positions where they are employed hourly and therefore the amount that they are paid depends on the hours that they work. If this is the case then missing work shifts could severely impact a person's finances.

Missing work in order to travel to obtain an abortion can not only affect a person's finances but can also affect their ability to continue working. Many people who miss work for their abortion appointments end up losing their job (Ostrach & Cheyney, 2014). This can place a person in a position where they must choose between losing their job and obtaining the abortion that they need. This is a practically impossible choice. On one hand you could have the added financial burden of a child, or in some cases *another* child, but remain employed at a job that likely doesn't pay very well. On the other hand you could lose your job and not have the added financial burden of a child. This is an impossible choice, and frankly, when pregnant people are faced with this "choice," they do not really have a choice. They are not experiencing the same amount of bodily autonomy as someone who does not have these financial concerns surrounding their access to reproductive health because they are not faced with the same decision and options that other people in better financial situations may have.

Childcare in Maine

Another factor to consider as an obstacle to obtaining abortion care in Maine is childcare. If a person must travel a great distance to receive an abortion, they likely will have to be gone for most of the day. Outside of travel time, a person also may need time to recover physically. People often experience cramping, light bleeding, and nausea after

receiving an abortion (Davis, Westhoff, & De, 2000). If the person in need of an abortion already has children, they likely would need someone to watch their child for the day. According to the Maine Child Care Advisory Council's Report to the 127th Legislature of Maine, in 2016 there were 21,975 children under the age of 13 living in poverty with all adults in the workforce. If a parent must pay out of pocket for their procedure, the miles traveled to the reproductive health center, and childcare this could take an enormous toll on a person's finances.

A group of Maine researchers conducted a study in which a random telephone survey was conducted in which the researchers completed 800 phone surveys of parents whose youngest child was below the age of five, as well as 391 mail surveys of parents who received government support for child care. The researchers found that on average, Maine women who worked 35 or more hours per week used 37 hours of childcare per week, compared to 21 hours per week for Maine mothers who were employed part-time, and 17 hours for Maine mothers who were not employed. Center-based care accounts for 39% of the childcare in Maine, while Relative care accounts for 25%, Family Child Care Home for 21%, Friends Care for 11% and Other for 4%. 24% of those living in rural locations reported that there were "No Good Choices" for childcare near their home. This would be an enormous issue for women living in poorer, more rural areas of Maine that are farther removed from locations where they can receive an abortion. (Lahti, Connelly, Nigro, & Fraser-Thill, 2009).

Food Insecurity in Maine

When examining access to food in the State of Maine, food deserts must be considered. Food deserts are geographic areas distantly located from the closest well-stocked food outlet. These outlets most commonly refer to grocery stores where individuals would have access to healthy food at a manageable price. The size of the store allows for food to be more reasonably priced (Forsyth, Lytle, & Van Riper, 2010). Most commonly, researchers define an acceptable distance as ten miles from the closest grocery store for rural locations. (Morton & Blanchard, 2007).

Researchers from the Rural Food Access Needs Assessment of Maine created a scale to measure a "total risk rate" of food insecurity or inability to access healthy foods based on the following three criteria: low population density, prevalence of low income, and high participation in SNAP. The researchers then created the following map which shows the risk rates of inability to access food broken down by county. The map also notes Maine's largest municipalities: Bangor, Augusta, Lewiston, and Portland. It is convenient for this study that researchers chose to include that information because it allows us to examine the rural areas where Mainers must travel to access food in comparison to the three locations that provide abortion care in the state.

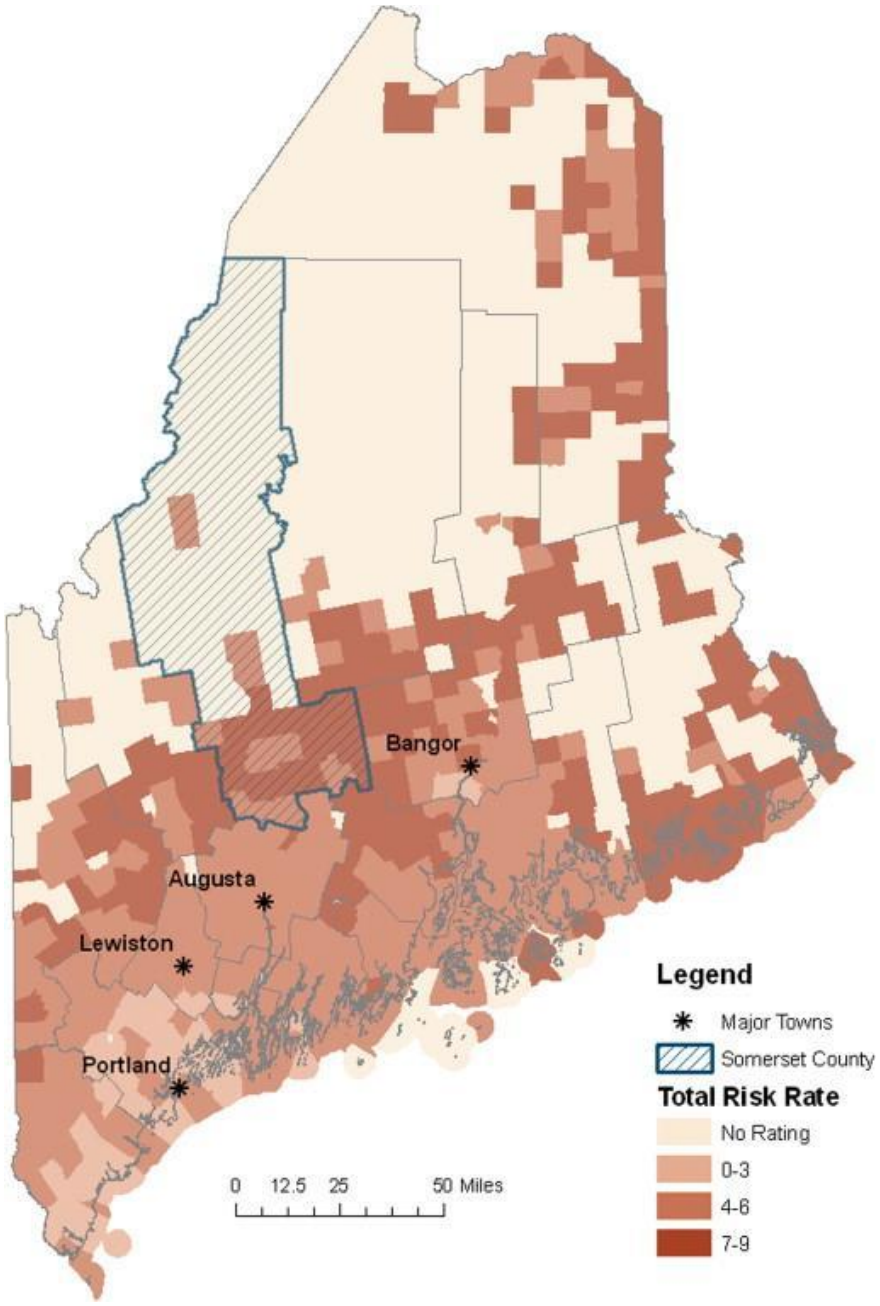

Figure 5

This map shows us that two of the three abortion providers in the state are located in areas with 4-6 risk ratings. It also demonstrates that some areas with the highest risk ratings of 7-9 are located in counties that do not have abortion providers. For example, if

we look specifically at the risk rates in Aroostook and Washington Counties we see that they are located quite far from Maine's three abortion providers. This indicates that families in these areas would already have to travel long distances to access food and therefore the added burden of paying for transportation, childcare, and their appointment could severely impact a family's ability to access food. Not only could their ability to afford the food itself be at stake, but they may not be able to afford the travel distance to the closest grocery store after the procedure.

If a person located in Presque Isle, Aroostook County is seeking an abortion, without the pilot program being launched by Maine Family Planning, they would have to travel to the Mabel Wadsworth Center in Bangor. Presque Isle is located 155 miles away from the Mabel Wadsworth Center. This travel distance alone could render obtaining the procedure nearly impossible. After a 310-mile round-trip trek and an expensive procedure the 20-mile round-trip trek to the grocery store to provide food for a family may not be feasible. Often times after paying for such a procedure expenses fall through the cracks. If we take into consideration the fact that many mothers already have at least one child (Jerman, Jones, & Onda, 2016), this suggests that parents may have to choose between providing food for their families and having an abortion.

As previously discussed, when a person has to miss work in order to obtain their abortion they also miss pay from that day. When we add the financial burden of missing pay on top of paying for transportation, the procedure, childcare, and the distance required to access food to feed a family we begin to see that for low-income women in Maine accessing an abortion can be extremely difficult if not downright impossible. Some of counties located farthest away from abortion providers have the highest rates of

poverty which indicates that the ability to access abortion is truly not equal for all people, especially in Maine.

Abortion Funding in Maine

Although Medicaid reimbursements are not reliable, there are other funding options for abortion care like Safe Abortions For Everyone (S.A.F.E) and National Abortion Federation (N.A.F). In addition to these organizations that provide funding to those who struggle to pay for their abortions many health centers will cover the cost of a procedure or charge a person based on a sliding pay scale if a person cannot afford the procedure themselves. However, many patients may not be aware of these programs or may feel embarrassed to use them. Often the center must wait to receive reimbursements from these programs. This can severely impact a health center's ability to provide care because not receiving reimbursements can mean that there are not enough funds for a center to operate at the level at which it normally does.

Although the Hyde Amendment stipulates that Medicaid may cover abortions when performed under three very specific circumstances, many providers have found that it is extremely difficult to receive reimbursements from Medicaid for the procedure. The regulation also states that two doctors must certify that carrying a pregnancy to term would cause "severe and long-lasting" damage to the pregnant person's physical health in order for it to qualify as an endangerment to the life. Secondly, in the case of sexual assault and incest, the event must have been reported to the police (Guttmacher Institute, 2007). These guidelines can and do cause serious complications. The concept of "severe and long-lasting" is rather vague and leaves a great deal up for interpretation by Medicaid. Furthermore, the guideline that requires a police report is problematic because

many people do not report their sexual assaults to the police for many reasons (Felson, Messner, & Deane 2002).and therefore would not be able to have their abortion covered. .

One study of abortion access being impacted by the Hyde Amendment researched 10 states (Florida, Idaho, Iowa, Kansas, Kentucky, Maine, Pennsylvania, Rhode Island, Wisconsin, and Wyoming) where states had not chosen to expand coverage for abortions. This study found that only 54% of Hyde-qualifying cases were actually reimbursed by Medicaid and many clinic staff members reported that they were completely unaware how to apply for Medicaid reimbursement because the process was so complicated (Dennis & Blanchard 2013). In some areas, the conditions are extreme. For instance, South Dakota only allows Medicaid funding to cover the cost of an abortion if the pregnancy places the pregnant person's life in danger. This is in direct violation of the federal requirements. Additionally, in 2001 Idaho, Illinois, Indiana, and Montana were under a court order to reimburse health centers for all medically necessary abortions. Despite the fact that these four states were under this court order, they reimbursed zero medically necessary abortions. (Henshaw, Joyce, Dennis, Finer, & Blanchard, 2009).

A study conducted in 1996 found that restricting Medicaid funding for abortions was associated with a statistically significant increase in probability of a pregnancy being carried to term. For white women, the probability increased by 3% and for high income women the probability was increased by 4%. Alternatively, the probability that a black woman would carry a pregnancy to term was increased by 10% and that of lower income women was increased by 5%. The study found that enforced restrictive laws lead to an increase in probability of birth most directly for African-American women and lower-

income women. The research also suggests that restrictive laws may increase the probability of birth in white women and high-income women indirectly by reducing the number of abortion providers. Therefore, we can begin to see the ways in which women of color and low-income women are disproportionately affected by Medicaid funding restrictions. (Currie, Nixon, & Cole, 1996) It is important to note that when conducting research about abortion, under-reporting can affect a study, and abortions are most under reported among low income women and women of color.

This lack of funding has had a severe impact on the lives of people who aren't able to access necessary health care due to financial obstacles. The Center of Disease Control reported that on October 3rd 1977, just one year after they Hyde Amendment was introduced, a 27-year-old woman died in a hospital on the Texas-Mexico border from septic complications of an abortion as a direct result of the lack of public funding. (Health Effects of Restricting Federal Funds for Abortion, 1979).

When I learned how often Hyde-qualifying abortions are not reimbursed by Medicaid I asked the Director of Billing at a sexual and reproductive health center to explain the process of receiving Medicaid reimbursement to me. She explained that the definitions and criteria that each case must meet to be considered Hyde-qualifying is specific that the abortions that should be covered are rarely covered. In fact, the center where she works has received only one reimbursement over twenty years because so often the case does not fit within the narrow standards set forth by this legislation. If a person doesn't report their sexual assault before becoming aware that they are pregnant their abortion will not be covered by Medicaid. If a physician does not use the correct

terminology to demonstrate that the effects would in fact be severe and long-lasting, the abortion will not be covered by Medicaid

The Director of Billing that I spoke with explained that when Medicaid is meant to cover an abortion, meaning the procedure was a Hyde-qualifying abortion, receiving the funding is incredibly difficult. First you must fill out the application online to receive funding, according to this woman the application is almost always denied. The center then has the option to appeal the decision, which again is often rejected. She explained that in the past 20 years their center has only received reimbursement from Medicaid for a single Hyde-qualifying case. According to her, cases are often deemed "not medically severe enough" or there is "not enough evidence" for cases of sexual assault or incest. For this reason, the center often relies on these other organizations that provide funding, however, as she explained to me N.A.F covers around 30% of the procedure based on the household size & monthly income. S.A.F.E can only provide up to $100. As previously discussed, the national average for the cost of an abortion can be around $650. A family of three that relies on Medicaid for health insurance has an income of $930 or less a month (Guttmacher Institute, 2007), and seven in ten Medicaid beneficiaries are women. Another employee reported that organizations may overlap, and Maine's version of Medicaid, called "MaineCare," will cover the $125 ultrasound. Therefore, with the price of the ultrasound covered, the $125 from N.A.F and $100 from S.A.F.E the procedure will cost $150.

CURRENT STUDY

The current study aims to examine the experiences of people seeking abortion care in Maine. Which financial obstacles, if any, make obtaining an abortion in Maine more difficult? This paper has examined obstacles that appear to severely impact a person's ability to receive the abortion care that they need, therefore it is necessary to see which obstacles people seeking abortion care in Maine report as being the most relevant to their lives. This will be done through a survey distributed at a sexual & reproductive health center in Maine.

Methodology

This study examines the financial impacts that people self-report through survey data collected at the Mabel Wadsworth Center in Bangor. This survey is distributed to all abortion patients at the Center and is anonymous. A total of 158 people participated in the survey in 2 015. The survey includes mostly open-ended questions rather than close-ended questions. The Mabel Wadsworth Center collects these surveys each time a person comes in for an abortion and therefore these data reflect several years of responses. The survey is meant to help the Center improve their ability to provide care and understand the needs of their patients. This study analyzes the questions that are relevant to the obstacles experienced when seeking abortion care.

It is important to note that some respondents do not answer every question and therefore the number of respondents to each question does not always equal the number of respondents to the survey itself. The surveys are collected into one document throughout a period of time when occasionally a staff member will update the working

document where responses are indicated. The data presented in this study were last updated in 2015. The data are collected cumulatively and therefore reflect difficulties faced at different time periods and therefore we cannot examine the ways that obstacles may have changed over time or been affected by legislation.

Additionally, it is important that there may have been human error in recording the survey responses. The data are all kept on one working document which indicates that there could have been confusion or errors when updating. The document is saved as a new document each time it is updated in an attempt to minimize errors. It is also important to recognize that the data show how many times a response was given and therefore it is unknown if a patient listed more than one financial concern in their responses.

Results

Once the data were collected I separated the results out by each question and created bar graphs for the responses to each question. This allowed me to observe the frequency of responses to each question and to visualize which types of responses were most apparent throughout the questions. Additionally, I looked for responses that were common to more than one question. In this particular survey there are questions that allow for similar responses. For example, one question asks, “Did any of the following make it difficult for you to make your appointment today?” while another asks “How far did you have to travel today?” and another asks about payments skipped or delayed in order to afford the abortion. Placing these data into bar charts allowed me to see responses that were common to more than one question. This suggests that the obstacle

named was an important one to that patient, or that this obstacle may have been particularly pressing for them.

The third question on the survey asks respondents if they had trouble paying for their appointment that day. Out of 158 total respondents (n=158) 38.6% reported having trouble paying for their appointment. 59.4% indicated that they did not have difficulty paying for their abortion. The surveys indicate that some of the obstacles to faced most by low-income people in Maine are getting time off of work, paying for travel care, losing pay from missing work, and transportation.

The obstacle with the highest rate of response is keeping a secret from people close to you. This was not an obstacle that I had previously considered in this paper. I had not anticipated the degree to which keeping a secret would affect the person's actual ability to make their appointment. If a person must keep their procedure a secret from people close to them it could make travelling to obtain the procedure very difficult. Especially if a person has to travel a long distance to obtain the procedure this could impact their ability to make the voyage. Often times a person might need a ride to the health center or might want someone to accompany them for emotional support. Additionally, if a person needs to borrow money or needs financial assistance in anyway this could strain their ability to receive the funds that they need.

Unfortunately, the way that the data were collected inhibits our ability to examine the ways that these obstacles interact. For example, we cannot tell how many people who travelled over 50 miles also worried about losing pay from missing work. In this case, it would be beneficial to examine which people had to travel long distance and worried

about keeping their procedure a secret from their loved ones. The first table demonstrates, however, what the main obstacles are and demonstrates that the anticipated results correctly indicated that childcare, transportation, and work problems would be the largest obstacles to receiving abortion care.

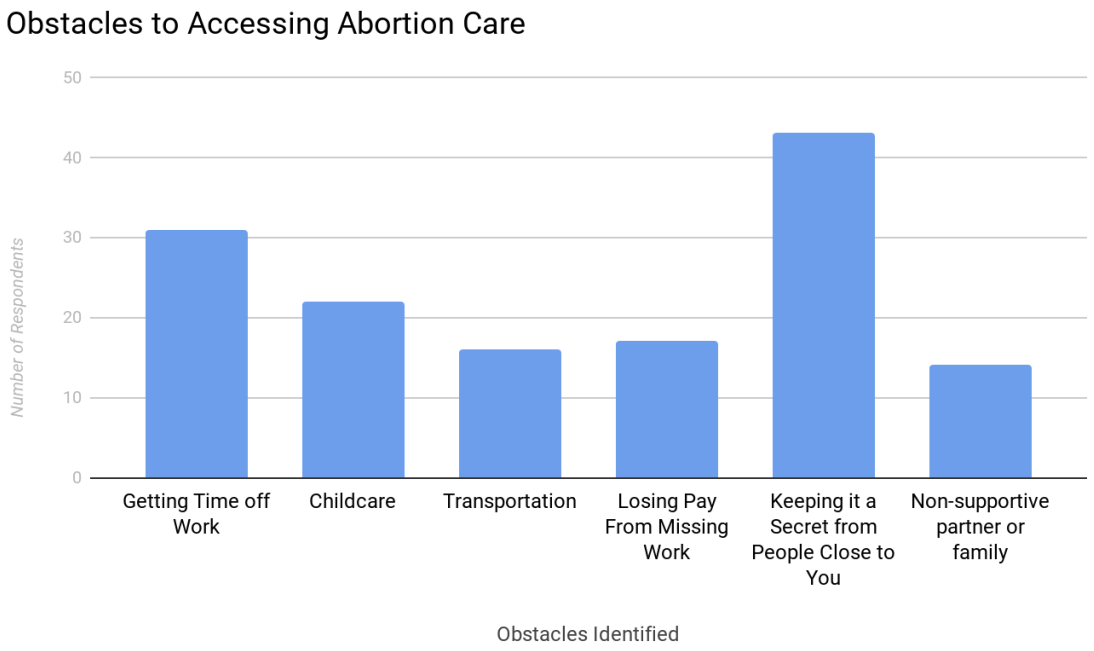

Figure 6

The table demonstrates the responses from abortion patients at the Mabel Wadsworth Center when asked: "Did any of the following make it difficult for you to make it to your appointment today?" The options given are getting time off work, childcare, transportation, losing pay from missing work, keeping it a secret from people close to you, non-supportive partner or family and other. Only three respondents answered other and indicated that the choice itself, getting time off school, and college classes were obstacles to receiving abortion care. 31 out of 158 respondents indicated that getting time off work was a concern. 22 indicated that childcare was an obstacle. 16

indicated that travel was a concern. 43 responded that keeping the procedure a secret was a concern, and 14 indicated that non-supportive partner or family was a concern. 29 people who took the survey chose not to answer this question.

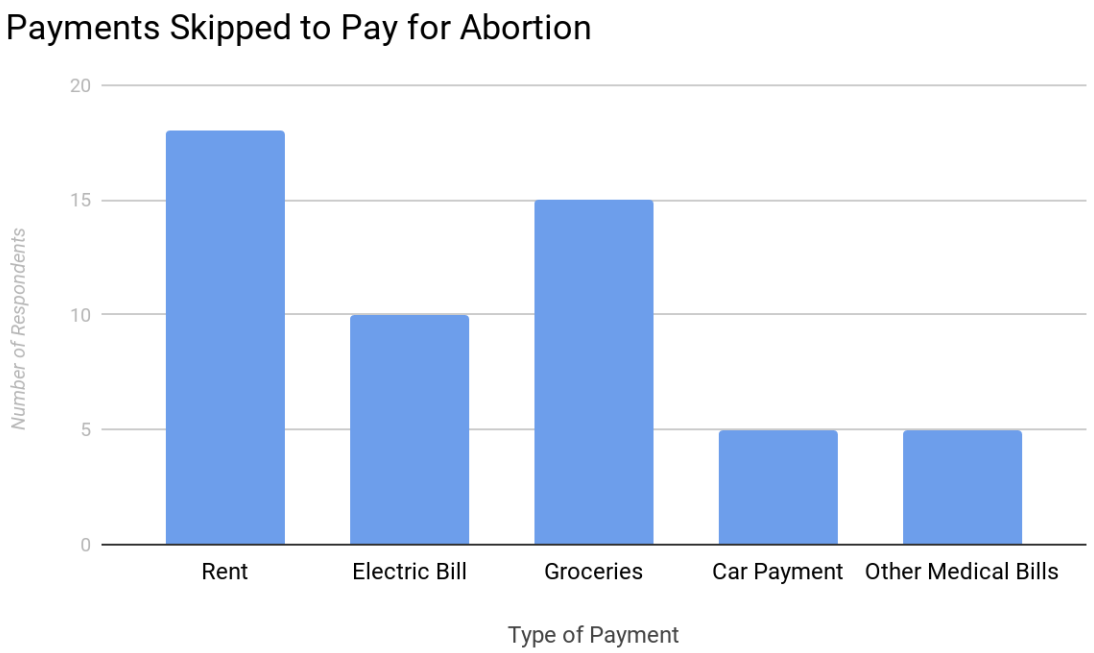

Figure 7

The third question on the survey asks if the patient had any trouble coming up with money to pay for their abortion, the results of this question have already been discussed. The fourth question on the survey is a follow up question and asks: "If yes, will you have to skip or delay any payments in order to pay for your abortion?" Of the 158 respondents to the survey 18 indicated that their rent payment would be skipped or delayed. 10 indicated the electric bill would be skipped. 15 indicated that grocery shopping would be delayed. 5 indicated their car payment would be delayed and 5 also indicated that other medical bills would be delayed. 7 responded other and indicated that credit card payments, essentials, depleted savings account, and a personal loan were concerns.

These data indicate that 9.5% of patients obtaining an abortion at the Mabel Wadsworth Center would have to delay grocery shopping due to the financial burden of paying for their appointment. Comparing these results to the research conducted on food deserts in the more rural areas of Maine we can see that accessing food after paying for an abortion is a concern for low-income people seeking abortion care. When grocery shopping has to be delayed after paying a few hundred dollars for a medical procedure we can reasonably assume that a person would have extreme difficulty supporting a child once the pregnancy was carried to term. This leaves a person with an impossible choice. Additionally, if they already have a child having to pay for the abortion could impact their ability to feed the family that they may already have.

Of all the options given respondents indicated most commonly that their rent payment would be delayed. 11% of respondents said that they would delay their rent payment due to the price of their procedure. This demonstrates that the financial burden of paying for the procedure is extreme enough that it impacts the living situation of an individual or a family. This is demonstrative of all of the smaller ways that the financial burden could impact a family. If a person cannot afford the price of the place they live after they must pay for the procedure they likely cannot afford things like groceries or the electric bill, much less things like school supplies or coffee in the morning. These small expenses that we often overlook as required bills can have a significant impact on a person's wellbeing. This impacts a person's ability to truly "choose;" it adds weight to the choice. Again, it is unfortunate that we have no way of knowing if respondents chose multiple options on this question.

This paper has previously noted that it is important to examine the distance traveled in order to obtain an abortion. The data collected from the Mabel Wadsworth Center asks the question: "If transportation was difficult can you tell us how far you traveled to get here today?" The options given are: less than 10 miles (In the Bangor area), 10-20 miles, 20-50 miles, and more than 50 miles. It would be interesting to examine how far those who traveled over 50 miles actually had to travel. This paper has speculated some towns that would require an extreme amount of travel to reach the Mabel Wadsworth Center. These data only tell us that 34 out of 158 respondents traveled over fifty miles to obtain their abortion. The wording of this question also skews our understanding of the distance traveled because it does not specify if the distance accounted for the journey there and the journey back or simply the journey there. If a person is indicating that their voyage was 50 miles from their home and therefore 100 miles in total, that is a very different result than if the person lives 25 miles from the Center.

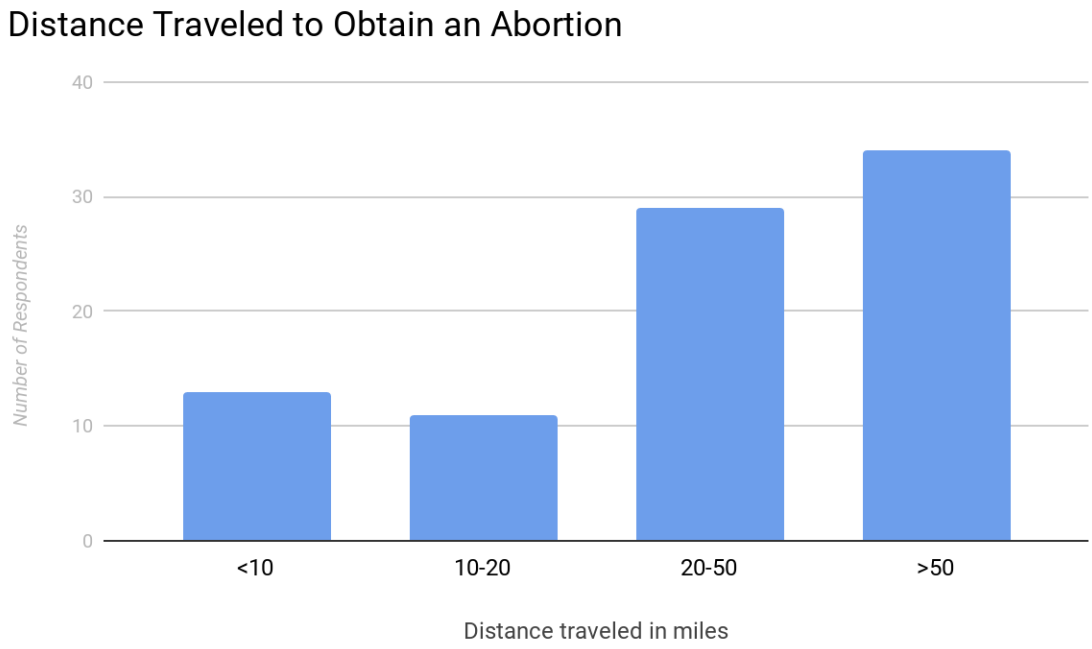

Figure 8

13 patients indicated that they traveled within the Bangor area to obtain their abortion, which means 91% of respondents to this survey traveled over 10 miles to obtain their abortion. If we assume that respondents are indicating the distance traveled to the Center rather than distance traveled round trip these data then indicate that 91% of respondents had to travel the same distance to reach an abortion clinic that people who live in food deserts must travel to get to the grocery store. If that is an unreasonable distance to drive in order to buy groceries this paper supposes that it is also an unreasonable distance to drive in order to receive a necessary medical procedure. Approximately 40% of respondents had to drive over 20 miles to reach the health center. These numbers indicate that, in fact, very few of Mabel Wadsworth Center's patients are local. The community they serve appears to overwhelmingly be comprised of people driving considerable distances to obtain an abortion. Again, it is unfortunate that from

these data we cannot examine which patients struggled financially due to the price of their procedure and which patients had to travel long distances.

The following question, which does not indicate necessarily the financial burdens overcome in order to receive an abortion, asks instead for the patient's opinion on the Hyde Amendment. The question asks: "Most health insurance covers abortion care services, but MaineCare (Medicaid), a program for people with low income does not. It covers all pregnancy related care if a woman chooses to carry her pregnancy to term, but will not pay for an abortion. Do you think it should cover abortion too?" The options given for a response are: yes, no, undecided, no answer. Out of 158 respondents 126 answered yes, 18 answered no, 3 answered undecided, and 8 answered no answer. Out of all the patients who answered this survey approximately 79.75% indicated that they believe MaineCare should cover abortion services. These data are extremely important because they demonstrate that a majority of those who are actually receiving abortion care disagree with the Hyde Amendment. Additionally, because so many people answered yes to this question we can safely assume that at least some of them were patients who struggled financially to afford their procedure. Therefore we can observe people who are being affected by this legislation disagreeing with the policy. This, I believe, should tell us all we need to know. It is feminist praxis to listen to the voices of marginalized communities, and in this case we can hear them. Both the voices of those who are members of low-income communities, but also those who belong to the socially marginalized identity of someone who has had an abortion.

Those who have had abortions at the Mabel Wadsworth Center clearly are saying that they believe federally funded insurances should pay for abortion care. Due to the fact

that so many of the respondents to this survey indicated that they traveled far distances we can observe that those who hold this belief are not restricted to one geographic area. In fact, a majority of them were not local to the Bangor area and therefore are distributed throughout different parts of the State. There is no way to tell which respondents indicated that they traveled long distances and which indicated that they believe MaineCare should cover abortion care; however, because only 13 participants indicated that they traveled within the Bangor area and 126 participants answered that MaineCare should cover abortion services we can assume that there is some overlap within those who traveled and those who answered yes.

CONCLUSION

There are innumerable reasons why a person might choose to get an abortion. From medical reasons, to financial reasons, to personal reasons, we will never fully be able to understand the scope of a person's situation and why they have made the choice that they have. Abortion is about bodily autonomy. It is about having control over your life's path. Our social perception of abortion is deeply rooted in misogynist beliefs that have shaped our understanding of abortion. Our society has inherited these conceptions that abortion is a reproductive luxury rather than a reproductive right. As we discussed at the beginning of the paper doctors had compared abortion to a woman's love of fashion and society. The heated debate in American society over abortion rights has created an environment in which we often see abortion rights as a comprise. It's a right, but only if you can afford it. It's a right, but only if you have a dramatic reason to use it. The right is not universal and the existence of the Hyde Amendment makes this clear.

Additionally, we live in a society where multiple institutions of privilege and oppression can overlap and severely impact a person's life. In this paper, I've examined the institutions of gender and class can compound and affect a person's ability to access the healthcare that is vital to their survival. The equating of a necessary medical procedure to luxuries such as fashion dismisses the idea that abortion is a valid healthcare procedure because it has been associated with femininity. Our society has a history of dismissing any activity that is associated with women and the feminine as trivial. Furthermore we live in a classist society where health services are much less accessible to those who are in a lower socioeconomic status. As seen throughout the paper access to

healthcare is not guaranteed for lower-income people. The Medicaid program that America has in place is filled with holes and does not cover all those who need access to healthcare. Additionally, when looking at the qualifications for Medicaid it is not enough to be low-income, a person has to also fit into a category for qualification. If a person is low income, but in the wrong age range, or a person doesn't have children, they won't qualify for Medicaid. This demonstrates that as a society, we don't believe that low-income people are not entitled to health care. The income qualification is 138% of the Federal Poverty Line which leaves out a great deal of lower-income people who do not quite fit under that cut-off.

Moreover the ways that poverty affects a family or a person reach well beyond healthcare. While healthcare is often a major issue for many because it is so expensive and it does have perhaps the most tangible effects on a person, as we have seen throughout this paper other financial burdens such as childcare, travel costs, and the cost of food can also severely impact a person's ability to live a healthy lifestyle. These obstacles become greater the more people are added to a family. This puts a person in the middle of an impossible set of choices: carry through with a pregnancy or face financial turmoil. On one side, carry through with a pregnancy and be put in a position of added financial burden when it comes to food and childcare; or, have an abortion and use up your financial resources and struggle further to afford food and childcare.

This impossible choice is where the compounding impacts of the institutions of gender and class leave lower-income women. These structures of power affect lower-income people throughout the entire reproductive experience. It affects their ability to access birth control, their ability to access quality sex education, their ability to to work,

and of course, their ability to obtain an abortion. These structural inequalities are what have provided the grounding for the existence of the Hyde Amendment. They primed society for such legislation and we can observe this through the history of abortion in America even prior to 1976. We have examined the ways that abortion was viewed and we have examined the ways that classism and sexism interact to affect women in very specific ways.

The data collected from the Mabel Wadsworth Center over the years has demonstrated that there are many ways in which the Hyde Amendment impacts a person's experience obtaining an abortion. As the data show, by denying poor women access to abortion, the Amendment has created serious financial concerns for people in Maine seeking an abortion. They show us that a great deal of people have to prioritize the abortion over paying certain bills which is compounded by often being required to travel far distances to access the procedure. They demonstrate that the impact of the Hyde Amendment reaches far beyond the access to health care, it permeates into many aspects of that person's life. We can observe that some patients had to delay or skip their rent payment in order to afford their abortion, while others had to skip grocery shopping, or borrow money.

These data from the Mabel Wadsworth Center also demonstrate that the biggest obstacle patients had listed was keeping the procedure a secret from those close to them. This paper's main focus has been the financial obstacles and in reviewing other studies concerning the Hyde Amendment the burden of keeping a secret has not been explored. While these studies often include data that demonstrates how necessary help from another person can be in obtaining an abortion they do not explore the consequences of having to

keep an abortion a secret. However our data suggest how the need to keep an abortion secret has a major economic impact in addition to the possible emotional toll. Additionally, these data show that keeping it a secret goes beyond the emotional toll. Keeping your abortion a secret was the most selected answer to the question "Did any of the following make it difficult for you to make it to your appointment today?" The inclusion of the phrase "make it to your appointment" changes the meaning of the question. The survey does not ask "Did any of the following make your appointment difficult today?" from which we could postulate that keeping it a secret made the appointment emotionally difficult for the patient. Rather, it specifically referred to making it to the appointment. The responses to this question clearly show that keeping an abortion secret from those around you can actually impact your ability to make your appointment.

Keeping an abortion secret is therefore a financial obstacle to receiving the abortion that you need. For starters, if a person is not able to share your abortion with close ones then they will not be able to receive financial support from those people. This would impact their ability to ask someone for a ride, to ask for help with the rent, to ask for any kind of financial assistance that they may need. It also complicates their ability to secure childcare. If, for instance, a person cannot tell their mother or their sister that they are driving down to Bangor to get an abortion they cannot ask them to watch their child for the day. If a person cannot tell their friend that they had an abortion then they cannot ask them for $50 for groceries the next week. What these data show us is that abortion stigma is a financial issue. Abortion stigma has an impact on lower-income people seeking abortion care.

Knowing that stigma has an effect on a person's ability to obtain an abortion can change the way abortion activists are able to approach the subject. It better informs the experience of the patient and therefore deepens the understanding of activist who are attempting to improve access to care. This can allow activists to improve their actions and programs meant to make abortion more accessible.

The Hyde Amendment alters lower-income people's ability to get the care that they need. It was born from a tradition of misogyny and classism. Abortion has traditionally been viewed as something that should be available to those who can afford it rather than to all those who need it. The Hyde Amendment specifically harms lower-income people who rely on federally funded insurance programs to access healthcare.

When a person has limited financial resources having to pay for an abortion leaves fewer resources available. This impacts a person's ability to travel to and from their nearest health center, secure childcare, pay rent, and buy groceries. The stigma surrounding abortion becomes an added limitation to a person's financial ability to access an abortion.

Overall, the Hyde Amendment leaves lower-income people who need an abortion at risk. It renders abortion disproportionately difficult to access for those who are not financially privileged. It harms individuals and families who have to allot their financial resources to this procedure rather than to their basic needs. Our harmful stigma surrounding abortion coupled with the Hyde Amendment leaves people in a position where they are faced with enormous financial issues especially because those affected by

the Hyde Amendment are already economically disadvantaged. This results in an inequity of bodily autonomy and an unnecessary added financial burden.

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