Women's Health Issues 26-5 (2016) 483–487

WOMEN'S HEALTH ISSUES
www.whijournal.com

Editor's Choice

The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion

Jessica N. Sanders, PhD, MSPH [a,*], Hilary Conway, MD [a], Janet Jacobson, MD [b], Leah Torres, MD, MSCI [a], David K. Turok, MD, MPH [a]

[a] *Department of Obstetrics and Gynecology, University of Utah, Salt Lake City, Utah*
[b] *Planned Parenthood of Orange and San Bernardino Counties, Orange, California*

Article history: Received 1 February 2016; Received in revised form 17 June 2016; Accepted 21 June 2016

A B S T R A C T

Purpose: To assess the impact of Utah's 2012 law increasing the mandatory abortion waiting period from 24 to 72 hours.
Methods: This paper includes two assessments of this change: (1) Comparison of the proportion of women returning for an abortion after counseling before and after the introduction of the 72-hour law and (2) self-reported wait times between abortion and procedure, distance traveled, financial expenditures, and perceived impact of the law in a subset of women who were surveyed.
Main Findings: Aggregate counseling and procedural data were available at three Utah clinics; 2,793 of 3,618 women (77%) returned for abortion procedures under the 72-hour law, compared with 2,513 of 3,130 (80%) in the previous year ($p < .05$). Among 307 women surveyed, 63% reported more than 7 days between signing the consent form and their procedure, and women frequently had to travel further to get their procedure than they did for the counseling. Close to two-thirds (62%) reported the 72-hour wait affected them negatively in some way, including the lost wages of needing to take extra time off work (47%), increased transportation cost (30%), lost wages by family or friend(s) (27%), and having to disclose their abortion to someone they would not had told without the waiting period (33%).
Conclusion: Utah's extended waiting period showed a small reduction in the proportion of counseled women who returned for their abortion procedure statewide. Women who had abortions after the law was enacted reported several burdensome aspects of the law.

Utah is 1 of 28 states that require a waiting period between a state-mandated abortion information visit and obtaining an abortion (Guttmacher Institute, 2015). The majority of these states require 24 hours to pass between counseling and the procedure (Guttmacher Institute, 2015). On May 8, 2012, Utah became the first state to enact a mandatory 72-hour waiting period between abortion counseling and procedure. Utah House Bill 461 modified the required waiting period from 24 hours to 72 hours, except in cases of rape or incest, maternal life endangerment, or uniformly diagnosable lethal fetal anomalies (Abortion Waiting Period, 2012).

Utah was the first of the now five states that have passed or enacted a 72-hour waiting period to obtain an abortion. Utah's legal decision was followed by South Dakota (2013), Missouri (2014), North Carolina (2015), and Oklahoma (2015). These states all have different legal specifications, but all require a minimum of 72 hours between consent and an abortion procedure. Utah requires voluntary and informed consent to be obtained during a "face-to-face" abortion information consultation at "any location within the state" at least 72 hours before an abortion (Abortion Waiting Period, 2012). The counseling requires the use of state-issued material, which has been shown to contain medically inaccurate and out-of-date information regarding the mental and physical health consequences of having an abortion (Richardson & Nash, 2006).

In addition to the patient and provider side restrictions, the number of abortion clinics and providers has decreased over the last 5 years. In 2011, there were four abortion clinics and nine providers in the state of Utah, all located in Salt Lake City (Jones & Jerman, 2014). At that time, two-thirds of residents lived in

IRB: 00058996.
Funding Source: None.
REDCap 8UL1TR000105 (formerly UL1RR025764; NCATS/NIH).
Conflict of Interest: None.

* Correspondence to: Jessica N. Sanders, PhD, MSPH, Department of Obstetrics and Gynecology, University of Utah, 30 N 1900 E Room 2B200, Salt Lake City, UT 84132. Phone: 801-518-2143; fax: 801-585-5146.
E-mail address: Jessica.sanders@utah.edu (J.N. Sanders).

1049-3867/$ - see front matter © 2016 Jacobs Institute of Women's Health. Published by Elsevier Inc.
http://dx.doi.org/10.1016/j.whi.2016.06.004

counties without abortion services. In addition, the limited abortion services in surrounding states require many women to travel considerable distances to neighboring states to obtain a wanted abortion (Jones & Jerman, 2014). The largest clinic in the state and the only one providing second trimester services in 2011 closed permanently in August of 2013. Another clinic has increased its service capacity and options to compensate for this closure. A timeline of events can be seen in Figure 1. Currently, there are seven providers in two clinics operating in Utah. Both are located in Salt Lake County.

This study examines the impact of the increase from a 24-hour mandatory waiting period to a 72-hour waiting period on the proportion of women who obtain an abortion among those who completed the abortion information consultation and consent at the three largest family planning clinics in Utah. At the time the law was enacted, these three clinics served more than 90% of women obtaining procedures in the state. Additional information was collected directly from patients accessing abortion services at one clinic. Collectively, these findings provide insight into the impact of this legislative change on women seeking and receiving an abortion within the state of Utah.

Methods

This study presents findings from two assessments. Assessment 1 is a retrospective chart review of three abortion clinics and eight associated clinic locations that offer abortion counseling and consent within the state of Utah. These data were used to compare the proportion of women returning for abortion procedures between two time periods: May 8, 2011, to May 7, 2012, which required a 24-hour waiting period; and May 8, 2012 to May 7, 2013, after the law requiring a 72-hour waiting period was enforced. We used χ^2 tests to assess differences in patient characteristics of women who received abortions in the state of Utah during the two time periods. Demographic information was obtained through the Utah Department of Health abortion registry.

Assessment 2 consists of data collected directly from patients while waiting for their abortion procedure after the 72-hour law went into effect. Trained study staff approached abortion patients at a single clinic at the time of appointment check-in. All abortion patients were eligible for participation. Staff did not track the number of women who were offered participation or the number who declined. If women agreed to participate, they were provided an iPad to complete a brief anonymous survey via REDCap, a secure web-based electronic data capture system. We used consent language in the survey cover letter explaining the risks and benefits and that completion of the survey served as implied consent for participation in the study. We assessed questions regarding lost wages, childcare costs, school days missed, distance traveled for counseling, distance traveled for procedure, transportation costs, and the ability to keep their abortion confidential. We also asked women about their perception of the benefit or harm of the 72-hour wait, using a 100-mm visual analog scale, with contextual anchors of "very helpful" at 0, "neither helpful, nor harmful" at 50, and "very harmful" at 100. In addition, for each participant we assessed the number of days between initially calling the clinic and attending the abortion information session, as well as the number of days between attending the abortion information session and undergoing the procedure. We also asked participants about prior awareness of the law and perceived value of the counseling visit. We described these data with one-way tabulation. We conducted all data analysis with Stata 13 statistical software (StataCorp LP, College Station, TX). The University of Utah Institutional Review Board approved this investigational protocol.

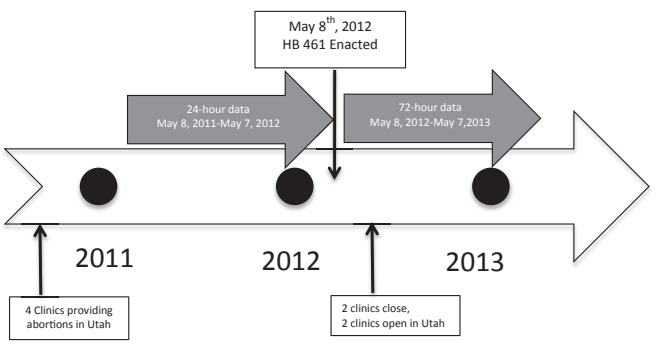

Figure 1. Timeline of clinical changes.

Results

Assessment 1

Using clinic-reported data, we determined that under the 72-hour law, 2,793 of 3,618 women (77%) returned for abortion procedures compared with 2,513 of 3,130 (80%) in the previous year ($p < .05$) for the three clinics for which we had both counseling and abortion data available (Figure 2). Using Utah Department of Health data, we examined demographic characteristics of women obtaining abortions at the three Utah clinics under the 24-hour law and the 72-hour law (Table 1). Bivariate analysis indicated statistical differences in age, marital status, race, and the proportion of women having their procedures during their second trimester of pregnancy ($p < .05$); however, these differences are not substantive.

Assessment 2

A total of 307 women completed the patient questionnaire while waiting for their procedure at one Utah family planning clinic. Forty-three percent of the women surveyed were pregnant for the first time. Most women (80%) contacted the clinic for consent before 8 weeks after their last menstrual period. Although 72% of the women visited the clinic for the abortion information session within the first 3 days of calling the clinic,

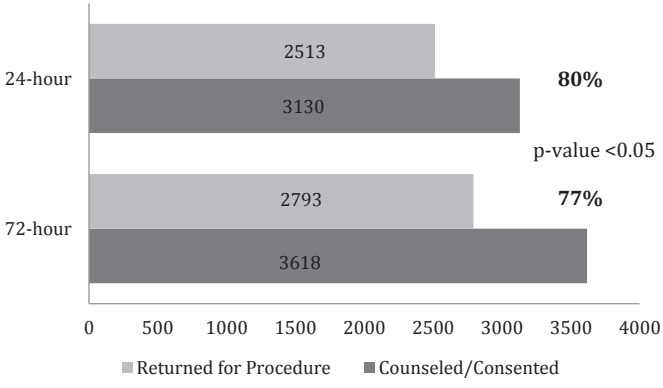

Figure 2. Proportion of women returning for procedure after completing counseling at three clinics in Utah (serving 90% of women in Utah).

Table 1
Utah Department of Health Characteristics of Women Obtaining Abortions at Three Utah Clinics under the 24-hour Law Compared with the 72-hour Law ($N = 5,775$)

	24-hour Wait ($n = 2,777$)		72-hour Wait ($n = 2,998$)		p value*
	n	%	*n*	%	
Age category (y)					
<18	129	5	92	3	.006
18–29	1,799	65	1,914	65	
30-39	704	26	827	28	
>40	119	4	135	5	
Education					
Less than high school graduate	139	5	170	6	.523
High school graduation	1,118	40	1,206	40	
Beyond high school	1,520	55	1,622	54	
Marital status					
Never married	1,394	50	1,547	52	.002
Married	808	29	755	25	
Widowed/divorced/separated	575	21	696	23	
Race					
White	2,094	75	2,165	72	.006
Other	683	25	833	28	
Hispanic ethnicity					
Yes	494	20	528	19	.316
No	2,006	80	2,299	81	
Second trimester abortions	208	8	168	6	.003
Total	2,777	48	2,998	52	

* χ^2 test.

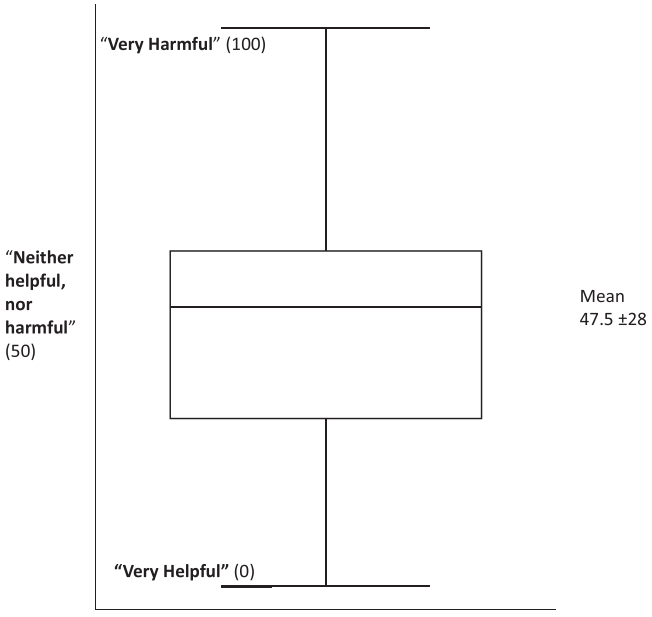

Figure 3. Perceived harm/benefit of the 72-hour wait ($n = 305$).

63% of the women receiving an abortion reported that more than 7 days had passed since they visited the clinic for counseling and signed the consent form.

Two-thirds of the women (67%) were unaware of the 72-hour waiting period between counseling and procedure before contacting the clinic. Close to one-half of women (45%) obtaining their abortion found that "the counseling provided valuable information and it was helpful to hear in person." One in five women found that "making two trips to the health center, and waiting 72 hours in between, did not provide any benefits and made it harder to obtain an abortion."

The mean score from the 100-mm visual analog scale assessing perceived benefit and harm was 47.5 (SD 28); however, 13% of women's scores were in the bottom one-quarter, indicating that they felt the law was somewhat or very harmful (Figure 3). Two of three women (62%) indicated the additional wait affected them negatively in some way. Of the women who were negatively affected, close to one-half had to take extra time off of work and 15% missed an extra day of school. A substantial number of women reported lost wages (47%), excess childcare cost (18%), increased transportation cost (30%), and additional expenditures and lost wages by a family member or friend (27%). One in three women negatively impacted by the 72-hour waiting period indicated that they had to tell someone they would not have told if the wait had only been 24 hours. There was a wide range of distances traveled for women obtaining their abortion. About two-thirds of women could be counseled and consented within 25 miles from their home; however, only 42% could receive their abortion procedure within 25 miles. More than 10% of women traveled more than 100 miles from their home for their procedure.

Discussion

Utah's 72-hour waiting period was associated with a small but statistically significant decrease in the percentage of counseled women who returned for their abortion procedure (77%) compared with the percentage returning during the 24-hour waiting period (80%) ($p < .05$). Women obtaining an abortion after the implementation of the 72-hour law reported several burdensome aspects, including lost wages and increased expenses.

Assessment 1 was not designed to parse out the reasons that women did not return for their procedure. However, among a sample of 309 Utah women recruited during the abortion information visit after then enactment of the 72-hour law, researchers found that 86% returned for their abortion procedure within 3 weeks (Roberts, Turok, Belusa, Combellick, & Upadhyay, 2016). Their findings on mean wait time between information visit and procedure were similar to the data presented here. Roberts et al. (2016) also found that the law did not prevent abortions. In their study, women who ultimately did not have the abortion procedure reported higher levels of decisional conflict at the time of the information visit. The majority of women were not conflicted in their decision.

The findings from assessment 2 of our study corroborate previous studies, which found mandatory counseling and waiting periods burdensome to some patients (Althaus & Henshaw, 1994; Karasek, Roberts, & Weitz, 2016; Lupfer & Silber, 1981). The legal restriction on abortion in the United States is a changing landscape. Studies conducted in Mississippi found that when the 24-hour waiting period was enacted with an in-person visit before procedure, overall abortion rates decreased; however, the proportion of women obtaining an abortion during the second trimester increased, as did the number of women traveling out of state to obtain their procedure (Joyce, Henshaw, & Skatrud, 1997; Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009). These findings are likely a result of the two-visit requirement rather than the wait time between information visit and procedure, which was not what was examined here, given that both time periods required two visits. Other research has shown that states requiring two visits impose substantial time cost and travel expenses without having a significant effect on states abortion rates (Medoff, 2012). States that require

in-person counseling session increase the direct and indirect cost of having an abortion (Medoff, 2012). Of note, states with mandatory waiting periods that allow for the counseling material to be read over the phone, delivered via recorded message, or email rather than in person have been shown to reduce patient burden as compared with when the counseling must occur in person (Medoff, 2012).

Strengths of the study include use of state-level data, which allowed us to confirm that the number of abortions being captured by direct contact with clinics was similar to the number of procedures reported to the state health department. Another notable strength is the relatively large sample size, which captures statistically significant differences with modest changes in demographics between the two periods. However, the 1% to 2% difference in the distribution age, marital status, race, or having a second trimester procedure is unlikely a clinically significant difference for population-level care. The difference in the primary outcome of the proportion of women returning for their abortion procedure may be better assessed as a trend over several years.

There are a number of limitations that should be noted. Given that we were unable to access counseling data from all abortion clinics, there is potential for misclassification regarding the number of women completing mandated counseling. Additionally, the abortion information session and 72-hour consent can be completed at independent medical providers; however, very few physicians in Utah do this counseling and many may be unaware that this is an option. This study could have been strengthened had we been able to obtain patient-level data at the time of the information session and followed patients prospectively. This information would have allowed us to create a predictive model of who was able to return for their procedure after the law went into effect while controlling for sociodemographic characteristics. For assessment 2, the use of the survey allowed us to capture patient perspectives but was retrospective in nature and therefore subject to recall bias. Additionally, we only used a single center for the patient survey and surveyed only women who returned for their desired abortion procedure, which has the potential to introduce sampling bias and reduced generalizability. Thus, our findings about perceived harm may be more conservative if the women who did not return for their procedure had more negative experiences that were not reported in this sample.

The wide range of harm–benefit perception presented here emphasizes the complexity of individuals' understanding of the law and reminds us that this is not and should not be a one-size-fits-all solution for women seeking abortions. Previous research has called for individualized patient counseling for women who are conflicted in their decision (Roberts et al., 2016). The use of telemedicine can reduce cost and barriers to women seeking medical care and is perceived as favorable for many women. The requirement of face-to-face counseling is not evidence based, and many medical consent processes are successfully using remote counseling to reduce barriers to accessing health care and improve overall patient care.

The 72-hour waiting period constitutes one of many hurdles for women in Utah when attempting to access safe and legal abortion. There are multiple legal rules that restrict a woman's access to abortion procedures—including state-directed in-person counseling, limited insurance coverage, parental consent for minors, parental notification for minors, provider admitting requirements, and surgical center requirements for clinics providing abortion services. Although the extended waiting period is a significant hurdle for many, it is challenging to quantify the additional burden of this restriction in the context of all other restrictions.

Implications for Practice and/or Policy

These findings add to existing literature on the hurdles that state-level legislation can create, many of which disproportionally impact women with fewer resources and those who must travel longer distances to access medical care. Researchers should continue to tease out the impact of burdensome laws, and policymakers should understand the potential impacts of legislating medical care. The finding that many women do not know about the 72-hour waiting requirement indicate that additional statewide education on medical legislation is necessary. Additionally, we need to share patient perspectives with policymakers to increase the awareness of how medical legislation plays out on real patients.

Acknowledgments

The authors gratefully acknowledge Planned Parenthood Association of Utah, Utah Women's Clinic, Wasatch Women's Clinic, and the Utah Department of Health for their assistance with this study. We also want to thank the staff and patients at Planned Parenthood Metro Clinic for supporting us in the completion of this project. We would also like to acknowledge ANSIRH for following up with the women who did not return for their procedures.

References

Abortion Waiting Period, H.B. 461, Legislature of the state of Utah (2012).

Althaus, F. A., & Henshaw, S. K. (1994). The effects of mandatory delay laws on abortion patients and providers. *Family Planning Perspectives*, 26(5), 228–233.

Guttmacher Institute. (2015). *State Policies in Brief–Counseling and Waiting Periods for Abortion*. [Press release]. New York: Author.

Jones, R. K., & Jerman, J. (2014). Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health*, 46(1), 3–14.

Joyce, T., Henshaw, S. K., & Skatrud, J. D. (1997). The impact of Mississippi's mandatory delay law on abortions and births. *JAMA*, 278(8), 653–658.

Joyce, T. J., Henshaw, S. K., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *The impact of state mandatory counseling and waiting period laws on abortion: A literature review*. Available from: http://www.guttmacher.org/pubs/MandatoryCounseling.pdf. Accessed: December 17, 2015.

Karasek, D., Roberts, S. C., & Weitz, T. A. (2016). Abortion patients' experience and perceptions of waiting periods: Survey evidence before Arizona's two-visit 24-hour mandatory waiting period law. *Womens Health Issues*, 26, 60–66.

Lupfer, M., & Silber, B. G. (1981). How patients view mandatory waiting periods for abortion. *Family Planning Perspectives*, 13(2), 75–79.

Medoff, M. H. (2012). Unintended pregnancies, restrictive abortion laws, and abortion demand. *ISRN Economics*, 2012, 8.

Richardson, C. T., & Nash, E. (2006). Misinformed consent: The Medical accuracy of state-developed abortion counseling materials. *Guttmacher Policy Review*, 9(4).

Roberts, S. C., Turok, D. K., Belusa, E., Combellick, S., & Upadhyay, U. D. (2016). Utah's 72-hour waiting period for abortion: Experiences among a clinic-based sample of women. *Perspectives on Sexual and Reproductive Health*, 48(4), TK-TK. http://dx.doi.org/10.1363/48e8216.

Author Descriptions

Jessica N. Sanders, PhD, MSPH, is the Director of Family Planning Research at the University of Utah School of Medicine. She received her MSPH and PhD from the University of Utah. Her research interests include contraception, sexual satisfaction, and women's health policy.

Hilary Conway, MD, is an Obstetrician-Gynecologist in Yakima, Washington. She received her medical degree from the Oregon Health & Science University and completed her residency training at the University of Utah.

Janet Jacobson, MD, is an Obstetrician-Gynecologist. She completed her Planning Fellowship at the University of Utah School of Medicine. Her research interests include female genital tract microflora and contraception. Dr. Jacobson served as a pilot in the U.S. Navy from 1992 to 2002.

Leah Torres, MD, MSCI, is an Obstetrician-Gynecologist in Salt Lake City, Utah. She completed her Planning Fellowship at the Department of OB/GYN, University of Utah School of Medicine. Her research interests include long acting contraception, preterm birth reduction, and family planning.

David K. Turok, MD, MPH, is an Associate Professor in the University of Utah Department of Obstetrics and Gynecology. His areas of clinical interest and expertise include all aspects of women's health care, particularly family planning.