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BARRIERS TO AND FACILITATORS OF CARE: EXPLORING HOW LOW-INCOME WOMEN ACCESS REPRODUCTIVE HEALTHCARE IN A RURAL COMMUNITY

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BARRIERS TO AND FACILITATORS OF CARE: EXPLORING HOW LOW-
INCOME WOMEN ACCESS REPRODUCTIVE HEALTHCARE IN A RURAL
COMMUNITY

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Sydney T. Casey
May 2024

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ABSTRACT

The purpose of this research study was to gain a comprehensive understanding of the experiences of low-income women living in a rural community when accessing reproductive care and bring awareness to the barriers and facilitating factors they encounter. The present study adopted a post positivism paradigm and was conducted in a rural county in Northern California. A combination of quantitative and qualitative data was gathered through demographic surveys and individual interviews with twenty-two participants. A bottom-up approach was utilized for the phases of qualitative data analysis, which included open coding, axial coding and selective coding. Data analysis revealed thirteen open codes and various connections between those codes. These codes were broken down into three broader categories: the power of personal experiences at the micro level, the community environment in which services are provided and received, and the broader systemic issues at a macro level.

The researcher identified the deeply interpersonal nature of reproductive healthcare, which is often directly related to a cultural or societal stigma, as a core issue among low-income women living in rural areas. This core issue is further explored along with actions that can be taken to help mitigate this issue including but not limited to helping clients process core beliefs and emotions around care, teaching clients how to advocate for themselves in a medical setting and collaborating with healthcare agencies to provide relevant training for

medical professionals. This research addresses a gap in the existing literature and contributes to both micro and macro social work by offering insight to the barriers that low-income women face, which can guide both clinical practice and policy development. Understanding the experiences of low-income women can be especially helpful to social workers in healthcare settings and better equip them to work with clients.

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CHAPTER ONE: ASSESSMENT

Introduction

This chapter introduces the research focus, exploring access to reproductive healthcare among low-income women, and explains the importance of this topic. The chosen paradigm, post positivism, is also defined and rationalized in relation to the present study. The guiding theory of this research, Empowerment Theory, is introduced and succinctly explained. This chapter also identifies two potential contributions of the study to micro and macro social work, specifically in the field of reproductive justice.

Research Focus

This research explored how low-income women access reproductive healthcare in rural communities including, but not limited to, hormonal contraception, emergency contraception, medical abortions, sexually transmitted infection (STI) screening and care, counseling for infertility, prenatal and postnatal care, screening and care for endometriosis, and counseling for gender-based violence. The research question is as follows: What barriers do low-income women face when accessing reproductive healthcare services and what factors contribute to increased accessibility.

Although progress has been made to increase access to reproductive healthcare over the last century, access is still inconsistent and uncertain for some populations and in certain geographical regions. Existing literature

thoroughly examines inequities in access based on race, gender identity, sexual orientation and disability status (Lovejoy et al., 2022; Ptacek et al., 2021; Trani et al., 2011). Less attention, however, has been given to reproductive healthcare inequities based on socioeconomic status among women or female-identified people in the United States specifically. Thus, the intention of the present research project was to address this gap in literature by providing in-depth insight into the barriers that low-income women face in accessing reproductive healthcare. This research project also offered realistic action steps to take, based on the first-hand experiences of low-income women, to address such inequities.

Paradigm and Rationale for Chosen Paradigm

The present research project employed the post positivist paradigm, which adopts an exploratory lens to identify a problem focus from an area of interest. Once the problem focus is identified, the goal is to develop a logical and comprehensive understanding of that problem (Morris, 2013). In this case, the goal is to develop an understanding of the experiences of low-income women as they attempt to access reproductive healthcare. As this research focuses on the inequities that low-income women face, it is important to acknowledge how individual and collective beliefs surrounding reproductive justice perpetuate those inequities in modern society. Post positivism acknowledges that it is not possible to fully step outside the research and have a completely objective perspective. Thus, to assume that the values of the student researcher have no impact on the observations and analyses of this study would be naïve because the researcher

is a woman and thus, has personal experiences with this issue. Recognizing how personal this problem focus is for the student researcher and being continuously aware of that throughout the process is crucial to mitigate subjectivity.

According to Morris (2013), post positivist research involves collecting qualitative data to capture the complexity of the human experience. In this case the researcher conducted interviews with low-income women to gain insight into their personal experiences. Post positivist research does not begin with a specific hypothesis, but rather allows themes and questions to arise as data collection and analysis progresses.

The rationale for choosing the post positivist paradigm was that it aligned well with the exploratory goal of the present study. The researcher intended to preserve the balance between utilizing the scientific method and invoking creativity to truly glean what the data is conveying, as is expected with post positivist research. This study also aims to help build a foundation for future research to be conducted which will help empower low-income women in their experiences with accessing reproductive healthcare.

Literature Review of Access to Reproductive Care in the US.

This literature review explores the history of access to reproductive healthcare in the U.S. in an effort to provide a more comprehensive understanding of the research topic. Obstacles to accessing reproductive care throughout history are discussed along with how those barriers impact different demographic groups. This review also examines the existing strategies for

increasing access to reproductive healthcare within a community. Lastly, the connection between existing literature and the present study is discussed.

Historical Overview of Access

Throughout the entire history of the US., women's access to reproductive healthcare has been limited and controlled by the government and the patriarchal values of society. In the early 1900's, it was illegal for medical providers to give women any information regarding pregnancy prevention or birth control. In New York in 1916, Margaret Sanger founded Planned Parenthood in an effort to combat the horrific experiences women faced as a result of childbirth complications and illegal abortions (Richards, 2017).

The fight for reproductive rights really gained momentum, however, in the 1960's, alongside the second wave of feminism and the civil rights movement. Although some more perilous forms of birth control, such as drinking liquid mercury, date back to the early 1800's, the first FDA approved oral contraceptive was created in 1960 (Baer, 2002). It was illegal, though, for *unmarried* women to use this birth control until the 1972 Supreme Court decision in *Eisenstadt v. Baird* (Francome, 2004). Correlating a woman's right to use birth control to her marital status is a perfect example of the role that the patriarchy plays within reproductive healthcare.

Forced sterilization has been another method of controlling women's bodies and infringing on their right to have or *not* to have children throughout history. In 1907, the first law surrounding legalized sterilization was passed in

Indiana. This law allowed women to be sterilized involuntarily if they were a prisoner, in a psychiatric institution, or had any other type of physical or mental condition (Amy and Rowlands, 2018). This law, and others like it, illustrate the historical power imbalance in our society based on gender, incarceration status, and disability status. Additionally, for much of the 1900's, women who wanted to be sterilized often couldn't be due to the "Rule of 120," which only allowed the procedure to be performed on women whose age, multiplied by the number of children they had, was equal to 120 (Baer, 2002). Finally, in 1979, sterilizing a woman without consent became illegal, but the practice unfortunately continued in prisons up until 2014 when the Anti Sterilization Bill was passed (Whatcott, 2018).

It would be amiss to explore the history of reproductive healthcare access without discussing abortion access, including the monumental Roe v. Wade case of 1973. On June 24th, 2022, in Dobbs v. Jackson Women's Health Organization, the Supreme Court made the detrimental decision to overturn Roe v. Wade, meaning abortion is currently not a federally protected right. This decision has turned abortion rights over to the states which has resulted in 15 states enforcing bans on abortion, with many having no exceptions for rape or incest. Additionally, abortion rights are limited or ambiguous in many other states (Sommers, 2022). Access to abortions has always been precarious and without access to safe abortions, women will be forced to seek out abortions from untrained providers and will be at a much higher risk for infection and even death

(Painter, 2019). Some researchers estimate that maternal mortality rates could increase by over 20% as state abortion bans come into effect, although there isn't enough data yet to show this conclusively (Compton and Greer, 2022). This Supreme Court Decision was a huge step backwards for reproductive rights and will have significant repercussions for all people who can get pregnant, but especially for low-income women.

Just three years after Roe v. Wade was first passed came the Hyde Amendment, which essentially prohibits the use of federal funding for abortion care, except in a few special circumstances (Adashi and Occhiogrosso, 2017). These circumstances include if the abortion is necessary to save the woman's life or if the pregnancy resulted from rape or incest. This amendment makes it so that women cannot use federally funded insurance, such as Medicaid, to help pay for their abortion. Medicaid can use state funds to pay for abortions, but only sixteen states choose to do so. According to Jones et al. (2013), the abortion procedure alone can cost anywhere from \$500 to \$2,500. Thus, this is an immense barrier for low-income women in particular who either do not have medical insurance or rely solely on their insurance for medical care.

Impacts on Different Demographic Groups

This history of inadequate access to reproductive healthcare is still apparent today and does not affect all women equally. Women of color, queer and transgender people, low-income women, immigrant women, incarcerated women, shelter less women, women with disabilities and women living in rural

areas all experience inequalities in reproductive care to a greater extent (Hooks, 1984). According to one study by Missmer et al. (2011), compared to white women, African American and Hispanic women found it more difficult to get an appointment for infertility treatment and more difficult to take time off work for the treatment. Another study on Somali refugee women showed that lack of insurance, language barriers, and having experienced female genitalia mutilation were the most common obstacles in receiving maternal and reproductive healthcare (Banke-Thomas et al., 2018). These are all barriers that most white, middle-class women simply do not encounter.

One population that experiences some of the most extreme and intersectional inequalities when it comes to accessing reproductive healthcare is incarcerated women. There are higher rates of incarceration among women of color and women with substance abuse issues (Sufrin et al., 2015). As jails and prisons are strictly organized institutions, there is an inherent lack of bodily autonomy. Incarcerated women are also more frequently exposed to violence, injury, sexual assault, and communicable diseases; in fact, the rate of chlamydia is 9% higher for incarcerated women and the rate of HIV is 2.22% higher for incarcerated women, compared to non-incarcerated women (Sufrin et al., 2015). Despite the 1976 Supreme Court case, *Estelle v. Gamble*, which declared access to medical care a constitutional right for incarcerated people, many jails and prisons do not consider contraception a medical priority as it is considered preventative care (Clarke et al., 2006). Providing consistent contraceptive care

for incarcerated individuals is not only a basic right but would benefit the criminal justice system during their incarceration and the greater society upon their release.

Existing Strategies for Increasing Accessibility

There is a plethora of research examining how to increase accessibility to healthcare, but less research specific to strategies regarding reproductive healthcare (O'Reilly-de Brún et al., 2015; Stopka et al., 2017). This specification is important because the target population for reproductive healthcare is narrower than the general population, so strategies that are specifically designed to engage reproductive-age, female-identifying people would be most effective. One study of young, Latina women in Alabama showed that participants identified social barriers of discrimination in the clinical setting and the stigma surrounding sexual healthcare access (Morales-Alemán et al., 2019). This research from Morales-Alemán et al. (2019) also proposed that community-driven, multilevel intervention strategies should include educating healthcare professionals on the effects of discrimination and destigmatizing sexual and reproductive healthcare.

In recent research from Singla et al. (2021), a unique strategy was suggested for increasing access to reproductive healthcare, maternal mental health services. This research suggests “task-sharing” among non-specialist providers so that more women can be seen quicker and more frequently in order to be screened and treated for perinatal depression and anxiety. Telehealth

practices have already increased during the COVID-19 pandemic but utilizing non-specialist providers could help increase care access as long as the quality of care is not compromised due to a lack of specialized knowledge (Singla et al., 2021).

Connection Existing Literature to the Present Research

This literature review illustrates the historical inequalities in accessing reproductive healthcare, which should be considered a basic human right. It is clear that certain populations are impacted disproportionately by this issue and this disparity can have serious medical and mental health consequences. Although the existing literature acknowledges that low-income women face additional barriers to accessing reproductive care, little research has been done to explore the experiences of low-income women, from their perspective. The existing strategies for increasing access to reproductive care also do not adequately address the barriers specific to low-income women. Thus, the present study aims to build on existing research by seeking out the first-hand experiences of low-income women and using their opinions to create a plan of action for addressing this unequal access.

Literature Review of Empowerment Theory

This literature review adopts a diachronic approach to critically examining one of the theories underlying this study: empowerment theory. A historical overview of empowerment theory, within the context of social work, is provided.

The eleven core assumptions of the theory are also discussed. Lastly, this review addresses the merits and limitations of empowerment theory.

Historical Development

The nature of empowerment makes it possible for empowerment theory to be applied to a broad range of fields. Historically, it has been applied to social work (Evans, 1992), psychology (Spreitzer, 1995), public health (Ratna and Rifka, 2007), political science (Bachrach, 1992), gender studies (Eger et al., 2018), and nursing (Laschinger, 1996). Many scholars credit Julian Rappaport as the earliest, explicit advocate of empowerment theory (Carr, 2003; Joseph, 2020). In the early 1980's, Rappaport published multiple articles defining empowerment theory as both a process and an outcome (Rappaport 1981; Rappaport 1984), which is an assumption that has been unclear in literature over the past four decades (Carr, 2003). For example, Peterson (2014) describes empowerment as an "active, participatory process" (p. 1) whereas Wilkinson (1998) posits empowerment as a solution to be achieved. Despite this historical ambiguity in defining empowerment, it seems that more recent literature is shifting towards describing it as processual (East, 2000; Gutierrez 1995). Specifically, East (2000) explains that empowerment itself is a process which often leads to individual and interpersonal outcomes.

Core Assumptions

The core assumptions of empowerment theory were initially put forth by Rappaport (1987). These eleven core assumptions have been adapted for

various domains since then, but have generally been consistent (East, 2002; Peterson, 2014). The first two assumptions are that empowerment is a multilevel construct and the impact of one level of analysis on the others is important (Rappaport, 1987). Another scholar, Marc Zimmerman (1995), similarly identified three subcomponents of psychological empowerment: an interpersonal component, an interactional component and a behavioral component. It is through these components that one experiences empowerment.

The third and fourth assumptions relate to historical and cultural context. Essentially these assumptions adopt an ecological perspective in concluding that the environment and culture in which a person operates have an impact on the outcomes of the process of empowerment. The fifth tenet, according to Rappaport (1987), proposes that longitudinal research is necessary when it comes to studying empowerment because the process of empowerment is not always linear or swift. This speaks to human nature as humans are inherently flawed. The sixth assumption relates to the utilitarian nature of empowerment theory as it suggests the theory is a worldview theory (Rappaport, 1987). Despite the theory's American origin, it can be and has been applied to populations and agencies all over the world (Kim et al., 2017; Ray, 2014; Yazdkhasti et al., 2019).

The seventh tenet put forth by Rappaport (1987) assumes that the conditions of participation will affect the empowerment of the participants. For example, an individual grudgingly engaging in an empowerment program to fulfill some requirement may not experience the same level of empowerment as

someone choosing to participate in the program. The eighth and ninth assumptions relate to community-level empowerment and state that an empowerment ideology increases resourcefulness and that locally developed solutions are more empowering than general solutions (Rappaport, 1987). These tenets offer a helpful starting place for agencies looking to empower their communities. The tenth value of empowerment theory posits that the size of the setting matters; carrying out a process of empowerment on a micro level will look much different and have differing results than on a macro level.

The eleventh and final tenet of empowerment theory is perhaps the most important and powerful as it assumes that empowerment is not a limited resource, but rather one that tends to spread once it has been adopted by an individual, community, or society (Rappaport, 1987). This tenet seems to align best with the ethics and work of social workers. The goal of social workers, whether working on a micro, mezzo or macro level, is generally to empower people through knowledge, skills, and support to gain control over their lives and reduce inequities in society. Understanding that something as valuable as empowerment is not scarce or finite is crucial to the efforts of social workers as change agents.

Merits and Limitations

One frequently discussed limitation of empowerment theory is the inherent difficulty in measuring empowerment (Richardson, 2017). Richardson (2017) points out that improving empowerment measurement techniques is a commonly

identified priority in psychological and sociological research. On the other hand, the theory of empowerment does hold up well regarding empirical support as there is an abundance of literature, which is utilized in this review, on the theory over the past four decades. This data includes a variety of qualitative and quantitative studies and seems to support the early work of Rappaport (Eger et al., 2018; Gorter et al., 2015; Gutierrez, 1995; Kim et al., 2017). Thus, although there are some challenges to measuring empowerment, it is a coherent and empirically supported theory which can be applied to a broad range of fields of study and populations.

Potential Contribution of the Study to Micro and Macro Social Work Practice

This research contributes to both micro and macro social work by revealing the inequitable access that low-income women face while also offering personal insights which can guide both clinical practice and policy development. Understanding the experiences of low-income women attempting to access reproductive care can help micro level social workers be better equipped to work with clients by specifically targeting the barriers that these women feel most inhibited by. This knowledge could be especially useful for medical social workers who may see inequities in health care firsthand and those working with reproductive age women who come from a lower socioeconomic background.

On a macro level, policy makers are not always members of the communities for which they develop policies. Therefore, they may not completely understand the challenges that these communities face. For example, a middle-

class, male identifying policy maker cannot truly understand the barriers that low-income women face when accessing reproductive health care. Having some insight into the direct experiences of those groups, however, could help them gain a more realistic and comprehensive understanding of their needs. As a result, policy development surrounding access to reproductive healthcare can be more informed and ultimately more effective.

Chapter Summary

This chapter introduced the research topic: How do low-income women access reproductive healthcare in their communities and what factors act as barriers or facilitators? A post positivist paradigm was proposed and justified along with a guiding theory, empowerment theory. This chapter provided a literature review of the research topic, including a historical overview of the issue and its roots, the impacts on different populations and existing strategies for combating the issue. A literature review was also provided on empowerment theory, which included the theory's historical development, core assumptions and merits and limitations. Lastly, this chapter illustrated how the present study could contribute to the field of social work by providing essential insight for social workers into the unique experiences of low-income women.

CHAPTER TWO: ENGAGEMENT

Introduction

This chapter outlines the preliminary process of the engagement phase of the present research study. It begins with providing an overview of the county in which the researcher will conduct the study, including the demographic composition of the county. This chapter also covers how the researcher will prepare for the study personally and regarding data collection. Issues of diversity are addressed, along with ethical and political issues that may arise, and strategies to acknowledge and mitigate them are proposed. Lastly, this chapter discusses the role that technology plays in the study.

Study Site

The researcher did not directly partner with an organization, but rather recruited participants from an entire rural community in the Northern California. As of 2021, this county's estimated population is 68,766 people with 49.9% of those being female (*U.S. Census Bureau QuickFacts, California*, n.d.). That means there are roughly 34,380 female identifying individuals in the county. This same data also shows that 21.8% of the county's population is under the age of 18 and 23.1% are over the age of 65. As the only age requirement for the present study was being over the age of 18, that left 78.2% of the population as potential participants based on age alone. The racial breakdowns for the county are as follows: 66.7% White, 23.9% Hispanic or Latino, 4.7% American

Indian/Alaskan Native, 2.1% Black, 1.5% Asian and 1.1% identify as multiple races. There was no race requirement for the present study, but it is important to be aware of. Perhaps the strictest constraint of this study, however, was that of income. According to this data, the median household income is \$49,254 and 15.9% of the population is living in poverty (*U.S. Census Bureau QuickFacts, California*, n.d.). Thus, from a solely socioeconomic standpoint, nearly 16% of the population was eligible to participate in the present study. As the researcher did not partner directly with an agency or organization, there were no relevant gatekeepers to engage.

Self-Preparation

Post positivism, the chosen theoretical orientation for this study, focuses on collecting and analyzing data from an exploratory lens. In this case, the population of low-income women may experience intersectional forms of oppression due to overlapping identities, such as socioeconomic status *and* race or socioeconomic status *and* gender identity. It is for this reason that self-reflection was a very important step for the researcher; this included reflecting on the researcher's own privilege and biases as white woman and considering how those may emerge during data collection. Although the researcher comes from a low-income background, it was crucial not to assume that others' experiences are the same. Thus, self-reflection was not only critical in preparing for the implementation of the study but continued to be important throughout the collection and analysis of the data.

Another important aspect of self-preparation was for the researcher to be knowledgeable on the history of access to reproductive healthcare and empowerment theory as it relates to reproductive justice. This involved education not only from existing literature, but also from community members who have been involved in this social justice issue. Thus, the researcher worked on making connections with community members who had relevant knowledge and experience to gain a comprehensive understanding of the issue at a local level. The researcher was able to connect with an educator at the local Planned Parenthood center via Zoom to ask questions and gain some insight on the issue in the community of focus.

To prepare for data collection, the researcher focused on building rapport with the participants, as they were often discussing sensitive topics, and cultivating a teaching learning relationship. Once the interview questions had been decided upon, it was important for the researcher to conduct a few mock interviews with family and friends to get feedback on comprehensibility and pacing. These mock interviews gave valuable insight into the clarity of the questions and offered helpful practice for the researcher. The researcher also prepared a system for ensuring all data collected remains confidential. The researcher was also required to take trainings related to working with human subjects, so being mindful of completing those in a timely manner was important.

Diversity Issues

As the only requirements for participation in the present study were being low-income, female-identifying, and over 18 years old, this allowed for a diverse group of research participants. Identities such as sexual orientation, race, religion, and disability status were not specified and thus varied significantly. As the researcher is white, being aware of and acknowledging this privilege was especially important. The primary strategy to address these diversity issues involved being honest with participants about the goal of exploring individual experiences and how their participation could contribute to that goal. Employing basic therapeutic skills such as active listening, open body language and reflection of feelings helped with this. Another key strategy to address these diversity issues was making sure that intersectional identities are properly represented in the data collection, which was accomplished by asking about race and ethnicity in the demographic section. This aided in providing a more comprehensive picture of the barriers to accessing reproductive healthcare.

Ethical Issues

Given the sensitive nature of the research topic of reproductive care, it was expected that many participants would be concerned about confidentiality. Asking questions about a personal topic such as this would have been very difficult if participants were not assured that their participation would be confidential. Thus, the researcher made sure to inform the participants that no identifying information would be shared. All identifying information was password

protected and only accessed by the researcher. Video recordings were not used as this may have made people feel uncomfortable or unsure of their confidentiality. Instead, the Zoom transcription feature was used, and those recordings were encrypted, password protected, and deleted once the data analysis was complete. Taking the time to thoroughly explain this process to the participants before the interview helped them feel more confident in their anonymity and thus, more comfortable sharing personal details.

Another ethical issue that arises with most studies involving human subjects is the potential for harm. In this case, the interviews had potential to cause some degree of psychological harm depending on the participant's past experiences within the healthcare system and in regard to their sexual health. Assessing and anticipating these risks can be helpful in mitigating the impact on participants (Morris, 2013). The researcher asked participants to read and sign an informed consent prior to the interview, which informed them of the topics being discussed so they are fully aware before beginning. This debriefing statement also included a list of relevant community resources for obtaining mental health treatment and emotional support if desired.

Political Issues

The issue of reproductive justice has been a very prominent topic in the media and politics the past few years, in large part due to the Supreme Court overturning *Roe v. Wade* and multiple states passing laws that significantly limit abortion access (Tanne, 2021). Thus, it was expected that political issues would

arise throughout the implementation of this study. Participants could have felt hesitant to share details of their experiences accessing care for fear of retaliation or judgment. The study also highlights the fundamental flaws in our healthcare system which create barriers to care, so individuals who work in the healthcare field or have loved ones who do could have been hesitant to engage with the researcher at first. These issues were successfully combated, however, by taking the time to build a solid foundation of trust with the study participants.

Some aspects of reproductive healthcare, such as abortion, can also be very controversial due to religion and other personal beliefs. The researcher was prepared for this to arise and approached all conversations with respect for others' beliefs, even if they are different from those of the researcher. This approach aligns with the ethical value of respecting the dignity and worth of a person (National Association of Social Workers [NASW], 2008, Ethical Principles). Social workers are expected to treat all people in a respectful manner, while being mindful of cultural differences. This includes when conducting research.

The Role of Technology

The researcher utilized email to communicate with study participants. Email, Facebook, and other social media sites were also used for outreach efforts in order to recruit eligible participants for the study. Lastly, Zoom was also used to interview the participants and the audio transcript feature was enabled so that transcripts were automatically produced after the interview.

Chapter Summary

Chapter two discussed the county in which the study was conducted and gave an overview of the demographic makeup of the community. This chapter also addressed multiple ways in which the researcher prepared for the study, including self-reflection and education to prepare for any diversity issues that may have arisen. Ethical and political considerations were also explored, including strategies to address them. Lastly, the role of technology in the study was discussed.

CHAPTER THREE: IMPLEMENTATION

Introduction

This chapter presents practical strategies related to the implementation of the study. The characteristics of study participants are discussed as well as the sampling strategy for selecting the participants. This chapter also addresses specific techniques for gathering the data, along with a step-by-step explanation of each phase of data collection. Lastly, the processes of recording and analyzing the data are described.

Study Participants

A total of twenty-two female participants were selected for this study using the methods explained in the subsequent section. The number of participants reflected the researcher's recruitment efforts. For this study, demographic metrics such as age, ethnicity, income, insurance status, education level and employment status were asked. The following graph illustrates the age distribution of these participants.

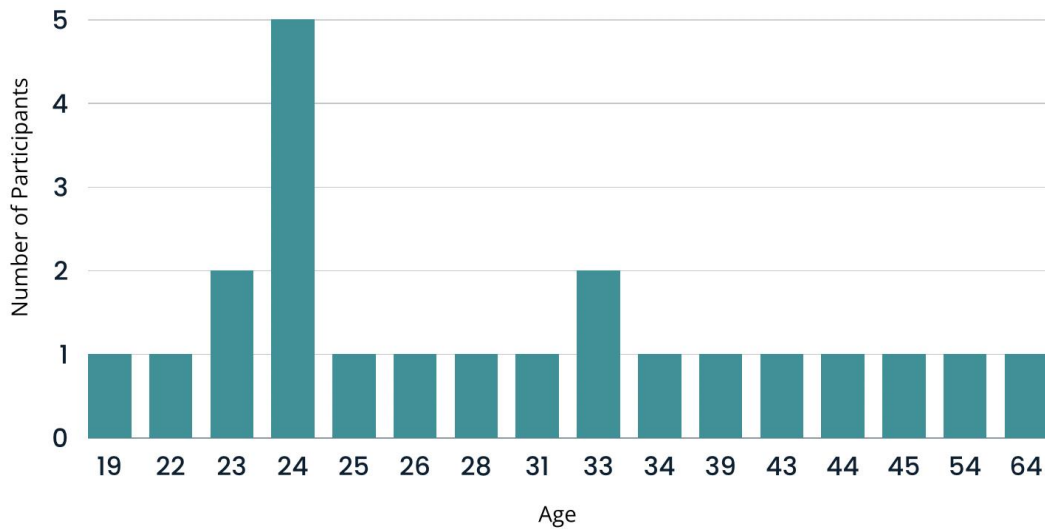


Figure 1. Participant Ages.

The participants' ages ranged from 19-64 years old. Ethnicity was also accounted for in the demographic survey to ensure that any racial or ethnic disparities in care were acknowledged. The following graphs display the ethnic makeup of the twenty-two participants.

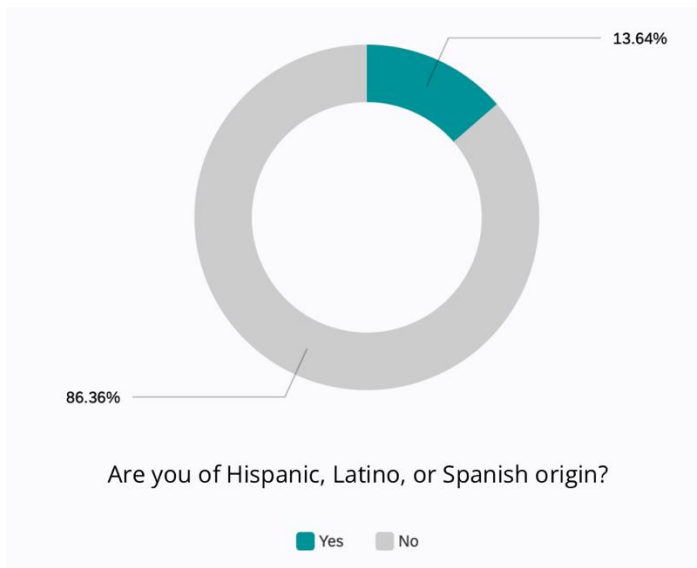


Figure 2. Participant Racial Identification.

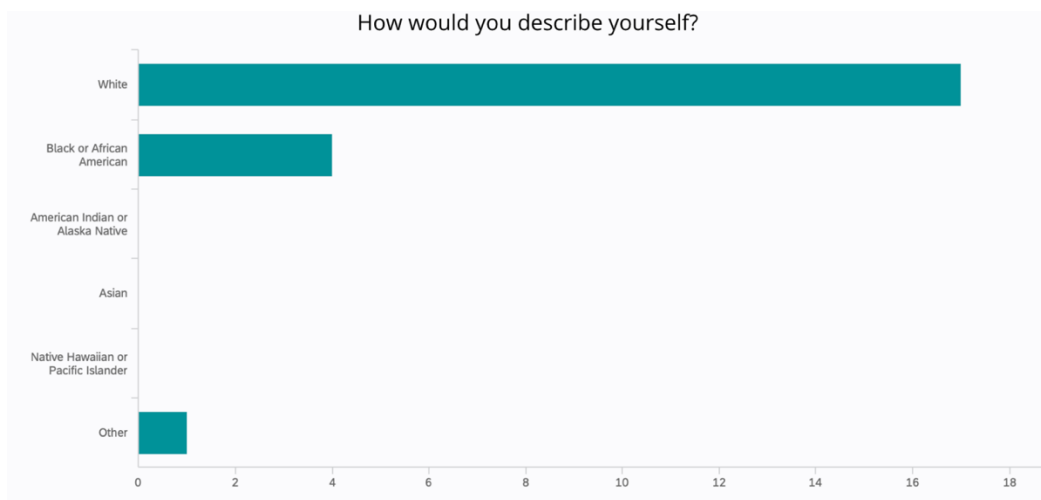


Figure 3. Participant Racial Breakdown.

These graphs show that most participants (17) identified as White, which is important to note. One participant did mark “other,” but did not provide any details in the text box. It is also clear that most participants (86.36%) were not of Hispanic, Latino, or Spanish origin. Income level was also accounted for as this

study specifically explored low-income women; the income distribution is shown in the graph below.

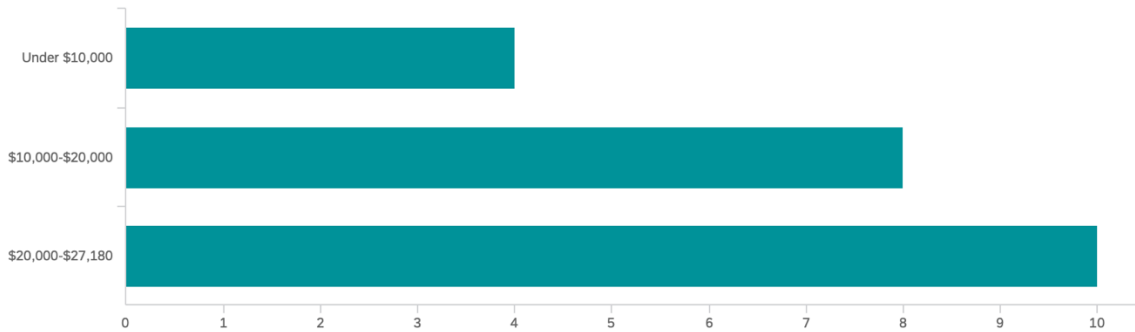


Figure 4. Participant Income.

Insurance status was also accounted for in the demographic survey. The following chart shows that most participants did in fact have some type of health insurance, which is important to note as this arose as both a barrier and a facilitating factor in the interviews.

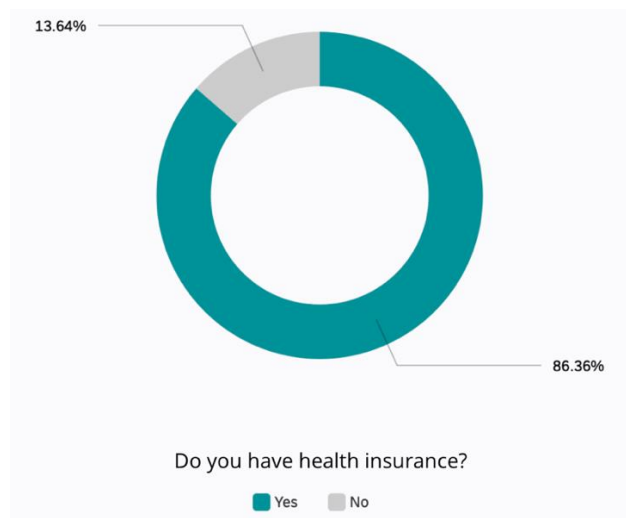


Figure 5. Participant Insurance.

There was also a text box for those participants who responded “yes” to list their insurance carrier. The carriers reported included Kaiser, United, Medical, Cigna, Alameda Alliance, Blue Cross, Blue Shield Blue Cross (BCBS), and Aetna. Completed education level was also accounted for, which is illustrated in the chart below.

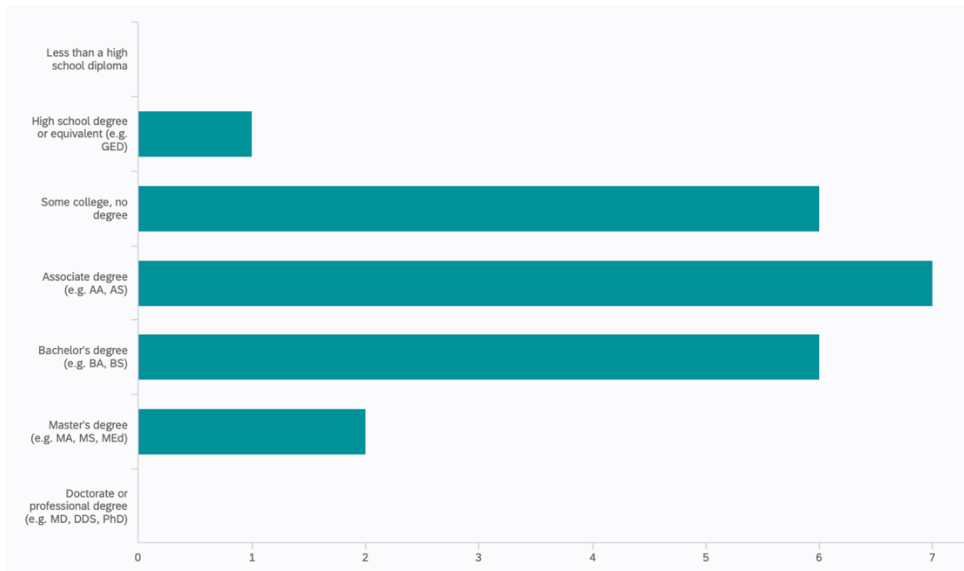


Figure 6. Participant Insurance Type.

Lastly, employment status was accounted for and arose as both a barrier and facilitating factor in the subsequent interviews. The reported employment statuses are shown in the following chart.

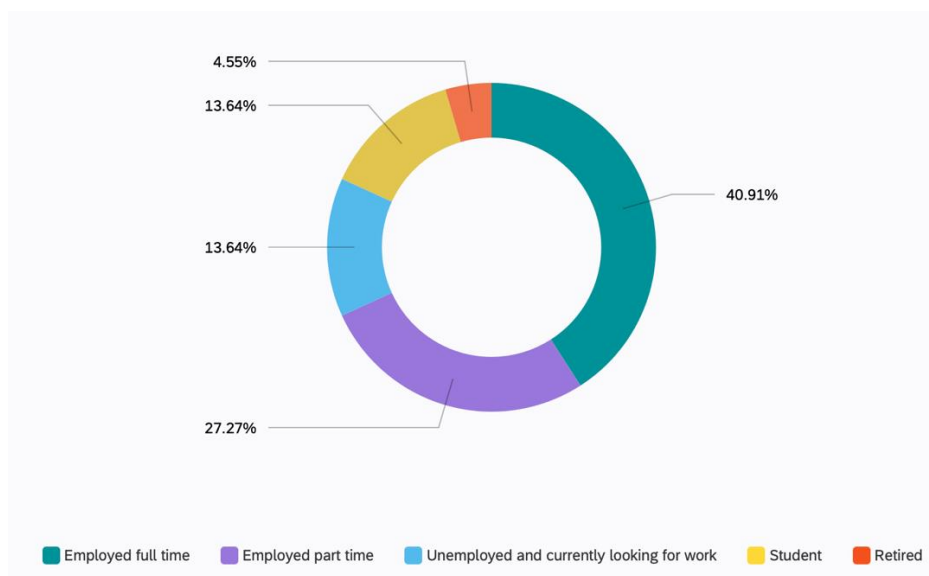


Figure 7. Participant Employment Status.

Selection of Participants

For this study, the participants were required to be low-income women. By the standard of the US. government, “low-income” includes anyone whose income is less than double the federal poverty level (FPL). The FPL for 2022 depends on the number of people in a household but, for a single person household, is \$13,590 (*Poverty Guidelines, 2022*). By these standards, anyone who makes less than \$27,180 (double the FPL) in 2022 is considered “low-income” if they are the only person in their household/family. Thus, using these standards by the US. government, the present study included participants whose annual income is less than \$27,180. As this study also focused on the experiences and oppression of women, in particular, the participants were all female identifying to fit the criteria. As this research project focused on adult

women, not teens or children, the participants were also required to be 18 years of age or older. Thus, these requirements were used when selecting participants.

Purposive sampling is commonly used for qualitative studies and involves selecting individuals for inclusion based on their characteristics. As this study required participants to have specific characteristics, purposive sampling was the most appropriate approach. Specifically, this study utilized criterion sampling because it is a purposeful strategy for selecting participants due to the fact that they meet relevant, predetermined criteria. It involves selecting participants based on certain characteristics, such as income level and gender identity in this case, that are important to the study (Morris, 2013). In this case, income, gender, and age were criteria deemed important for the specific purpose of this study and thus, had to be met in order to participate. The goal of the present study was to explore the experiences of low-income women, so it would not have made sense to select participants with a high income.

Data Gathering

As the present research employed a post positivism paradigm, data needed to be gathered in a more naturalistic setting through interviews. First, data related to Empowerment theory was collected via research and literature reviews in order to develop the ideological analysis which served as a guiding framework for the study. A combination of qualitative and quantitative data was collected from the study participants, with the qualitative data being the primary method of exploring the personal experiences of the women. In terms of

quantitative data, the researcher utilized a short Qualtrics survey in order to gather demographic information such as age, annual income, racial background, employment status and medical insurance status. Informal interviews were then used to gather qualitative data from participants about their personal experiences and history with accessing reproductive health care. This data was used to gauge the needs of low-income women, which then informed the action plan.

Data Recording

The transcription feature on Zoom was used to record the one-on-one interviews with all participants. These recordings were then reviewed by the researcher to ensure an accurate depiction of the interviews was produced and used. The demographic data was recorded in Qualtrics. Two research journals were utilized throughout this study, one journal documenting the narrative account of everything that was happening and one reflective journal recording rationales for decisions made regarding the research (Morris, 2013). As this study adopted a post positivism paradigm, the researcher used these journals to brainstorm possible approaches to the problem focus.

Data Analysis

As the present study yielded a mixture of quantitative and qualitative data, various types of data analysis were used. The Qualtrics study only included closed-ended questions, meaning the participants were required to select one answer from multiple choice questions. Thus, this data yielded numerical

statistics using univariate analysis. Most of the data collected, however, was qualitative. This data was analyzed using a bottom-up approach as this method is more exploratory. Bottom-up qualitative analysis involves breaking down the interview transcripts into general themes through a process called open coding (Morris, 2013). This process allowed the researcher to identify commonalities and differences among reported barriers and facilitators to accessing reproductive care and develop various open codes. The next step in the bottom-up analysis was axial coding, which involved identifying relationships between the various open codes (Morris, 2013). This helped to recognize overarching themes conveyed by the data. Lastly, selective coding was completed, which involved using the open codes and connections from the prior stages of analysis to glean the story being told by the data and the relevant implications for social work practice. This analysis allowed the researcher to truly understand the relationship between participant's identities and their experiences with accessing care.

Chapter Summary

Chapter three explained the process of selecting study participants using purposive sampling, specifically criterion sampling, and discussed what characteristics those participants possessed. The methods of data gathering were also explored, including conducting literature reviews, administering a quantitative demographic survey, and conducting qualitative one-on-one interviews. The phases of data collection were also described. Lastly, the

process for recording all collected data was explained along with a detailed bottom-up approach for analyzing the qualitative data.

CHAPTER FOUR: EVALUATION

Introduction

This chapter describes and interprets the study findings. The data analysis methods are discussed more in depth including open coding axial coding, and selective coding. The specific open codes discovered are stated and thoroughly defined, including direct quotes from participants. The connections and themes derived from the process of axial coding are explained and depicted in a graph to provide a simple yet comprehensive picture for the reader. Lastly, the process of selective coding is described including the core issue identified by the researcher and the implications of this issue for social work practice.

Data Analysis

The present study utilized post positivist qualitative data analysis. The researcher annotated the twenty-two participant transcripts and created a list of open codes based on the recurring themes. The process of open coding involved reading each transcript and identifying words and phrases and categorizing them into different labels which were then defined based on the detailed responses of participants.

Open Coding

During the process for open coding, the researcher developed thirteen primary open codes. The open codes that arose were as follows: negative feelings around care, positive feelings around care, neutral feelings around care,

cost as barrier, free/low-cost resources as facilitating factor, impact of insurance, types of care, lack of personal and organizational knowledge, impact of employment, negative stigma around care, logistics (positive or negative), impact of religion, and prejudice based on identity. These codes are thoroughly defined in the following sections.

Negative Feelings Around Care. This code encompasses specific negative emotions surrounding receiving reproductive care that emerged when speaking with participants. These negative feelings included inconvenienced, afraid/scared, annoyed, frustrated, uncomfortable, hesitant, apprehensive, overwhelmed, worried, anxious, nervous, embarrassed, and ignored. For example, when asked how they felt about making an appointment to receive care, Participant #5 said, “It feels like such a chore...I just wish it wasn’t such a hassle.” In another interview, Participant #4 described their experience getting a pap smear and recounted, “It was terrible and uncomfortable I literally hated every second of it.”

Another negative emotion that fit into this category was a distrust in the medical system. Participant #15 described their negative experience with receiving prenatal care and explained, “How in the world can we have a reliable health care system for women, especially women of color like me... they wouldn’t listen to me.” The negative feelings described by participants were either connected to the individual’s own experiences and beliefs or to the treatment they received from medical providers. For example, Participant #19 stated,

“...even when I said I wasn’t comfortable with it, he [medical provider] really kept pushing me and insisting that I do it... that kind of made me hesitate about getting reproductive healthcare in general.”

Positive Feelings Around Care This code refers to specific positive feelings related to receiving reproductive care that came up in interviews. The positive emotions described include feeling comfortable and responsible. When asked how they feel about receiving reproductive care, Participant #3 stated, “Well, it feels good to stay on top of my health.” Similarly, Participant #7 mentioned, “I feel good about taking care of my body and just being responsible.” Additionally, this open code includes positive emotions specifically because of treatment from medical professionals. For example, Participant #2 explained, “The doctor at the local one [low-cost clinic] is really kind and down to earth so she makes everything really comfortable for me.” Although this was the only participant to use the word comfortable as a descriptor, it was important to include it as it illuminates how a medical provider can impact one’s experience around receiving care.

Neutral Feelings Around Care This code refers to any times when participants described neutral emotions around receiving reproductive care. The two neutral emotions named by participants were fine and ambivalent. For example, Participant #9 simply said, “I feel fine” when asked how they feel about receiving care. Similarly, Participant #19 explained, “I feel pretty much okay about it.” Occasionally when these neutral feelings were mentioned, they were

accompanied by a description of negative feelings. For example, Participant #3 stated, "... so that time I felt weird and annoyed, but I usually feel fine, ambivalent I guess."

Cost as a Barrier. This code was chosen because fifteen participants specifically talked about how the cost of medical treatment, or a lack of personal financial resources have prevented them from seeking or receiving reproductive care. For example, Participant #7 recalled, "I moved to [another state] for a while and I no longer had affordable access to the birth control pill, so I just stopped taking it." In this case, the participant was forced to stop using contraceptive care due to financial barriers. During another interview, Participant #9 revealed, "when I think about making an appointment, the very first thing that crosses my mind is cost. I always worry about how much this will cost and if it will be worth it." Similarly, Participant #12 explained, "I just instantly think about how much it's going to cost me and where I'm going to come up with the money. If it's not something super serious I'll usually just put it off because I can't afford it." While recounting their experience with attempting to receive prenatal care, Participant #14 stated, "I couldn't even afford just one appointment."

Free/Low-Cost Resource as a Facilitating Factor. This code refers to the instances in which participants mentioned a free or low-cost resource as a helpful factor in their experience accessing reproductive care. These resources included free community clinics, teen clinics, and nonprofit agencies. When asked about factors that make it easier to get reproductive healthcare, Participant 8 explained,

“...the teen clinic has also been helpful to me, I think every time I have accessed Plan B has been for free through them.” Similarly, Participant 11 stated, “...honestly, without the teen clinic, I don’t know what I would do.” Ultimately, eleven out of the twenty-two participants mentioned a free or low-cost resource as a factor that helped them access reproductive care at one point.

Impact of Insurance on Care. This open code encompasses anytime a participant mentioned the impact, positive or negative, of health insurance on their ability to access reproductive care. Some participants spoke about the benefits of having health insurance, whether it be their own or their parents’. For example, Participant 3 mentioned, “The most helpful thing, though, is still being on my parents’ insurance.” Likewise, Participant 19 told the researcher, “I know that having insurance is a blessing, it’s always been helpful.”

On the other hand, many participants explained how their lack of insurance has been a barrier to receiving care or how the insurance they have is inadequate and thus, still acts as a barrier to care. Specifically, Participant 2 remarked, “When I didn’t have insurance, I couldn’t go to my regular doctor for a while.” Additionally, Participant 9 recalled, “It was definitely easier when I was younger and still had my parents’ insurance because now my insurance has limitations and pretty high co-pays so things can get costly.” Similarly, Participant 10 stated, “There was a time when I was younger and didn’t have insurance because I just didn’t know how to get it... during that time, I didn’t really go to the

doctors at all.” It is important to note that all but two participants mentioned the impact of insurance on their ability to access reproductive care.

Types of Care. This code simply denotes the various types of reproductive care mentioned by participants throughout the interviews. The specific types of care that arose in conversation include abortion related care, STI/HIV prevention and treatment, birth/delivery related care, prenatal care, postpartum care, infertility care, menstrual care, contraceptive care and general preventative care. Specifically, Participant 10 recalled, “I also had an abortion once, also a long time ago, in college because— I just wasn't ready.” Participants 1 and 14 also mentioned receiving abortion related care. When asked if they had any experience with STI testing, Participant 15 explained, “...it was confirmed I had STIs, but I was given medications to treat it.” Participant 20 remarked, “I gave birth in a hospital with all 4 of my kids.” While discussing their experience with prenatal care, Participant 17 recalled, “when I was about to give birth to my first child, I went to that free clinic a few hours away because I wanted a checkup to make sure my baby was okay, and they did a free ultrasound and gave me free vitamins.” Contraceptive care was a very common type of care accessed by participants. In fact, every single participant acknowledged having some experience accessing some type of contraceptive. Participant 8 stated, “I’ve accessed birth control and Plan B a few times.” General preventative care, such as annual checkups and pap smears, were mentioned in twelve of the twenty-two interviews.

Lack of Personal and Organizational Knowledge. This code refers to the instances in which participants expressed confusion, unawareness, or misinformation regarding either the healthcare system and available resources or the actual nature of reproductive care. For example, Participant 2 was detailing their experience receiving care at a low-cost clinic and explained, "...if I had to go somewhere else for some reason, I wouldn't know where to go." Similarly, Participant 4 remarked, "If I needed something besides birth control, I wouldn't know where to go." In some cases, this lack of knowledge prevented the participant from even seeking care. Specifically, Participant 7 admitted, "...I had no clue where to start so I just didn't bother." When Participant 18 was recounting their experience seeking reproductive care for the first time, they said, "I didn't really know the healthcare system or even where to go so it was very overwhelming and I felt like there were no resources to guide me."

The lack of knowledge about reproductive care itself can be seen in statements like that of Participant 8 when they said, "...it can be really confusing and difficult to make informed decisions like what type of birth control is right for me." Likewise, Participant 10 recalled, "I remember just going with the pill because I didn't know about any other options. I probably would've got something more long term if I would have known." Additionally, Participant 11 stated, "I feel like so many people just don't know what safe sex really means and a lot of the outcomes of having unsafe sex are preventable."

Impact of Employment. This open code refers to the times that participants mentioned the impact of their employment, either positive or negative, on their ability to access reproductive care. Only one participant, though, mentioned their employment having a positive impact. While discussing their experience going to multiple reproductive care appointments in a short period of time, Participant 3 explained, “My job has been pretty flexible with me going to appointments and I know that not every job is like that.” On the other hand, Participant 18 stated, “My company doesn't offer any sort of health care benefits for part time people, so I'm just kind of stuck.” In this case, the employer's benefits acted as a barrier, but more often, participants expressed employment obligations as a barrier. For example, Participant 14 explained, “There've been times when I didn't have enough time [to receive reproductive care] due to my work.” Likewise, Participant 15 acknowledged, “I usually do not have enough time off work during the week to get reproductive health care.”

Negative Stigma Around Care. This code refers to the instances in which participants spoke about experiencing or being impacted by a perceived negative stigma around reproductive care. Specifically, Participant 18 described, “...there's just so much judgment I feel like and I think sometimes people assume why a woman might be going to a clinic and they make a judgment about her just because of it.” Similarly, Participant 10 recalled, “When I was younger, those things [STI/HIV testing] were really kind of taboo so you didn't want to go get tested because people would think you're— I don't know, dirty, I guess.” When

asked how they felt about receiving reproductive care, Participant 4 explained, "...it [sex education] just makes the female body seem so icky and gross, that's just the viewpoint of the society I grew up in, so, yeah I just feel so icky because of the stigma surrounding it." As can be seen from these quotes, the negative stigma around care was often internalized by participants and impacted their decision or ability to seek care.

Logistics. This open code encompasses the various instances in which participants discussed experiencing some kind of logistical barrier to receiving care. The *negative* logistical barriers mentioned by participants include long wait time, lack of transportation, scheduling, navigating online systems, communicating with pharmacies, and the locations of healthcare facilities. For example, when asked what factors make it difficult to access care, Participant 3 explained, "I think the wait time is the biggest thing, especially because this stuff can be time sensitive if you know you're going to be sexually active." Similarly, Participant 10 revealed, "I don't bother making appointments because they just take so long to get." When asked about barriers to care, Participant 2 stated, "Being out of a car at times has made it hard." Participant 21 was describing an incident in which they ran out of birth control pills and said, "It was really hard for me to get it filled again so I had to be off it for two weeks I think because my doctor's office was backed up, so that messed with me." Participant 17 mentioned a free clinic they received care at once, but stated, "...it's very far away from my house, though, so I can't use that often which sucks."

The *positive* logistical factors mentioned include virtual or mail services, resources at an educational institution, having access to transportation, and short wait time. Specifically, Participant 21 explained, "...the online advice nurse has been helpful a few times since I didn't know if I needed to come in or not for certain symptoms." Participant 6 recounted, "When I was in undergrad, it was so easy to just walk into student health with any problem and they could help pretty fast." While discussing facilitating factors, Participant 10 stated, "I've always had a car or a friend to give me a ride, which has been helpful." Participant 13 stated, "There is a long wait to get in to see the doctor if you are not already a patient, so I was able to see my doctor the same week since I was already established."

Impact of Religion. This code refers to any time a participant mentioned the impact of religion, positive or negative, on their ability to access reproductive health care. Participant 18 explained, "It was also a very religious state and so that kind of created some barriers with that added shame." Similarly, Participant 20 explained, "I've never had an abortion, I couldn't- the church doesn't really allow that." Participant 15, however, found support in their religious organization. Participant 15 stated, "My church has really played a great role in my reproductive health; they have supported me financially throughout my thirty-six weeks of being pregnant." Additionally, Participant 14 said, "My church paying for prenatal appointments was a huge help because it meant that me and my baby could actually receive quality care." Only four participants brought up religion as a factor, but it was an important aspect of their experiences.

Prejudice Based on Identity. This code encompasses the instances in which participants described experiencing some form of prejudice while seeking or receiving reproductive care due to their gender identity, race, or sexual orientation. Participant 1, for example, acknowledged the gender disparity in reproductive care. They remarked, “They should make birth control for...why do women have to deal with mood swings and weight gain to prevent pregnancy when men are the ones who can get a different girl pregnant every day? It pisses me off.” Participant 6 also described their experience receiving care as a member of the LGBTQ+ community and explained, “I’ve just had pretty negative experiences whether it’s getting birth control or just general checkups when they ask about things like your sex life, just the ‘being gay’ aspect of it is always so awkward because it forces you to come out, which is not fun... it’s pretty uncomfortable.” Participant 6 went on to suggest that medical providers receive more training around the nuances of reproductive care for the LGBTQ+ community.

Racial prejudice was an issue that arose in multiple interviews with participants. Specifically, Participant 19 described a traumatizing experience in which their pain was ignored and minimized while receiving reproductive care and they stated, “I think it’s kind of common, especially for Black women.” Participant 15 stated, “I feel reluctant to access care because a lot of medical professionals have treated me poorly in the past due to my race and honestly, I often worry if they will give me less quality care because of my race...if people

say racism in healthcare isn't a problem anymore, they're either oblivious or white.”

The thirteen open codes described above successfully encapsulate the different themes, issues and experiences discussed across the twenty-two interviews. Although some open codes were more prominent than others, each code helped convey the unique experiences of participants. This stage of data collection allowed the researcher to begin to understand the barriers and facilitating factors that low-income women face when accessing reproductive health care.

Axial Coding

Once the process of open coding was completed, it was clear that axial coding was needed to further explore the intertwining relationships between the various open codes. The following axial coding chart illustrates the connections between the open codes and offers a visual depiction for the reader. The associations shown in the chart emerged as a result of thoughtful, in-depth analysis of the twenty-two interviews.

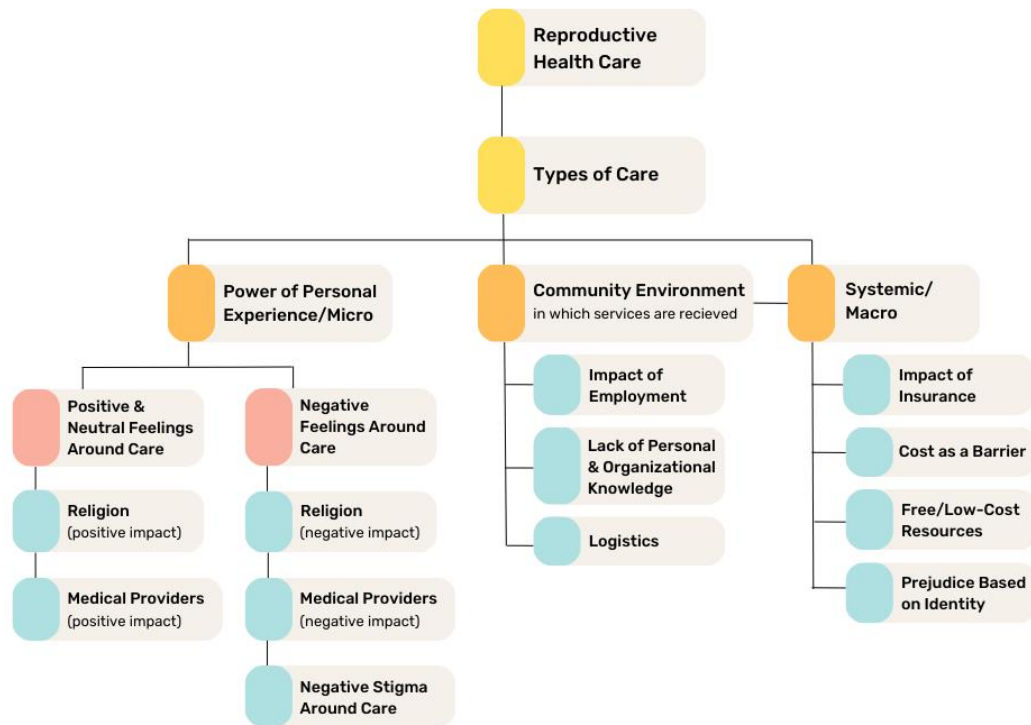


Figure 8. Axial Coding Chart.

While examining the open codes discovered from the interviews, some distinct connections and patterns arose between the codes. First, it became clear that the codes all fell under the umbrella of “reproductive care” and more specifically “types of care” as the content of the interviews revolved around individual experiences receiving different types of reproductive care. Then, three categories of open codes emerged: the power of personal experiences at the micro level, the community environment in which services are provided and received, and the broader systemic issues at a macro level. There was some

overlap between the two latter categories in that systemic issues largely influence community level factors and vice versa.

The “Power of Personal Experiences” category emerged as the researcher noticed that a great deal of content from the interviews related to participants’ deeply personal experiences with receiving care and the factors that directly impacted their feelings around care. Two significant factors that caused participants to report positive or neutral feelings around care were medical providers and religion. In some cases, participants received emotional or financial support from a religious institution such as their church. This offered relief for those participants and helped alleviate some stress. Medical providers were perhaps the most impactful factor for those who felt neutral or positive about receiving reproductive care. The providers’ identities, communication abilities, empathy levels and cultural competency often determined how safe and respected participants felt while receiving care.

On the other hand, medical providers, religion, and a negative stigma also caused many participants to report negative feelings around reproductive care. Negative feelings around care were reported much more often than positive or neutral feelings. Religion played a small role in this in that some participants felt as though they couldn't access specific types of reproductive care, such as abortions, due to their own religion. Medical providers played a significant role in participants’ negative experiences. Specifically, many participants felt as though the provider didn’t care about their well-being or that their concerns weren’t being

heard or acknowledged. Some individuals also felt oppressed, dismissed or misunderstood by their medical provider because of an aspect of their identity such as their race or sexual orientation. The medical providers' interactions with participants had the power to make them feel unsafe and uncomfortable receiving care.

Another significant factor that negatively influenced participants' experiences with receiving care was the deeply ingrained and internalized negative stigma surrounding reproductive health. Although this negative stigma is often perpetuated at the systemic level, the interviews revealed that many participants have internalized this stigma, and it greatly impacts the decisions they make when receiving reproductive care and how they feel about it. Some participants didn't seek care because they were worried that they might be judged, either by strangers or family members, while others did seek care and felt judged afterwards or during. A couple of participants used words like "icky" and "dirty" to describe how seeking care felt for them. Additionally, when asked what they would change about their experiences, many participants expressed a desire for reproductive health to be more normalized.

The second primary category or theme, "Community Environment," emerged from participants' emphasis on community involvement, education and resources surrounding reproductive care, or the lack thereof. Specifically, the impact of employment arose as a factor that acted as either a barrier or a facilitator to accessing care for different participants. Some noted that their

employer was flexible and allowed them to leave early for appointments, while others explained a lack of flexibility and understanding from employers.

Additionally, some described a complete reliance on the insurance they receive as an employment benefit and a fear of losing their employment and thus, their ability to access care. A lack of personal and organizational knowledge was also a significant barrier to care, which is ultimately the responsibility of communities to address. Many participants were completely unaware of local resources, which could be combatted by public education and outreach. Additionally, logistical barriers and facilitators were very prominent across the interviews, which are largely a result of community wide efforts. The quality of a community's public transportation system, for example, impacts the ease in which some participants can access care.

The third and final category that arose as an overarching theme was barriers and facilitating factors at the macro or systemic level. This included the impact of insurance, which nearly all participants mentioned. The researcher noticed that whether or not a participant had health insurance and the quality of that insurance had a very significant impact on their ability to access reproductive care. Despite this significance, its impact varied greatly. Some described insurance as the single most helpful factor in seeking care, while others explained that they didn't even attempt to seek care due to a lack of insurance. This ultimately stems back to the prominent issue of cost as a barrier; participants are so reliant on insurance because most low-income women cannot

afford reproductive care at all without it. For some participants, the cost of care directly resulted in not receiving care, while others *were* able to receive care eventually, but cost was a consistent worry or challenge for them throughout the process. Because of this, free and low-cost resources were a facilitating factor that many participants mentioned. These resources fall under the systemic category because many are federally funded or operated by the government. Some of these resources are locally funded, though, which is one reason why the “Community Environment” and “Systemic” categories are connected on the axial coding chart.

The last factor in the “Systemic” category was the barrier of prejudice based on participants’ identity. This barrier had significant negative impacts for some participants and, to some extent, is the result of a gap in training for medical professionals, which needs to be addressed at the systemic level. Whether it be a lack of cultural competency or a misunderstanding of someone’s experience with reproductive health based on their identity, it was clear from analyzing the open code that some participants face additional barriers to care as a direct result of their identity. Medical professionals should treat all patients the same, regardless of their identity, and should be well equipped with knowledge of all communities they may come into contact with when providing care. In summary, this category largely included barriers that should be addressed at the systemic level as well as facilitating factors that are the result of successful macro systems.

Selective Coding

The last stage of data analysis was selective coding, which allowed the researcher to integrate the themes that emerged from axial coding to derive meaning from the data and develop theory. This stage of data analysis helped reveal the underlying story within the data. Taking into consideration the open codes that emerged from the first step of data analysis and the various categories and their connections that arose from axial coding, the researcher was able to identify a unifying theme in the research.

It became clear that a core issue, especially among low-income women living in rural areas, is the deeply interpersonal nature of reproductive healthcare. This was repeatedly conveyed throughout the twenty-two interviews as women described how their experiences at an interpersonal level drastically impacted how they felt about receiving care and if they choose to seek care at all. For example, sixteen participants mentioned that an interaction with a medical provider affected their overall experience with and attitude towards reproductive care. Personal beliefs, some of which were a result of a cultural or societal stigma, also greatly impacted participants' experiences with reproductive care.

Socioeconomic status further reinforces this issue as low-income women often cannot afford to seek out different care if they are uncomfortable due to an interpersonal relationship or interaction. Similarly, options for medical providers are typically limited in rural areas compared to densely populated cities. Thus,

low-income women in rural areas may have less autonomy when it comes to decisions regarding their reproductive care.

Implications for Micro and Macro Social Work Practice. Despite the prevalence of this core issue, there are action steps that social workers can take at both the micro and macro level. At a micro level, social workers can work directly with clients to process any hindering beliefs or stereotypes about reproductive care to help them feel more comfortable seeking care. Additionally, social workers can teach clients how to advocate for themselves in a medical setting so that, if a situation arose in which they became uncomfortable or felt dismissed, they would have the necessary tools to voice their concerns and needs. These micro level changes wouldn't be very difficult or costly to implement but would be very effective. It would simply require making social workers aware of this core issue so that they can specifically target interpersonal barriers with clients seeking reproductive care.

At a macro level, community social workers and medical social workers could work with healthcare facilities to offer trainings for medical staff. These trainings could address trauma-informed care and cultural awareness, among other topics. Additionally, macro social workers could help advocate for policy changes to increase resources and funding for reproductive healthcare and education in rural areas. Social workers could even run for public office at the local and state levels, although these macro level changes would be more time intensive and costly.

The selective coding process revealed a frequently overlooked core issue that disproportionately impacts low-income women residing in rural areas: The inherent interpersonal nature of reproductive healthcare significantly impacts how individuals feel about care and the decisions they make regarding care. This can include interactions with medical providers, personal values and beliefs, and an internalized negative stigma surrounding care. There are actions that social workers can take, however, to mitigate the negative impacts of this issue. Micro level social workers can intervene on an individual level with clients, while macro level social workers can provide education, training and advocacy within the larger systems that perpetuate this core issue.

Chapter Summary

Chapter four thoroughly reviewed the data analysis phase of the present study, including the stages of open coding, axial coding, and selective coding. The researcher first conducted an in-depth analysis of the twenty-two interviews with low-income women to identify thirteen open codes that encapsulated the unique experiences of these women. The researcher then discovered connections and themes between the open codes during the axial coding process. It was determined that there were three main categories including the power of personal experiences, the community environment in which services are provided and received, and the broader systemic issues. The selective coding process then revealed a core issue at the interpersonal level that low-income women face, especially those who live in rural areas such as the location

in which this study was conducted. The implications for micro and macro social work practice were then discussed, including tangible action steps to take.

CHAPTER FIVE: TERMINATION AND FOLLOW UP

Introduction

Chapter five outlines the termination and follow up processes the researcher plans to engage in. The intended method for communicating the findings of the study to the twenty-two participants is discussed as well as the task of termination through a post-positivist lens. Lastly, the components of follow up for the present study are detailed, including intended methods for disseminating the research so that it can help inform social work and medical practice.

Communicating Findings to Study Participants

A critical component of a post-positivist perspective, the guiding theory for the present study, is to communicate study findings to the participants. Thus, the researcher plans to create an infographic detailing the study's purpose, participants demographics, and the core issue discovered from data analysis. This infographic will then be emailed to all study participants. A poster will also be created and presented at California State University, San Bernardino during the "poster day." All study participants will be invited to this presentation well in advance.

Termination of Study

Termination of the present study will involve reporting the research findings to colleagues within the university's MSW program. As there was no formal study site for this research, termination with a gatekeeper will not be necessary. The study's findings will also be shared with all twenty-two participants. At the end of each interview with the participants, the researcher was very intentional about reviewing the debriefing statement, offering resources and thanking them for their willingness to participate and share their experiences.

Follow Up and Dissemination

The findings of this study could be helpful information for community social workers, medical social workers, policy social workers and medical providers in that it could help them understand the personal experiences of low-income women when receiving reproductive healthcare. Thus, the researcher plans to disseminate the study's findings to relevant community providers. The infographic that will be shared with study participants will also be emailed to directors and supervisors at local agencies including various nonprofits that serve low-income women in addition to the local clinic and hospital. This infographic will convey the research project's purpose and results in a very digestible manner and thus, will be appropriate for anyone to read.

In the rural county where the research was conducted, there are two licensed medical social workers. The researcher plans to reach out to these individuals to request an informal Zoom meeting where the findings and

implications of this study can be shared and discussed. The researcher plans to create a brief PowerPoint presentation for the social workers and will offer to come present to their paraprofessional colleagues as well. Additionally, the county holds a monthly town hall meeting to address social and mental health issues in the community. The researcher plans to reach out to the county director of behavioral health, who coordinates these meetings, to be added to the agenda. Typically, community members, police officers, nonprofit paraprofessionals, nurses, school board members, etc. attend these town hall meetings, so it would be a perfect opportunity for the researcher to present the purpose, findings and implications of this research to a larger audience. Lastly, the researcher plans to reach out to the local newspaper, "The X County Record Bee," to request to write a short article on this research or to have an infographic included in the paper. These forms of dissemination will ensure that this research is shared with a wide variety of community members and professionals within the rural county.

Chapter Summary

Chapter five discussed the researcher's process of sharing findings with the study participants using an infographic via email as well as inviting them to the university's "poster day." The process of termination was discussed, which involved sharing findings with colleagues. Lastly, a plan for disseminating the study's findings with relevant local agencies was outlined. The researcher learned a great deal from this research about the unique experiences of low-

income women in rural areas receiving reproductive healthcare and the barriers they face. These findings can help educate community providers and bring awareness to such barriers so they can be addressed.

APPENDIX A:
RECRUITMENT FLYER

PARTICIPANTS NEEDED!

This study explores how low income women access reproductive healthcare in their communities and the challenges they face



Why Participate?

- You may contribute valuable information that could help increase accessibility to reproductive health care for low income women in your community

Who is Eligible:

- Female identifying individuals who make \$27,180/year or less
- Must be at least 18 yo.

What Does Participation Entail?

The required time commitment includes a 5-10 minute online survey a 30 minute Zoom interview

This study has been approved by the California State University, San Bernardino Institutional Review Board. If you have any questions, please contact Dr. Morris at TMorris@csusb.edu



If you are interested in participating, please complete this google form



APPENDIX B:
INFORMED CONSENT

INFORMED CONSENT

The study in which you are asked to participate in aims to provide insight into the challenges that low-income women face when accessing reproductive healthcare so that our community can take steps to address those barriers. The study is being conducted by Sydney Casey, a graduate student, under the supervision of Dr. Morris, Professor Emerita in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of this research study is to bring awareness to the experiences of low-income women in accessing reproductive care and empower them to challenge the oppressive systems that impose on their bodily autonomy.

DESCRIPTION: Participating in this study involves completing a short, online demographics survey and a half an hour interview via Zoom.

PARTICIPATION: Your participation in this research is completely voluntary and you do not have to answer any questions you do not wish to answer. You may skip or not answer any questions and can freely withdraw from participation at any time.

CONFIDENTIALITY: The information you provide will be handled as confidentially as possible. As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk. All survey responses will be assigned a number and will not be associated with your name. Your surveys will be stored in an encrypted file on a password-protected computer. The interview recordings will be deleted as soon as they have been transcribed (no longer than 2 weeks after your interview date).

DURATION: The demographic survey should take no more than 5-10 minutes to complete, and the Zoom interview will be approximately 30 minutes.

RISKS: Participating in this research poses a low risk of emotional discomfort as talking about these topics can be sensitive for some people. You can choose to skip any question you don't feel comfortable answering and you will also be provided with a list of local counseling resources at the end of the study to utilize if you choose.

BENEFITS: Participating in this study offers a safe space to process your experiences with accessing reproductive healthcare and you may contribute valuable information to the study, which could help increase care accessibility for other women.

CONSENT TO RECORDING: I agree to have this interview audio recorded.

Yes_____ No_____

APPENDIX C:
QUALTRICS DEMOGRAPHIC SURVEY

Demographic Survey Questions:

1. What is your age?
2. Are you of Hispanic, Latino, or Spanish origin?
3. How would you describe yourself? Please select all that apply.
 - a. White
 - b. Black or African American
 - c. American Indian or Alaska Native
 - d. Asian
 - e. Native Hawaiian or Pacific Islander
 - f. Other (please specify)
4. What is your annual income?
 - a. Under \$10,000
 - b. \$10,000-\$20,000
 - c. \$20,000-\$27,180
5. Do you have health insurance? (If yes, please list the insurance provider)
6. What is the highest degree or level of school you have completed?
 - a. Less than a high school diploma
 - b. High school degree or equivalent (e.g. GED)
 - c. Some college, no degree
 - d. Associate degree (e.g. AA, AS)
 - e. Bachelor's degree (e.g. BA, BS)
 - f. Master's degree (e.g. MA, MS, MEd)
 - g. Doctorate or professional degree (e.g. MD, DDS, PhD)
7. What is your current employment status?
 - a. Employed full time
 - b. Employed part time
 - c. Unemployed and currently looking for work
 - d. Unemployed and not currently looking for work
 - e. Student
 - f. Retired
 - g. Homemaker
 - h. Self-employed
 - i. Unable to work
 - j. Other (please specify)

APPENDIX D:
INTERVIEW QUESTIONS

Topic List:

1. Understanding what reproductive healthcare consists of
2. Identifying factors that are barriers to accessing care
3. Identifying facilitating factors to accessing care
4. Identifying feelings and attitudes surrounding accessibility to care
5. Identifying possible solutions/action steps to increase accessibility to care

Questions:

- Topic 1:
 - What do you think of when you think of reproductive healthcare?
 - What types of reproductive healthcare services have you accessed before?
 - Prompts:*
 - Have you ever seen a medical professional about birth control before?
 - Have you ever seen a medical professional to get emergency contraception like Plan B or Ella?
 - Have you ever seen a medical professional to get tested for STI's or HIV?
- Topic 2:
 - Are there any things that have prevented you from asking for or getting reproductive healthcare? This can include things like not having transportation to a clinic or not having money to pay for a doctor's visit.
 - Can you describe a time when you needed reproductive care but couldn't get it?
- Topic 3:
 - Are there any things that have made it easier for you to get reproductive healthcare?
 - Can you describe a time when you were able to get reproductive care and what helped you do so?
- Topic 4:
 - How do you feel when receiving reproductive healthcare?
 - When you think about making an appointment to receive care, how do you feel?
 - Follow Up:* What about making an appointment causes you to feel this way?
- Topic 5:
 - If you could change anything about your experience with getting reproductive healthcare, what would you change?
 - What could our community do to make reproductive healthcare easier for you to get?
- Is there anything else we haven't talked about that you feel like I should know?

APPENDIX E:
DEBRIEFING STATEMENT

Debriefing Statement

Thank you for taking the time to participate in this study. The purpose of this study was to explore the challenges that low-income women face when accessing reproductive healthcare in their local community. Here is a list of local counseling and crisis resources that you can utilize if you'd like. If you have any questions about the study, feel free to contact myself, Sydney Casey, at 007731640@coyote.csusb.edu or Dr. Teresa Morris at TMorris@csusb.edu.

Mental Health Resources:

- Lake Family Resource Center (707)-279-0563
 - 5350 Main Street Kelseyville, CA 95451
 - [Lake Family Resource Center | Strengthening our community one family at a time \(lakefrc.org\)](https://lakefrc.org)
- The Big Oak Peer Support Center (707)-998-0310
 - 13300 E Highway 20 Suite O Clearlake Oaks, CA 94523
 - [Facilities • Lake County, CA • CivicEngage \(lakecountyca.gov\)](https://lakecountyca.gov)
- La Voz de la Esperanza Centro Latino (707)-994-4261
 - 14092 Lakeshore Drive Clearlake, CA 95422
 - [Facilities • Lake County, CA • CivicEngage \(lakecountyca.gov\)](https://lakecountyca.gov)
- Mother Wise Counseling (707)-349-1210
 - 180 N. Main Street Lakeport, CA 95453
 - [Mother-Wise](https://motherwise.org)
- Circle of Native Minds (Indigenous Individuals) (707)-263-4880
 - 525 N Main Street Lakeport, CA 95453
 - [Facilities • Lake County, CA • CivicEngage \(lakecountyca.gov\)](https://lakecountyca.gov)

Crisis Hotlines:

- Verity (sexual assault) (707)-545-7270
 - [Verity ~ Verity \(ourverity.org\)](https://ourverity.org)
- YWCA (domestic violence) (707)-546-1234

APPENDIX F:
IRB APPROVAL

Study Details Submissions

Approved

IRB-FY2023-254 Exploring How Low-Income Women Access Reproductive Healthcare

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Approval Date: 05-31-2023	Expiration Date: N/A	Organization: Users loaded with unmatched Organization affiliation, College of Social & B Sciences Current Policy	Active Submissions: N/A Sponsors: N/A
Admin Check-In Date: N/A	Closed Date: N/A	Post-2018 Rule	

Key Contacts

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