FROM RESEARCH TO POLICY CHANGE: ADDRESSING DISPARITIES AMONG LOW-INCOME WOMEN SEEKING ABORTION IN OREGON

By Bayla Ostrach and Jessica Matthews

Introduction

Women seeking abortion frequently encounter barriers that may be socioeconomic, logistical, or social. Of particular concern for policy development, women of lower socioeconomic status are more affected by these barriers (Jones and Weitz 2009). The focus of this article is to describe the process by which applied medical anthropology research was transformed into a joint medical anthropology/public health effort to reduce these barriers. The desired outcome was to create policy change to improve reproductive health care access for low-income women in Oregon. Working in the traditions of applied and critical medical anthropology to improve access to reproductive health care, we sought to utilize data to effect policy improvements and to offer women a tool to advocate on their own behalf.

Through an earlier mixed-methods study conducted at an abortion clinic, the first author, Ostrach, found that the process of applying for Oregon's state-run Medicaid program (referred to as the Oregon Health Plan or OHP) that covers abortion produced notable obstacles[1] to abortion for low-income women (Ostrach and Cheyney 2014). As an applied medical anthropologist, Ostrach developed her original research with the intention of documenting women's lived experiences with accessing abortion care, a contested and marginalized form of reproductive health care, in the hopes of illuminating one form of gendered disparities. The hope all along was to eventually use the data produced through this medical anthropology study to advocate for applied interventions to reduce such inequalities. We entered into the advocacy project described here with the goal of fully implementing the value of applied medical anthropology—to improve marginalized populations' access to care. Oregon is one of a rapidly dwindling number of scarcely more than fifteen states in the nation that fund abortion for women covered by Medicaid. Funding is provided through state-level exceptions to the Hyde Amendment, which bans the use of federal funds for most abortions (Guttmacher Institute 2014). Barriers related to Medicaid eligibility and coverage are well-known to disproportionately affect women in poverty, whose income-based eligibility suggests they are at higher risk for encountering other socioeconomic and logistical barriers. Women in poverty may be more affected by difficulties with transportation, the need to take time off work, and paying for childcare (Jones and Weitz 2009). Staff at the clinic where data were collected noted that patients complained about delays in obtaining coverage, and unanimously agreed that waiting for OHP coverage was a noticeable risk factor for being delayed into later stages of pregnancy.

Based on these findings (Ostrach and Cheyney 2014), second author Matthews developed an unpaid legislative internship, working with a Democratic state representative's office to improve OHP accessibility and shorten waiting periods for eligible pregnant women through state-level policy efforts. She did so as a community-based intern for a master's program in public health (MPH) at an Oregon university. Matthew's emphasis on maternal-child health disparities within the MPH program motivated her interest in this topic. She volunteered by performing data-entry for the study prior to beginning her internship, and sought Ostrach's support for developing this project designed to apply anthropological findings to public policy.

In discussing the earlier findings, we concluded that difficulties with OHP represented a systemic obstacle to abortion access that could potentially be addressed through public health-focused advocacy more readily than some of the other obstacles identified. Within just a year from the completion of the study, our combined efforts resulted in a new binding policy transmittal that was sent out by administrators of the state health agency to all OHP eligibility workers. This transmittal directed all staff to prioritize and expedite applications from pregnant women *regardless of the intended outcome of the pregnancy*. Moreover, workers were specifically directed to process pregnancy-related OHP applications within one to two business days after receiving them; each regional office was required to create an internal procedure to ensure that occurred.

Medicaid Obstacles and Abortion Access in Oregon

The original study was designed as an applied anthropology project. It explored whether women coming to one clinic in Oregon encountered obstacles to abortion access, what those obstacles were, and how women overcame them. Using modified grounded theory data collection and analysis techniques, Ostrach employed a critical medical anthropology approach (Singer 1986), with a focus on the ways low socioeconomic status and marginalization present more obstacles to reproductive health care for some (Jones and Weitz

2009). The precise methods of the study and a full description of the findings and broader implications can be found in a separate publication (Ostrach and Cheyney 2014).

Participants encountered financial, logistical, and emotional obstacles in the process of seeking abortion. These included problems with delays in the OHP application process and a lack of social support. Forty-two percent of women surveyed found the cost of the abortion procedure "very or somewhat challenging," revealing the extent to which poverty and Medicaid eligibility were important factors. Twenty-five percent of women surveyed identified difficulty with OHP as "very or somewhat challenging." While 70 percent of women reported an income level identifying them as eligible for pregnancy-related OHP coverage, only 30 percent were covered.

Of women who applied for OHP to cover a current pregnancy, 46 percent waited more than a week for confirmation of eligibility. Eighty-five percent of women who applied for OHP received confirmation of eligibility within two to three weeks; however this delay understandably constituted a serious burden for pregnant women who are most likely aware that each passing week can affect their ability to obtain first-trimester care, or simply to obtain an abortion at all (Jones & Weitz 2009). In interviews, women who reported waiting the longest (three weeks or longer) for OHP were the poorest women from rural areas. Several (four out of eleven in the qualitative sample) were delayed into the second trimester while waiting. The difficulties caused by such delays are evident in this illustrative excerpt from an interview transcript:

> I went to DHS and filled out all the paperwork. I gave it to the lady; I thought they were going to call me back [to talk to a case worker]... I sat there for half an hour and I went up and asked, "Do I have an appointment?" and they said, "No, no, we're going to give it to your caseworker. If there are any problems he'll give you a call." I figured since I'm pregnant, they're going to realize that and they're going to work it out quickly. I gave them all my paperwork and my birth certificate. I went back in there a week later because they hadn't contacted me. I was just waiting for a phone call, and I couldn't go take care of it. I didn't know if I was approved. Finally, I went back there, I said, "Hey, I wanted to know what's the status of this, is my caseworker here?" and they said, "Oh, he's not here right now, here's your paperwork..." They went and found it and told me, "Oh, it's at the bottom of the pile, it hasn't been processed." I asked, "Hey, when will this be processed?" and she said, "Oh it can take up to thirty days." I started yelling at the [receptionist]. I said, "I'm *pregnant*, I don't know how far along I am... but I need to get this taken care of *right now*!" [The receptionist] said, "Well, okay, I'll write a memo to your case worker..." Another week goes by. I end up calling my worker every day, I'm leaving him messages, "Hey, by the way, I'm pregnant, I'm one of your clients, and you have my paperwork. I need you to process it *immediately*, let me know when you do that!" I called him a couple times a day, left messages and never got a hold of him. Then finally [a]nother week of that goes by, I finally get a hold of him and he says, "Oh hey, yeah! I have your paperwork... yeah, it's all been processed." He didn't call to tell me I was covered. He just finally answered the phone one time when I called (Madeleine,[2] 20 years old).

Madeleine, a college student who initially applied for OHP coverage when she was eight or nine weeks pregnant, was thirteen weeks pregnant and needed a second-trimester procedure by the time she was able to confirm her coverage. Her experience was an example of what we found throughout the study; low-income women in Oregon experienced excessive and unnecessary delays in the process of applying for OHP. This reduced their ability to seek reproductive health care in a timely manner. Such findings motivated the advocacy for policy change described here.

Transforming Research into Policy Change: Medical Anthropology/ Public Health Collaboration

Following completion of the study, both authors engaged in proactive dissemination of the findings. Together, as master's-level students in medical anthropology and public health (respectively), we gave presentations to providers and reproductive health advocacy organizations across the state, in addition to sharing the findings with various Oregon legislators with health-related committee appointments. We developed the idea of Matthews setting up a legislative internship to advocate for the improvement of the OHP application process, with the goal of removing or reducing an obstacle to both accessible abortion and timely prenatal care. We approached several Oregon state legislators we knew to have progressive ("pro-choice") reputations and health care committee appointments or connections to discuss the possibility of organizing the project through one of their offices. Matthews ultimately secured an unpaid internship position with a state representative, Mitch Greenlick,[3] who had paved the (legislative) way for the creation of the Oregon Health Authority (OHA), which oversees the Department of Human Services (DHS) and all Medicaid-funded or matched programs in the state. The internship occurred throughout late winter and spring 2011. In that role, Matthews contacted and met with multiple DHS and OHA staff, including OHP eligibility workers. She shadowed an OHP eligibility worker in one county to observe the process in action and sought documentation of the official state policy and employee training memos.

Based on the combination of meetings with DHS officials during the

dissemination phase of the research study, and Matthews' findings during her internship, it was clear that eligibility workers were widely unaware of an existing internal policy that stipulated they prioritize applications from pregnant women to process them within one to two business days and ahead of all other applications. Additionally, in some cases, anti-abortion caseworkers would deliberately delay or withhold OHP from pregnant women who disclosed an intention to terminate their pregnancy. Moreover, other research found that implementing new federal citizenship verification requirements within the various DHS programs had the unintended effect of delaying OHP coverage for eligible low-income pregnant women who did not have easy access to proof of citizenship (Bauer et al. 2011).

In the interest of public health advocacy, as well as for political and strategic reasons, we decided to emphasize the need for early access to prenatal care throughout the OHP application process and de-emphasize the implications this would have on earlier access to abortion services. Discussions with legislators, policy-makers, and DHS staff, organized by Matthews, highlighted the dangerously increased risk of pregnancy complications and negative health outcomes for pregnant women and their infants when prenatal care is delayed (Arias 2003).

Matthews emphasized to stakeholders that ensuring low-income women's access to early and appropriate prenatal care not only reduces health complications, but actually saves money budgeted in state programs such as OHP in the long run. Prevention efforts directed at low birth-weight and preterm deliveries have the potential to save infant lives, in addition to effectively reducing subsequent, costly, morbidity rates, more effectively even than improvements in neonatal care (Arias 2003). Improving the rapidity with which low-income pregnant women can access OHP is clearly of particular importance for women who wish to carry to term in Oregon. A recent study (Thorburn and DeMarco 2010) found that more than 37 percent of deliveries to Oregon mothers in recent years were paid for by OHP. Women who later rely on OHP to cover labor and delivery presumably also need to use it for prenatal care, once they are covered.

Infants born to Medicaid enrollees and other women in poverty are at higher risk for low birth weight (National Governors Association 2013). Medicaid enrollees tend to initiate prenatal care later than privately enrolled pregnant women, demonstrating the need for facilitating earlier access to prenatal care for these at-risk women by effectively expediting pregnancy-related Medicaid applications (Kiely and Kogan 2013). The United States continues to rank poorly in international comparisons of infant mortality rates, ranking lower than more than forty other industrialized nations (Central Intelligence Agency 2012), leading public health researchers, including Matthews, to speculate that United States rankings may be correlated with women's comparatively later entry to prenatal care, as compared to countries with single-payer national or public health systems, especially among low-income, at-risk women (Chen, Oster, and Williams 2014). Disorders related to shorter than optimal gestations and low birth weight are the second leading cause of infant death in the United States, responsible for 37 percent of all infant deaths (Tanner-Smith, Steinka-Fry, and Lipsey. 2012). These statistics sanitize the imaginably wrenching experience of losing an infant, and serve as another reminder of the importance of early access to prenatal care for low-income women who wish to carry pregnancies to term. These findings are equally important from a public health policy perspective as is ensuring early access to abortion services.

With the support of the state representative's office, we developed a policy clarification request to be presented to the OHA. We asked the OHA to instruct DHS staff to honor and enforce the existing policy of expediting Medicaid applications from pregnant women, and to direct them to do so explicitly, regardless of the intended outcome of the pregnancy. This was based on anecdotal accounts in Ostrach's research that suggested many women's applications were deliberately delayed from processing by caseworkers because of a stated intent to terminate the pregnancy. We requested that DHS clarify to all eligibility workers who process Medicaid applications that applications from pregnant women must be processed within a reasonable amount of time, preferably within one to two business days. The OHA then quickly issued a policy transmittal (internal employee memo) to all offices and employees associated with state-and-federally funded medical programs for low-income Oregonians, reiterating that Medicaid applications from pregnant women must be prioritized and processed in an expedited manner, ahead of other medical applications.

To our surprise and delight, the transmittal further stipulated that not only should pregnancy-related Medicaid applications be processed within one to two business days, but that each office would be required to create a specific *process* for doing so. It further outlined that providing a r*eason* for the expedited application would not be required (thus eliminating the need for women to specifically mention a scheduled abortion appointment, potentially resulting in a stigmatized response). While this was primarily a policy *clarification*, given the widespread disregard for (or ignorance of) the existing policy about expediting pregnancy-related OHP applications, the resulting communication of the expedited processing timeline to all staff constituted a dramatic directive to all employees to process OHP applications with greater attention to low-income pregnant women's needs for timely reproductive health care, whether it be prenatal care or abortion services. As the policy transmittal stated, "This transmittal is being sent to ensure eligibility staff give priority to medical applications for pregnant women" (Oregon Health Authority 2011).

It was no small feat that this meaningful policy change occurred

as the result of a collegial and warm collaboration between an applied medical anthropologist and a public health student. Given the tensions sometimes found between these disciplines (e.g., Foster 2009), the teamwork involved in carrying this project from the research phase to a conclusion that achieved change at the state level was crucial. We believe it also offers a model for future research-based advocacy work carried out jointly by medical anthropologists and public health researchers, both fields concerned with the impacts of social inequality and structural, policy-determined disparities in care and on human health.

What is Next? Building on a Positive Change

Low-income pregnant women in Oregon asserted their agency in the face of structural violence by advocating for themselves with OHP workers and by being persistent in getting their needs met despite policy-related and bureaucratic obstacles, as identified through Ostrach's data analysis. Systems-challenging and systems-correcting praxis were utilized by women who assertively communicated with state employees that have power over women's access to reproductive health care services (Singer 1986). Elsewhere, women navigated the process of applying for OHP to get the care they needed within the system, while also demystifying and democratizing the process, to subconsciously or consciously challenge inherent power inequalities (discussed at further length in Ostrach and Cheyney 2014). The emergence of the policy change described here thus offered low-income pregnant women yet another tool to use while advocating for themselves; a PDF of the updated policy was widely distributed to community agencies and providers.

As we shared news of the policy change with providers and advocates throughout the state and nationally, we believed it had the potential to significantly reduce delays in low-income women's access to abortion and prenatal care services. It offered a tangible and theoretical tool for pregnant women and reproductive care advocates to use when holding eligibility workers, case managers, and supervisors accountable for following agency policies, regardless of employees' personal views on abortion. Several Oregon clinics voluntarily reported to Ostrach that their patients experienced faster OHP processing times within just a few weeks of the 2011 policy transmittal. (A follow-up study was later conducted examining the actual impacts of the policy change on OHP coverage delays [Ostrach 2015]).

Critical medical anthropology specifically, and applied medical anthropology more generally, offer strategic avenues for identifying, documenting, and demystifying inequalities in health systems. Moreover, it advocates for policy-based, practical changes that have the potential to improve marginalized populations' access to various forms of health care. In this case, applied medical anthropology research, informed by critical medical anthropology frameworks, was effectively employed in collaboration with public health approaches to gain improvements in the Medicaid application process for low-income pregnant women in Oregon. The resulting policy change and clarification, as well as the community-based advocacy efforts that were established as a result, had the potential to tangibly reduce one obstacle to abortion access in the state, while simultaneously expanding low-income women's early access to prenatal care. This victory can be used as a model in attempts to transform research into policy change in other states and across the country. We hope that this research will inform further reductions in reproductive health disparities among low-income women, reduce barriers to abortion, and improve maternal-child health outcomes for women seeking to carry to term.

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Notes

[1]Of note in this discussion is a terminology issue, which arose in the course of the original study. While not a finding per se, Ostrach noticed that research participants did not find the term "barriers" to abortion care relevant, despite its frequent usage in the literature. Rather,

women seemed to think of 'barriers' as phenomena that would have entirely prevented them from obtaining abortion services, while the term "obstacles" resonated much more meaningfully with participants. Participants seemed to regard obstacles as the better descriptor of factors that made the process of seeking care more difficult or that delayed them from obtaining care.

[2]All participant names used are pseudonyms.

[3]This state representative was eager to have his name used publicly in conjunction with the legislative effort, as evidenced by a press release he approved in mid-2011.

References Cited

Arias, Elizabeth with Marian MacDorman, Donna Strobino, and Bernard Guyer
2003 Annual Summary of Vital Statistics – 2002. Pediatrics 112 (6-1):1215–30.

Bauer, Joanna, Lisa Anus, Nurit Fischler, Kenneth Rosenberg, Teresa Gipson, and Jennifer Devoe
2011 The Impact of Citizenship Documentation Requirements on Access to Medicaid for Pregnant Women in Oregon. Journal of Maternal Child Health 15(6):753–58.

Central Intelligence Agency
2012 The World Factbook. URL:<https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html (November 12, 2014).

Chen, Alice, Emily Oster, Heidi Williams
2014 Why is Infant Mortality Higher in the US than in Europe? NBER Working Paper Social Science Research Council Working Papers series w20525 (2014):1-35. URL: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2502707&download=yes (November 16, 2014).

Foster, George
2009 Bureaucratic Aspects of International Health Programs. *In* Anthropology and Public Health. Robert A. Hahn and Marcia Inborn, eds. Pp. 1039-48. New York: Oxford University Press.

Guttmacher Institute
2014 State Facts about Abortion: Oregon. URL:<www.guttmacher.org/pubs/sfaa/pdf/oregon.pdf.> (November 12, 2014).

Jones, Bonnie Scott with Tracy Weitz
2009 Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences. American Journal of Public Health 99(4):623-30.

National Governors Association
2013 Improving Birth Outcomes in Medicaid. National Governors Association Paper. URL:<http://www.nga.org/files/live/sites/NGA/files/pdf/2013/1307ImprovingBirthOutcomesMedicaid.pdf> (November 12, 2014).

Oregon Health Authority (OHA)
2011 DHS/OHA Treatment of Applications for Benefits for Pregnant Women. Policy Transmittal: Oregon Health Authority SS-AR-11-007. URL:<http://www.dhs.state.or.us/policy/selfsufficiency/publications/ss-ar-11-007.pdf> (November 12, 2014).

Ostrach, Bayla
2015 Did Policy Change Work? Women Continue to Encounter Delays in Medicaid Coverage for Abortion. Journal of Applied Anthropology in Policy and Practice. In press.

Ostrach, Bayla and Melissa Cheyney
2014 Navigating Social and Institutional Obstacles: Low-Income Women Seeking Abortion. Qualitative Health Research 24(7):1006-17.

Singer, Merrill
1986 Developing a Critical Perspective in Medical Anthropology. Medical Anthropology Quarterly 17(5):128-29.

Tanner-Smith, Emily, Katarzyna Steinka-Fry, and Mark Lipsey
2012 A Multi-Site Evaluation of the CenteringPregnancy® Programs in Tennessee. Final Research Report. Nashville, TN: Peabody Research Institute. URL:<https://www.centeringhealthcare.org/forms/bibliography/Tanner-Smith_2012.pdf> (November 12, 2014).

Thorburn, Sheryl, Molly De Marco
2010 Insurance-based Discrimination during Prenatal Care, Labor, and Delivery: Perceptions of Oregon Mothers. Maternal and Child Health Journal 14(6):875-885.

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