Experiences with health care and public assistance in states with highly restrictive abortion policies

State Brief: Oklahoma

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Acknowledgements:

This report is the result of collaboration between Ibis Reproductive Health (Ibis) and the Center for Reproductive Rights (the Center). We are grateful to Kelly Blanchard at Ibis for her oversight on the project. We also acknowledge Sophie Higgins, Courtney Johnson, Katie Johnston, Jessica Nichols, Annie Norman, Mackenzie Sumwalt, and Samantha Xia of Ibis who provided editorial assistance in preparing this report. Angela Hooton, Kelly Baden, and Fran Linkin of the Center provided critical feedback on our project approach. The Center sponsored this project. Views and opinions expressed in this paper are those of the authors and do not necessarily represent the views of the Center.

Suggested citation:

Dennis A, Bridgit B, Douglas-Durham E. Experiences with health care and public assistance in states with highly restrictive abortion policies. State brief: Oklahoma. *Ibis Reproductive Health*; September 2014.

CONTEXT

Since abortion was legalized in the United States (US) in 1973, states have implemented numerous restrictions that limit whether, when, and under what circumstances a woman may obtain an abortion.[1] Anti-choice groups claim these restrictions are necessary to protect and support the health and well-being of women, their pregnancies, and their children.[2] However, women and children living in states with a large number of abortion restrictions often have poorer health outcomes than those living in states with fewer restrictions.[3] Also, states with a high number of abortion restrictions tend to have few policies in place that support women in their efforts to meet their own day-to-day needs (throughout the life course, including during pregnancy), or the needs of their children.[3]

Little is known about women's experiences engaging with health care systems and public assistance programs in states with highly restrictive abortion policies. To explore this issue, Ibis Reproductive Health and the Center for Reproductive Rights collaborated to conduct in-depth interviews with women in three of the nation's most restrictive states in terms of abortion: Oklahoma, Arizona, and Kansas. During the interviews, we asked women about their experiences seeking routine, prenatal, pediatric, and abortion care. We also explored women's experiences with various public assistance programs.

Oklahoma overview

Oklahoma is home to an estimated 784,610 women of reproductive age[4] and 981,500 children under the age of 18.[5] In 2011, approximately 69,200 Oklahoma women became pregnant; 76% of these pregnancies resulted in live births and 8% in abortions.[6]

Oklahoma women and children have much poorer health outcomes and face greater social and economic challenges, compared to those in other states.[7] Yet, the state has implemented relatively few policies that are designed to address the unmet needs of women and children.[7] Primarily through federal-state partnerships, Oklahoma has, however, put in place a small number of programs that are meant to meet Oklahomans' daily living needs and improve their health and access to health care.[8] We list the programs that are most relevant to this report below.

- SoonerCare is Oklahoma's Medicaid program and offers health insurance to low-income, qualifying Oklahoma residents.
- The State Children's Health Insurance Program (SCHIP) is an insurance program for low-income, qualifying Oklahoma children aged 18 or younger.

- Oklahoma's Women, Infants, and Children (WIC) program provides supplemental foods, nutrition education, and referrals to health care for low-income pregnant, breastfeeding, and postpartum women; infants; and children up to age five.
- Supplemental Nutrition Assistance Program (SNAP) benefits (often called food stamps) can be used to purchase food at grocery stores, convenience stores, and some farmers' markets and co-op food programs.[9] Oklahoma residents with SNAP benefits receive an average of $128 in SNAP benefits every month. [10]
- Childcare assistance programs help families with the costs of childcare at select state-approved facilities.

Compared to other states, Oklahoma has the highest number of abortion restrictions in the country (alongside Kansas and Mississippi), with 14 restrictions on abortion in place (Table 1).[3]

Table 1: Oklahoma abortion restrictions

Abortion restrictions	Yes	No
Parental involvement before a minor obtains an abortion	✓	
Mandatory waiting periods between time of first appointment and abortion	✓	
Mandatory counseling prior to abortion	✓	
Requirement to have or be offered an ultrasound	✓	
Restrictions on abortion coverage in private health insurance plans	✓	
Restrictions on abortion coverage in public employee health insurance plans	✓	
Restrictions on abortion coverage in Medicaid	✓	
Only licensed physicians may perform abortions	✓	
Ambulatory surgical center standards imposed on facilities providing abortion	✓	
Hospital privileges or alternative arrangement required for abortion providers	✓	
Refusal to provide abortion services allowed	✓	
Gestational age limit for abortion set by law	✓	
Restrictions on provision of medication abortion	✓	
Below average number of providers (per 100,000 women aged 15-44)	✓	
Total number of restrictions	**14**	

STUDY DESCRIPTION

We conducted in-depth interviews with 30 women who had recently had abortions in Oklahoma, Arizona, and Kansas. All women provided verbal informed consent before participating in the interviews. The interviews were largely unstructured so that women could share whatever was most important to them about their experience with the health care system and public assistance programs. Trained qualitative interviewers conducted the interviews either in-person at local abortion clinics or over the phone. Recordings of the interviews were transcribed verbatim

and analyzed using qualitative analysis techniques. After identifying the most salient themes, we selected representative quotes. In this report, we focus on our findings from Oklahoma.

FINDINGS

Interviewee characteristics

We spoke with ten women in Oklahoma who had recently had abortions. We did not systematically ask women for demographic or other background information, but during the interviews, women spontaneously provided some of this information. Four women lived in urban areas of Oklahoma, four lived in suburban environments, and two lived in rural areas. Seven women were single and three were living with a romantic partner. All women had been pregnant more than once. Eight women had given birth; seven were raising children; and one had placed a child for adoption. Six women were working and/or in school. Six women reported having insurance coverage. Of the seven women who were raising children, all reported their children had insurance coverage.

Access to public assistance programs

Women said limited educational and employment opportunities made it difficult to financially provide for themselves and their children. Reflecting on her own financial distress, Amber[i] said simply, "I would say the challenge is money." Seven women reported receiving some form of benefits from public programs. Such programs, when accessible, were described as critical to supporting the health and well-being of women and their families. The most commonly described programs were insurance, nutrition, and child-care support programs.

Health insurance programs

Women reported no difficulties securing public insurance coverage for their children. However, four women who were uninsured reported desiring public insurance coverage, but not being sure how to obtain it. They shared stories of trying to enroll in the state's Medicaid program, but being rejected due to the strict financial enrollment criteria. Marie summed this up when she said of SoonerCare, "They have very strict criteria, like, income regulations or rules that can make or break whether or not you get the coverage…. I don't qualify for general health care." Also, some women were insured by SoonerCare in the past, but had been bumped off of the program for reasons they were unclear about.

Nutrition-support programs

[i] All interviewees are identified by a unique pseudonym.

Some participants said SNAP and/or WIC benefits were essential for mitigating the costs of food and ensuring they and their families did not go hungry. For example, Danielle stated, "I am on food stamps which helps tremendously…. For my daughter and I, we get $340 a month, and we also get WIC for like, milk and cheese. If we didn't, I don't know what I would do for food."

Childcare assistance programs

The seven women who were raising children said that quality, affordable day care is essential. Women related that they need a trusted daycare source in order to work, but that it is often financially out of reach, even when they receive public aid for daycare. Amber said of this:

> I went through incidences where I haven't been able to find a daycare that would accept state aid for him [my son], so I've had to pay out-of-pocket, and that gets difficult when your whole paycheck is going to childcare. The challenge of finding a decent daycare that accepts state aid has definitely been an issue.

Routine health care

For routine health care, four women sought care from primary care physicians (PCPs), three from urgent care facilities, and three had no source of routine health care. Women who obtained routine care said they selected their source of care by considering the nature of care they needed, how urgent it was, and whether they could afford care.

Many women, and in particular low-income women, reported difficulties obtaining affordable routine health care. Women with health insurance reported their deductibles and copays were high, and uninsured women said it was difficult to pay out-of-pocket for care. Anna summed this up when she said, "Medical is very expensive any way you look at it."

Women also reported it was difficult to secure appointments in a timely manner. They described an overburdened health care system with a small number of providers able to see new patients or patients with urgent issues. Lindsay said of making appointments, "Well it's hard because it's a small town. It's a very busy clinic and they don't always have a lot of slots open…. You might just end up waiting two or three weeks and you're just better off going to the emergency room, which is more expensive." Like Lindsay, several other women shared they go to emergency rooms or urgent care clinics when appointments for PCPs are hard to obtain.

Obtaining timely appointments was a particular problem for women on SoonerCare. Interviewees attributed this to the extensive referrals process required to see a physician other than one's PCP. Brittany explained:

> So, getting health care in general is kind of hard. Especially with SoonerCare, it's just jumping through hoops, one day after the next…. Just say for me to go to the OB/GYN, I have to go to a primary [care physician], get a referral. The referral can take up to two weeks before it's ever approved and then it has to be processed through the state and then I can go. And then every procedure is referral, referral, referral, referral. And it can take *forever* to get something done…. In order to get one thing done, it's like a three-ring circus.

Further, more than any other state where we conducted interviews, women in Oklahoma were dissatisfied with the care they received. In particular, women seeking care at public health clinics stated they rarely saw the same health care provider twice, which frustrated them and led to them not receiving continuous care. Catherine said of her experiences, "Every time I went it was like a different person, and I'm like, well who is my doctor?"

Pediatric health care

Most women said they take their children to see a pediatrician for routine health care and rely on emergency departments when more urgent care is needed.

Also, women largely reported their children had comprehensive health insurance coverage with low or no-cost copays, which made care affordable.

As with their own health care, women reported they could not secure timely appointments for their children. However, many women with children were quick to point out that the health care system worked better for children than it did for themselves. Brittany stated, "For them it's a bit easier. We still have the hoops to jump through, but there's not quite as many. The SoonerCare for child health care is a lot more organized than it is for adults."

Also consistent with women's experiences with their own health care, interviewees said they were generally displeased with the quality of care their children received. In particular, women whose children attended public clinics were very concerned that their children rarely saw the same health care provider and rarely received consistent health care recommendations from their providers. Asked what she would like to see changed about this, Melissa said, "Let us have a doctor that will remain our doctor for at least six months in a row."

Prenatal care

All women who had given birth reported obtaining care from an OB/GYN (as opposed to a midwife or other prenatal care provider) and giving birth in a hospital.

Many women reported it was easy to enroll in and stay on insurance when pregnant, which helped women manage the costs of both of their prenatal care and other health care services they needed during and shortly after

pregnancy.[ii] Danielle said of the services she received, "The SoonerCare was great…. I think it was six weeks after [birth] I got put on the Mirena birth control…. And then I got to go to the dentist and get my teeth fixed and all of that before it ended." Similarly, Amber said, "Through the Oklahoma program here, they have a program called SoonerCare. It's a very good program. I was able to receive all of the pre-maternal care I needed. Everything as far as dentistry too. It was a very good health insurance program."

Women also described generally positive experiences with their prenatal care and birthing experiences. However, women who were insured by SoonerCare did describe some challenges accessing that care. As Brittany put it, wait times for prenatal care when on SoonerCare are "almost hellacious." This appears to be related to the few doctors that accept SoonerCare and have availability. Amber eventually found a doctor she was very comfortable with, but said it was hard because she had limited options. She stated, "A lot of the doctors that are available through SoonerCare or who will accept SoonerCare weren't my preference. It was difficult to find any doctor who would accept it."

Abortion

Characteristics

Most women reported they were not using contraception at the time of pregnancy because they had challenges finding an acceptable and affordable contraceptive. All women but one reported they were in the first trimester of pregnancy at the time of their abortion. Eight had surgical procedures and the rest had medication abortions. Their procedures cost an average of $639 (range $550-$815).

Decision making

Many women spontaneously discussed the reason they decided to have an abortion, reporting most often that they did not have the emotional, practical, or financial resources necessary to take care of a(nother) child. Abortion, therefore, felt like the "only option," a phrase often repeated. Danielle said of her decision, "It's a decision I wish I didn't have to make. But, I just felt like I need to focus on my daughter that I already have. And focus on giving her the life that I want to."

More than the women in any other state where we conducted interviews, women in Oklahoma said they told few people about their abortion because they feared judgment for the unplanned pregnancy and for deciding to have an

[ii] Enrollment in SoonerCare can be terminated shortly after birth as once no longer pregnant a woman may no longer qualify for the program.

abortion. Amber shared, "I had to go through lots of loopholes to find my way here. A lot of people in my life are not okay with abortion, so getting here was definitely a challenge." A number of women chose not to disclose their abortion to anyone. For example, Lisa related she was alone in her decision making, and therefore had no support: "I'm doing this all by myself. I haven't told anybody…. I just didn't want them to think bad."

Access to abortion care

All interviewees obtained abortion care at stand-alone abortion clinics and noted they did not have a lot of options for where to receive care since so few local health care providers offer abortion. A couple of women reported only being able to find one abortion provider in the state (though there are more). Amber said of this, "Oklahoma is a very conservative state. When I did the research before to find a clinic here in Oklahoma, there is only one clinic that's available for the procedures, so that makes it very complicated." Women who were able to find more than one clinic often reported they picked the clinic that they perceived as of the highest quality. Stephanie shared what she found after looking for clinics online, "I read reviews on the different clinics, and I decided I wanted to come here because people had nothing but good things to say."

All women paid out-of-pocket for their care because their insurance did not cover abortion. Though some woman had the funds available to pay out-of-pocket for care, the majority of women did not. Abortion was described as a large, looming, and immediate expense. To afford care, many women had to borrow money from others in their lives, but felt they could not disclose their reason for needing financial support. Amber said of this, "I've had to borrow some money from my family and friends, not informing them on what it was for. I guess there's a lot of people who still aren't acceptable of abortion, especially in Oklahoma, which is a very conservative state." Other women delayed car payments, rent, or bills (which in some cases led to utilities being shut off) or went without food or other needs. Lindsay said she "had to use rent money" to cover the abortion. Asked what would happen when her rent came due the following month she said, "Well it's going to be hard. I guess when I'm over this situation I'll concentrate on how to get the money for the rent. But for now because of the time and stages, I mean you can't sit there and think about it. You just have to take action."

Overall, women reported it was easy to schedule an appointment for abortion and to coordinate the travel necessary to get to the appointment. Women reported it took them an average of 68 minutes (range 20-180 minutes) to get to the clinic. For a minority of women, the distance to the clinic was burdensome. One woman in particular had numerous travel-related challenges. Stephanie explained what she had to do to get to the clinic:

> Getting here was kind of difficult because it is three hours away. My fiancé is not able to drive at the moment and I didn't have a driver's license…. So I got my driver's license pretty much as soon as I found

> out [about the pregnancy]. Like, three days learning and then I took the test on the fourth day. I passed it. It was amazing. And, well, getting your driver's license isn't everything. We don't have a car. So, we had to ask my fiancé's father to drive us which is not fun. He doesn't know about our decision. He doesn't know I'm pregnant. He's extremely, *extremely, extremely* pro-life. So we decided not to tell him. So we're just going for a doctor's appointment. That kind of sucks, but we can't do anything about it.

Once at the clinic, women overwhelmingly reported positive experiences with their care, experiences that far exceeded their expectations of what an abortion clinic would be like. Catherine reflected:

> It's more than what I expected. I thought it was going to be like a place where they're like, "Alright, c'mon, your turn, your turn. Figure it out, c'mon honey, you're okay. Go home, sleep it off." But it's very pleasant when you walk in. It's very calm, and I like the music and the [waiting room] couch was so comfortable.

Abortion restrictions

Prior to obtaining an abortion, few women were aware of existing or impending restrictions on the procedure. Women were asked about their opinions about and experiences with the following state-level restrictions: mandatory counseling and waiting periods, restrictions on abortion coverage, and potential changes to how medication abortion is regulated (Table 2, below).

Women generally felt that mandatory counseling and waiting period laws had negative motivations and impacts. Regarding the counseling, women said they felt the state-mandated information was "intimidating" and "in your face." They also felt the information provided implied they did not take the decision to end a pregnancy seriously, and that the materials were designed to make them feel guilty about the decision. Women reported the mandatory waiting period increased the emotional difficulty of their decision.

Similarly, women saw restrictions on insurance coverage as "unfair" attempts to put abortion out of financial reach. Amber said of restrictions on insurance coverage, "I think you should have a choice…. How's an abortion any different than a surgical procedure, or what have you? I don't agree with that."

Potential changes to medication abortion regulations were perceived as an "ill-conceived tactic" to prevent women from accessing the service altogether. Women speculated that the proposed regulations would make it difficult or impossible to access the service, delay care, and increase the cost and emotional difficulty of obtaining a medication abortion. Brittany said of the potential regulation:

> I don't feel like they should make it harder, but they should make it more educative than anything. Don't make it harder, don't make it feel like you're trying to impede them. It should be presented more of you're trying to help them understand what they're doing, not, "Oh, we don't like this, so we're going to make it tougher for you." You should try to educate more than you should try to put down.

Additionally, Catherine inferred if a more restrictive medication abortion law were in place more women would buy medications online to self-induce an abortion. She had found information about this online herself and said, "It was going to be easier, faster, and quick. Don't have to worry about it or have to take the day off." However, in the end Catherine decided she felt safer seeing a health care professional for the service.

After learning about Oklahoma abortion restrictions, either through their experience obtaining an abortion or during their interview about their abortion, Oklahoma women frequently stated that restrictions on abortion were not surprising given that abortion is "frowned on" in the state. They felt the state is trying to prevent women from having abortions by making the service so inaccessible it may as well be illegal. When asked what she knew about the laws in Oklahoma, Melissa said, "I just know that it's not illegal—yet. It just seems like they [politicians] always want to try that."

Reflecting on these restrictions, women often related the importance of keeping abortion available. They recommended that abortion regulation be grounded in the realities of women's everyday lives, instead of in people's opinions about the morality of abortion. Lisa said:

> I hope they continue to allow this procedure to be available because I really do not know what I would do in my situation. I'm older, I've been through chemo, I was very concerned how the baby was going to be because of my age and because of my treatments that I've been through. I'm just in a point right where I cannot take care of a baby. I'm way past that and so I really don't know what I would have done if this hadn't been available.

Table 2. Restrictions on abortion coverage women were asked about during interview[11]

Restriction	Implementation
Mandatory counseling and waiting periods	A woman may not obtain an abortion until at least 24 hours after the attending physician, the referring physician, or an agent of either physician tells her, in person or by telephone: 1) the name of the physician who will provide the abortion, 2) the medical risks of the procedure, 3) the probable gestational age of the fetus, 4) the medical risks of carrying the pregnancy to term, and 5) the locations where the woman can obtain a free ultrasound. In addition, at least 24 hours prior to the abortion, in person or by telephone, the woman must receive from the attending or referring physician or physician's agent, a state-mandated lecture that includes the following statements : 1) medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, 2) the man involved in the pregnancy is liable for child support, and 3) she has the right to review state-prepared materials in printed form or on a state-sponsored website. If the woman chooses to review the materials in printed form, they must be mailed to her and: 1) provide a geographically indexed, comprehensive list of public and private agencies and services and their telephone numbers, including adoption agencies and the locations where the woman can obtain a free ultrasound, available to assist the woman through pregnancy, upon childbirth, and while the child is dependent, or include a 24-hour toll-free hotline to obtain such a list, 2) describe the probable anatomical and physiological characteristics of the fetus, 3) describe the commonly employed abortion procedures, the medical risks associated with each, the "possible detrimental psychological effects" of abortion and carrying a pregnancy to term, and the medical risks of carrying a pregnancy to term, and 4) state that after the fetus has reached a gestational age of 20 weeks, the fetus may feel pain, and anesthesia is often used after a gestational age of 20 weeks during prenatal surgery.
Restrictions on abortion coverage	Oklahoma restricts coverage of abortion in public and private health insurance plans, as well as in public employee health insurance plans.
Medication abortion restrictions	At the time of these interviews, Oklahoma was considering implementing a law that would have required medication abortion to be administered in accordance with outdated labeling. The law would have likely led to women making four trips to a clinic to complete the procedure.

DISCUSSION

These findings suggest that, overall, the health care system and public assistance programs in Oklahoma are lacking in many ways. Importantly, almost half of women in this study lacked insurance coverage and some had trouble maintaining insurance coverage. Other research confirms challenges adults face securing insurance coverage in the state. An estimated 23% of women in Oklahoma lack coverage; rates of uninsurance that are higher than the national average.[7] Inaccessible insurance coverage is of concern because, as we heard in these interviews and has been confirmed in other research, adults without health insurance are more likely than the insured to skip routine medical care, which increases the risk of serious and disabling health conditions. They are also often burdened with large medical bills and out-of-pocket expense.[12]

Though lack of insurance coverage for children did not emerge as an issue in this study, other research shows that approximately 10% of Oklahoma residents under the age of 18 lack insurance, a rate of uninsurance which is also higher than the national average.[7] Children without health insurance are more likely to have unaddressed health needs, including delayed care, unmet medical care, and unfilled prescriptions.[13]

The expense, both of insurance coverage and of health care services, emerged in our interviews as a deterrent to health care-seeking, particularly for low-income women. Prior research also finds that insurance coverage and health care services are prohibitively expensive, preventing uninsured Oklahomans from enrolling in public or private insurance plans and forcing 27% of Oklahomans to delay desired health care.[14]

Many of the women we interviewed reported neither they nor their children had a usual source of health care, another finding confirmed by other research. An estimated 20% of women and 44% of children in Oklahoma lack a usual health care provider, both rates higher than the national average.[7] This is another troubling trend as having a usual health care provider increases an individual's trust in and communication with a provider, as well as the likelihood of receiving appropriate care.[12] Also, as seen in this study and confirmed by other research, not having a usual source of care is associated with decreased use of preventive care and increased use of emergency departments for nonemergency conditions.[13]

Women who did see a health care provider, or whose children saw a provider, reported difficulties securing timely appointments, a challenge that was disproportionately experienced by low-income women. This is likely related to the lack of local health services. An estimated 19% of women in Oklahoma live in medically underserved areas, one of the highest rates in the nation.[15]

One bright spot is that women reported positive experiences obtaining and maintaining health insurance coverage while pregnant and positive experiences with their prenatal health care provider. However, women, particularly those on SoonerCare, often reported they did not receive timely care or that it was hard to find a prenatal care provider that accepted their insurance. One prior study finds that an estimated 33% of women on SoonerCare (and 14% of privately insured women) did not receive prenatal care as early as they wanted, largely because of limited physician options and because appointments were unavailable.[16]

Also, we underscore that we found evidence of disparities in access to health insurance and timely health services. Indeed, we found that low-income individuals struggled with access to insurance and high-quality care more so than individuals with higher income levels. This finding needs to be viewed with some caution since most of the women we interviewed were low-income; therefore we are unable to compare their experiences with a larger number of higher-income women. However, disparities in insurance coverage, access to health care, and health status along the lines of income have been documented in prior statewide surveys and evaluations.[14,17] This gives support to our finding that health insurance and care experiences in Oklahoma differ by income and further suggests that those with higher incomes have comparatively better health outcomes.

According to our interviews, access to health insurance and care also appears to differ by age. Women perceived that their children's insurance and health care services are more accessible than their own. Certainly, this trend has been seen statewide. More children are insured than non-elderly adults.[14] Also, research in Oklahoma and other states shows that children tend to receive more timely appointments and report higher satisfaction with care received, when compared with adults.[18,19]

In terms of abortion, women reported traveling significant distances to get care, an unsurprising finding given that 55% of women in Oklahoma live in a county with no abortion provider.[6] Interviewees also consistently related challenges affording abortion care. In the absence of insurance coverage for abortion, women had to search for the financial resources to pay for abortion out-of-pocket, which often led to enduring financial hardships to afford care. Other restrictions on abortion in the state largely led to increased emotional difficulty of obtaining abortion and to women feeling judged for their decision to have an abortion. To our knowledge, there is no prior research investigating Oklahomans' experiences with abortion care or abortion restrictions. However, prior research conducted with women from across the US does show that restrictions like those in place (or being considered) in Oklahoma are not beneficial to women and that they can lead to a number of emotional, financial, and physical harms.[20-22]

Further, many women, and in particular low-income women, reported struggling financially to take care of themselves and their families. This may be reflective of the fact that 17% of Oklahoma women and 24% of children in Oklahoma are living in poverty,[23] a rate higher than the national average. Further, only 56% of women in Oklahoma are participating in the labor force, and women in the state continue to earn lower wages compared to men.[7]

It should be noted that because our sample is small, our findings are likely not representative of the experiences of all women seeking abortions in Oklahoma. Specifically, our interviewees tended to be young and have young children; the experiences of comparatively older women are not represented. Also, none of the interviewees were married and the experiences of married women may differ than those presented here. Additionally, interviewees tended to be low-income; more research is needed to explore the experiences of those with higher incomes. Despite these limitations, our results provide a starting point for understanding the on-the-ground experiences with health care systems and public assistance programs in one of the nation's most restrictive states in terms of abortion. Also, the fact that many of our findings are supported by a well-regarded state-wide survey on health care (as noted above) gives us confidence in our results.

NEXT STEPS

Our results suggest five priority next steps for improving the health and well-being of women and children in Oklahoma.

1) Provide women adequate employment and education opportunities. Findings about women's struggles gathering the financial resources to meet the basic daily living needs of themselves and their families speak to the need to ensure that women are financially stable through education,[24,25] employment, and other efforts.[26]
2) Implement and/or expand state and federal programs for low-income populations. Public programs are critical resources for ensuring the health and well-being of populations living on limited means. Oklahoma heavily restricts or lacks many such programs.[iii]
3) Improve access to a routine source of health care, particularly for those publicly insured. This must be addressed to improve the poor health outcomes of many women living in the state.[iv] The state has the opportunity to do this under the forthcoming "Oklahoma Plan," which includes state-based solutions to improve health outcomes.[18]
4) Improve access to timely prenatal care. Oklahoma has very few policies in place to support pregnant women.[7] So that women and their families can experience the numerous benefits of prenatal care,[27] policies must be put into place to ensure timely access to this service.
5) Ensure abortion regulations are responsive to women's needs. Women's descriptions of abortion restrictions revealed that the restrictions often made women feel bad about themselves and their decision. This, in light of other research which shows the harms of restricting abortion, highlights the importance of ensuring abortion is accessible to all women in the state.

Evidence of experiences navigating the health care system and public assistance programs is critical for advocating for state programs and policies that are rooted in residents' needs. Ultimately, our results reveal Oklahoma policies and programs must focus on addressing the unmet needs of women and children and not on restricting access to needed health care services such as abortion.

[iii] For more information about these programs and other state policies relevant to women's and children's well-being, please see, *Evaluating priorities: Measuring women's and children's health and well-being against abortion restrictions in the states. State brief: Oklahoma.*

[iv] For more information about Oklahoma women's health outcomes and how they compare to women's health outcomes nationally, please see, *Evaluating priorities: Measuring women's and children's health and well-being against abortion restrictions in the states. State brief: Oklahoma*.

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