

# GEOGRAPHIC ACCESS TO ABORTION SERVICES POST-DOBBS IN GEORGIA: A GEOSPATIAL HEALTH EQUITY ANALYSIS

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## Introduction

The 2022 *Dobbs v. Jackson Women’s Health Organization* decision returned abortion regulation to the states, ending federal constitutional protection under *Roe v. Wade*.<sup>1</sup>

In Georgia, this triggered enforcement of the Living Infants Fairness and Equality (LIFE) Act, banning most abortions after fetal cardiac activity is detected—typically around **6 weeks of gestation**, often before pregnancy is confirmed.<sup>2</sup> Narrow exceptions exist for medical emergencies, irreversible impairment, documented rape or incest, and fatal anomalies.<sup>3</sup>

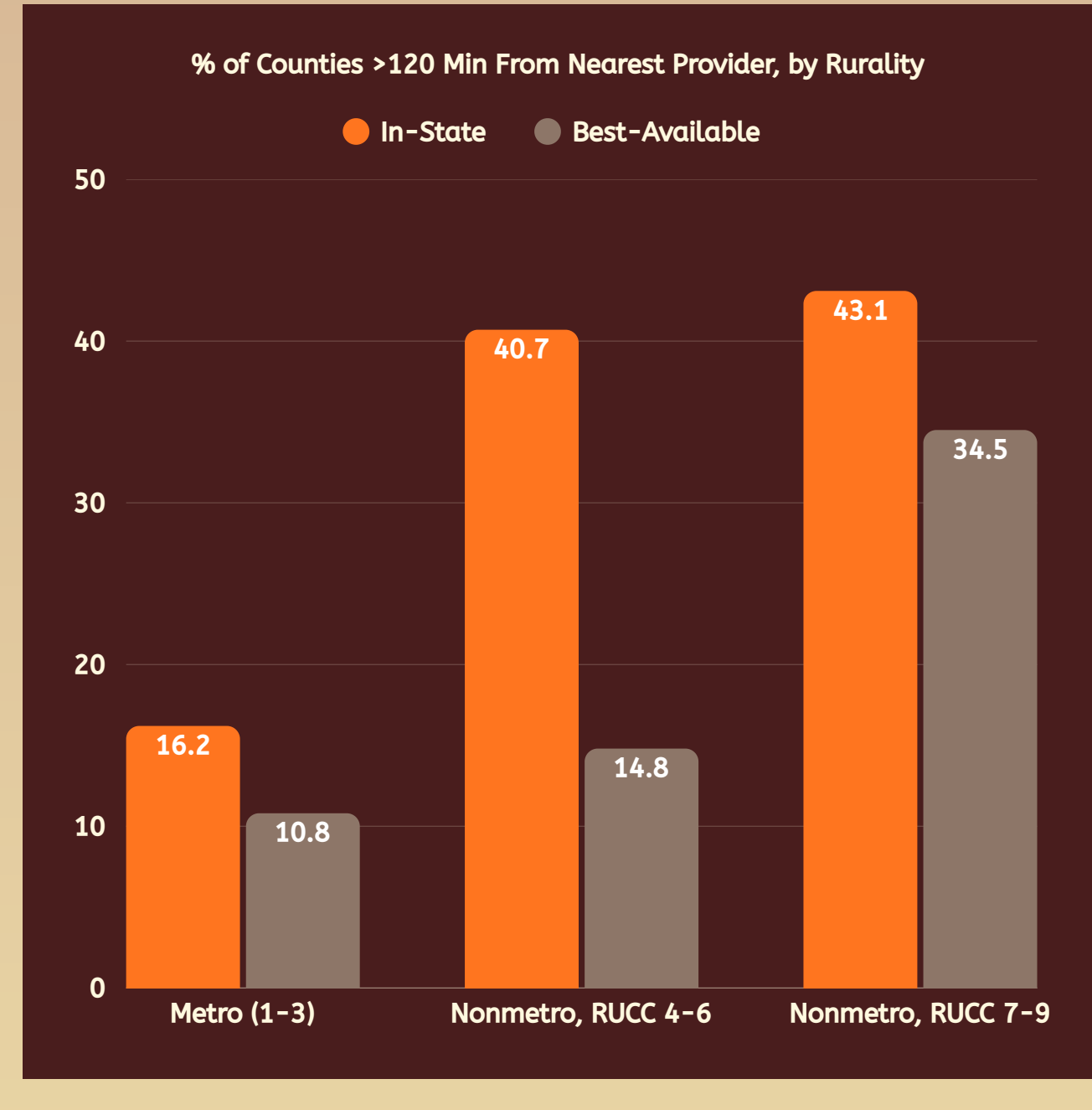
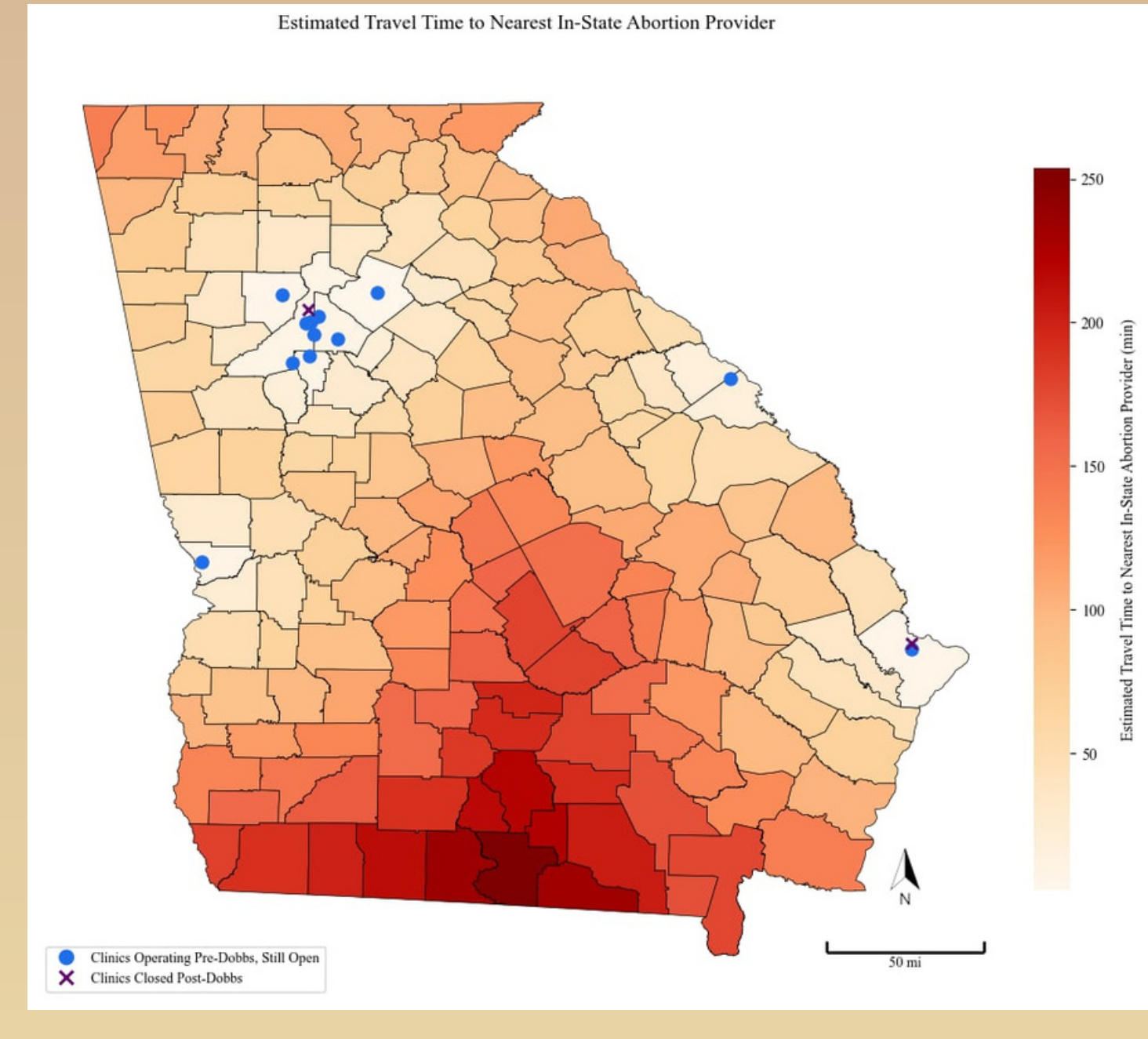
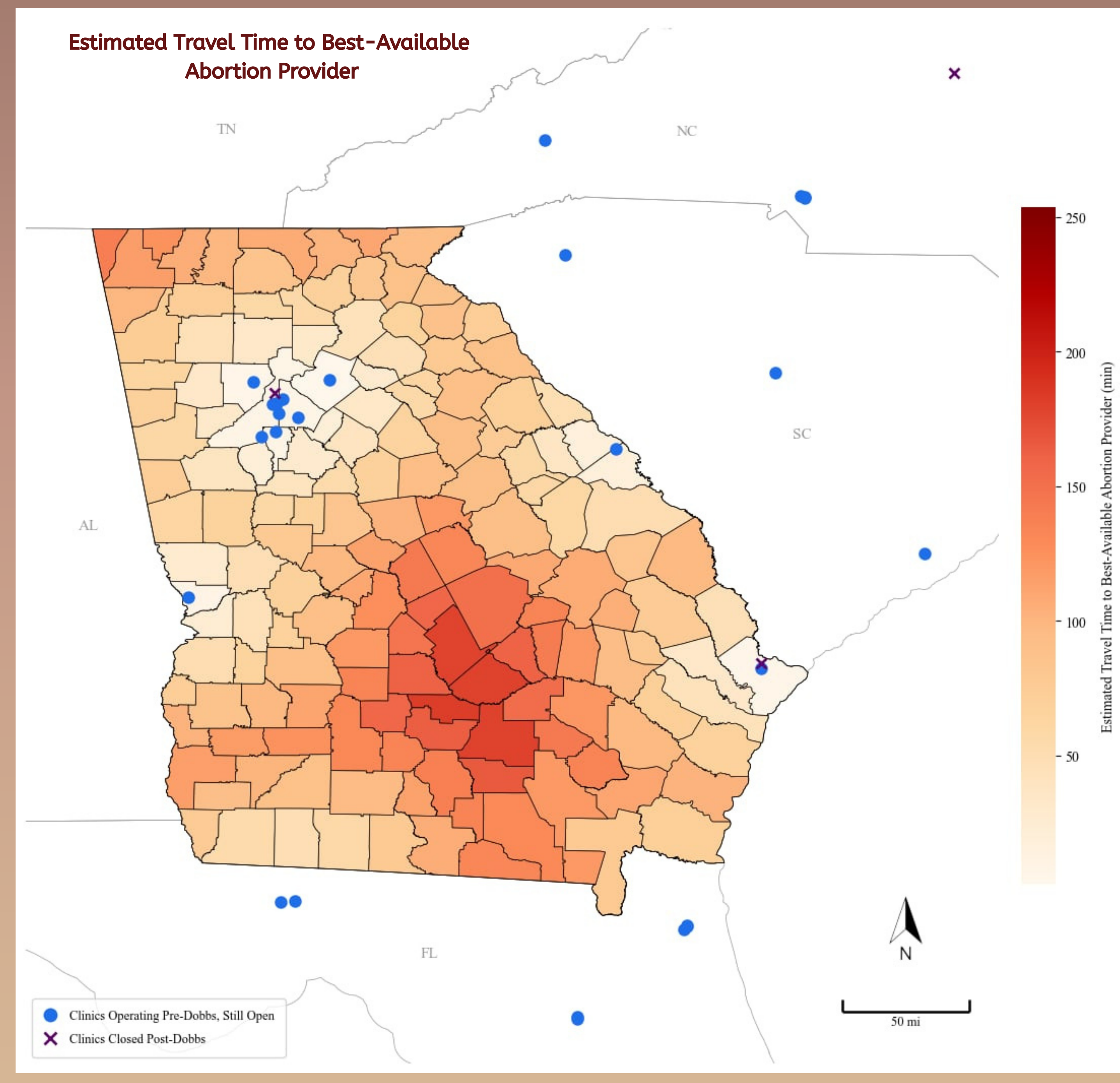
Since the ban took effect, clinic closures have reduced Georgia’s in-state abortion provider network, raising concerns about geographic access disparities—particularly for rural and low-income patients facing substantial travel burdens.

This study quantifies that burden across all 159 Georgia counties, examining how estimated travel time to abortion care varies by rurality, race, and household income in the post-Dobbs landscape.

## Methodology

- Distance calculation** – Straight-line (geodesic) distance was calculated from each of Georgia’s 159 county centroids to the nearest geocoded abortion clinic location.
- Routing adjustment** – Straight-line distance was multiplied by 1.25 to approximate real road-network travel distance, since roads rarely run point-to-point.
- Travel time conversion** – Adjusted distance was converted to estimated drive time assuming an average speed of 45 mph: **estimated travel time (min) = (distance x 1.25 x 60) / (45)**.
- Travel time was modeled under **two access scenarios**: in-state-only (13 open GA clinics) and best-available, which allowed out-of-state clinics when they were closer.
- Equity stratification** – Counties were grouped by rurality (Rural-Urban Continuum Code), quartile of % Black population, and household income relative to the Georgia median, to test whether travel burden differs across these groups.

| Key Findings                                                                                              |                                                                                                            |                                                                                                            |
|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <b>Counties over 2hr travel, in-state</b><br><b>30.2%</b><br>falls to 20.1% best-available                | <b>Nonmetro RUCC 7-9 counties over 1hr</b><br><b>94.8%</b><br>unchanged by out-of-state access             | <b>Georgia clinics, pre-to post-Dobbs</b><br><b>15 → 13</b><br>13.3% reduction                             |
| <b>Income gap, in-state median</b><br><b>36.7 min</b><br>106.7 vs. 70.0 min, below vs. at/above GA median | <b>Rurality gap, in-state median</b><br><b>50.9 min</b><br>58.7 vs. 109.6 min, metro vs. Nonmetro RUCC 7-9 | <b>Longest-drive counties, in-state</b><br><b>197-254 min</b><br>top 10 counties, concentrated in South GA |



## Results

Median estimated travel time to the nearest abortion provider was **92.0 minutes** in-state and **81.9 minutes** best-available (regardless of state). Overall, **30.2%** of Georgia’s 159 counties exceeded a 2-hour travel threshold in-state, falling to **20.1%** best-available.

Burden increased sharply with rurality. Metro counties (n=74) had a median in-state travel time of 58.7 minutes. Nonmetro RUCC 4-6 counties (n=27) faced a median of 101.7 minutes in-state, dropping to 88.9 minutes best-available. Nonmetro RUCC 7-9 counties (n=58) faced the greatest and most persistent burden—109.6 minutes in-state, 101.1 minutes best-available—with **94.8%** remaining over 1 hour from care under either scenario, a burden which out-of-state access barely reduced.

Georgia’s operating clinic count fell from **15 to 13** post-Dobbs (**13.3% reduction**). Counties with lower Black population share and below-median household income faced longer median travel times than their counterparts (83.3 vs. 75.2 minutes in-state; 106.7 vs. 70.0 minutes in-state, respectively).

## Discussion

Georgia’s post-Dobbs geographic disparities in abortion access are **driven primarily by rurality, not race**. Nonmetro counties (RUCC 7-9) face a median estimated travel time of 109.6 minutes to an in-state provider, and unlike metro and less rural counties, out-of-state access provides little relief—**94.8%** remain over one hour from care regardless of scenario, and 34.5% remain over two hours even when neighboring state providers are considered. This pattern is consistent with national evidence that abortion restrictions substantially increased travel burdens, with the share of reproductive age women living over 60 minutes from a facility rising from 14.6% to 33.3% nationally post-Dobbs.<sup>4</sup>

Income compounds this disparity: counties below Georgia’s median household income face a median travel time of 106.7 minutes to an in-state provider, versus 70.0 minutes for higher-income counties. Race shows a more complex pattern, as counties with a lower Black population share have a longer median travel time overall (83.3 vs. 75.2 minutes). This largely reflects the concentration of Georgia’s remaining clinics in metro areas (Atlanta, Columbus, Augusta) that also have large Black populations. When restricted to rural counties specifically, those with a higher Black population share still face substantial travel burdens, averaging 86.3 minutes, confirming that rurality, not racial composition, is the primary geographic driver of access burden statewide. Increased travel distance compounds the financial and logistical barriers, including lodging, time off work, and delays in care, that patients already face when seeking services across state lines.<sup>5, 6, 7</sup>

## Conclusion

**Rurality, not race, is the defining geographic barrier to abortion access in post-Dobbs Georgia, and out-of-state travel is not a reliable solution for the counties that need it most.** Closing this gap will require investment in transportation support, telehealth options, and provider access specifically targeted at rural Georgia, not statewide policy alone.

## Key Sources & Acknowledgements

- Dobbs v. Jackson Women’s Health Organization*, 597 U.S. 215 (2022).
- Living Infants Fairness and Equality (LIFE) Act, H.B. 481, 2019 Ga. Laws (codified as amended at Ga. Code Ann. § 16-12-141 (2022)).
- Center for Reproductive Rights. Georgia. *Reproductive Rights: State by State*. Accessed August 27, 2026.
- Rader B, Upadhyay UD, Sehgal NKR, et al. Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the *Dobbs v. Jackson Decision*. *JAMA*. 2022;328(20):2041-2047.
- Odouard IC, Guadamuz JS, Chakraborty A, et al. Induced Abortion and Out-of-State Travel Among Insured Women Before and After Dobbs. *O G Open*. 2024;1(2):16.

- Wasser O, Ralph LJ, Kaller S, Biggs MA. Catastrophic Health Expenditures for In-State and Out-of-State Abortion Care. *JAMA Netw Open*. 2024;7(11):e2444146.
- Riley T, Fiastro AE, Benson LS, et al. Abortion Provision and Delays to Care in a Clinic Network in Washington State After Dobbs. *JAMA Netw Open*. 2024;7(5):e2413847.

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