Confronting Our Ambivalence

THE NEED FOR SECOND-TRIMESTER ABORTION ADVOCACY

By Susan Yanow

Abortion continues to be one of the most politically contentious and divisive issues in the United States. In attempts to reframe the issue, many prochoice groups are prioritizing messages of "prevention" and "reducing the need for abortion." These frames mirror public sentiment that abortion should be "safe, legal and rare," but are problematic. While it is critically important to increase access to comprehensive sexuality education and contraception, these frames may be used to support those who seek to impose increased restrictions on abortion access. Our messages must embrace the reality that women will always need contraception *and* abortion services, that these services need to be more accessible and that they need to be available throughout pregnancy.

Since abortion was legalized in 1973, the right to abortion has been eroded through laws that create barriers to care. Second-trimester abortion is particularly vulnerable. Opinion polls show that only a quarter of the public agrees that abortion should be legal in the second trimester.

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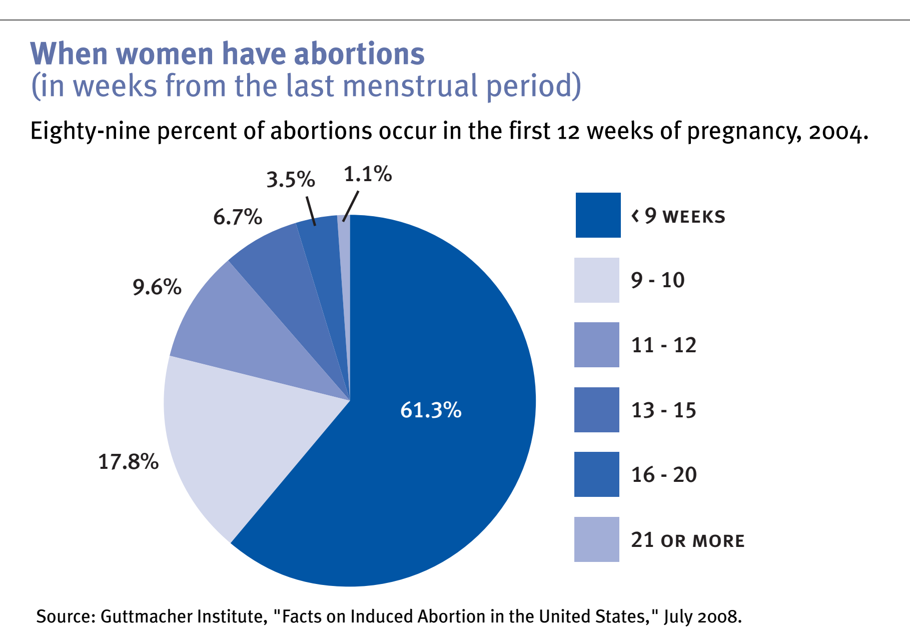

Intense public debate over so-called "partial-birth abortion" has inserted graphic descriptions, often misleading, of later abortion into the public arena. The widespread availability of high-resolution ultrasonography, which brings vivid images of fetal development into the public eye, adds fuel to the debate. News stories about very premature infants being "kept alive" through medical intervention call into question for some the definition of "viability."

As a movement, we have not engaged fully in the debate over later abortions, aware that we do not have public support or compelling ways of talking about the women who need these services. Some prochoice writers, such as William Saletan, have even questioned the wisdom of continuing to fight for later abortions, arguing that efforts should be focused on securing first trimester abortions. (*Washington Post*, March 5, 2006) This position threatens the reproductive rights of the thousands of women every year who need second-trimester abortion services, and reflects a lack of knowledge about who these women are and why they do not seek abortion care earlier.

Too many conversations about second trimester abortion start defensively with the statement, "Of course, most abortions take place in the first trimester." However, approximately 55,000 women in the US obtain abortions at 16 weeks or later every year. This is not new; women have consistently needed access to later abortions. The distribution of abortions by gestational age has remained fairly constant since 1983 with approximately 88 percent of abortions occurring before 13 weeks, six percent occurring between 13 and 15 weeks, four percent occurring between 16 and 20 weeks and one percent occurring after 21 weeks.

Who are these women? The women who seek later abortions are dispropor-

tionately young women, low-income women and women of color who often face numerous delays in obtaining services that contribute to the later gestational ages at which they present for care. Of the abortions provided to white women, 11.5 percent occur after 12 weeks compared to 13.1 percent of abortions to African Americans. A Guttmacher Institute study found that adolescents took a week longer to suspect a pregnancy than adults.

While women who detect severe fetal abnormalities in the second trimester have been the "face" of advocacy for later abortions, in fact they represent a minority of the women who need this service. Two recent studies of why women obtain abortions in the second trimester suggest that late detection of pregnancy, cost and access barriers, and difficulty making a decision, all play a role in the use of second-trimester abortion. Fifty-eight percent of women reported that they would have liked to have had the abortion earlier, but faced barriers. These barriers include a shortage of second-trimester abortion providers, the cost of a second-trimester abortion (which is covered by Medicaid in only 17 states), referral issues and low public support for women who seek later abortions.

There is little understanding that many women end up in the second trimester of an unwanted pregnancy due to barriers and delays, while other women can only make the decision to have an abortion when they are in the second trimester.

A SHORTAGE OF PROVIDERS

While the shortage of abortion providers outside of urban areas in the US is widely acknowledged, there is an acute shortage of clinicians trained and willing to provide abortions after twelve weeks for non-maternal and fetal indicators. According to a survey of abortion providers conducted by the Guttmacher Institute, approximately 60 percent of abortion-providing facilities offer abortion services after 14 weeks, and only 33 percent of the facilities offer abortions at 20 weeks. Only 24 percent of the facilities offer abortions at 21 weeks and beyond. Five states lack a provider performing abortions after 12 weeks for non-maternal or fetal indications, ten states lack a provider performing abortions after 15 weeks of pregnancy and 22 do not have a provider offering abortions after 20 weeks. Consequently, access to second-trimester abortion care is severely limited for women living in those states. Getting an accurate referral, making travel and child-care arrangements, and raising the extra money needed to travel, sometimes including plane fares and overnight stays can cause substantial delays in women getting the abortions they seek.

Some states have passed burdensome requirements that restrict providers. For example, in 2003 in Texas, there were 3,066 post-16 week abortions performed. In 2004 the Texas legislature passed a law that abortions after 16 weeks can only be provided in surgicenters, which are extraordinarily expensive to construct. In 2004, there were only 403 post-16 week abortions provided in Texas.

COSTS OF SECOND-TRIMESTER ABORTION

The cost of second-trimester abortion, which can include travel, accommodations, lost wages and child care, continues to be a barrier and cause of delay for many women, in spite of the ongoing efforts of the 100 grassroots abortion funds affiliated with the National Network of Abortion Funds (NNAF) and other funding resources. Fees for second-trimester abortion vary depending on gestational age and location, and range from $600 to $3,000. If the procedure is done in a hospital rather than a freestanding clinic or surgical center, the fee can be even higher.

The Hyde Amendment (first passed in 1976 and reauthorized every year since) prohibits the use of federal funds to pay for abortions except for cases of rape, incest or life endangerment. Only 17 states allow the use of state funds for abortions outside of these three narrow circumstances. Additionally, 12 states restrict abortion coverage in insurance plans for public employees, and five states restrict insurance coverage of abortion in private insurance plans. Three quarters of the women receiving outpatient abortions pay for the procedure with their own funds.

Insurance carriers and Medicaid (in the 17 states where Medicaid covers abortions) reimburse second-trimester abortions at a rate that does not cover the costs. Additionally, many malpractice policies increase rates for post-16 week abortions, with another increase at 19-20 weeks. The cost of providing later abortions and poor reimbursement provide a disincentive for clinics and hospitals to provide second-trimester services.

INACCURATE REFERRALS

Inaccurate referrals can contribute to many of the delays imposed on women seeking abortion services. If a woman calls the clinic closest to her, they may schedule an appointment for the following week without adequately screening her. When she arrives, she may learn that she is above the clinic's gestational age or be above their weight limit. Many organizations refer only to other providers within their membership systems rather than to the closest appropriate provider. Most states do not have comprehensive guides available to assist in good referrals to the nearest and most appropriate provider.

Currently, there are a number of referral sources for women seeking abortions, but each is limited. Planned Parenthood and the National Abortion Federation maintain only listings of their members. The

various abortion funds often only have information about the clinics that are geographically most proximate, and must do extensive research with each caller to find appropriate referrals for women needing later procedures. The lack of a comprehensive referral network means that women are often delayed needlessly, or must travel further than necessary.

LOW PUBLIC SUPPORT FOR WOMEN AND PROVIDERS

"You are 16 weeks pregnant and you want an abortion? Why did you wait so long?"

Despite the ongoing need for second-trimester abortion services, public support for abortions after the first trimester is very low. In addition to the visibility of later pregnancies, many members of the public have themselves experienced pregnancy at this stage and have uniquely personal experiences with fetal movement. This experience leads some to ask, "How can a woman who experiences fetal movement still opt for an abortion?" There is little understanding that many women end up in the second trimester of an unwanted pregnancy due to barriers and delays, while other women can only make the decision to have an abortion when they are in the second trimester. Some women need more time to wrestle with the decision—for example, they may be against abortion while at the same time knowing that they cannot possibly become a parent at this point in their lives—and this deep ambivalence delays their decision. Other women have desired pregnancies and then find themselves in a changed situation, either medically or socially (a partner becomes abusive or leaves, a job loss, a hurricane that destroys her home, a cancer diagnosis), which necessitates an abortion, despite the initial desire to keep the pregnancy and have a child.

Additionally, the general public and many medical professionals do not recognize or honor the work of abortion providers. The public image of a second-trimester abortion provider is a negative one, fueled by antichoice rhetoric and sensationalist stories after rare complications occur. In order to protect their safety and the privacy of their families, physicians who perform later abortions often do not discuss their work in any public forum. As abortions are primarily done in free-standing clinics, the procedure and those who provide it are often marginalized by colleagues in mainstream medicine.

DEVELOPING A SOLUTION

While there is good data on the multiple reasons women delay seeking abortions and the obstacles they face, we don't know why the second-trimester abortion rate has remained steady and which barriers, if removed, would result in women accessing services earlier. For example, would free pregnancy tests result in earlier detection and earlier decision making around abortion? What would the impact of comprehensive sexuality education be on women's recognition of pregnancy symptoms? There is a clear need for more quantitative and qualitative research on women who seek second-trimester abortions, and more collaborative strategies to increase abortion access.

In 2007, recognizing this need for a coordinated effort by the reproductive health, rights and justice communities, Advancing New Standards in Reproductive Health (ANSIRH), a program of the University of California San Francisco, launched the National Strategic Initiative to Secure and Expand Second-Trimester Abortion to develop strategies to increase second-trimester abortion services and support those who offer this service. This initiative has evolved into the Second Trimester Access Network, a collaboration that includes leadership from many prochoice organizations and seeks to promote work across the field on second-trimester issues. The mission of the network is to thoroughly understand all aspects of second-trimester abortion and support member groups in removing barriers that delay a woman's access to abortion, while recognizing that some women will always need abortions late in the second trimester for a myriad of complicated reasons.

The Initiative and the Network have identified some initial strategies to removing barriers to women's access to second-trimester abortion.

INCREASE TRAINING AND SERVICES

Acquiring the skills needed to provide second-trimester abortions requires experienced trainers and a sufficient volume of patients, both during the training experience and afterwards to maintain skills. Possible solutions include establishing regional hubs that would provide a sufficient volume of procedures to train all types of clinicians (doctors, advanced practice clinicians, registered nurses), or expanding the training capacity and increasing the gestational age at some current sites that provide later abortions. It is also important to recognize that training is only a first step. Once trained, providers need support to overcome obstacles to practice, including building public and clinical support for their practice.

Second-trimester abortion services are unevenly distributed. While many states have no providers of second-trimester abortions, some urban areas have a wealth of resources (for example, in the Greater Boston area there are eight facilities that offer abortion after 16 weeks.) For first trimester abortion, it is reasonable that no woman should have to travel further than the nearest primary care provider. However, second-trimester abortions require a different set of skills and different types of facilities. How many providers are needed? How far is it reasonable to expect a woman to travel for a later abortion? Research is needed to gather detailed information on current providers (including whether they are in solo practice, retirement plans, etc.), develop a model for a rational geographic distribution of services and explore the potential of providing incentives for trainees to provide abortions in underserved areas to expand services beyond where they are currently located.

PROVIDE FUNDING FOR ABORTION AND ALL REPRODUCTIVE HEALTH CARE

The *Hyde Amendment*, which bans Federal Medicaid coverage of abortions, is blatantly unjust and must be repealed. A strong coalition to repeal the *Hyde Amend-*

ment exists (Hyde: 30 Years is Enough!) and activity within the coalition is increasing as new possibilities are seen with the change of power in Washington. In the interim, legal and advocacy strategies must be developed in each state to ensure a fair reimbursement rate to providers. In states with coverage only for rape survivors or danger to a woman's health, advocates must ensure that at least these exceptional cases are covered.

However, the repeal of the *Hyde Amendment* is only a first step. Health-care reform of some kind is coming. Advocates must make sure that health-care reform efforts at both the state and federal levels include coverage of comprehensive reproductive health services. Several coalitions, including Raising Women's Voices for the Healthcare We Need, are working for health-care reform that explicitly includes coverage of abortion care.

PROVIDE ACCURATE, TIMELY REFERRALS

There is a clear need for a comprehensive referral resource that includes information on gestational limits for each provider, weight restrictions if any, cost schedules and other services (e.g. translation services). The resource should also provide funding assistance if a woman is facing economic challenges, be regularly updated and accessible to all possible referral sources. The National Network of Abortion Funds (NNAF) is currently collecting information from its member funds to begin compiling this resource.

DEVELOP A MULTIFACETED COMMUNICATIONS STRATEGY

The general public is unaware or misinformed about the reasons that women seek abortion in the second trimester. The complicated issues that lead women to make this decision must be shared with the public in a sympathetic light to increase political support for second-trimester abortion care. To create messages that resonate with different communities, we must engage those who work most closely with young women, rural women and women of color. The strategy must destigmatize abortion, incorporate respect for women and providers and avoid the devaluation of any groups, including disabled people, in the development of messaging. We must find ways to clarify that our goal is to prevent unwanted pregnancy, not to prevent abortions.

A first step is to begin with ourselves. Within our organizations and across our movement, we must clarify our values and remind ourselves that a definition of reproductive justice must include all women with unintended pregnancies, regardless of gestational age. Prevention will not eradicate the need for second-trimester abortion. Instead of using the frame of "prevention," we must begin to advocate for abortion "as early as possible, as late as necessary." ■

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