LATE TERMINATION OF PREGNANCY: AN INTERNATIONALLY COMPARATIVE STUDY OF PUBLIC HEALTH POLICY, THE LAW, AND THE EXPERIENCES OF PROVIDERS

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ABBREVIATIONS

ACN	Abortion Care Network (US)
ACOG	American College of Obstetricians and Gynecologists (US)
AMA	Australian Medical Association (AUSTRALIA)
ANMF	Australian Nursing and Midwifery Association (AUSTRALIA)
ARC	Antenatal Results and Choices (UK)
ARCC	Abortion Rights Coalition of Canada (CANADA)
ASN	Abortion Support Network (UK)
BPAS	British Pregnancy Advisory Service (UK)
CLSC	*Centre Local de Services Communautaires* (community health centre) (CANADA)
CMQ	*Collège des médecins du Québec* (Québec College of Physicians) (CANADA)
D&E	Dilation and evacuation
DfC UK	Doctors for Choice UK (UK)
FSRH	Faculty of Sexual and Reproductive Healthcare (UK)
GP	General practitioner
MFM	Maternal-Fetal Medicine
MSFC	Medical Students for Choice (US)
MSI	Marie Stopes International (UK)
NAAPOC	National Alliance of Abortion and Pregnancy Options Counsellors (AUSTRALIA)
NAF	National Abortion Federation (US/CANADA)
NARAL	National Abortion Rights Action League (US)
NHS	National Health Service (UK)
NM RCRC	New Mexico Religious Coalition for Reproductive Choice (US)
NWAAF	Northwest Abortion Access Fund (US)
OB-GYN	Obstetrician-gynaecologist
OR	Operating room
PRH	Physicians for Reproductive Health (US)
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (AUSTRALIA)
RCOG	Royal College of Obstetricians and Gynaecologists (UK)
SAAAC	South Australian Abortion Action Coalition (AUSTRALIA)
SAFDA	Support After Fetal Diagnosis of Abnormality (AUSTRALIA)
SALRI	South Australian Law Reform Institute (AUSTRALIA)

INTRODUCTION

This report addresses the issue of late termination of pregnancy, defined in Australia as abortions performed at or after 20 weeks gestation. Late terminations are a rare and stigmatised procedure that can be challenging to discuss. Too often, the rhetoric and narratives that surround this procedure are dominated by opponents of abortion who vilify the patients who seek them and the health care workers who provide them.

Frequently, there is an assumption that if only a woman or pregnant person had been more 'responsible' they could have avoided both an unwanted pregnancy and a late termination. Yet the factors that lead people to access later abortions are complex, frequently stemming from negative changes in the conditions surrounding the pregnancy or difficult and often tragic personal circumstances.

This report is grounded in the belief that abortion is health care and should be lawfully and safely provided by trained medical professionals. Using this lens, it explores the voices and experiences of medical personnel who provide later abortion care in Australia, the United Kingdom, Canada, and the United States. Their perspectives are central to understanding how the needs of patients are or are not met, what barriers impact access and provision, and how legal and public health regimes explicitly and implicitly shape this medical care.

AIMS

This report highlights the factors that shape access to and provision of late termination of pregnancy in regions of Australia, the United Kingdom, Canada, and the United States. It is designed to help government, health care services, and individual providers in South Australia meet the needs of both patients seeking later terminations and the abortion care workforce that performs them.

This study aims to:

- Explore the context in which late termination of pregnancy occurs in South Australia and comparable parts of the Western world;
- Outline the place of abortion in law and public health in each region;
- Illuminate the experiences of patients who access this care and providers who offer it; and
- Identify a model of what 'best practice' for patients and providers might look like in South Australia.

EXECUTIVE SUMMARY

In the regions visited, between 1-3% of abortions are performed from 20 weeks onwards.[1] Interviewees were clear that the patients they treated had compelling reasons for seeking later abortions and accessed this care despite considerable stigma. As a medical procedure, core elements were common across the regions visited. So too was a commitment amongst interviewees to patient-centred care and ensuring that late termination of pregnancy occurred in a supportive, non-judgmental environment. What differed in each region, and had a marked impact on provision and accessibility, were the institutional, social, legal, and political issues that surrounded the procedure.

These non-medical factors included:

- Accessibility of abortion before and after 20 weeks;
- Policies of hospitals and health departments;
- Medical education, training, and professional bodies;
- The law and gestation limits; and
- Political and community attitudes.

This report makes recommendations for changes in South Australia relating to law, health policy, service delivery, and medical education and training, intended to:

[1] Abortions at or over 20 weeks made up 2.6% of the abortions performed in South Australia and 2% of the abortions performed in England. In the United States, abortions at or over 21 weeks made up 1.2% of the total performed. In Canada, the official figure of abortions at or over 21 weeks is 0.6% of the total performed, but this is almost certainly too low, because Québec does not report gestational age details and the national figures do not include women and pregnant people who travel to the United States for care. The Abortion Rights Coalition of Canada estimated the rate as between 1% and 1.16%. See Pregnancy Outcome Unit, "Pregnancy Outcome in South Australia, 2017," (October 2019), 50 https://www.sahealth.sa.gov.au/wps/wcm/connect/5a2705b2-1034-4c1b-8420-095d076a28bf/Pregnancy+Outcome+in+South+Australia+2017+V1+Feb.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5a2705b2-1034-4c1b-8420-095d076a28bf-n5j2ySq; Department of Health and Social Care, "Abortion Statistics, England and Wales: 2019," (June 2020), 12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf; Tara Jatlaoui, Lindsay Eckhaus, Michele Mandel, et al., "Abortion Surveillance — United States, 2016," *Morbidity and Mortality Weekly Report Surveillance* Summary 68 (2019), 8 https://www.cdc.gov/mmwr/volumes/68/ss/pdfs/ss6811a1-H.pdf; Dorothy Shaw and Wendy Norman, "When there are no abortion laws: A case study of Canada," *Best Practice and Research Clinical Obstetrics and Gynaecology* 62 (2020), 54; Abortion Rights Coalition of Canada, "Statistics – Abortion in Canada," (March 2020), 4 https://www.arcc-cdac.ca/wp-content/uploads/2020/07/statistics-abortion-in-canada.pdf.

- Reduce the structural factors that cause women and pregnant people to have an abortion over 20 weeks;
- Increase support for patients who need to access later abortion care;
- Increase support for health care providers who offer later abortion care;
- Ensure the future of the abortion care workforce;
- Reduce confusion surrounding abortion and the law; and
- Work to destigmatise abortion for both patients and providers.

NOTES ON LANGUAGE AND CONCEPTS

Abortion fund: Abortion funds are non-profit organisations or charities that offer support (financial and logistical) to women and pregnant people who cannot afford an abortion and/or cannot afford to travel to access abortion. They are most prevalent in the US, but a small number exist in Canada, England, and Australia.

Abortion stigma: Abortion stigma (the notion that abortion is "morally wrong and/or socially unacceptable") occurs at multiple levels, including social, political, legal, institutional, and personal. It "leads to the social, medical, and legal marginalization of abortion care around the world and is a barrier to access to high quality, safe abortion care."[1]

Elective versus therapeutic abortions: In medical writing and in some public health documents, abortions performed on request are described as 'elective abortions,' while abortions performed for medically indicated reasons (such as an adverse fetal anomaly diagnosis) are described as 'therapeutic abortions.' Both categorisations are problematic and are generally avoided in this report.[2]

Late termination of pregnancy: Defining and labelling abortions performed after the first trimester is fraught and politically loaded. There is not consensus about when an abortion becomes 'late' or what that means. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) describes procedures from 20 weeks onwards as "late termination of pregnancy" and "late abortion."[3] This language and periodisation is also in the SA Health public health statistics and is thus used in this report.

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[1] Kate Cockrill, Steph Herold, Kelly Blanchard, et al., "Addressing Abortion Stigma Through Service Delivery: A White Paper," (2013) 3 https://www.ansirh.org/sites/default/files/publications/files/addressing_abortion_stigma_through_service_delivery.pdf. See also Kate Cockrill and Leila Hessini, "Introduction: Bringing Abortion Stigma into Focus," *Women and Health* 54 (7) (2014): 593-8; Lisa Harris, Michelle Debbink, Lisa Martin, et al., "Dynamics of stigma in abortion work: findings from a pilot study of the Providers Share Workshop," *Social Science & Medicine* 73 (7) (2011): 1062-70; Anuradha Kumar, Leila Hessini, and Ellen Mitchell, "Conceptualising abortion stigma," *Culture, Health and Sexuality* 11 (6) (2009): 625-39.

[2] For discussion of the problem with the positioning of elective versus therapeutic abortion, see Benjamin Smith, Deborah Bartz, Alisa Goldberg, et al., "'Without any indication': stigma and a hidden curriculum within medical students' discussion of elective abortion," *Social Science and Medicine* 214 (2018): 26-34; Katie Watson, "Why We Should Stop Using the Term 'Elective Abortion,'" *AMA Journal of Ethics* 20 (12) (2018): e1175-80.

[3] Lauren Megaw and Jan Dickinson, "Feticide and late termination of pregnancy," *O & G Magazine* 20 (2) (2018): 32-3; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "Late Abortion statement,"

However, other labels and categorisations exist. While UK public health data also uses 20 weeks, Canada and the US use 21 weeks. Notably, the American College of Obstetricians and Gynecologists (ACOG), responding to the particularly polarised and contentious status of abortion in the US, emphasise that the concept of a "late-term abortion" has "no medical definition and is not used in a clinical setting."[4] US interviewees tended to express discomfort with the language of early and late. Instead, several classified abortions by procedure (early medical abortion, surgical abortion, induction abortion), number of weeks, or trimester.

Psychosocial: Psychosocial refers to the intersection of psychological and social aspects. This term is often used to describe abortions chosen for non-medical reasons.

Reproductive Justice: The Reproductive Justice movement is led by women of colour and trans people and asserts "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[5] The Reproductive Justice movement has been central in emphasising access to abortion rather than just individual choice, and the research and findings in this report are shaped by this approach.

Women and pregnant people: Most people who access abortion identify as women. However, transmen, non-binary, and gender non-conforming people also become pregnant and access abortion and reproductive health services. Except when quoting, this report uses trans-inclusive language.[6]

(November 2019) https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Re-write-Late-abortion-(C-Gyn-17a).pdf?ext=.pdf.

[4] American College of Obstetricians and Gynecologists, "Facts Are Important: Abortion Care Later in Pregnancy is Important to Women's Health" (February 2019).

[5] Sister Song, "Reproductive Justice" https://www.sistersong.net/reproductive-justice. For further reading see Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (California: University of California Press, 2017); Jael Silliman, Marlene Fried, Loretta Ross, et al. (eds) *Undivided rights: Women of color organize for reproductive justice* (Cambridge: South End Press, 2004).

[6] Canada appeared to be at the forefront of creating guidelines about providing trans-inclusive abortion care. See A. Lowik, "Trans-Inclusive Abortion Services: A manual for providers on operationalizing trans-inclusive policies and practices in an abortion setting, Canada," (*Fédération du Québec pour le planning des naissances* and National Abortion Federation Canada, 2018) https://www.ajlowik.com/s/FQPN18-Manual-EN-NTL-PRESS.pdf; Abortion Rights Coalition of Canada, "Position Paper #101 Transgender Inclusivity," (2015) https://www.arcc-cdac.ca/wp-content/uploads/2020/06/101-transgender-inclusivity.pdf.

BACKGROUND

Like every Australian, I know people who have had abortions, sometimes in difficult or tragic circumstances, and sometimes because they did not want to continue with that pregnancy at that point in their life. Personally and politically, I have always been committed to feminism and reproductive rights.

In the 2000s, I did my undergraduate and postgraduate studies at the University of Melbourne in Victoria, culminating in a PhD on the history of the US anti-abortion movement. In 2009, I moved to Adelaide to take up a Lecturer position at Flinders University. I knew that South Australia was the first Australian state to liberalise its abortion law but until I moved here, I had not realised that abortion remained in the criminal law. At Flinders and in Adelaide more generally, I was surrounded by a multi-disciplinary network of colleagues interested in abortion, the law, and public health. In mid-2016, I joined the South Australian Abortion Action Coalition (SAAAC), a group of health care workers, social workers, academics, and activists working to improve abortion access.

In my academic research, I have long been interested in historicising US anti-abortion political and legal activism against later abortions.[1] In the US and the Western world, as the public became more pro-choice in the late 20th century, "the question of late-term abortion [began] to assume a prominence only recently attributed to abortion itself."[2] In the 21st century, abortions performed after 20 weeks are highly stigmatised, in part because of the rhetoric of politicians and opponents of abortion. In recent years, former US President Donald Trump made multiple false and inflammatory claims that abortion doctors "rip the baby out of the womb in the ninth month, on the final day" and "execute babies" after birth.[3] Similarly inaccurate and disturbing rhetoric was used by conservative Australian politicians as Queensland and New South Wales debated abortion

[1] For recent examples, see Prudence Flowers, *The Right-to-Life Movement, the Reagan Administration, and the Politics of Abortion* (Basingstoke: Palgrave Macmillan, 2019); Prudence Flowers, "The purists and the pragmatists: The right-to-life movement and the problem of the exceptional abortion in the United States, 1980s-2010s," *Women's Studies International Forum* 78 (2020).
[2] Michael Gross, "After Feticide: Coping with Late-Term Abortion in Israel, Western Europe and the United States," *Cambridge Quarterly of Healthcare Ethics* 8 (4) (1999): 449-62.
[3] Pam Belluck, "Trump Said Women Get Abortions Days Before Birth. Doctors Say They Don't," *New York Times*, 20 October 2016; Chris Cameron, "Trump Repeats a False Claim that Doctors 'Execute' Newborns," *New York Times*, 28 April 2019.

decriminalisation. [4] Yet the Australian public is strongly pro-choice and, depending on circumstances, accepts second and third-trimester terminations.[5]

It was through my association with SAAAC that I became aware of specific issues surrounding the provision of late termination of pregnancy in South Australia, issues that primarily stem from the place of abortion in the criminal law, divergent interpretations of that law, and different gestation limits at public health sites. This legal and public health framework creates a confusing situation for patients and a precarious situation for those providing later abortion care in South Australia.

This report offers an internationally comparative exploration of the provision of later abortion in regions of Australia, the UK, Canada, and the US. It identifies the combination of social, medical, political, and legal factors that ensure the patients who access this care and the providers who offer it are meaningfully supported.

[4] Andrew Backhouse, "Toowoomba senator hits out at 'barbaric' abortion bill," *The Chronicle*, 15 August 2016; Prudence Flowers "How the US right-to-life movement is influencing the abortion debate in Australia," *The Conversation*, 22 August 2019.

[5] In a recent South Australian survey, 63% of respondents believe an abortion after 20 weeks is acceptable "in all circumstances where the woman and health care team decide it is necessary." A further 21% believe it is acceptable in some circumstances and of these respondents, a majority believe it is acceptable when there is a serious fetal abnormality, when there is major illness, injury or health risk in the woman, or in instances of rape, incest, or domestic violence. Monica Cations, Margie Ripper, and Judith Dwyer, "Majority support for access to abortion care including later abortion in South Australia," *Australian and New Zealand Journal of Public Health* 44 (5) (June 2020): 349-52. See also Lachlan de Crespigny, Dominic Wilkinson, Thomas Douglas, et al., "Australian attitudes to early and late abortion," *Medical Journal of Australia* 193 (1) (2010): 9-12.

LITERATURE REVIEW

This project builds off a body of academic scholarship, drawing from national histories of abortion, studies focused on abortion and the medical profession, and research specifically on late termination of pregnancy and the experiences of patients and providers.

Access to abortion is greatly shaped by national contexts and I drew heavily from studies exploring the specific construction of abortion as a historical, legal, political, and health issue in the late 20th and early 21st centuries. There is a small but significant body of scholarship, particularly by Barbara Baird, Caroline de Costa, Heather Douglas, and Erica Millar, which explores the contemporary history of abortion in Australia and the legal and non-legal barriers surrounding abortion at the state and national level.[1] A handful of studies focus closely on the law reform process and its impact on provision and access.[2] Apart from studies on South Australian law and early medication abortion, most academic research on this state focuses primarily on the period before liberalisation or on the 1980s.[3]

For the UK, the work of Fran Amery, Ellie Lee, Judith Orr, and Sally Sheldon provided important background on the way that the Abortion Act 1967 has been interpreted and implemented.[4] For

[1] Barbara Baird, "Abortion Politics During the Howard Years: Beyond Liberalisation," *Australian Historical Studies* 44 (2) (2013): 245-61; Barbara Baird, "Medical abortion in Australia: A short history," *Reproductive Health Matters* 23 (46) (2015): 169-76; Barbara Baird, "Decriminalization and Women's Access to Abortion in Australia," *Health and Human Rights* 19 (1) (2017): 197-208; Caroline de Costa, Heather Douglas, Julie Hamblin, et al., "Abortion law across Australia - A review of nine jurisdictions," *Australian and New Zealand Journal of Obstetrics and Gynecology* 55 (2) (2015): 105-11; Erica Millar, "Mourned Choices and Grievable Lives: The Anti-Abortion Movement's Influence in Defining the Abortion Experience in Australia Since the 1960s," *Gender and History* 28 (2) (2016): 501-19; Erica Millar, *Happy Abortions: Our Bodies in the Era of Choice* (London: Zed Books, 2017). See also Caroline de Moel-Mandel and Julia Shelley, "The legal and non-legal barriers to abortion access in Australia: A review of the evidence," *European Journal of Contraception and Reproductive Health Care* 22 (2) (2017): 114-22; Mridula Shankar, Kirsten Black, Philip Goldstone, et al., "Access, equity, and costs of induced abortion services in Australia: a cross-sectional study," *Australian and New Zealand Journal of Public Health* 41 (3) (2017): 309-14.

[2] Alissar El-murr, "Representing the problem of abortion: Language and the policy making process in the Abortion Law Reform Project in Victoria, 2008," *Australian Feminist Law Journal* 33 (2010): 121-40; L. Keogh, D. Newton, C. Bayly, et al., "Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia," *Journal of Family Planning and Reproductive Health Care* 32 (1) (2017): 18-24.

[3] Barbara Baird, "'I had one too - ': An oral history of abortion in South Australia before 1970" (PhD Thesis, Flinders University of South Australia, 1990); Mary Heath and Ea Mulligan, "Abortion in the shadow of the criminal law? The case of South Australia," *Adelaide Law Review* 37 1 (2016): 41-68; Ea Mulligan and Hayley Messenger, "Mifepristone in South Australia: The first 1343 tables," *Australian Family Physician* 40 5 (May 2011): 342-5; Clare Parker, "A Parliament's right to choose: Abortion law reform in South Australia," *History Australia* 11 2 (2014): 60-79; Lyndall Ryan, Margie Ripper, and Barbara Buttfield, *We women decide: women's experience of seeking abortion in Queensland, South Australia and Tasmania 1985-1992* (Women's Studies Unit, Flinders University of South Australia, 1994).

[4] Fran Amery, *Beyond Pro-Life and Pro-Choice: The Changing Politics of Abortion in Britain* (Bristol: Bristol University Press, 2020); Ellie Lee, "Whither Abortion Policy in Britain?" *Journal of Family Planning and Reproductive Health Care* 39 (2013): 5-8; Judith Orr, *Abortion Wars: The Fight for Reproductive Rights* (Bristol: Policy Press, 2017); Sally Sheldon,

Canada, scholarship by Rachael Johnstone, Wendy Norman, Shannon Stettner, and Raymond Tatalovich contextualised the 1988 *R v. Morgentaler* decision and outlined the medical and geographical factors that currently shape provision.[5] For the US, the work of Sara Dubow, David Garrow, Carol Sanger, and Mary Ziegler charted the politicisation of abortion after the 1973 *Roe v. Wade* decision and the intense polarisation that impacts abortion access in that country.[6]

The project was also greatly informed by academic research on the role of the medical profession in ensuring the accessibility of abortion. There are a small but significant number of studies exploring the experiences and motivations of doctors who provide abortion on request.[7] There is far less research on the experiences of other clinicians (for example, nurses, social workers, counsellors) involved in abortion care, and this work often focuses on a single provision site or abortions performed for reasons of fetal anomaly.[8]

Beyond Control: Medical Power and Abortion Law (London: Pluto Press, 1997); Sally Sheldon, Gayle David, Jane O'Neill, et al., "The Abortion Act (1967): A biography," *Legal Studies* 39 (2019): 18-35.

[5] Rachael Johnstone, *After Morgentaler: The Politics of Abortion in Canada* (Vancouver: University of British Columbia Press, 2017); Wendy Norman, Edith Guilbert, Christopher Okpaleke, et al., "Abortion health services in Canada: Results of a 2012 national survey," *Canadian Family Physician* 62 (4) (2016): e209-17; Shaw and Norman, "When there are no abortion laws"; Shannon Stettner, Kristin Burnett, and Travis Hay (eds), *Abortion: History, Politics, and Reproductive Justice after Morgentaler* (Vancouver: University of British Columbia Press, 2017); Raymond Tatalovich, *The Politics of Abortion in the United States and Canada* (Armonk: M.E. Sharpe, 1997).

[6] Sara Dubow, *Ourselves Unborn: A History of the Fetus in Modern America* (New York: Oxford University Press, 2011); David Garrow, *Liberty and Sexuality: The Right to Privacy and the Making of Roe v. Wade* (Berkeley: University of California Press, 1998); Carol Sanger, *About Abortion: Terminating Pregnancy in Twenty-First Century America* (Cambridge: Harvard University Press, 2017); Mary Ziegler, *After Roe: The Lost History of the Abortion Debate* (Cambridge: Harvard University Press, 2015); Mary Ziegler, *Abortion and the Law in America* (New York: Cambridge University Press, 2020).

[7] For further reading on Australian doctors, see Barbara Baird, "Happy Abortionists: Considering the Place of Doctors in the Practice of Abortion in Australia Since the Early 1990s," *Australian Feminist Studies* 29 (82) (2015): 419-34; Jennifer Beattie, "'Gatekeepers' of abortion in Australia: Abortion law and the protection of doctors" (PhD Thesis, Australian National University, 2018). For further reading on UK doctors, see Siân Beynon-Jones, "Timing is Everything: The Demarcation of 'Later' Abortions in Scotland," *Social Studies of Science* 42 (1) (2012): 53-74; Ellie Lee, Jan Macvarish, and Sally Sheldon, "Doctors who provide abortion: their values and professional identity," (University of Kent, 2017). For further reading on Canadian doctors, see Jennifer Dressler, Nanamma Maughn, Judith Soon, et al., "The Perspective of Rural Physicians Providing Abortion in Canada: Qualitative Findings of the BC Abortion Providers Survey," *PLoS One* 8 (6) (2013) e67070; Jessica Shaw, "'Physicians of Conscience': A Narrative Inquiry with Canadian Abortion Providers" (PhD Thesis, University of Calgary, 2015); Drew Halfmann, *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain, and Canada* (Chicago: University of Chicago Press, 2011). For further reading on US doctors, see Lori Freedman, *Willing and Unable: Doctors' Constraints in Abortion Care* (Nashville: Vanderbilt University Press, 2010); Lisa Harris, Lisa Martin, Michelle Debbink, et al., "Physicians, abortion provision and the legitimacy paradox," *Contraception* 87 1 (2013): 11-16; Carole Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (Boston: Beacon Press, 1995); Carol Joffe, Tracy Weitz, and Clare Stacey, "Uneasy Allies: Pro-choice physicians, feminist health activists, and the struggle for abortion rights," *Sociology of Health and Illness* 26 6 (2004): 775-96; Johanna Schoen, *Abortion After Roe* (Chapel Hill: University of North Carolina Press, 2015).

[8] Jackie Nicholson, Pauline Slade, and Joanne Fletcher, "Termination of pregnancy services: experiences of gynaecological nurses," *Journal of Advanced Nursing* 66 10 (2010): 2245-56; Catherine Chiappetta-Swanson, "Dignity and Dirty Work: Nurses' Experiences in Managing Genetic Termination for Fetal Anomaly," *Qualitative Sociology* 28 (1) (2005): 93-116; Trish Hayes, Suzanne Hurley, and Chanel Keane, "Counselling 'late women' – The experience of women seeking abortion in the eighteen to twenty-four week gestation period: Critical reflections from three abortion counsellors," *Women's Studies International Forum* 78 (2020).

Most of the academic work on late termination of pregnancy comes from a medical, ethical, or legal perspective. An important subset of this research focuses upon diagnoses of fetal abnormality and medical decision making within a hospital unit or region.[9] Specific research into the experiences of patients who terminated a wanted pregnancy after a fetal anomaly diagnosis has been extremely useful.[10] Quantitative and qualitative studies have also explored why patients seek late termination of pregnancy, their experiences in accessing this care, and the barriers they face. Of particular importance are the findings of the longitudinal Turnaway Study in the US, as well as several UK reports.[11]

This project has drawn from scholarship across diverse fields of research. I also seek to fill several gaps in knowledge: documenting the current state of public health policy, the law, and abortion provision in South Australia; providing an international study of how regions approach late termination of pregnancy; and exploring the experiences of providing clinicians (relying on a broader definition of clinician than is frequently used). I offer a social science study of an area dominated by medical, legal, and ethical research, and grounds my observations and analysis through reference to the opinions of those with first-hand experience of this health care.

[9] Kirsten Black, Heather Douglas, and Caroline de Costa, "Women's access to abortion after 20 weeks' gestation for fetal chromosomal abnormalities: Views and experiences of doctors in New South Wales and Queensland," *Australian and New Zealand Journal of Obstetrics and Gynaecology* 55 (2015): 144-8; Heather Douglas, Kirsten Black, and Caroline de Costa, "Manufacturing mental illness (and lawful abortion): Doctors' attitudes to abortion law and practice in New South Wales and Queensland," *Journal of Law and Medicine* 20 (3) (2013): 560-76; Joanna Erdman, "Theorizing Time in Abortion Law and Human Rights," *Health and Human Rights Journal* 19 (1) (2017): 29-40; Julian Savulescu, "Is current practice around late termination of pregnancy eugenic and discriminatory? Maternal interests and abortion," *Journal of Medical Ethics* 27 3 (2018): 165-71; Helen Statham, W. Solomou, and Josephine Green, "Late termination of pregnancy: law, policy and decision making in four English fetal medicine units," *British Journal of Gynaecology* 113 (12) (2006): 1402-11; Elizabeth Wicks, Michael Wyldes, and Mark Kilby, "Late termination of pregnancy for fetal abnormality: medical and legal perspectives," *Medical Law Review* 12 (3) (2004): 285-305.

[10] Franz Hanschmidty, Julia Treml, Johanna Klingner, et al., "Stigma in the context of pregnancy termination after diagnosis of fetal anomaly: associations with grief, trauma, and depression," *Archives of Women's Mental Health* 21 (4) (2017): 391-99; Caroline Lafarge, Sophia Rosman, and Isabelle Ville, "Pregnancy termination for fetal abnormality: Ambivalence at the heart of women's experiences," *Women's Studies International Forum* 74 (2019): 42-51.

[11] For a sampling of some of the findings of the Turnaway Study, see Diana Foster and Katrina Kimport, "Who Seeks Abortion at or After 20 Weeks?" *Perspectives on Sexual and Reproductive Health* 45 (4) (2013): 210-18; Diana Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having – or Being Denied – an Abortion* (New York: Scribner, 2020); Ushma Upadhyay, Tracy Weitz, Rachel Jones, et al., "Denial of Abortion Because of Provider Gestational Age Limits in the United States," *American Journal of Public Health* 104 (9) (2014): 1687-94. For research on later abortion patients in the United Kingdom, see British Pregnancy Advisory Service, "'But I was using contraception …': Why women present for abortions after 20 weeks," (2017); Roger Ingham, Ellie Lee, Steve Clements, et al., "Second-trimester abortions in England and Wales," *Reproductive Health Matters* (2008): 18-29; Marie Stopes International, "Late Abortion: A Research Study of Women Undergoing Abortion Between 19 and 24 Weeks Gestation" (2005).

RESEARCH DESIGN

METHODOLOGY

This report relies on qualitative research. I undertook semi-structured, one-on-one interviews with health care workers with experience providing later abortion care, along with activists and advocates involved in this issue. I also analysed documents such as legislation, legal cases, government policies, clinical guidelines, government health websites, and relevant statements from medical professional bodies and advocacy groups. This primary research was contextualised through reference to academic scholarship in fields such as medicine, public health, law, and the social sciences.

The international regions visited were chosen after a review of relevant secondary scholarship and consultation with individuals knowledgeable about abortion, the law, and health care. Each region has elements that are relevant for the South Australian context.

The purpose of this research project was to investigate provision of and access to late termination of pregnancy. The research focused on several core questions:

- How did the interviewee experience the legal frameworks and public health policies surrounding late termination of pregnancy in their region?
- How did they think their patients experienced the legal frameworks and public health policies surrounding late termination of pregnancy in their region?
- What did the interviewee think were the major factors that shaped access to and provision of late termination of pregnancy?[1]

RESEARCH ACTIVITIES

44 participants were interviewed for the study and 2 international trips were taken. In April 2019, I spent 2 weeks in London, England, interviewing 11 people. In November-December 2019, I spent 5 weeks in North America. In Canada, I interviewed 7 people from British Columbia and 6 from Québec. In the US, I interviewed 7 people from Washington and 6 from New Mexico. I also interviewed 7 people in South Australia.[2]

[1] The full list of open-ended questions and issue prompts is attached as Appendix A.
[2] The full list of interviewees is attached as Appendix B.

38 participants were health care workers: doctors (obstetrician-gynaecologist (OB-GYN), General Practitioner (GP)/Family Medicine), physician's assistants, nurses, social workers/counsellors, genetic counsellors, clinic staff. Of these, 14, were currently or had been in positions of leadership at either the hospital department/clinic level or in medical or professional organisations. I conducted 11 interviews with activists and lobbyist who provided insights into the regional politics surrounding abortion. I also interviewed 5 people involved with abortion funds who highlighted the formal and informal barriers for patients seeking later abortions. Some interviewees occupied more than one role.

The interview length varied (from 25 minutes to 2 hours 30 minutes) depending on participant availability; most interviews (35 of 44) were 1 hour or more. Several interviewees gave me additional primary materials that they thought were important in understanding late termination of pregnancy. In every region, at least 1 interview was conducted at a site that provided late termination of pregnancy and in several of these facilities I was offered an informal tour.

ETHICAL CONSIDERATIONS

Ethics approval was received from the Flinders University Social and Behavioural Research Ethics Committee (approval number 8243), the British Pregnancy Advisory Service (reference number 2019/04/PF), and the Central Adelaide Local Health Network Human Research Ethics Committee (approval number 12652). The conditions surrounding ethics approval were carefully adhered to.

Interviews were recorded, transcribed, and checked. Most participants chose to have their identifying details anonymised. Details of the study were confidential and transcripts have only been seen by myself and transcribers who signed a non-disclosure agreement.

Although I am a member of SAAAC, the details of the research were not shared with the group. SAAAC, like equivalent organisations in the UK, US, and Canada, circulated details of the study but was not involved in the interviews that were conducted and did not have input into any sections of this report.

DATA COLLECTION AND ANALYSIS

I followed an inductive, semantic thematic approach to qualitative data analysis developed by Virginia Braun and Victoria Clarke.[3] Drawing from a cross-section of experiences and perspectives

[3] Virginia Braum and Victoria Clarke, "Answers to frequently asked questions about thematic analysis" https://cdn.auckland.ac.nz/assets/psych/about/our-

ensured the research was formative and process-oriented, helping to explore the nuances and specificities of the social world.

Because interviews were semi-structured and question prompts were open-ended, interviewees focused their attention on the issues they found most relevant. Thus this report does not presume to offer a definitive account of later abortion care in each region, nor does it endeavor to offer equivalent levels of detail for every issue in each region.

research/documents/Answers%20to%20frequently%20asked%20questions%20about%20thematic%20analysis%20April%202019.pdf.

WHO GETS A LATE TERMINATION OF PREGNANCY?

Globally, most abortions occur in the first trimester. Later abortions are and always have been rare (hovering between 1%-3% in most Western nations).[1]

In South Australia, the 1969 amendment to the Criminal Law Consolidation Act 1935 (SA) mandates that abortion is lawful only in certain circumstances and must be provided either on fetal or maternal grounds.[2] In the most recent South Australian statistics, 91.2% of abortions were performed in the first trimester. 2.6% of abortions (111 in total) were performed at or after 20 weeks. Of these, 2.7% were because of specified maternal medical conditions, 47.7% were because of a serious fetal anomaly, and 49.5% were sought on maternal mental health grounds (e.g. psychosocial factors relating to personal circumstances).[3]

There are an array of factors that cause women and pregnant people to seek a later abortion. These hold true for all the regions considered in this study.

Medical issues can emerge as an issue at any point in pregnancy, and certain maternal complications can be life threatening in the second and third trimester.[4] Many significant fetal anomalies are first detected at the 20-week morphology ultrasound and require further scans and testing for diagnosis.[5] Some tests are only processed at a few sites, meaning waits of 1-2 weeks for results. A very small number of women and pregnant people have dire fetal anomalies detected in the third trimester.[6]

When women and pregnant people seek later terminations for psychosocial reasons, one significant cause can be not knowing they are pregnant in the first trimester.[7] When an unwanted pregnancy is not detected until the second trimester, structural issues, system delays, geography,

[1] For statistics and sources of data, see note 1 in Executive Summary.
[2] *Criminal Law Consolidation Act 1935 (SA) 82A (1) (a) (i) (ii), (3).*
[3] Pregnancy Outcome Unit, "Pregnancy Outcome in South Australia, 2017," 49-50.
[4] ACOG quoted in Ariana Chu, "Tough questions – and answers – on 'late-term' abortions, the law and the women who get them," *Washington Post,* 7 February 2019.
[5] Ashleigh Foley, "I chose to have a late-term abortion so my baby wouldn't suffer," *Brisbane Times,* 16 October 2018; Lyndsay Werking-Yip, "I had a late-term abortion. I am not a monster," *New York Times,* 19 October 2019.
[6] Jia Tolentino, "Interview with a woman who recently had an abortion at 32 weeks," *Jezebel,* 15 June 2016.
[7] Some people never experience pregnancy symptoms, while other may discount the symptoms of pregnancy because of either their age (adolescence or menopause), use of long-acting methods of contraception, breastfeeding an infant, or having a gynaecological disorder or infertility diagnosis.

and finances can prevent patients from accessing abortion care quickly (detailed further in 'Key Findings' section).

Interviewees described the psychosocial late termination patients they saw as having "pretty chaotic" lives.[8] They discussed a patient body that was more likely to experiencing one or more of the following: significant mental health issues, problems with drug or alcohol dependency, homelessness, intimate partner violence, and sexual violence and trauma. Their characterisations are affirmed by findings in relevant academic literature.[9] As Brooke in South Australia recalled about her early experiences working in abortion care, "it became evident very quickly that women didn't just go, 'Oh I had to wait to have a termination later in pregnancy because I couldn't be bothered' … This group in particular came with highly complex needs related to the decision."[10]

[8] Brooke, interview by author, South Australia, 2020, 14.
[9] On the US, see Foster and Kimport, "Who Seeks Abortion at or After 20 Weeks?"; Upadhyay, Weitz, Jones, et al., "Denial of Abortion Because of Provider Gestational Age Limits in the United States." On Australia, see Hayes, Keane, Hurley, "Counselling 'late women.'"
[10] Brooke, interview by author, South Australia, 2020, 6.

ENGLAND, UK

In England, I interviewed 11 people: Anna, Anne, Bridget, Catherine, Claire, Henry, Joy, Mara, Mary, Sally, and Wendy. They spoke to their experiences in National Health Service (NHS) hospitals, Marie Stopes International (MSI), British Pregnancy Advisory Service (BPAS), Royal College of Obstetricians and Gynaecologists (RCOG), Doctors for Choice UK (DfC UK), Antenatal Results and Choices (ARC), Abortion Support Network (ASN), and Alliance for Choice. While in England I also attended the annual DfC UK conference, where I heard research presentations on a range of issues surrounding abortion provision and education.

The law	The Abortion Act 1967 substantially liberalised access to abortion in England, Scotland, and Wales. Abortion is lawful if the 'maternal health' or 'fetal disability' grounds are satisfied; two doctors agree in "good faith" the abortion is necessary; the abortion is performed by a doctor; and the abortion is performed in an approved place.[1] The 1967 law did not include a gestation limit. In practice, an upper limit of 28 weeks was assumed by reference to other legislation.
Gestation limits	The Human Fertilisation and Embryology Act 1990 introduced a 24-week gestation limit for abortion on request. The law also outlined legal exceptions where no gestation limit was in place: for reasons of severe fetal abnormality (Ground E), if the pregnant woman's life is in danger (Ground A), or if there is a risk of grave physical or mental injury to the woman (Ground B).[2] In 2019, 0.1% of terminations occurred after 24 weeks, 98.5% of which were because of a fetal anomaly diagnosis.[3]

[1] The language surrounding the maternal health and fetal disability grounds are as follows: "the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated" or "there is a substantial risk that a child would have such physical or mental abnormalities as to be seriously handicapped." *Abortion Act 1967, 1 1 (a) (b), 3.*

[2] *Human Fertilisation and Embryology Act 1990, Section 37, (b), (c), (d).*

[3] Department of Health and Social Care, "Abortion Statistics, England and Wales," 12.

Cost	England has publicly funded universal health care. In general, procedure cost is not a significant barrier for English residents, but if patients have to travel to access care, they incur unreimbursed ancillary costs. 1% of patients, many of whom have travelled from countries with extremely restrictive abortion laws, pay privately for abortion care in England. For later abortion care, the procedure costs in independent sector clinics are between £1510 and £1750, hospitals can cost over £6000.[4]
Abortion provision	There are approximately 360 sites in England and Wales that are licensed to provide abortion care. 74% of abortions are performed in the independent sector (BPAS, MSI, or National Unplanned Pregnancy Advisory Service) under NHS contract; BPAS and MSI operate more than 130 clinics.[5] 24% of abortions are performed in hospitals. Most hospitals either do not provide abortion on request or cease abortion services after the first trimester. Many hospitals licensed to provide abortion care only do so in instances of fetal anomaly and provide care to less than 50 people annually.[6]
Population	England has a population of approximately 56 million. London is the largest city, with almost 9 million.[7]

[4] For statistics, see Department of Health and Social Care, "Abortion Statistics, England and Wales," 9. For independent sector prices, see British Pregnancy Advisory Service, "Prices" https://www.bpas.org/abortion-care/considering-abortion/prices/; Marie Stopes UK, "NHS-Funded and Private Abortions" https://www.mariestopes.org.uk/abortion-services/nhs-funded-and-private-abortions/. NHS hospital prices are much less transparent but this was the sum charged one overseas patient who travelled to terminate a fatal fetal anomaly. Mara, interview by author, England, 2019, 16.
[5] Department of Health and Social Care, "Abortion Statistics, England and Wales," 8; Olivia Petter, "Stalking, 'lies' and harassment: The fight to enforce buffer zones outside abortion clinics," *The Independent*, 7 November 2019.
[6] Department of Health and Social Care, "Abortion statistics 2019: clinic data tables," (June 2020) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903062/abortion-statistics-clinic-tables-2020.ods.
[7] Office for National Statistics, "Population estimates" https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates; Wikipedia, "London" https://en.wikipedia.org/wiki/London.

KEY LEARNING OUTCOMES FOR PATIENTS AND PROVIDERS

POSITIVES

Provision of abortion care after 20 weeks

There are approximately 13 sites in England providing abortion on request to the legal limit, consisting of 3 NHS hospitals and 10 independent sector clinics. The clinics and 2 of the hospitals offer D&E. All 3 hospitals offer induction abortion. For residents in or near London, later abortion on request is provided at multiple sites, including the 3 NHS hospitals. For residents in or around West Midlands, South Yorkshire, Liverpool, and Manchester, later abortion is offered by independent sector providers.

Late termination of pregnancy for fetal abnormality is much more geographically accessible, offered at all the above listed sites and over 120 hospitals in England and Wales. In 2019, approximately 60 hospitals provided Ground E abortions after 24 weeks.[8] There are several Fetal Medicine Units at NHS hospitals in Liverpool, Birmingham, and London that specialise in this care.

In the last 5 years, there has been a slight increase in the number of later abortion providers. In 2016, MSI suspended its second-trimester surgical service after an adverse Care Quality Commission report.[9] Henry explained that at his London NHS hospital, which already provided D&E to 16-17 weeks, staff decided to increase provision to the legal limit to help alleviate the "enormous strain on other providers of second-trimester abortion care."[10] After MSI resumed provision of later surgical services, the NHS hospital continued to offer D&E to the lawful limit with the explicit purpose of assisting medically complex patients (detailed further in the 'Negatives' subsection).[11] When I was in England, one of the independent sector providers was also working to offer later abortion at an additional regional clinic site.[12]

Connections between NHS and independent sector providers

Although provision of abortion primarily occurs within the independent sector, there are numerous connections between the NHS and the independent sector and a striking amount of

[8] Department of Health and Social Care, "Abortion statistics 2019."
[9] Sarah Boseley, "Marie Stopes suspends some abortion services over safety issues," *The Guardian*, 20 August 2016.
[10] Henry, interview by author, England, 2019, 2-3.
[11] Henry, interview by author, England, 2019, 6.
[12] Joy, interview by author, England, 2019, 13.

communication and good will. Several doctors who provide (or have provided) terminations over 20 weeks in the independent sector also work or have worked in NHS hospitals. Efforts have been made to coordinate between services to reduce wait times for later presenting patients and those with medical complexities. Interviewees were in relative agreement about the core problems that impacted provision of and access to later termination in England.

Evidence-based care

There is a strong commitment from providers and relevant medical professional bodies to research and academic knowledge, to ensuring later abortion practices are evidence based and draw from the latest knowledge, and to conduct research into the experiences and needs of patients.

Information for patients

NHS and independent sector provider websites offer clear, factual information about abortion procedures, how patients access abortion services, legal gestation limits, and resources about pregnancy options and counselling services.[13] Several large NHS hospitals make detailed resources available specifically about induction abortion and the medical processes surrounding termination of pregnancy for fetal anomaly.[14]

The independent sector clinics have website tools that allow people to find abortion providers; one allows people to search by number of weeks gestation.[15] Independent sector providers also have their own centralised booking numbers, although there is no NHS or national equivalent. The NHS website has a finder tool, but the actual information it provides is confusing and inaccurate for women and pregnant people looking to access services.[16]

[13] National Health Service, "Abortion" https://www.nhs.uk/conditions/abortion/; British Pregnancy Advisory Service, "Abortion care" https://www.bpas.org/abortion-care/; Marie Stopes UK, "Abortion services" https://www.mariestopes.org.uk/abortion-services/.

[14] Guy's and St Thomas' NHS Foundation Trust, "Termination of pregnancy due to fetal abnormality: Medical termination of pregnancy over 18 weeks' gestation," (January 2018) https://www.guysandstthomas.nhs.uk/resources/patient-information/gynaecology/medical-termination-over-18-weeks-gestation.pdf; Manchester University NHS Foundation Trust, "Termination of pregnancy and compassionate induction," (November 2018) https://mft.nhs.uk/app/uploads/sites/4/2019/01/18-154-Termination-of-pregnancy-and-compassionate-induction-Nov-18.pdf.

[15] British Pregnancy Advisory Service, "Find a clinic" https://www.bpas.org/contact-us/find-a-clinic/; Marie Stopes UK, "Find your nearest Marie Stopes clinic" https://www.mariestopes.org.uk/find-us/?SelectedCategoryServiceId=3135&SelectedLocation=.

[16] British Pregnancy Advisory Service, "Make a booking" https://www.bpas.org/contact-us/book-an-appointment/; Marie Stopes UK, "I'm pregnant, what are my options?" https://www.mariestopes.org.uk/contact-us/; National Health Service, "Find pregnancy termination services" https://www.nhs.uk/service-search/other-services/Pregnancy%20termination/LocationSearch/292.

Care for patients after a fetal anomaly diagnosis

The charity ARC provides UK fetal anomaly patients with emotional and practical support during "antenatal screening, diagnosis, and the consequences of both."[17] ARC also offers educational resources for health care providers, as well as training in non-directive counselling and "formal values clarification workshops" for health care workers.[18]

The independent sector, ARC, and NHS hospitals are beginning to coordinate to support patients in having choice of method between induction abortion and D&E, developing referral pathways that are sensitive to the specialised needs of this group. However, if patients choose D&E they are unlikely to have continuity of care, as surgical termination is almost non-existent in NHS hospitals (discussed in the 'Negatives' subsection).

RCOG was one of the first international medical bodies to develop clinical guidelines on Termination of Pregnancy for Fetal Abnormality. Since 1996, it has recommended a feticidal injection before induction abortion and this is very widely in practice.[19]

In the Human Fertilisation and Embryology Act 1990, abortion is permitted after 24 weeks when there is "a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."[20] There are not specific legal definitions of these terms and RCOG advises members that a diagnosis should always be assessed on a "case-by-case" basis.[21] Interviewees saw this framing as a strength and felt confident that as long as decisions were made 'in good faith,' doctors were acting lawfully. Every interviewee viewed the lack of legal gestation limits for patients with a fetal anomaly diagnosis as positive and believed this should continue after decriminalisation, a model supported by peak professional bodies.

[17] Mary, interview by author, England, 2019, 2.
[18] Henry, interview by author, England, 2019, 5.
[19] Royal College of Obstetricians and Gynaecologists, "Termination of Pregnancy for Fetal Abnormality in England, Scotland, and Wales," (May 2010) https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf; Royal College of Obstetricians and Gynaecologists, "The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guidelines Number 7," (November 2011), 57 https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf. 2019 data indicated 96% of induction abortions over 22 weeks included a feticidal injection, see Department of Health and Social Care, "Abortion Statistics, England and Wales," 14.
[20] *Human Fertilisation and Embryology Act 1990, Section 37, (d).*
[21] Royal College of Obstetricians and Gynaecologists, "Termination of Pregnancy for Fetal Abnormality in England, Scotland, and Wales," viii.

Professional and advocacy groups

Peak professional bodies such as the British Medical Association, Royal College of Midwives, Royal College of General Practitioners, Royal College of Nurses, Faculty of Sexual and Reproductive Healthcare (FSRH), and RCOG strongly support decriminalisation and the normalisation of abortion care.[22] These groups endorse keeping the current gestation limits (e.g. 24 weeks for abortion on request and no upper limit for terminations for fetal anomaly or several maternal health reasons).

Organisations such as DfC UK and British Society for Abortion Care Providers offer professional dialogue, lobby for decriminalisation and to improve access, and work with RCOG to run abortion care training workshops.

Charitable groups such as ASN assist people in European countries with restrictive national abortion laws to access abortion care in the UK, including offering financial and accommodation support. Many of these travelling patients are accessing second-trimester and later abortion care.

Efforts to address the future of the abortion workforce

In England, medical students and junior doctors lack exposure to abortion care. In 2015, RCOG identified this as an urgent priority and united with the independent sector and providing doctors to form the Abortion Task Force. It is proposing formal mechanisms that would make first-trimester abortion care part of the core curriculum for all OB-GYN trainees (except conscientious objectors). It is also exploring the bureaucratic and institutional changes needed to ensure NHS trainees and doctors can gain skills and exposure at independent clinics.

RCOG has updated one of its Advanced Skills Modules to include second-trimester D&E skills up to the legal limit; FSRH has also introduced a Special Skills Module in abortion care open to doctors, nurses, and midwives.[23]

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[22] Denis Campbell, "Abortion should not be a crime, say Britain's childbirth doctors," *The Guardian*, 23 September 2017; Royal College of General Practitioners, "RCGP to support decriminalisation of abortion," (22 February 2019) https://www.rcgp.org.uk/about-us/news/2019/february/rcgp-to-support-decriminalisation-of-abortion.aspx; Royal College of Obstetricians and Gynaecologists, "RCOG backs decriminalisation of abortion," (22 September 2017) https://www.rcog.org.uk/en/news/rcog-backs-decriminalisation-of-abortion/.

[23] Royal College of Obstetricians and Gynaecologists, "Safe Practice in Abortion Care" in "Advanced Training in Obstetrics and Gynaecology, Definitive Document 2019," (30 August 2019), 167-74 https://www.rcog.org.uk/globalassets/documents/careers-and-training/curriculum/curriculum2019/advanced-training-definitive-document-2019.pdf; Faculty of Sexual and Reproductive Healthcare, "About the Special Skills Module (SSM) Abortion Care" https://www.fsrh.org/about-the-special-skills-module-ssm-abortion-care/.

NEGATIVES

Geographical concentration and second-trimester services

Interviewees were generally accepting of the number of sites where late termination was provided, but they were more critical of the limited number of sites providing abortion services between 13-19 weeks.[24] Multiple interviewees suggested that when patients only learned they were pregnant in the second trimester, scheduling difficulties and appointment wait times often significantly delayed their ability to access care.

Most sites for late termination on request are in or around London, with a small number of independent sector providers near other major cities in England. There are no sites in Scotland, Wales, or Northern Ireland. Patients needing later abortion for reasons of fetal anomaly can access care from a more geographically distributed range of NHS hospitals but except at 2 London sites, their only option is induction abortion.

The majority of available appointments for later abortion on request are in London, meaning patients frequently travel to access time-sensitive care. Anne explained that every week at her London NHS, later abortion patients came from all over the country and "go through a hell of a lot to get here."[25] In addition to the logistical and scheduling difficulties, patients incur unreimbursed ancillary costs. Some interviewees described situations where patients slept in their cars or cheap hostel dorms whilst in London for a multi-day procedure.[26]

Care for medically complex patients

Patients with complex medical conditions or comorbidities often need hospital-based abortion care.[27] For a decade, there has been direct coordination between BPAS and the NHS to schedule appointments for these patients. However, there are so few NHS hospitals that provide D&E that patients can wait 4-8 weeks for a procedure and 1 patient per week is unable to access abortion.[28] Henry described patients who were told that "there is nowhere where they can be treated" or experienced "months of toing and froing" to sites that could not provide care.[29]

[24] Catherine, interview by author, England, 2019, 7.
[25] Anne, interview by author, England, 2019, 8.
[26] Mara, interview by author, England, 2019, 8; Anne, interview by author, England, 2019, 10.
[27] Conditions that cannot always be managed safely in a free-standing abortion clinic setting include epilepsy, diabetes, asthma, high blood pressure, stroke, cardiac diseases, haemophilia, deep-vein thrombosis, and placenta accrete.
[28] British Pregnancy Advisory Service, "Medically complex women and abortion care," (March 2018), 4-5, 6-7 https://www.bpas.org/media/2074/briefing-medically-complex-women-and-abortion-care.pdf.
[29] Henry, interview by author, England, 2019, 13.

Additional difficulties for fetal anomaly patients

Multiple interviewees highlighted the impact of an early 2000s legal case brought by Anglican priest Joanna Jepson over a Ground E termination after 24 weeks. Ultimately, Crown Prosecution Services determined that the two doctors involved had acted lawfully, but for years the case received extensive coverage and the doctors were photographed and named in the press.[30] Bridget described this case as "put[ting] shivers down the spine of the whole profession" and making doctors wary of providing this care.[31]

In the wake of the Jepson case, multiple NHS hospitals set up panels to consider requests for Ground E terminations over 24 weeks. These panels, which were not legally required, often took weeks to convene and patients could not directly advocate for themselves. Over 15 years later there are still some NHS hospitals in England where a Ground E termination over 24 weeks will only be approved for a fatal fetal anomaly (which is not the criteria in law).[32]

There has also been sustained anti-abortion political lobbying and activism focused on the lack of gestation limits for Ground E terminations, which they present as discriminatory towards people with disabilities. Mary of ARC believed that this activism, combined with the institutional shifts after the Jepson case, dramatically increased the difficulties and stigma faced by patients who terminated after a fetal anomaly diagnosis and made them ashamed of their decision.[33]

Lack of abortion provision in NHS hospitals

Trainee doctors and residents, who gain experience almost exclusively within NHS hospitals, no longer gain routine exposure to abortion care. Nationwide, only 5.5% of OB-GYN doctors offer sexual health and abortion care. At one of the independent sector providers, almost none of the doctors offering later abortion care were trained in the UK.[34] Henry asserted that when it came to D&E, "the [surgical] skills have almost completely been lost," which also has significant consequences for the management of second-trimester miscarriage.[35]

[30] Mary, interview by author, England, 2019, 4; Sarah Womack, "Vicar loses court battle to prosecute doctors over abortions," *The Telegraph,* 17 March 2005.
[31] Bridget, interview by author, England, 2019, 14, 22.
[32] Mary, interview by author, England, 2019, 4-5.
[33] Mary, interview by author, England, 2019, 6-8.
[34] Claire Dunn, "Abortion care: Our responsibility," *O & G* (2017), 17; Catherine, interview by author, England, 2019, 9.
[35] Henry, interview by author, England, 2019, 3-4.

NHS hospital staff also have very little exposure to abortion patients. Multiple interviewees believe that this has created a situation where hospital workers do not understand why patients access abortion care and do not see the value of providing that care. Anne was one of a handful of nurses at an NHS hospital who worked with late termination of pregnancy patients. Our interview touched on issues around workforce sustainability and burnout, along with concerns about equitable distribution of labour.[36]

Trial by media

Media coverage, particularly the tabloid culture of the British press, was cited as a factor that exacerbated stigma and discouraged doctors from working in abortion care. Most interviewees listed examples where an abortion providing doctor had been subject to inflammatory media coverage even as no further legal or professional sanctions followed.

Abortion, the law, and health policy

Despite the seemingly plain language in the Human Fertilisation and Embryology Act 1990, bureaucratic interpretation has sometimes led to confusion, particularly around late termination of pregnancy. In 2018, a letter from the Chief Medical Officer to all doctors who performed abortion announced that all elements of the procedure had to be completed by 23 weeks 6 days. Interviewees described a frantic period as abortion care providers sought clarification about what this meant for a multi-day procedure. 9 months later, the Department of Health and Social Care reversed elements of the decree, determining that the feticidal injection "effectively ends the pregnancy."[37]

Although abortion is widely available in England and is a relatively routine element of the public health system, interviewees were still acutely conscious of the law as a force in their professional lives that shaped their ability to provide health care. At least one of the 'trial by media' examples related to components of the 1967 law. Most of the doctors interviewed reflexively incorporated

[36] Anne, interview by author, England, 2019, 6-7.
[37] Department of Health and Social Care, "Clarification of time limit for termination of pregnancy performed under Grounds C and D of the Abortion Act 1967," (23 July 2018) https://www.gov.uk/government/publications/abortion-clarification-of-time-limit/clarification-of-time-limit-for-termination-of-pregnancy-performed-under-grounds-c-and-d-of-the-abortion-act-1967; Department of Health and Social Care, "Further clarification of time limit for termination of pregnancy performed under Grounds C and D of the Abortion Act 1967," (28 March 2019) https://www.gov.uk/government/publications/abortion-further-clarification-of-time-limit/further-clarification-of-time-limit-for-termination-of-pregnancy-performed-under-grounds-c-and-d-of-the-abortion-act-1967.

the language of the law into their descriptions of their work. Every interviewee believed abortion should have been decriminalised long ago.

BRITISH COLUMBIA, CANADA

In British Columbia (BC) I interviewed 7 people: Diane, Jill, Joyce, Patricia, Ruth, Sandra, and Sarah. They spoke to their experiences in public hospitals and clinics, National Abortion Federation (NAF) Canada, and Abortion Rights Coalition of Canada (ARCC).

Court decisions	The Supreme Court of Canada ruled in *R. v. Morgentaler* (1988) that abortion provisions in the Criminal Code were unconstitutional because they violated a woman's right to security of person.[1] It also ruled in *Tremblay v. Daigle* (1989) that the fetus has no legal status as a person.[2] In Canada there are no national, provincial, or territorial criminal laws relating to abortion. Abortion is regulated by provincial or territorial medical policies.
Provincial policies	The BC government has policies guaranteeing access to abortion services and mandates provision in at least one hospital per jurisdiction.[3] The College of Physicians and Surgeons of BC requires that terminations over 16 weeks be performed in a hospital setting.
Gestation limits	There is no gestation limit in law in Canada. After 25 weeks, abortions for reason of fetal anomaly or adverse maternal health diagnosis are provided in BC, but patients who seek abortion for psychosocial reasons are sent to the US to receive care.[4]
Cost	Canada has publicly funded universal health care. The BC provincial health department covers transport, a capped accommodation allowance, and some ancillary costs for all patients who have

[1] *R v. Morgentaler,* 1 S.C.R. 30 (Supreme Court of Canada 1988).
[2] *Tremblay v. Daigle*, 2 S.C.R. 530 (Supreme Court of Canada 1989).
[3] Norman, Guilbert, Okpaleke, et al., "Abortion health services in Canada."
[4] British Columbia does not collect data on out-of-country abortions, but in Québec (with a population approximately 1.5 times that of British Columbia) 10-25 patients travel to the US annually, see Lia Lévesque, "Québec health minister calls for improved access to late-term abortions," *Montreal Gazette,* 5 February 2020.

	to travel to access health care. This funding is available for travel within and outside the province, thus it also covers the procedure and some travel costs for later abortion patients who access care in the US. In general, cost is not a significant barrier for BC residents.
Abortion provision	In BC, there are approximately 24 sites where abortion is provided.[5] Abortion providers are concentrated in the three largest urban areas (Vancouver, Kelowna, and Victoria) where 57% of women of reproductive age live. Approximately 4 sites offer abortion on request between 14-18 weeks. After 18 weeks, abortion on request is only performed in Southwestern BC.
Population	BC has a population of approximately 5 million. Vancouver is the largest city, with approximately 2.5 million.[6]

KEY LEARNING OUTCOMES FOR PATIENTS AND PROVIDERS

POSITIVES

Provision of abortion care after 20 weeks

There are approximately 3 hospital sites that provide abortion on request over 20 weeks (Vancouver and 2 cities on Vancouver Island). The gestation limits range from 23 weeks 6 days to 24 weeks 6 days. All sites offer D&E and induction abortion. The Vancouver hospital clinic has the highest on record gestation limit in Canada for abortion on request.

Patients who receive a serious fetal anomaly or maternal health diagnosis can access care at a broader range of sites, with all the above locations and approximately 10 rural hospitals providing care in the second trimester.[7]

Over the last 15 years, there has been an expansion in the accessibility of later abortion. Both the hospitals on Vancouver Island initially offered abortion care only to the start of the second

[5] Action Canada for Sexual Health and Rights, "Access at a Glance: Abortion Services in Canada factsheet," (2019) https://www.actioncanadashr.org/resources/factsheets-guidelines/2019-09-19-access-glance-abortion-services-canada.
[6] Wikipedia, "British Columbia" https://en.wikipedia.org/wiki/British_Columbia; Wikipedia, "Vancouver" https://en.wikipedia.org/wiki/Vancouver.
[7] Wendy Norman, Judith Soon, Nanamma Maughn, et al., "Barriers to rural induced abortion services in Canada: findings of the British Columbia Abortion Providers Survey (BCAPS)," *PLoS One* 8 (6) (2013): e67023.

trimester. Ruth and Diane worked with administrators and other medical personnel to increase the limits at their respective hospitals. The Vancouver hospital, which is the major later abortion care site provincially and nationally, also expanded its gestation limit by 1 week. This increase was initiated by Maternal Fetal Medicine (MFM) specialists because they felt that the existing limit did not allow for sufficient testing or give patients enough decision-making time. After the MFM unit increased its limit, the hospital clinic followed suit because as Patricia explained, "it felt very arbitrary to say you can have an induction for a week longer than you can have a dilation and evacuation procedure, because we say so."[8]

The number of people providing second-trimester and surgical abortion services after 20 weeks has also increased. At one Vancouver Island hospital, once the gestation limit increased, subsequent appointees were willing to offer D&E and later care. At the Vancouver hospital clinic, Patricia estimated that the number of later abortion providers had doubled in a decade, which she saw as vital for "contingency planning and succession planning."[9]

Care after an adverse medical diagnosis

Patients who receive a serious fetal anomaly or maternal health diagnosis can access compassionate abortion care within the province, no matter what stage of pregnancy, although they may have to travel to Southwestern BC.

At the Vancouver hospital, all MFM doctors provide induction abortion care for fetal anomaly and maternal health reasons and patients are supported by nursing and midwifery staff. Providing this care is part of the hiring and employment agreements for MFM doctors as a salaried staff group.

Fetal anomaly and maternal health patients can also access care even if they are over an institutional gestation limit. The Vancouver hospital relies on a Board of Physicians to make decisions, but Patricia felt that these cases were nearly always heard quickly and care was nearly always provided.

Provincial policies when patients exceed gestational limits

Established pathways exist to refer patients to US providers (primarily in Washington) if they exceed the Vancouver hospital gestation limit and are seeking abortion on psychosocial grounds. As previously noted, the health department covers most of the costs associated with accessing abortion in the US.

[8] Patricia, interview by author, British Columbia, 2019, 4.
[9] Patricia, interview by author, British Columbia, 2019, 7.

Dedicated community of providers

There is a dedicated and inter-connected community of BC abortion care providers who share knowledge, expertise, and information. Often, interviewees had worked at multiple abortion providing sites and/or had multiple points of connection through academic research.

Former and current abortion care providers also occupy significant roles as administrators and researchers in hospitals and universities. Several interviewees felt that this contributed to the provincial emphasis on evidence-based sexual and reproductive health care.

Hospital provision of abortion care

Under 25 weeks, all later termination patients, whether they need an abortion for psychosocial or fetal anomaly reasons, access care in a hospital setting. Interviewees viewed this as positive for several reasons: it allowed for full anaesthetic support, minimised potential risks, and was a more efficient use of public health dollars. Ruth also believed another significant benefit was that it "really normalises abortion care within the greater context of health care."[10]

This policy has several significant byproducts that benefit patients and the abortion care workforce. D&E is routinely provided in a hospital setting, meaning there are multiple skilled surgical providers in the province and trainee doctors have the ability to gain exposure and skills if they desire. Fetal anomaly patients at the 3 hospitals have choice of method and continuity of care within one site. And medically complex patients do not face additional barriers and delays in accessing care.

The Vancouver hospital was an exceptional model of abortion care provision in a hospital setting. Compared with the situation in most other regions I visited, there seemed to be a high level of cooperation between the MFM unit and the hospital clinic. Interviewees believed that the work of the hospital clinic was professionally and institutionally valued.

Medical education and training

In BC, there are multiple ways that abortion care is incorporated into the training of future doctors. Family Medicine residency programs offer routine training in abortion care. This is striking, because 80% of Canadian family medicine residents receive less than 1 hour of formal education

[10] Ruth, interview by author, British Columbia, 2019, 14.

on abortion.[11] For OB-GYN residents, a provincial university has embedded the Ryan Program into first-year training. The Ryan Program, which began in the US in 1999, is a 1-month 'opt out' family planning rotation that includes proficiency in first-trimester abortion care. After OB-GYN residency, the same university also offers a 2-year Fellowship in Family Planning that includes proficiency in second-trimester abortion care.[12]

The Vancouver hospital clinic is involved with the Ryan Residency and Fellowship as well as providing training for senior residents seeking to increase their proficiency in abortion care. Independent abortion clinics also provide training to 16 weeks for residents and doctors.

Each year, Patricia and an MFM staff member talk to student organisations about their career trajectories and work providing later surgical and induction abortion care.[13] This is part of a conscious effort to normalise abortion as health care for trainee doctors.

Provincial and national advocacy groups

Most BC abortion care providers and clinics are active in NAF Canada, which provides community and professional dialogue while lobbying to improve services nationwide. At the annual North American NAF conference, there are also workshops and skill-development sessions focused specifically on D&E and later abortion care.[14]

Advocacy groups such as ARCC are based in BC and work with clinics and organisations, including NAF Canada, to highlight barriers to access and provision.[15]

NEGATIVES

Geographical concentration

Outside Southwestern BC, abortion services are less accessible, particularly from the mid-second trimester. Most rural hospitals only offer second-trimester abortion for fetal anomaly reasons.[16] The lack of abortion services is compounded by physical distance and wait times for related forms of health care, such as GP and ultrasound services.

[11] Norman, Guilbert, Okpaleke, et al., "Abortion health services in Canada"; Daniel Myran, Jillian Bardsley, Tania El Hindi, et al., "Abortion education in Canadian family medicine residency programs," *BMC Medical Education* 18 (2018), 2.
[12] Patricia, interview by author, British Columbia, 2019, 6, 7, 13; Diane, interview by author, British Columbia, 2019, 10, 19.
[13] Patricia, interview by author, British Columbia, 2019, 11.
[14] Ruth, interview by author, British Columbia, 2019, 13-4; Sarah, interview by author, British Columbia, 2019, 6.
[15] Joyce, interview by author, British Columbia, 2019; Jill, interview by author, British Columbia, 2019; Sarah, interview by author, British Columbia, 2019.
[16] Norman, Soon, Maughn, et al., "Barriers to rural induced abortion services in Canada," e67023.

While provincial health covers some travel expenses, the financial assistance is quite basic. Interviewees described patients travelling 10+ hours by bus and who were not able to afford accommodation within 1 hour of the Vancouver hospital.

Vague or inaccurate website information

Health and government websites provide information about abortion, options counselling, and procedures in frank and accessible language, as do clinics and some hospitals.[17] BC also funds a free hotline that provides resources, counselling, and referrals for abortion services.[18]

But when it comes to later abortion, government websites are vague and use alarming language. They are silent on provincial gestation limits, do not assist patients in finding providers, and repeatedly use language about risk and safety that could alarm people seeking second-trimester abortion care.[19]

Provincial health regulations

Provincial health regulations impact provision of later care. Nationally, Family Medicine doctors perform almost three quarters of all abortions.[20] But College of Physicians and Surgeons of BC policies prevent Family Medicine doctors from offering second-trimester abortion care. Ruth, who had performed D&E for over a decade before moving to British Columbia, had to get a special exemption to provide abortions over 14 weeks.[21] The requirement that abortions over 16 weeks must be performed in hospitals can also cause problems outside Vancouver because patients cannot self-refer to OB-GYN specialists.

Later abortion care is often tied to individuals

For the two hospitals on Vancouver Island, the expansion of gestation limits occurred because of the tireless advocacy of the person interested in providing abortion care. Ruth and Diane both

[17] Health Link BC, "Abortion" https://www.healthlinkbc.ca/health-feature/abortion; Health Link BC, "Dilation and Evacuation" https://www.healthlinkbc.ca/health-topics/tw2462; Health Link BC, "Induction Abortion" https://www.healthlinkbc.ca/health-topics/tw2562; Options for Sexual Health, "Abortion" https://www.optionsforsexualhealth.org/facts/abortion/; BC Women's Hospital and Health Centre, "Abortion Services" http://www.bcwomens.ca/health-info/sexual-reproductive-health/abortion-services; Everywoman's Health Centre, "Abortion" https://everywomanshealthcentre.ca/abortion/.
[18] Health Link BC, "Abortion."
[19] Health Link BC, "Abortion"; Health Link BC, "Abortion: British Columbia Specific Information" https://www.healthlinkbc.ca/health-topics/tw1040. Scholarly research suggests that legal abortion at almost any stage of pregnancy is 14 times safer than childbirth, see Elizabeth Raymond and David Grimes, "The Comparative Safety of Legal Induced Abortion and Childbirth in the United States," *Obstetrics & Gynecology* 119 (2 Part 1) (2012): 215-9.
[20] Myran, Bardsley, El Hindi, et al., "Abortion education in Canadian family medicine residency programs," 2.
[21] Ruth, interview by author, British Columbia, 2019, 12.

described working with nurses, anaesthetists, and other hospital staff to ensure universal comfort with increasing the gestation limit. These doctors also played a leading role in advocating and modelling a patient-centred approach to care, consistently working to ensure other hospital employees saw "the human side [as] to why women want or need this service" and to ensure that they had "buy-in" for providing later care.[22] While hospital administrators and department heads did not obstruct the expansion of the service, they seemed to play little role in values-clarification work or mediating with staff. Initially, these doctors were the only individuals at each hospital providing abortion on request into the second trimester.

Inflexible hospital processes

Almost every interviewee supported the provision of later abortion care in a hospital setting, but some highlighted that hospital processes were often overly rigid and worked to impede timely provision of care. If patients arrive late at the Vancouver hospital clinic on the first day of their multi-day procedure, care will be delayed by a week, which Sandra saw as a failure of hospital systems and as completely avoidable.[23] Similarly, at one of the Vancouver Island hospitals, Diane explained that she regularly engaged in "ad hoc juggling" to fit later abortion patients in, swapping OR list times and doing prep on her day off because patients "can't wait two or three weeks to be done, you need to somehow figure out OR time right away."[24]

Past history of anti-abortion violence

There have been a small number of high profile acts of anti-abortion violence and attempted assassinations in Canada, several of which occurred in Vancouver. This history was brought up by almost every BC interviewee (as well as several in Québec). Some interviewees speculated that this provincial history of anti-abortion violence contributes to present-day timidity, particularly from rural and remote medical professionals, about becoming involved in abortion care.

National lack of providers over 20 weeks

Abortion after 20 weeks is only accessible in 3 Canadian provinces - British Columbia, Québec, and Ontario. The Vancouver hospital clinic regularly provides care to women and pregnant people from across the country. But not all provinces and territories fund travel costs and thus despite

[22] Diane, interview by author, British Columbia, 2019, 4-6, 10; Ruth, interview by author, British Columbia, 2019, 5-7.
[23] Sandra, interview by author, British Columbia, 2019, 15.
[24] Diane, interview by author, British Columbia, 2019, 7.

universal public health care, two national charitable abortion funds often financially support these patients.

When patients cannot travel to the United States

Patients who cannot travel to the US for personal, health, or immigration reasons are unable to access later abortion care. In Jill's opinion, the status quo in BC and much of Canada effectively means "shifting the responsibility" to provide on to American colleagues. She felt that the Canadian medical profession should take "more responsibility" and recognise that "this is health care that people need."[25]

[25] Jill, interview by author, British Columbia, 2019, 23.

QUÉBEC, CANADA

In Québec, I interviewed 6 people: Agatha, Alice, Christopher, Helen, Jean, and Yves. They spoke to their experiences in local community health centres (*Centre Local de Services Communautaires* - CLSC), clinics, and hospitals, *le Comité de vigilance,* and Québec College of Physicians (*Collège des médecins du Québec* – CMQ).

Court decisions	In Canada, abortion is regulated by provincial or territorial medical policies (for further discussion see the 'British Columbia, Canada' section).
Provincial policies	Since the 1970s, Québec has had laws and health policies that support provision of and access to abortion care. The province has an oversight committee on abortion delivery and training. Since the early 2000s, government funding policies ensure that all 17 administrative regions have at least one first-trimester abortion provider. Abortion is treated by the provincial government both as a public health issue and as "a right necessary to women's equality."[1] According to a 2006 national survey, Québec is "a model of how abortion services should be offered in the rest of Canada."[2] The CMQ regulates the medical provision of abortion care. It is notably proactive, focusing on expanding access while ensuring safety and medical standards are maintained.
Gestation limits	There is no gestation limit in law in Canada. After 24/25 weeks, abortion because of a fetal anomaly or adverse maternal health diagnosis is provided in Québec hospitals, but patients who seek

[1] Canadians for Choice and Fédération du Québec pour le planning des naissances, "Focus on Abortion Services in Québec," (2010), 32-3 http://www.fqpn.qc.ca/main/wp-content/uploads/2015/07/ResearchCFCFQPN2010.pdf; Johnstone, *After Morgentaler,* 99-100.
[2] Jessica Shaw, "Reality Check: A close look at accessing abortion services in Canadian hospitals," (Canadians for Choice, 2006), 35 https://lib.ohchr.org/HRBodies/UPR/Documents/Session4/CA/CC_CAN_UPR_S4_2009_anx_AccessReport07_EN.pdf.

	abortion for psychosocial reasons are sent to the US to receive care. Annually, between 10-25 patients travel to the US.[3]
Cost	Canada has publicly funded universal health care. The Québec provincial health department covers transport, a capped accommodation allowance, and some ancillary costs for all patients who have to travel to access health care. This funding is available for travel within and outside the province, thus it also covers the procedure and some travel costs for later abortion patients who access care in the US, including expedited passport and visa fees.[4] In general, cost is not a significant barrier for Québec residents.
Abortion provision	In Québec, there are approximately 49 sites where abortion on request is provided, the largest number in any Canadian province.[5] Indeed, nearly half the abortion care facilities in Canada are located in Québec, a province where only 22.3% of reproductive-age women reside.[6] For earlier care, it is also the province with the best geographic distribution of providers. However, for patients over 20 weeks, abortion on request is only available in the Montreal area.
Population	Québec has a population of approximately 8.5 million. Montreal is the largest city, with approximately 4 million.[7]

[3] Lévesque, "Québec health minister calls for improved access to late-term abortions."
[4] Alice, interview by author, Québec, 2019, 5.
[5] Action Canada for Sexual Health and Rights, "Access at a Glance."
[6] Norman, Guilbert, Okpaleke, et al., "Abortion health services in Canada."
[7] Wikipedia, "Quebec" https://en.wikipedia.org/wiki/Quebec; Wikipedia, "Montreal" https://en.wikipedia.org/wiki/Montreal.

KEY LEARNING OUTCOMES FOR PATIENTS AND PROVIDERS

POSITIVES

Provision of abortion on request over 20 weeks

In Québec, there is approximately 1 site that provides abortion on request over 20 weeks, a Montreal CLSC. It offers D&E care. Its gestation limit is 24 weeks but this is not a rigid limit, and some doctors go beyond it on a case-by-case basis.[8] There is a strong emphasis on ensuring very little wait time for patients over 20 weeks. Agatha explained, if "I don't have any more places for an appointment but they are on the limit, we'll find a place for her, that's for sure. We won't send her into the United States."[9]

The gestation limit at the Montreal CLSC has evolved over time, gradually increasing from 20 weeks in the mid-2000s. Doctors were focused on ensuring the safety of the D&E technique for patients and the confidence and competence of providers. Because of an agreement brokered by Jean, one Montreal hospital also offers abortion care to patients between 24-28 weeks if they have mental health problems or are addicted to drugs.[10] Jean, Christopher, Alice, and Agatha emphasised that the gestation limit currently in place at the Montreal CLSC was because it lacked the financial resources and staff to routinely offer care after that point.

In Québec, hospitals provide later abortion care for patients with a fetal anomaly or adverse maternal health diagnosis and do not have gestation limits in these situations. The decision to provide care over 24 weeks is usually made by a committee rather than the treating physician.

Provincial policies when patients exceed gestational limits

Established pathways exist to refer patients to US providers (primarily in New Mexico) if they exceed the Montreal CLSC's gestation limit and are seeking abortion on psychosocial grounds. Workers at the Montreal CLSC liaise with US clinics and the provincial Health Department to arrange appointments and provide bureaucratic support for those who lack official government documentation.

But this will not be required for much longer. The CMQ has spent several years working with Québec providers, hospitals, and the Health Department to ensure that all women and pregnant people needing abortion care can receive it in the province rather than "forcing them to do an

[8] Christopher, interview by author, Québec, 2019, 3.
[9] Agatha, interview by author, Québec, 2019, 4.
[10] Jean, interview by author, Québec, 2019, 12.

inappropriate trip." The new model was expected to be in place in by 2020/2021. It will involve one main Montreal hospital and potentially two other regional hospitals; in the CMQ's view the service should not rest on "the shoulders of a physician, [rather] it relies on the shoulders of all stakeholders of the health system."[11] There does not seem to be equivalent discussion occurring in other Canadian regions about 'repatriating' later abortion care.

Dedicated community of providers

Abortion provision in Québec has been influenced by decades of activism by feminists and progressive health care providers. This history means that abortion is explicitly framed as a positive right that the government needs to ensure is accessible.[12]

There is a dedicated and inter-connected community of providers who share knowledge, expertise, and information. Jean is part of a small network of doctors, many of whom have provided abortion care since the late 1970s, who play an important role in shaping provincial attitudes towards abortion care. These doctors are routinely consulted by the CMQ and Health Department as key stakeholders in policy discussions. Christopher felt that the close connection between provincial abortion providers, government departments, and professional bodies helps normalise abortion as health care.

Medical education and training

Abortion providers are working to ensure there will be enough doctors trained for the future. Christopher explained that when he started, all the doctors had been working in abortion care since the 1970s. Concerned about what would happen when they retired, he started offering training to doctors who approached him. Several years ago, the CMQ formalised this arrangement and began to direct people to him. Over the last four years the Montreal CLSC has had a small but steady stream of medical students and residents (both OB-GYN and Family Medicine) doing placements, along with doctors seeking to gain exposure to the clinical skills required in abortion care. Christopher reported that "we have more people that asked us to come and work here than the number of places."[13] However, in-depth training and exposure to abortion care does not seem to occur as a routine element in Montreal teaching hospitals and is not embedded in the curriculum or in residencies.[14]

[11] Yves, interview by author, Québec, 2019, 3; Lévesque, "Québec health minister calls for improved access to late-term abortions."
[12] Johnstone, *After Morgentaler,* 96-8.
[13] Christopher, interview by author, Québec, 2019, 9-10.
[14] Danielle Goren, "When it comes to abortion, do medical schools need to smarten up?" *Chatelaine*, 21 January

NEGATIVES

Divisions between French and English Canada

When it comes to abortion, there are clear divisions between Francophone and Anglophone institutions within Canada. Québec providers seemed relatively disconnected from organisations such as NAF and NAF Canada and people outside the province knew comparatively little about the processes and procedures within Québec. Despite the Montreal CLSC's gestation limit it did not seem to be a major referral point except for patients from Ontario, Québec's neighbour. Within the province, there did not appear to be links between Québec's Francophone abortion care providers and the Anglophone hospitals or universities.

Geographical concentration

Québec is Canada's largest province. Although government policies ensure all administrative regions have at least one first-trimester abortion provider, in the northern regions, patients can travel hundreds of kilometres to access this care.[15] Outside major urban centres, there are also problems with the limited number of providers and lengthy wait times.[16] For remote patients, health system factors can cause significant delays in accessing abortion.

Vague website information about later abortion, provision, and gestation limits

Québec clinic, health, and government websites provide information in English and French about abortion, options counselling, and different procedures in frank and accessible language. [17] Québec government websites have a tool that allows people to search for providers based on their location and Montreal offers a centralised phone booking service.[18]

But Québec government and health websites offer little information about gestation limits or induction abortion. Hospitals, which provide most later abortions for reasons of fetal anomaly, seem to offer almost no information about abortion on their websites, nor are hospital limits or decision-making processes publicly available.

2015.

[15] Daniela Kotlier, "Accessibility of Abortion in Canada: Geography as a Barrier to Access in Ontario and Québec," *Inquiries Journal: Social Sciences, Arts, and Humanities* 8 (6) (2016).

[16] Fanny Samson, "Long wait times for abortion 'unacceptable,' Québec Premier Legault says," *CBC News,* 27 October 2019.

[17] See "Abortion services" https://www.quebec.ca/en/health/health-system-and-services/service-organization/abortion-services/; Québec, "Sexual Health: Abortion" https://jeannemance.ciusss-centresudmtl.gouv.qc.ca/soins-et-services/sante-sexuelle/avortement.

[18] Québec, "Finding a Resource Offering Abortion Services" https://sante.gouv.qc.ca/en/repertoire-ressources/avortement/; Health Montreal, "Abortion: Appointment Centre" https://santemontreal.qc.ca/en/public/support-and-services/abortion-montreal-appointment-centre/.

Tension between health care providers

Most interviewees referred to tension between health care sites and providers over later abortions. Jean recounted numerous instances of quite significant professional hostility and harassment from other doctors who opposed his advocacy on behalf of late termination patients. Helen, the director of a clinic in a western Québec city, explained her difficulty in retaining locally-based staff because of the discrimination they experienced from other medical colleagues.[19] Montreal CLSC interviewees were matter-of-fact that many hospital doctors would not refer fetal anomaly patients to their centre and did not let patients know that D&E was an option.

Attitudes and actions of hospitals

Most Québec hospitals only offer later abortion care to fetal anomaly patients but even the interpretation of fetal anomaly varies and the processes of ethics committees are not transparent. In 2016, a McGill University ethics committee denied abortion care to a woman who had received a severe fetal anomaly diagnosis in the third trimester. The hospital's position was that there was "no moral justification" unless the patient's life was at risk, although the committee did recommend that she could access a termination in the US. The woman worked with a lawyer and her doctors to find a Québec hospital that would provide an abortion and the case attracted provincial press coverage because the reason for refusal contradicted judicial precedent.[20]

In Québec, there are areas where the provision of care in hospitals does not align with models of best practice for patients or staff. Induction abortion is generally the only method offered to patients from 16 weeks gestation, even to very young adolescents. Most hospital OB-GYNs are not trained to perform D&E, do not give their fetal anomaly patients information about induction abortion versus D&E, and do not refer patients. By and large, Québec hospitals do not offer fetal anomaly patients choice of method. Several interviewees noted disapprovingly that Montreal hospitals frequently do not perform a feticidal injection, although this has been the norm in the United States and Canada since the early 2000s. Agatha believed that even when individual hospital doctors were interested in offering later abortion care, little institutional effort was made to ensure that nursing staff were also willing.[21]

[19] Helen, interview by author, Québec, 2019, 5.
[20] Amélie Daoust-Boisvert, "Forced to use a lawyer to obtain an abortion," *Le Devoir,* 20 December 2016; Amélie Daoust-Boisvert, "Access dotted with obstacles," *Le Devoir,* 24 December 2016.
[21] Agatha, interview by author, Québec, 2019, 7.

Jean and Christopher both viewed the Québec hospital system, which has the resources and ability to manage induction abortion after 24 weeks, as obstructive and the primary reason why patients are sent to the United States to access abortion care.[22]

[22] Christopher, interview by author, Québec, 2019, 3.

WASHINGTON, USA

In Washington, I interviewed 7 people: Audrey, Deb, Donna, John, Lauren, Lucy, and Mercedes. They spoke to their experiences in independent clinics, Planned Parenthood affiliates, hospitals, NAF, Abortion Care Network (ACN), National Abortion Rights Action League (NARAL) Pro-Choice Washington, and the Northwest Abortion Action Fund (NWAAF).

Laws	In the United States, abortion was made lawful by the Supreme Court in *Roe v. Wade* (1973) and reaffirmed in *Planned Parenthood v. Casey* (1992).[1] *Roe* outlined a trimester framework for abortion regulation. After fetal viability (defined as between 24-28 weeks), states can ban abortion except to save the life of the mother. In Washington, the *Reproductive Privacy Act* (1991) ensures abortion will remain legal even if *Roe* is overturned. Unlike many US states, Washington does not have anti-abortion laws requiring mandatory waiting periods, counselling, or parental consent requirements for teenagers. The legislature has not passed 'fetal pain' or 'heartbeat' bills, method bans, or 'targeted regulation of abortion provider' laws. Nor has it passed laws barring private or employer-based health insurance plans from covering the cost of abortion.[2] Instead, Washington has passed protective legislation, discussed below.
Gestation limit	In Washington, abortion is lawful until viability, legally understood as approximately 27 weeks. After viability, abortion is only lawful if performed to protect the pregnant woman's life or health.[3]

[1] *Roe v. Wade* 410 U.S. 113 (U.S. Supreme Court 1973); *Planned Parenthood of Southeastern Pennsylvania v. Casey* 505 U.S. 833 (U.S. Supreme Court 1992).
[2] Guttmacher Institute, "An Overview of Abortion Laws" https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.
[3] Viability is defined in Washington law as "the point in the pregnancy when, in the judgment of the physician on the particular facts of the case before such physician, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures." *Reproductive Privacy Act, RCW 9.02.170.*

Cost	The United States has a user pays model of health care. Since 1977, the Hyde Amendment has prohibited the use of federal funds to pay for abortion except to save the life of the mother or if the pregnancy is the result of rape or incest. The Hyde Amendment impacts the health care of low-income and disabled Americans, along with active members of the US armed forces, veterans, members of the Peace Corps, federal employees, indigenous Americans, and people in federal prisons and immigration detention facilities.[4] Washington State Medicaid covers the abortion procedure for low-income residents. It also covers transportation and some ancillary costs for patients who have to travel. Alaska, the largest and most isolated US state, has formal arrangements with Washington for the provision of health care services. Under court order, Alaska State Medicaid covers the abortion procedure for low-income residents, along with ancillary travel costs.[5] The *Reproductive Parity Act* (2018) mandates that all insurance plans in Washington that cover maternity care must also cover abortion care.[6] Cost is still an issue for Washington residents, but it is less of an issue than in the rest of the US.
Abortion provision	In Washington, there are approximately 51 sites where abortion on request is provided, concentrated in Seattle and the broader Puget Sound region (including Tacoma, Everett, and the capital, Olympia). Counter to national trends, the number of sites has increased over the last decade.[7] As in the rest of the US, these sites are primarily free-standing clinics.[8] Most of these are first-trimester providers, with a small number of early-to-mid second

[4] Megan Donovan, "In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact," *Guttmacher Policy Review* 20 (January 2017).
[5] Northwest Abortion Access Fund, "Washington – Funding" https://nwaafund.org/info/washington#-tab-funding; Northwest Abortion Access Fund, "Alaska – Funding" https://nwaafund.org/info/alaska#-tab-funding; *State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001).*
[6] *Reproductive Parity Act, SB 6219 2017-18 (Washington).*
[7] Guttmacher Institute, "State Facts about Abortion: Washington Factsheet," (March 2020) https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-washington#1.
[8] Rachel Jones, Elizabeth Witwer, and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2017," (New York: Guttmacher Institute, 2019) https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.

	trimester sites. Abortion on request over 20 weeks is only provided in the greater Seattle area.
Population	Washington has a population of approximately 7.16 million. Seattle is the largest city, with approximately 3.4 million.[9]

KEY LEARNING OUTCOMES FOR PATIENTS AND PROVIDERS

POSITIVES

Provision of abortion care after 20 weeks

In Seattle, there are approximately 5 sites providing later abortion care, consisting of independent clinics, one Planned Parenthood affiliate, and one hospital. Their gestation limits range from 22 weeks to 26 weeks 6 days. All sites perform D&E. The hospital also offers induction abortion.

In the last decade in Washington, access to later terminations has expanded in terms of gestational limit and broader provision of care. One Seattle independent clinic increased from 24 to 26 weeks because of the 2009 assassination of later abortion care provider Dr. George Tiller in Kansas and a wave of state anti-abortion laws passed in the early 2010s. In the late 2010s, the Seattle hospital also increased its limit from 24 to 26 weeks and began providing care to abortion on request patients. The hospital changes occurred primarily because of staff retirements and advocacy from newer members of the OB-GYN department.

Formal and informal supports offered to later gestation patients

Government health websites provide little detail about abortion as health care, but clinic websites and advocacy groups offer information about providers and procedures in frank and accessible language.[10]

Providers frequently see later termination patients who have had to overcome multiple barriers to access care, barriers heightened by the hostile political, legal, and social climate that surrounds abortion care in the US. Clinic workers, particularly front office staff and phone counsellors, play

[9] Wikipedia, "Washington (state)" https://en.wikipedia.org/wiki/Washington_(state).
[10] Washington State Department of Health, "Abortion" https://www.doh.wa.gov/YouandYourFamily/FamilyPlanning/Abortion; Cedar River Clinic, "After 12 Weeks" https://www.cedarriverclinics.org/later-abortion-2nd-trimester/; Cedar River Clinics, "Videos" https://www.cedarriverclinics.org/videos/; All Women's Care, "Abortion Care" https://www.awcseattle.com/abortion-care; Northwest Abortion Access Fund, "Find clinics" https://nwaafund.org/providers.

a significant role in connecting patients with resources and information about Medicaid, private health insurance, and the network of local and national abortion funds that assist with procedure and other ancillary costs. Interviewees talked about the important work of NWAAF, a volunteer group that organises practical support for patients who have to travel to access abortion.

Ability to help

As in New Mexico, interviewees talked repeatedly about later abortion care as helping vulnerable and marginalised patients who could not access care in their home communities and the meaning they drew in being able to assist patients who travelled from other US states, from Canada (for example, BC refers to Washington), and from around the world.

Language and framing of the law

Interviewees were acutely aware that they were providing care in a state that was supportive of abortion access and rights, describing themselves as "really lucky" in comparison to health care workers in other states. Most also talked about Washington's future as a "haven state" if the Supreme Court overturns *Roe*.[11]

Although Washington has a gestation limit, the legal interpretation of viability has been broad rather than narrow. Interviewees also saw the language of the law as important for situations where the fetus would not live after birth. However, while they appreciated the pro-choice sentiment behind the law, many shared the view of Lauren: "Just like we don't have laws for hysterectomy, why do we have a law about abortion? I think it's ridiculous that it's in the law at all."[12]

Dedicated community of providers

Seattle and the Puget Sound region has a large and dedicated community of abortion care providers and independent clinics; several of the doctors characterised Seattle as having a "saturated" market.[13] This has multiple benefits for the normalisation of abortion as health care and in supporting providers who do this work.

The commitment to offering abortion care extended beyond their home communities. Interviewees referred to doctors who travelled long distances within Washington to ensure greater access, with flow-on effects for people in several border states. John has spent several years flying to a Southern state and was about to add another state to his rotation. Despite the many challenges

[11] Mercedes, interview by author, Washington, 2019, 2; Lucy, interview by author, Washington, 2019, 20.
[12] Lauren, interview by author, Washington, 2019, 10.
[13] John, interview by author, Washington, 2019, 3.

of providing abortions in more hostile states, he felt "travelling work is something that can be joyful in a lot of ways because you're able to come in and provide this very needed service for patients."[14]

Relationships between provision sites

The Seattle clinics and hospital have a cooperative and positive relationship and several staff work across sites. This means that medically complex patients seeking later abortion care can access D&E care at the hospital and that hospital patients with a fetal anomaly diagnosis can have choice of method. Interviewees highlighted that this relationship allowed clinic doctors to be confident that in rare situations where a patient has a complication and needs hospital care they will be assisted by skilled and supportive professionals.

Abortion is embedded in medical education and training

The Seattle hospital is a teaching hospital with a medical school. It has a clinic that provides abortion care where medical students and residents gain exposure to patients and training in surgical skills. It is also home to the Ryan Residency and the Fellowship in Family Planning (detailed in the 'British Columbia, Canada' section). Medical students and junior doctors gain experience and skills in a state that is "supportive of abortion rights."[15]

Deb noted that while people had once worried about the "greying of the abortion providers," in Washington the situation was now completely reversed, which she credited to the work of Medical Students For Choice (MSFC) and ACOG, which has worked for several decades to ensure abortion is a routine part of medical school training and education in OB-GYN programs.[16] In Deb's opinion, "right now we don't have a shortage of abortion providers [in the US], we have a misallocation of abortion providers. They are in the liberal states, they are in the liberal cities."[17]

Role played by advocacy, activist, and professional groups

Advocacy and activist groups such as NARAL Pro-Choice Washington and NWAAF have very close connections with the abortion provider community and deep knowledge of the issues and

[14] John, interview by author, Washington, 2019, 8.
[15] Jones, Witwer, and Jerman, "Abortion Incidence and Service Availability in the United States, 2017."
[16] American College of Obstetricians and Gynecologists, "Abortion Training and Education," *Committee Opinion* 612 (2014); Jody Steinauer, Jema Turk, Tali Pomerantz, et al., "Abortion Training in U.S. Obstetrics and Gynecology Residency Programs," *Obstetrics and Gynecology* 130 (2017): 44S-45S; Jody Steinauer, Jema Turk, Tali Pomerantz, et al., "Abortion Training in US Obstetrics and Gynecology Residency Programs," *American Journal of Obstetrics and Gynecology* 219 (1) (2018): 86.E1-86.E6.
[17] Deb, interview by author, Washington, 2019, 4.

barriers that clinics and their patients face. Because Washington is politically and socially supportive of abortion rights, Audrey explained that NARAL Pro-Choice Washington views lobbying as keeping "the conversation focused on what should access look like, not on what's the bare minimum we can get."[18] NARAL Pro-Choice Washington, along with the American Civil Liberties Union, have played an important role in expanding abortion rights through legislation and lawsuits, including measures such as the *Reproductive Parity Act*.

Interviewees described feeling extremely supported within the national reproductive health community and spoke of the professional and personal value of groups such as NAF. Several interviewees also had past or current connections with organisations such as Physicians for Reproductive Health, the Society of Family Planning, ACN, MSFC, and ACOG.

Patients who exceed gestation limits

If patients exceed 26 weeks 6 days and are seeking a termination for reasons of fetal anomaly, they can be referred to providers in New Mexico, Colorado, Maryland, and Washington, D.C. If they are seeking an abortion for psychosocial reasons, they can be referred to New Mexico. State Medicaid programs do not cover these costs and frequently health insurance does not either.

NEGATIVES

Procedure costs

Even with Washington's progressive requirements around State Medicaid and health insurance, interviewees still identified cost as a significant barrier to access.

Washington State Medicaid funding is capped at 22 weeks. However, the actual cost of the procedure increases with each week of gestation, resulting in negative financial consequences for clinics and providers. At least one site does not accept Medicaid funding for patients seeking a termination over 24 weeks.[19] Even with insurance, Washington residents can have large out-of-pocket deductible costs, while non-Washington patients often have to pay for the entire procedure because their insurance does not cover abortion care and/or does not cover out-of-state providers.[20] Members of the US military also pay out of pocket for abortion care because of the

[18] Audrey, interview by author, Washington, 2019, 6.
[19] Northwest Abortion Access Fund, "Washington – Funding."
[20] For discussion of insurance and US patients, see Rachel Jones, Ushma Upadhyay, and Tracy Weitz, "At What Cost? Payment for Abortion by U.S. Women," *Women's Health Issues* 23 (3) (2013): e178-8; Sarah Roberts, Heather Gould, Katrina Kimport, et al., "Out-of-pocket Costs and Insurance Coverage for Abortion in the United States," *Women's Health Issues* 24 (2) (2014): e211-18.

Hyde Amendment. John described regularly seeing active duty soldiers who came to a Washington military base "for some 'other reason' [and] accessed the abortion care while they were in town."[21]

Geographical concentration

In 2017, 59% of Washington counties did not have an abortion provider and "10% of Washington women lived in those counties."[22] After the first trimester, women and pregnant people who live in the western part of the state often drive hundreds of kilometres to access abortion. Unless they qualify for Washington or Alaska Medicaid, those who travel incur ancillary costs.

Difficult relationships between abortion providers and US hospitals

Seattle clinics have a positive relationship with the local hospital that provides abortion care, but this is an exception rather than the norm. Increasingly, US hospitals do not offer any abortion care.[23] Even in the Seattle hospital, until recently later abortions were only provided for patients with a significant fetal anomaly or maternal health diagnosis and it was not a service that was widely known.[24] Deb talked more broadly about tensions within hospitals that do offer later abortions noting that staff refused to work with patients and providers.[25]

Where once there were several Seattle hospitals that provided abortion care, Lauren believed there was now only one, a contraction which she linked to mergers with Catholic facilities.[26] Washington has a "high concentration of religious facilities," and Catholic hospitals follow doctrinal rules that ban abortion, sterilisation, contraception, and in-vitro fertilisation. Abortion care providers cannot assume that these hospitals will admit their patients if they experience a complication and are not confident that patients will receive non-judgmental care.[27]

Difficulties gaining exposure to abortion care

Health care providers who trained outside Washington talked about barriers that medical students still face in getting exposure to abortion care. In one instance, this was because of medical school policies that restricted rotations in abortion care to OB-GYN residents. These interviewees were not assisted by their medical schools to find elective opportunities, rather they relied on

[21] John, interview by author, Washington, 2019, 16.
[22] Guttmacher Institute, "State Facts about Abortion: Washington Factsheet."
[23] Jones, Witwer, and Jerman, "Abortion Incidence and Service Availability in the United States, 2017."
[24] Lauren, interview by author, Washington, 2019, 6.
[25] Deb, interview by author, Washington, 2019, 24.
[26] Lauren, interview by author, Washington, 2019, 6.
[27] Amy Littlefield, "A Miscarrying Woman Nearly Died After a Catholic Hospital Sent Her Home Three Times," *Rewire News,* 25 September 2019.

organisations such as MSFC and personally arranged out-of-state opportunities to get training in abortion and family planning.

Anti-abortion activity

Anti-abortion clinic protests in Seattle are comparatively small but appear focused on providers of later terminations. Interviewees emphasised that they did not personally worry about being harassed or targeted. Several contrasted the present with the acts of clinic violence and large protests that occurred in Washington in the 1990s.

But our conversations provided glimpses into some of the subtle ways that even in a progressive state, anti-abortion activity impacts providers, with several noting they had once been concerned about safety or were initially careful not to publicly identify as a provider.[28] Lauren, talking about the institutional impact of these concerns in the Seattle hospital, explained that senior OB-GYNs originally refused to make the abortion service more visible out of "fear of violence, fear of reprisals, fear of having the program shut down if that unknown somebody finds out about it."[29]

John, who flies to provide abortion care in a Southern state, is clear that when he travels he is more safety-conscious; "I would often find myself looking over my shoulder, is somebody following me, is something happening?"[30] His approach to providing care was also initially impacted. Although he was safely providing abortions to 20 weeks in Seattle, he initially imposed a personal cut off that was several weeks lower and not mandated by law because he was worried that if he ever had to transfer a patient for a complication, it would be used by anti-abortion state legislators to further restrict access.[31]

Hostile state and national context

Interviewees were frequently frustrated and angry at the national context in which they operated, bringing up the last decade of anti-abortion legislation in other states and the resulting contraction of services across the US.[32] Audrey, who volunteers on a phone hotline for NWAAF, regularly speaks to people who have known "what they wanted to do and they tried to access [an abortion] and they couldn't, and they jumped over hurdle, after hurdle, after hurdle, after hurdle."[33] Interviewees believed that the cumulative effect was that women and pregnant people were

[28] Lauren, interview by author, Washington, 2019, 7.
[29] Lauren, interview by author, Washington, 2019, 6.
[30] John, interview by author, Washington, 2019, 19.
[31] John, interview by author, Washington, 2019, 5.
[32] Esmé Deprez, "Abortion Clinics are Closing at a Record Pace," *Bloomberg Businessweek,* 24 February 2016.
[33] Audrey, interview by author, Washington, 2019, 14.

significantly delayed in accessing abortion care because they struggled to organise time-sensitive appointments and navigate state legislative barriers.

Every interviewee was acutely conscious of anti-abortion political and legal activity in other states and at the federal level and was concerned about the future of abortion access. According to Mercedes, independent clinics around the US were participating in national planning conversations about the post-*Roe* world.[34]

[34] Mercedes, interview by author, Washington, 2019, 2.

NEW MEXICO, USA

In New Mexico, I interviewed 6 people: Carmen, Joan, Joanna, Lynette, Shelley, and Sue. They spoke to their experiences in independent clinics, Planned Parenthood affiliates, and New Mexico Religious Coalition for Reproductive Choice (NM RCRC).

Laws	Abortion is legal in the United States (for further discussion, see the 'Washington, USA' section). In New Mexico, a 1969 statute categorises abortion as a felony except in instances of rape, birth defect or fetal anomaly, or serious threat to a woman's health.[1] Although it was overridden by *Roe,* it remains on the books. Unlike many US states, the New Mexico legislature has not passed anti-abortion laws (for further discussion of these types of laws see the 'Washington, USA' section).
Gestation limit	New Mexico is one of 8 jurisdictions in the US (7 states and the federal District of Columbia) that has no gestation limit in law. One Albuquerque independent clinic provides abortion care to 32 weeks.
Cost	The United States has a user pays model of health care. Under court order, New Mexico State Medicaid covers the abortion procedure for low-income residents, along with some ancillary travel costs (for further discussion of the national Hyde Amendment, see the 'Washington, USA' section). [2] Cost is still an issue for New Mexico residents, but it is slightly less of an issue than in the rest of the US.

[1] *N.M. Stat. § 30-5-1, 30-5-3 (Enacted 1969).*
[2] *New Mexico Right to Choose/NARAL v. Johnson,* No. 23239 (New Mexico Supreme Court, 1998).

Abortion provision	In New Mexico, there are approximately 7 abortion sites where abortion on request is provided, concentrated near the three largest cities (Albuquerque, Santa Fe, and Santa Teresa). In the last decade, the number of providers in New Mexico has contracted by almost a third, mirroring trends nationwide.[3] After 15 weeks, abortion is only available in Albuquerque.
Population	New Mexico has a population of approximately 2.1 million. Albuquerque is the largest city, with approximately 560,000.[4]

KEY LEARNING OUTCOMES FOR PATIENTS AND PROVIDERS

POSITIVES

Provision of abortion care over 20 weeks

In New Mexico, there are approximately 2 sites providing later abortion on request, one independent clinic and one hospital. The hospital offers D&E and induction abortion to 23 weeks 6 days. The independent clinic offers D&E to 23 weeks 6 days and induction abortion thereafter to 32 weeks.

In the last decade, there have been two significant shifts in the gestation limit at the Albuquerque independent clinic. The first occurred after Dr. George Tiller was assassinated in Kansas by an anti-abortionist. The owners of the Albuquerque clinic invited two of Tiller's colleagues to begin working in New Mexico to ensure that third trimester abortion care was still accessible in the US. With their arrival, the Albuquerque clinic increased its gestation limit from 24 to 28 weeks. In the mid-2010s, in response to the level of patient need, the doctors decided to increase the gestation limit for abortion on request to 32 weeks. Doctors make decisions about later abortion on a case-by-case basis, acutely conscious of patient health, best practice, risk, and safety.

Although first-trimester abortions are the majority of the terminations performed at the clinic, every week doctors assist patients seeking an induction abortion. This disproportionately large volume of later terminations is because of the clinic's national and international uniqueness in providing abortion into the third trimester.

[3] Guttmacher Institute, "State Facts about Abortion: New Mexico Factsheet," (March 2020) https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-mexico#1.
[4] Wikipedia, "New Mexico" https://en.wikipedia.org/wiki/New_Mexico.

The law

New Mexico interviewees uniformly supported the lack of a legally mandated gestation limit. Carmen noted that in medical care there is an "assumption that health care providers are going to use ethical and moral guidelines and use shared decision making with their patients."[5] This is the model that is practiced by staff at the Albuquerque clinic.

Interviewees supported efforts to pass a state law that would remove the 1969 statue and codify legal abortion, viewing this as necessary because of national attacks on *Roe*.

Formal and informal supports offered to later gestation patients

Government health websites offer little detail about abortion, but clinic and hospital websites offer information about procedures in frank and accessible language.[6]

Providers frequently see later termination patients who have had to overcome multiple barriers to access care, barriers heightened by the political, legal, and social climate that surrounds abortion in the US. Clinic workers, particularly front office staff and phone counsellors, play a significant role in connecting patients with resources, what Carmen described as "social working" the abortion.[7] Health care workers provide patients with information about Medicaid, private health insurance, and the network of local and national abortion funds that assist with procedure and other ancillary costs. Interviewees talked in particular about the important work of NM RCRC, a volunteer group which coordinates practical support for patients that travel to Albuquerque to access abortion.

Ability to help

As in Washington, interviewees talked repeatedly about later abortion care as helping vulnerable and marginalised patients who could not access care in their home communities and the meaning they drew in being able to assist patients who travelled from other US states, from Canada (for example, Québec refers to New Mexico), and from around the world.

[5] Carmen, interview by author, New Mexico, 2019, 27.
[6] Planned Parenthood, "Abortion in Albuquerque, NM" https://www.plannedparenthood.org/health-center/new-mexico/albuquerque/87108/san-mateo-2956-90210/abortion; Southwestern Women's Options, "Third Trimester Procedure" https://southwesternwomens.com/third-trimester/; Southwestern Women's Options, "Fetal Indications Program" https://southwesternwomens.com/fetal-indications-program/; University of New Mexico, "Family Planning" https://unmhealth.org/services/family-planning-reproductive-health.html.
[7] Carmen, interview by author, New Mexico, 2019, 19.

Model of induction abortion care

The Albuquerque clinic has an internationally unique approach that allows doctors to provide induction abortion within the limitations of an out-patient, freestanding clinic setting, adapting their model of care in response to clinic experiences and evidence-based findings. Doctors are acutely conscious of risk and safety, both because of medical ethics and also the political consequences when they have complications (discussed in the 'Negatives' section below).

In the mid-2010s, after a dramatic rise in both out-of-state patients and patients requiring induction abortion, doctors adjusted elements of medical practice, expanded the work week, and increased overnight staffing, changes made to ensure they could meet the volume of need while still providing "the same level of patient care."[8]

Because heavy anaesthetic sedation and epidural pain relief are not available, the clinic draws from the expertise of midwives and local doulas to ensure staff are trained in providing patients with emotional and practical support during their natural labour and delivery.

Relationship between provision sites

There is a cooperative and positive relationship between the Albuquerque hospital and independent clinic. This has numerous benefits, including that medically complex patients can access D&E care at the hospital if they are under 24 weeks.

Abortion is embedded in medical education and training

The Albuquerque hospital is also a teaching hospital with a medical school. It has a clinic that provides abortion care where medical students and residents gain exposure to patients and training in surgical skills. It is also home to the Ryan Residency and the Fellowship in Family Planning (discussed in the 'British Columbia, Canada' section). Medical students and junior doctors gain experience and skills in a state that is "supportive of abortion rights."[9] The teaching hospital also has relationships with an Albuquerque Planned Parenthood affiliate and the independent clinic.

Role played by advocacy, activist, and professional groups

Interviewees believed that abortion provision and access is supported at both the local and state level. Almost all interviewees raised the events of 2013, when anti-abortionists attempted to pass a municipal ban on abortion after 20 weeks. Respect ABQ Women formed and a coalition of local

[8] Carmen, interview by author, New Mexico, 2019, 11.
[9] Jones, Witwer, and Jerman, "Abortion Incidence and Service Availability in the United States, 2017."

organisations championed a reproductive justice message opposing the ban.[10] Staff at the Albuquerque clinic went door knocking and phone banking and described this as the moment when they found out "how our community really felt."[11] The municipal ordinance was defeated.

Since 2010, NM RCRC has coordinated local volunteers in supporting patients who travel to Albuquerque to access later abortion care. This support includes driving people to and from the airport/bus depot and to and from the clinic each day, homestay accommodation and food, and sometimes providing child care.[12] NM RCRC also speaks in support of reproductive rights as a representative of the faith community, rejecting the "argument that there's only one right moral value-based decision to make" about abortion.[13]

Because of the exceptional status of the third trimester care they provide, interviewees from the clinic (particularly the doctors) indicated they felt extremely supported within the national reproductive health community. They also discussed the professional and personal value of organisations such as NAF.

Patients who exceed gestation limits

If patients exceed 32 weeks and are seeking a termination for reasons of fetal anomaly, they can be referred to providers in Colorado, Maryland, and Washington, D.C. (although care is provided on a case-by-case basis after consultation with these clinicians). State Medicaid programs do not cover these costs and frequently health insurance does not either

NEGATIVES

Procedure and ancillary costs

While low-income New Mexico residents have the cost of their procedure covered by State Medicaid, for many other patients (both from New Mexico and elsewhere) cost is a significant barrier to access (for further discussion, see the 'Washington, USA' section).

Approximately 10.5% of New Mexico's population is Native American but because of the federal Hyde Amendment, indigenous women and pregnant people cannot access abortion care through

[10] Joan, interview by author, New Mexico, 2019, 22-3. For an overview of the coalition and its approach, see Frances Kunreuther, "The Respect ABQ Women Campaign: Winning through Vision, Strategy and Relationships," (Building Movement Project, 2015) https://buildingmovement.org/wp-content/uploads/2019/08/The-Respect-ABQ-Women-Campaign-Winning-through-Vision-Strategy-and-Relationships.pdf.
[11] Carmen, interview by author, New Mexico, 2019, 24.
[12] Joan, interview by author, New Mexico, 2019; Lynette, interview by author, New Mexico, 2019.
[13] Joan, interview by author, New Mexico, 2019, 22.

Indian Health Services and are instead referred to private providers, incurring out-of-pocket procedure and ancillary costs.[14]

Geographical concentration

New Mexico lacks abortion providers outside its major cities. Geographically, it is a very large state, with a significant amount of its population in rural and remote areas. In 2017, 91% of New Mexico counties did not have an abortion provider and "48% of New Mexico women lived in those counties."[15] Outside Albuquerque, abortion services are relatively limited, often reliant on 1 or 2 doctors.[16]

Patients that cannot receive care

Although the Albuquerque clinic has some of the highest gestation limits in the Western world, women and pregnant people are still turned away. Interviewees described this as extremely "challenging and heart breaking."[17]

Anti-abortion activity

Joan, Sue, and Shelley all discussed extremely significant past experiences of anti-abortion violence and harassment outside New Mexico.

In New Mexico, the Albuquerque clinic is regularly targeted by anti-abortion protests which are disruptive to patients, their support people, and health care employees. Joanna believed that the clinic protests compounded the "huge stigma" patients already experienced in accessing abortion care.[18] Anti-abortion activities in Albuquerque extend beyond picketing and include following patients back to their accommodation, following staff outside the clinic, covertly and overtly recording staff without their consent, and distributing hostile flyers to 'out' clinic workers to their neighbours. A small number of interviewees described targeted anti-abortion harassment that impacted their lives outside work. Working on behalf of the clinic, Joanna has built a relationship

[14] Government of New Mexico Economic Development, "Tribal Profiles: Native American Population" https://gonm.biz/site-selection/tribal-profiles#:~:text=Tribal%20Profiles%20%7C%20Native%20American%20Population,population%20(2015%20population%20estimates); Susan Dunlap, "Access to abortion limited in NM," *NM Political Report*, 13 November 2019.
[15] Guttmacher Institute, "State Facts about Abortion: New Mexico Factsheet."
[16] Dunlap, "Access to abortion limited in NM"; Carmen, interview by author, New Mexico, 2019, 13.
[17] Sue, interview by author, New Mexico, 2019, 23.
[18] Joanna, interview by author, New Mexico, 2019, 3.

with other clinics and local and national law enforcement and was relieved that there had been a crackdown on the most problematic and aggressive protesters.

National context

Between 2012 and 2017, New Mexico saw a 158% increase in the number of interstate abortion patients, the largest increase in the US.[19] Many later abortion patients in Albuquerque have travelled to access care and almost all of the induction patients are from outside New Mexico. This is because of a wave of hostile anti-abortion legislation passed in other states that has made abortion less accessible and led to significant rates of clinic closures.

State anti-abortion laws do not stop people choosing abortion, but they mean that a growing number of women and pregnant people must overcome significant barriers to access care. Shelley described this legislative activity as "cruel" because its impact is primarily felt by poor and low-income people. In her experience, many of the Albuquerque clinic's patients "do not have very much" and were "already living on the edge." Being delayed and having to travel significant distances to receive care made their lives even harder.[20] NM RCRC also reported a dramatic increase in need, with the number of patient requests for support doubling in 2019 alone.[21]

The Albuquerque independent clinic is a political and legal target, with a local newspaper describing it as "one of the most scrutinized clinics in the country" and New Mexico as "ground zero in the abortion wars."[22] This directly impacts the operation of the clinic. For example, Sue recalled a "nightmarish situation" in the mid-2010s when a federal Senate Sub-Committee "made our lives miserable for a period of 2 years in subpoenaing or requesting records."[23] The New Mexico Attorney General found that the clinic had not violated any state laws.

For the doctors, this scrutiny and polarisation clearly shapes their medical decision-making. Carmen explained the challenge of providing health care, where there is always the chance of a

[19] Christina Cassidy, "Women seek abortions out of state amid restrictions," *Albuquerque Journal*, 8 September 2019; Neha Bhardwaj, Cristina Murray-Krezan, Shannon Carr, et al., "Traveling for rights: Abortion trends in New Mexico after passage of restrictive Texas legislation," *Contraception* 102 (2) (August 2020): 115-8.
[20] Shelley, interview by author, New Mexico, 2019, 16.
[21] Lynette, interview by author, New Mexico, 2019, 10.
[22] Joey Peters, "A Moral Choice: As pressure mounts, faith sustains veteran ABQ doctor who performs third-trimester abortions," *NM Political Report*, 19 July 2017.
[23] Sue, interview by author, New Mexico, 2019, 20. She was referring to a Congressional Investigative Panel focused on the procurement of fetal tissue for research (Republicans claimed that clinics were illegally selling fetal tissue). The Committee was ultimately dissolved, the claims were not proved, and the Final Report of the Committee contained several significant errors. See Meredith Wadman, "Fact-checking Congress's fetal tissue report," *Science*, 5 January 2017; Susan Bryan, "New Mexico: No state law violations in fetal tissue case," *AP News*, 5 January 2018.

complication, with cultural assumptions that abortion is uniquely dangerous and constant anti-abortion efforts to pass hostile legislation:

> You take care of patients, you have complications, that's the reality … [But] every time we have a serious complication we think, is this going to be the one that shuts us down? … If we take on high risk patients, are we potentially risking not being able to see the next thousand people that need abortions?[24]

Every interviewee was acutely conscious of anti-abortion political and legal activity in other states and was concerned about the future of abortion access in New Mexico and the United States more broadly.

[24] Carmen, interview by author, New Mexico, 2019, 14-5.

SOUTH AUSTRALIA, AUSTRALIA

In South Australia, I interviewed 7 people: Anastasia, Brigid, Brooke, Elizabeth, Kim, Natalie, and Susan. They spoke to their experiences in the public clinic, public hospitals, and SAAAC.

Law	In Australia, abortion is regulated by the states and territories rather than at a national level. South Australia was the first region to liberalise its abortion laws, closely following the example of the UK's Abortion Act 1967. At the time of writing, abortion in South Australia is regulated by a 1969 amendment to the Criminal Law Consolidation Act 1935. Abortion is lawful if the pregnant woman has been a resident of South Australia for at least 2 months; 'maternal health' or 'fetal disability' grounds are satisfied; two medical practitioners agree the abortion is necessary; and the abortion is performed in a 'prescribed hospital' setting.[1] South Australia is the last Australian jurisdiction to decriminalise abortion. In October 2020, a private members' bill was put before the SA Legislative Council.[2] If it passes both houses of Parliament, abortion will be removed from the criminal law.
Gestation limits	The 1969 amendment set a gestation limit of 28 weeks. However, since the mid-2000s, the upper limit has been between 22 weeks 6 days and 23 weeks 6 days, dependent on public health setting. After 24 weeks, abortion is essentially inaccessible in South Australia.
Cost	Australia has publicly-funded universal health care. Some federal funding extends to abortion care via Medicare and the Pharmaceutical Benefits Scheme. But nationwide, Medicare rebates cover only about half of the

[1] *Criminal Law Consolidation Act 1935 (SA) 82A (1) (a) (i) (ii), (3).*
[2] Rebecca DiGirolamo, "Abortion law reform step," *The Advertiser,* 14 October 2020.

	procedure costs and abortion is primarily performed in the private sector. Australian patients often incur significant out-of-pocket costs.[3] South Australia (along with the Northern Territory) is nationally unique because abortion is solely available through the public health system. Surgical abortion is free, but early medication abortion patients may have to pay for prescription medication and/or the Medicare 'gap.' In general, procedure cost is not a significant barrier for South Australian residents. However, if patients have to travel to access care, they incur ancillary costs.
Abortion provision	In South Australia, there are approximately 10 'prescribed hospital' sites where abortion on request is available; 4 in Adelaide and 6 in rural and regional cities. After 12 weeks, abortion on request is available at 2 Adelaide sites and after 16 weeks, at only 1 Adelaide site.[4]
Population	South Australia has a total population of approximately 1.7 million. Adelaide is the largest city, with approximately 1.3 million.[5]

KEY LEARNING OUTCOMES FOR PATIENTS AND PROVIDERS

POSITIVES

Provision of abortion care after 20 weeks

The Adelaide public clinic performs the majority of abortions in the state and is the only site that offers later abortion on request, providing D&E to 23 weeks 6 days.[6] In the last few years, later D&E care shifted from the free-standing clinic location to an administratively-linked public hospital. This has increased the ability to care for medically complex patients, although there are

[3] Children by Choice, "Abortion and Medicare," (February 2019) https://www.childrenbychoice.org.au/factsandfigures/abortionandmedicare; Baird, "Medical abortion in Australia," 170; Baird, "Decriminalisation and Women's Access to Abortion in Australia"; Shankar, Black, Goldstone, et al., "Access, equity, and costs of induced abortion services in Australia."
[4] SA Health, "Unplanned pregnancy services" https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/womens+health+services/unplanned+pregnancy+services/unplanned+pregnancy+services.
[5] Wikipedia, "South Australia" https://en.wikipedia.org/wiki/South_Australia.
[6] Pregnancy Outcome Unit, "Pregnancy Outcome in South Australia, 2017," 48.

still case-by-case negotiations between clinic and hospital staff. There are multiple D&E providers at the Adelaide public clinic, which stands in contrast to the lack of surgical abortion providers in other states, where doctors often fly in to provide care.[7]

In the last 15 years, the Adelaide public clinic's gestation limit expanded by 1 week. This increase was tied to evidence-based refinements to the procedure and because doctors were confident from other national examples that D&E could be safely performed to that limit. The increase and interpretation of the law was supported and affirmed by the administratively-linked public hospital as well as the relevant local health network.[8]

Approximately 2 Adelaide public hospitals provide later abortions up to 22 weeks 6 days for reasons of serious fetal anomaly or maternal health diagnosis. From the perspective of all interviewees, it is almost unheard of for a termination to be performed at either hospital over this limit.

Nationally distinctive model of care

Interviewees noted the excellent and high quality abortion services in South Australia and the generally supportive attitude of SA Health and local health networks towards abortion care. They viewed the model of care, particularly the provision of abortion in the public health system, as one that other states and territories should aspire to.

Evidence-based approach to care

Due to the distinctiveness of the Adelaide public clinic, staff consistently look to academic research and national and international examples for evidence-based models of care and clinical guidelines. Clinic interviewees were closely involved in Children by Choice (a Queensland organisation) and NAAPOC. Second-trimester surgical providers seemed particularly focused on the international community of abortion providers, attending the NAF conferences in North America or visiting international sites that provide later abortion care. Kim felt that for one of her

[7] The lack of local providers in the eastern states was highlighted during the COVID-19 pandemic amidst border closures and the collapse of the domestic air travel sector. See Melissa Davey, "Later gestation abortions hit by Australia's coronavirus travel restrictions," *The Guardian,* 31 March 2020; Emilie Gramenz, "Abortion providers take private flights to regional Queensland as coronavirus triggers industry collapse," *ABC News,* 2 May 2020.
[8] Kim, interview by author, South Australia, 2020, 11-14.

colleagues, attending NAF and "being in a room full of people and all that experience and teaching" had played a significant role in their decision to begin offering later D&E care.[9]

Additional support for later termination patients

Patients seeking later terminations on psychosocial grounds often have complex personal circumstances, and staff at the Adelaide public clinic are able to offer additional support by connecting them with relevant government and social work services for domestic violence, rape and sexual abuse, homelessness, and addiction.

For fetal anomaly patients, interviewees emphasised the important role played by a small number of genetic counsellors who provide specialised services. There is also Support After Fetal Diagnosis of Abnormality (SAFDA), a South Australian group for patients who have terminated a pregnancy because of fetal anomaly. SAFDA is unusual as most other Australian support groups are for multiple types of pregnancy loss.

The campaign to decriminalise

For several years, there has been a concerted campaign to decriminalise abortion in South Australia. SAAAC, which was founded in 2015, has been at the forefront of community efforts advocating for law reform. National and state branches of professional medical organisations such as RANZCOG, the Australian Medical Association (SA), and the Australian Nursing and Midwifery Federation (SA Branch) are vocal supporters of state decriminalisation.[10] In February 2019, the Attorney General formally asked the South Australian Law Reform Institute (SALRI) to author a report on abortion, "with the aim of modernising the law in South Australia and adopting best practice reforms." The SALRI Report recommended decriminalisation.[11]

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[9] Kim, interview by author, South Australia, 2020, 17-18.
[10] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "Decriminalising Abortion Fundamental to Effective Sexual and Reproductive Health," (3 May 2019) https://ranzcog.edu.au/news/decriminalising-abortion-fundamental-to-effective; Chris Moy, "AMA (SA) submission to the SALRI Review of Abortion Law and Practice in South Australia," 12 June 2019 https://ama.com.au/sites/default/files/documents/SALRI%20abortion%20review-AMA%28SA%29%20Submission_120619_0.pdf; Australian Nursing and Midwifery Federation (SA Branch), "Law Abortion Reform – South Australia" https://www.anmfsa.org.au/Web/News/2020/Law_Abortion_Reform___South_Australia.aspx.
[11] John Williams, David Plater, Anita Brunacci, et al., "Abortion: A Review of South Australian Law and Practice," (South Australian Law Reform Institute: October 2019), Recommendations 1, 3, and 4 https://law.adelaide.edu.au/system/files/media/documents/2019-12/Abortion%20Report%20281119.pdf.

NEGATIVES

Geographical concentration and contraction of providers

South Australia is a large state and first trimester abortion care is provided at only a small number of rural sites, all but one of which is within 200 kilometres of Adelaide. Second-trimester care is only available in Adelaide, meaning some remote patients must travel hundreds of kilometres. If they require D&E, they will also need to stay overnight away from their home community. In 2017, only 16.3% of women and pregnant people from rural or remote South Australia accessed abortion care in the country.[12]

Recently, there has been a contraction of abortion providing sites in the state, including the end of abortion on request services at one Adelaide public hospital. In 2019, this likely contributed to significant system delays and wait times for appointments reached 4-6 weeks.[13]

Vague or inaccurate website information

Government and sexual health websites offer information about provision sites, gestation limits for abortion on request, options counselling, and some procedures in frank and accessible language.[14]

What is not clear on these websites is that 2 Adelaide public hospitals provide later abortions for fetal anomaly reasons and that they do not have the same gestation limits as the Adelaide public clinic. No detail is provided about induction abortion as a procedure. Confusingly, SA Health websites and brochures outline different state gestation limits for abortion on request ("up to approximately 22 weeks" versus "up to 23 weeks").[15]

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[12] Pregnancy Outcome Unit, "Pregnancy Outcome in South Australia, 2017," 48.
[13] Rebecca Puddy, "Concerns for women after SA closes two centres for surgical abortion," *ABC News,* 19 September 2019.
[14] SA Health, "Unplanned pregnancy services"; SA Health, "Information for women considering abortion" pamphlet, (March 2018) https://www.sahealth.sa.gov.au/wps/wcm/connect/444c2786-91c8-4c0b-985d-bd70aa8c5cde/Info%2Bfor%2Bwomen%2Bconsidering%2Babortion%2BMarch%2B18.pdf?MOD=AJPERES&CACHE=NONE&CONTENTCACHE=NONE; SA Health, "Medication or surgical abortion" https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/abortions/medication+or+surgical+abortion; SA Health, "Helping with decisions about unplanned pregnancy" https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/abortions/helping+with+decisions+about+unplanned+pregnancy; SHINE SA, "Pregnancy Options" https://www.shinesa.org.au/health-information/pregnancy/pregnancy-options/.
[15] SA Health, "Information for women considering abortion" pamphlet; SA Health "Abortions" https://www.sahealth.sa.gov.au/wps/wcm/connect/public%20content/sa%20health%20internet/health%20topics/health%20conditions%20prevention%20and%20treatment/abortions/abortions.

The law

The different gestation limits at SA public health institutions is a result of legal interpretation rather than determined by professional medical ethics, evidence-based care, or precedent from case law. In the early 2000s, abortion care was still provided in rare circumstances up to the 28 weeks specified in the 1969 amendment. However, uncertainty about the law led some hospitals to intermittently seek advice from Crown Solicitor's Office (what interviewees referred to as Crown Law). Over approximately 15 years, there have been contradictory instructions and institutional policies, some of which had to be reversed. On several occasions in the 2000s, abortion services in SA were interrupted because of divergence over how to interpret the law.[16]

Most of the interviewees felt that cumulatively, the presence of abortion in the criminal law and the different interpretations of what is lawful has had a chilling effect on the involvement of medical professionals in abortion. They believe it is perceived as being a legally 'grey' area of health care.

All interviewees strongly supported decriminalising abortion and all but one believed there should be no upper gestation limit in the law (one of the SALRI Report recommendations).[17] Susan, who supported legal gestation limits, did not believe that they should mark the end of access but rather should be a point after which there were different regulatory processes in place. She strongly believed that terminations for fetal anomaly patients should still be available over the gestation limit.[18]

Interviewees noted that women and pregnant people often did not realise that abortion was in the criminal law. Brooke described patients with a fetal anomaly diagnosis who were over the gestation limit and became distressed because they did not understand why they could not receive a termination after making the difficult choice about "what's good for my family."[19]

[16] Elizabeth, interview by author, South Australia, 2019, 9; Brigid, interview by author, South Australia, 2020, 18-21.
[17] Williams, Plater, Brunacci, et al., "Abortion," Recommendations 21 and 22.
[18] Susan, interview by author, South Australia, 2019, 17.
[19] Brooke, interview by author, South Australia, 2020, 8. This is also true of the broader South Australian population; a recent poll found 70% of South Australians were not aware abortion remains in the criminal law. See Cations, Ripper, and Dwyer, "Majority support for access to abortion care including later abortion in South Australia," 2.

Additional difficulties for fetal anomaly patients

Fetal anomaly patients in SA face additional pressures and stresses beyond grappling with a devastating diagnosis.

In the broader community, most patients (and their treating health care providers) are not aware of how time sensitive follow-up scans and testing are if anything unusual is detected at the 19/20-week morphology scan. The gestation limit in place often means extremely rushed decision making for patients, sometimes based on incomplete information because results cannot be returned in sufficient time. Elizabeth and Susan both described supporting patients who had less than 24 hours to make "one of the most significant decisions in their life and that is not good practice."[20]

Frequently, fetal anomaly patients do not receive continuity of care. Although multiple public and private hospitals offer maternity care, only a small number of OB-GYN staff at the 2 Adelaide public hospitals offer later abortion after a fetal anomaly diagnosis. Susan described seeing patients, particularly from the private system, whose doctors told them "I don't do terminations" and then did not offer further information about options or direct them to another provider.[21] Arguably, these experiences and the refusal of their primary physician to offer continuity of care contributes to potential stigma and shame surrounding the decision to terminate.[22]

It seems that patients at the 2 public hospitals are often only informed about induction abortion and are not truly given choice of method. Interviewees also indicated that at the 2 public hospitals, a feticidal injection is not routinely offered before induction abortion, a marked departure from the UK, US, and Canadian sites I visited.

Institutional ambivalence in the public hospitals

From interviews, the institutional culture at the 2 public hospitals appears ambivalent about later abortion care after a fetal anomaly diagnosis. While nurses and senior midwives were generally characterised as willing to support induction abortion patients in these circumstances, interviewees

[20] Elizabeth, interview by author, South Australia, 2019, 10.
[21] Susan, interview by author, South Australia, 2019, 11. For a South Australian patient's perspective on this type of experience, see ABC Radio, "Conversations: Losing Baby Miles," 30 October 2020 https://www.abc.net.au/radio/programs/conversations/annabel-bower-stillbirth-miscarriage-pregnancy-birth/12809272.
[22] Franz Hanschmidt, Julia Treml, Johanna Klingner, et al., "Stigma in the context of pregnancy termination after diagnosis of fetal anomaly: associations with grief, trauma, and depression," *Archives of Women's Mental Health* 21 (2018): 391-99.

described divisions amongst OB-GYNs and MFM specialists, with some doctors opposing all abortions.

Susan did not feel that non-directive care for fetal anomaly patients had been modelled and viewed her approach as essentially "self-taught." Susan also felt that she and others who provided induction abortion care kept a very low profile about their work, "because they want to do the right thing by the patients and don't want to attract attention to themselves and don't want to bring trouble."[23] Elizabeth's impression was that providing induction abortion care was a "very isolated role" for hospital doctors.[24]

Tensions between public health care sites

Although all public health institutions are part of SA Health, interviewees described tension between sites. A particular issue has been interpretation of the law and the different gestation limits in effect. Multiple interviewees indicated that at one Adelaide public hospital, staff were briefly instructed not to refer patients to the public clinic if they were over 22 weeks 6 days. Anastasia noted instances where she saw fetal anomaly patients at the public clinic who had been given inaccurate or misleading information about D&E and incorrect information about the clinic's gestation limit.[25]

Internal tensions have occasionally meant patients with severe fetal anomaly diagnosis are significantly delayed by hospital processes, ultimately travelling outside SA to access abortion care.

Medical training

For decades in Australia, there have been significant problems with abortion and medical training.[26] Most interviewees believed that abortion was not in the curriculum for medicine or nursing students in SA but explained that it was difficult to know what was or was not occurring. Susan indicated that abortion care has been recently reintroduced into the curriculum at one medical

[23] Susan, interview by author, South Australia, 2019, 15, 21, 23,
[24] Elizabeth, interview by author, South Australia, 2019, 20.
[25] Anastasia, interview by author, South Australia, 2020, 8, 13.
[26] Baird, "Happy Abortionists," 423-4; Kirsten Black and Deborah Bateson, "Medical abortion is fundamental to women's health care," *Australian and New Zealand Journal of Obstetrics and Gynaecology* 57 (2017): 245-7; Caroline de Costa, "Introducing abortion into medical school's curriculum and educating junior doctors," (Children by Choice conference, 2019) https://www.childrenbychoice.org.au/images/Conference_2019/powerpoints_day_1/powerpoints_day_2/Introducing_abortion_into_medical_schoolscurriculum_and_educating_junior_doctors.pdf; Jenna Price, "Doctors not developing skills, understanding necessary to provide abortions," *Sydney Morning Herald,* 23 November 2015.

school.[27] At a national level, RANZCOG is moving to rectify the long-standing problem with lack of exposure for OB-GYN trainees by offering an optional new Advanced Training Module in Contraception and Abortion.[28]

While there used to be formal links between the Adelaide public clinic, medical schools, and teaching hospitals, this has essentially stopped. Generally, students and residents who seek out the Adelaide public clinic for a rotation are extremely self-motivated and do the work of initiating an elective placement. Doctors at the Adelaide public clinic are keen and willing to offer rotations and training in first and second-trimester abortion care. As Kim explained, they were working "hard to try and make sure we're training as many people as we can in Adelaide because I'm just really concerned about the future."[29]

Patients who exceed gestation limits

Although South Australian public health data does not track the number of patients who exceed gestation limits, one interviewee at the Adelaide public clinic estimated that approximately 10-15 patients per year were turned away.

There are not formal referral pathways for women and pregnant people who seek care outside SA. For patients with a fetal anomaly diagnosis, there are some Adelaide connections with an inter-state public hospital and occasionally these patients have travelled nationally to access abortion. Interviewees also recalled examples of patients who travelled overseas, primarily to the United States, to access abortion (interviewees in Washington and New Mexico also described caring for patients from Australia and New Zealand). There are multiple barriers that make this inaccessible for most patients.

[27] Susan, interview by author, South Australia, 2019, 8.
[28] Mei Tan, "Mid-trimester surgical abortion," *O & G Magazine* 20 (2) (2018): 30-1; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "RANZCOG Advanced Training Module Contraception and Abortion," (2017) https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Training%20and%20Assessment/Specialist%20Training/Curriculum%20and%20Handbook/RANZCOG-Contraception-and-Abortion-ATM.pdf.
[29] Kim, interview by author, South Australia, 2020, 15.

KEY FINDINGS

In the regions visited, between 1-3% of abortions are performed at and after 20 weeks.[1] Interviewees were quite critical of the cultural distinction drawn between the types of patients who need later abortion care and resisted the notion that fetal anomaly terminations were the 'good' or 'deserving' abortions. They were clear that the patients they treated had compelling reasons for seeking abortion and accessed this care despite considerable stigma.

A significant number of patients seek later abortion care after a devastating fetal anomaly or maternal health diagnosis in the second or third trimester. Of those seeking abortion on request, many are likely to be experiencing one or more of the following: significant mental health issues, problems with drug or alcohol dependency, homelessness, intimate partner violence, and sexual violence and trauma. Both types of patients require specialised support. Most of the sites visited offered care adapted for the needs of fetal anomaly patients, including modified language and counselling, private spaces, referrals to genetic counsellors and disability support groups, keepsakes and mementos, time after the procedure to grieve with their baby, and assistance with funeral arrangements.[2] Interviewees also talked about the steps they took to address the psychosocial circumstances of women and pregnant people seeking later termination on request, including connecting them with financial and accommodation support for the procedure, modifying care to deal with patient experiences of sexual trauma, and when possible, referring them to domestic violence, housing, and addiction services. As Carmen in New Mexico explained about providing later abortions, "the kinds of things that we have to think about in terms of taking care of patients is way beyond just the abortion."[3]

All the doctors interviewed cited the patient's medical history and their own skill level as paramount when making decisions about care, followed by access to institutional resources and support. As a medical procedure, core elements (D&E or induction methods, types of medication,

[1] For statistics and sources of data, see note 1 in Executive Summary.
[2] With regards to abortions for reasons of fetal anomaly, patients are terminating a wanted pregnancy. Interviewees, as well as clinical guidelines on termination of pregnancy for fetal anomaly and perinatal loss, suggest that most patients in this situation understand themselves as parents and their pregnancy as a baby and that language and care should reflect this reality. For example, see Southwestern Women's Options, "Fetal Indications Program"; Royal College of Obstetricians and Gynaecologists, "Termination of Pregnancy for Fetal Abnormality"; SA Health, "South Australian Perinatal Practice Guideline: Perinatal Loss V9," (April 2020) https://www.sahealth.sa.gov.au/wps/wcm/connect/ca863c804ee5531ea858add150ce4f37/Perinatal+Loss_PPG_v9_0.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ca863c804ee5531ea858add150ce4f37-n5xr94G.
[3] Carmen, interview by author, New Mexico, 2019, 19.

steps in the procedure, and emphasis upon informed consent) were common across the regions visited.

Interviewees shared the view that late termination of pregnancy should be provided in a supportive, non-judgmental environment. They believed in centring the decision-making of women and pregnant people, accurately answering all patient questions, ensuring truly informed consent, and respecting their assessment of their life and capabilities. Many interviewees cited this approach and the power of listening to patient's stories as important in their decision to begin working in abortion care and a significant motivator when they decided to increase their gestation limit to work with later termination patients. As Deb in Washington explained, "For me it's always been about the patient … I'm a means to an end. I am not the decision maker. I am not the primary person in the room."[4]

Across regions and types of abortion providing sites, the health care workers interviewed described their jobs in highly positive and passionate terms, finding the work to be personally and professionally meaningful. Many noted how fulfilling it was to assist marginalised and stigmatised patients who had often found it extremely difficult to access care. Sandra in British Columbia found it "very rewarding to be involved with women during a very difficult time in their lives. It is important work, it requires you use all the skills you have in your tool box. It can be emotional but never boring. It's been a great honour."[5]

What differed in each region, and had a marked impact on provision and accessibility, were institutional, social, legal, and political issues that surrounded the procedure.

ACCESSIBILITY OF ABORTION BEFORE AND AFTER 20 WEEKS

- Most interviewees highlighted the lack of providers in their region offering abortion care earlier in the second trimester (14-19 weeks). Second trimester and later abortion care was also often geographically concentrated in 1 or 2 major cities. Wait times and logistical difficulties in scheduling appointments and ultrasound scans can thus mean women and pregnant people receive care weeks after they initially make contact. And whether patients need D&E or induction abortion, late termination of pregnancy is a multi-day procedure. Having to travel to access care introduces logistical and financial issues, including

[4] Deb, interview by author, Washington, 2019, 3.
[5] Sandra, interview by author, British Columbia, 2019, 15.

transportation, accommodation, time off work and/or child care, which can create additional delays.[6]

- Cost can be a significant barrier that delays access to abortion care.[7] Studies have found that abortion patients are frequently poor or low income.[8] In the US and most parts of Australia (except South Australia and the Northern Territory), a first-trimester abortion is approximately $AU/$US500. In the second trimester, costs increase each week. After 20 weeks, the average out-of-pocket costs for an Australian patient is $AU7,700; in the US, before 24 weeks an abortion can cost $US3,000 and after 24 weeks between $US8-15,000.[9] Interviewees in the US, along with academic and media articles, described patients desperately struggling to gather money for their procedure.[10] Shelley in New Mexico explained:

> We see so many women who come later in pregnancy because they were from another state and they were trying to raise money to cover the abortion. And this is an old story, by the time they've got enough money, they're too far, so then they have to go to another place and by the time they get the money for that, I mean, just the clock is ticking.[11]

The ancillary costs associated with travelling to access care also mean that even when the procedure is free (as in South Australia and England), patients must overcome financial barriers. Only in British Columbia and Québec, which have health department policies that compensate for travel to access health care, is cost a negligible issue.

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[6] Bhardwaj, Murray-Krezan, Carr, et al., "Traveling for rights"; Jenna Jerman, Lori Frohwirth, Megan Kavanaugh, et al., "Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States," *Perspectives on Sexual and Reproductive Health* 49 (2) (2017): 95-102.
[7] Foster and Kimport, "Who Seeks Abortion at or After 20 Weeks?"; Jones, Upadhyay, and Weitz, "At what cost? Payment for abortion care by U.S. women"; Roberts, Gould, Kimport, et al., "Out-of-pocket costs and insurance coverage for abortion in the United States"; Shankar, Black, Goldstone, et al., "Access, equity and costs of induced abortion services in Australia."
[8] For Australian research, see Shankar, Black, Goldstone, et al., "Access, equity and costs of induced abortion services in Australia"; Selina Utting, Susan Stark, Nicola Sheeran, "Hidden Women: The Impact of Poverty on Abortion Access," (Children By Choice conference, 2017) https://www.childrenbychoice.org.au/images/downloads/2017conference/Selina-Utting-Hidden-Women-The-Impact-Of-Poverty-On-Abortion-Access.pdf. For US research, see Jones, Upadhyay, and Weitz, "At What Cost?"; Rachel Jones and Jenna Jerman, "Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-14," *American Journal of Public Health* 107 (12) (2017): 1904-9.
[9] Shankar, Black, Goldstone, et al., "Access, equity and costs of induced abortion services in Australia"; Charlotte Cowles, "How Much Does An Abortion Cost? Learn the Facts," *The Cut,* 20 November 2018.
[10] Ray Levy-Uyeda, "Should I Crowdfund My Abortion?" *Rewire News,* 11 March 2020; Amy Littlefield, "How Abortion Funds Showed America That 'Roe' Is Not Enough," *The Nation,* 3 December 2019; Ema O'Connor, "She got an abortion in Arkansas at 21 weeks. Soon, that could be illegal," *Buzzfeed News,* 15 June 2019.
[11] Shelley, interview by author, New Mexico, 2019, 13.

- Being able to access clear, factually accurate information about pregnancy options, the abortion procedure, and sites that provide abortion assists patients, particularly those in vulnerable personal circumstances, make informed decisions. Co-ordinated booking services for appointments (which operate in British Columbia, parts of Québec, and amongst independent sector providers in England) meet the time-sensitive needs of women and pregnant people seeking abortion in the second-trimester.

- Medically complex patients seeking second-trimester abortions often struggle to access care in regions where hospitals do not provide D&E.

POLICIES OF HOSPITALS AND HEALTH DEPARTMENTS

- In England, Québec, and South Australia, later terminations for psychosocial reasons are almost exclusively available in free-standing clinic and community health sites rather than hospitals. This 'siloing' of abortion care was rarely a distinction enshrined in law, rather it was a byproduct of institutional and professional practice.

- Interviewees based in free-standing clinic and community health sites were generally the most confident about their ability to provide patient-centred care. They also described multiple ways in which they felt personally and professionally supported in the workplace.

- Later terminations for reasons of fetal anomaly are provided in a broader array of sites, including clinics, community health sites, and hospitals, often the primary providers of this care. Many interviewees were critical of the reliance on hospital ethics committees to determine provision after a specified point, viewing them as fundamentally antithetical to patient-centred care because the woman or pregnant person was rarely involved in the discussion.

- Interviewees based in hospitals indicated that hierarchical and inflexible policies sometimes made it difficult for them to meet the needs of later termination patients. They also talked with great empathy about how challenging later abortions could be for other hospital staff, particularly theatre nurses and anaesthetists who had minimal contact with the patient beyond the procedure.[12] These interviewees tried to help other staff understand later abortion care and to ensure all staff were patient-centred in their approach. In some

[12] Every region had health regulations or legislation that allowed health care workers with conscientious objections to decline to offer abortion. Interviewees were discussing attitudes and actions from hospital staff who were not conscientious objectors.

regions, these initiatives were undertaken by individuals rather than hospital administrators or department heads.

- In hospitals, induction abortion is often the only method of later abortion care offered and thus fetal anomaly patients in hospitals frequently do not have choice of method. Yet multiple academic studies have found late termination patients often prefer D&E, which they experience "as less painful, less psychologically traumatic, and faster." D&E is also safer than induction abortion.[13] In England, Québec, and South Australia, the provision of D&E appeared to be almost non-existent in hospitals, reflecting a significant loss of skills and impacting the ability to train the next generation of doctors in surgical abortion care, which also has consequences for the management of second-trimester miscarriage.

- In regions such as Québec and South Australia, interviewees described difficult relations between abortion providing sites and some hospitals. A handful of interviewees recounted instances where hospital staff in the same health system lacked information or misunderstood important elements about D&E or refused to refer fetal anomaly patients. In Washington and New Mexico, interviewees talked about the potential political ramifications of medical complications and hospital transfers and the impact this had on their decisions about providing health care.

- A feticidal injection was a nearly universal element of the late termination procedure, performed in every clinic/hospital/community health site I visited, except in South Australia, where usage varied depending on institution.

MEDICAL EDUCATION, TRAINING, AND PROFESSIONAL BODIES

- Most of the doctors interviewed had limited exposure to abortion care during their time in medical school; nurses recalled no exposure to abortion or sexual health care. In England and South Australia, interviewees saw the mainstreaming of abortion into medical education as an urgent matter.

- In each region, doctors are involved in efforts to offer education and training opportunities to medical students, residents, and abortion providers seeking to expand their gestation

[13] This body of research on patient preferences, which spans several decades, is summarised in Nathalie Kapp and Patricia Lohr, "Modern methods to induce abortion: Safety, efficacy and choice," *Best Practice & Research Clinical Obstetrics and Gynaecology* 63 (2020): 37-44. See also Helen Callaby, Jane Fisher, and Patricia Lohr, "Surgical termination of pregnancy for fetal anomaly: What role can an independent abortion service provider play?" *Journal of Obstetrics and Gynaecology* 39 (6) (2019): 799-804. For discussion of procedure safety see Amy Bryant, David Grimes, Joanne Garrett, et al., "Second-Trimester Abortion for Fetal Anomalies or Fetal Death," *Obstetrics and Gynecology* 117 (4) (2011): 788-92.

limit. These initiatives are sometimes undertaken at an individual level because of concern about the future of the workforce.

- In Washington, New Mexico, British Columbia, and England, professional bodies play a central role in ensuring reproductive health care is incorporated into medical education and training. However, these efforts are frequently from OB-GYN organisations. In most of the regions visited, GP/Family Medicine doctors are the majority of abortion care providers, but there appear to be no parallel efforts from their professional bodies. Some GP/Family Medicine interviewees described overcoming barriers to access training and to provide abortion care.

- In almost every region, professional bodies play an important role in shaping public discourse around abortion as health care. In England and South Australia, they are also central to calls for decriminalisation.

THE LAW AND GESTATION LIMITS

- In England and South Australia, interviewees offered examples where conflicting bureaucratic and legal interpretations of the law negatively impacted later abortion care and the willingness of providers and institutions to offer this care.

- Interviewees varied in their attitudes towards gestation limits, with views generally mirroring the legal and health model they were most comfortable with. Thus, most of the English health care workers approved of 24 weeks for abortion on request and no limit for serious fetal anomalies, while those who worked in contexts without a law (British Columbia, Québec, and New Mexico) strongly opposed legal gestation limits. All but 1 of the South Australian interviewees opposed gestation limits in law.

POLITICAL AND COMMUNITY ATTITUDES

- All interviewees agreed that abortion stigma impacted patients. They felt it was acute for those seeking late termination of pregnancy particularly, although not exclusively, when it was for psychosocial reasons. Many interviewees described instances where patients had internalised the belief that they deserved to be treated coldly and did not deserve kindness or to have their decision-making respected. Interviewees that worked closely with fetal anomaly patients also talked about their complex emotional experiences, particularly in how they relate to other types of pregnancy loss. There are multiple factors that contribute

to abortion stigma, but negative media and political commentary were cited as an issue in several regions (most particularly Washington, New Mexico, and England).

- Although most interviewees didn't identify as stigmatised, the health care workers nearly all recounted experiences of negative professional and personal interactions because of their jobs. Many did not disclose their work to people outside their immediate circle. Some doctors who worked in hospitals described feeling (or being directly told) that later abortion care could occur but needed to be concealed, either from other colleagues or the local community. Several Canadian and US interviewees had past experiences of significant anti-abortion harassment and intimidation.

- The specific political, legal, and social context of each region or country shaped the discourse surrounding late termination of pregnancy and its accessibility. The most notable example of this was the US, which has a very polarised political landscape and a long history of anti-abortion social and political activism. Even in Washington and New Mexico, states that were supportive of abortion rights, the national climate impacted the experiences of late termination patients and the health care providers and advocates who support them in accessing care. In contrast, British Columbia and Québec seem to be the closest to normalising abortion as health care. There were still geographical problems with the provision of abortion services, but abortion was not a matter for political or legal debate and the regulation of abortion was determined by professional bodies and health care institutions.

These non-medical factors shape the way that patients access abortion care and impact the way that health care workers offer and understand later abortion care.

KEY RECOMMENDATIONS FOR SOUTH AUSTRALIA

This report makes recommendations for changes in law, health policy, service delivery, and medical education and training in South Australia, intended to:

- Reduce the structural factors that cause women and pregnant people to have an abortion over 20 weeks (Recommendations 1 and 2);
- Increase support for patients who need to access later abortion care (Recommendations 1, 2, 3, 4, and 5);
- Increase supports for health care providers who offer this care (Recommendations 5, 6, 7, and 8);
- Ensure the future of the abortion care workforce (Recommendation 6);
- Reduce divergence and confusion surrounding later abortion and the law (Recommendation 8); and
- Work to destigmatise abortion for both patients and providers (Recommendations 2, 3, 4, 5, 6, 7, and 8).

RECOMMENDATION 1: COST SHOULD NOT BE A BARRIER TO ACCESS

a) Abortion is best provided in a public health care setting, which ensures cost is not a barrier to access and helps normalise abortion as health care. South Australia has had a long-standing commitment to public provision of abortion and when decriminalisation occurs, this should continue (as it has in the Northern Territory).

b) Formal state government programs should cover ancillary travel costs either for all rural and regional patients or rural and regional low-income patients with Health Care Cards.

RECOMMENDATION 2: ABORTION SHOULD BE EASIER TO ACCESS IN RURAL AND REGIONAL SOUTH AUSTRALIA

a) SA Health and regional local health networks should work to increase the number of first and early second trimester providers in rural and regional South Australia.

b) The categories of health care workers that can provide early medication abortion should be expanded.

c) The 'prescribed hospital' setting requirement should be removed.

RECOMMENDATION 3: WOMEN AND PREGNANT PEOPLE SHOULD BE PROVIDED WITH CLEAR, TIMELY, AND ACCURATE INFORMATION

a) SA Health websites and materials should have consistent, up-to-date information about the gestation limits at various sites and at the state level. They should also list information about hospitals that offer fetal anomaly terminations, outline the gestation limits in place at those hospitals, and the institutional processes after those limits.

b) Before prenatal diagnostic tests, all pregnant patients should receive information about the purpose of the test, the conditions that are tested for, potential outcomes, and a discussion of options and gestation limits. This should be routine information discussed before the test is performed.[1]

c) The SA Health Department website offers descriptions about early medication abortion and D&E. It should also include a description of induction abortion, the primary hospital method currently available for those with a later fetal anomaly diagnosis.

d) Health care workers in Adelaide public and private hospitals should ensure that patients are given accurate, non-biased information about all types of abortion care available after 20 weeks.

RECOMMENDATION 4: ALL LATE TERMINATION OF PREGNANCY PATIENTS SHOULD BE SUPPORTED

a) All patients faced with a fetal anomaly or maternal health diagnosis should be offered non-judgmental and supportive care, whether they choose to continue or terminate their pregnancy. The Adelaide public clinic offers non-directive counselling that draws from national and international research about language and models of care. Staff at Adelaide public and private hospitals that work with maternity patients should be exposed to this model and the work of NAAPOC and if necessary, receive appropriate training.

b) The Adelaide public clinic offers structural support to patients with psychosocial complexities such as homelessness, drug dependency, or who are experiencing domestic violence. Patients are connected with these resources whether they choose to continue or terminate their pregnancy. This model should continue, as it addresses issues that interviewees from multiple regions raised as challenges that they could not meet.

[1] This recommendation follows the insights and advice that has emerged from "Prenatal Testing: A Longitudinal Study," a project funded by the Australian Research Council. For further reading, see Jan Hodgson, Penelope Pitt, Sylvia Metcalfe, et al., "Experiences of prenatal diagnosis and decision-making about termination of pregnancy: A qualitative study," *Australian and New Zealand Journal of Obstetrics and Gynaecology* (2016): 1-9; Penelope Pitt, Belinda McClaren, and Jan Hodgson, "Embodied experiences of prenatal diagnosis of fetal abnormality and pregnancy termination," *Reproductive Health Matters* (2016): 1-10. See also Royal College of Obstetricians and Gynaecologists, "Termination of Pregnancy for Fetal Abnormality in England, Scotland, and Wales," Recommendation 1.

c) There is much to commend about the care offered to fetal anomaly patients in South Australia, with committed public hospital and clinic providers, genetic counsellors, and the volunteer organisation SAFDA working together to offer specialised support. SA Health practice guidelines on Perinatal Loss are comprehensive and patient-centred.[2]

i. However, fetal anomaly patients in South Australia experience intense time pressure in decision making. The gestation limit at the 2 Adelaide public hospital was the lowest limit of any region that I visited. All SA interviewees agreed that patients in the both the public and private systems often had insufficient time to fully understand a diagnosis and its implications. Unlike England and Canada, it seemed to be almost impossible for fetal anomaly patients to receive care after the gestation limit at the 2 Adelaide public hospitals. If a decriminalisation model is passed that outlines lawful conditions for abortion access over this institutional limit, SA Health, relevant local health networks, and the public hospitals should coordinate to ensure care is actually provided.

ii. Patients who choose a termination after a fetal anomaly diagnosis should have choice of method and be supported in accessing that care through pathways for referral and provision of non-biased information. Ideally, one of the 2 Adelaide public hospitals would undertake to gradually begin providing D&E (which would have flow-on effects for medical education and training, see Recommendation 6).

iii. Whether they have D&E or induction abortion, space, privacy, and time are very important for fetal anomaly patients, along with the ability to have a support person with them during recovery.[3] From South Australian interviews, it was unclear whether the public clinic and the public hospitals were able to consistently give these patients private space before, during, and after their procedure.

iv. Hospital Ethics Committee are frequently opaque in structure and it is often unclear whether the personal circumstances of the patient are fully considered.[4] Interviewees generally saw these committees as an impediment to patient-centred

[2] SA Health, "South Australian Perinatal Practice Guideline: Perinatal Loss."
[3] Royal College of Obstetricians and Gynaecologists, "Termination of Pregnancy for Fetal Abnormality in England, Scotland, and Wales," 24; Karen McNamara, Keelin O'Donoghue, Orla O'Connell, et al., "Antenatal and intrapartum care of pregnancy complicated by lethal fetal anomaly," *The Obstetrician and Gynaecologist* 15 (2013): 189-94; Pitt, McClaren, and Hodgson, "Embodied experiences of prenatal diagnosis of fetal abnormality and pregnancy termination."
[4] For further discussion of patient experiences with Australian hospital ethics committees, see Jan Hodgson, "Submission 73" in "Inquiry into Perinatal Services: Final Report," (Parliament of Victoria: 2018) https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/58th/Perinatal/Submissions/S073_Hodgson_et_al.pdf.

care; they are also opposed by RANZCOG and the SALRI Report.[5] Committee approval should not be a requirement to access abortion care.

RECOMMENDATION 5: LATE TERMINATION OF PREGNANCY CARE SHOULD FOLLOW NATIONAL AND INTERNATIONAL STANDARDS OF BEST PRACTICE

a) South Australian clinical guidelines for all methods of second-trimester abortion care should be implemented and reviewed regularly and should conform to international best practice. There should be uniformity across health institutions about processes for D&E and induction abortion.

b) A feticidal injection was a nearly universal element offered at the sites I visited in the UK, US, and Canada and is recommended by multiple international professional bodies.[6] The SA Health practice guidelines on Perinatal Loss also suggest that the option should be discussed with patients.[7] A feticidal injection should be offered to all patients before an induction abortion.

RECOMMENDATION 6: HEALTH CARE WORKERS SHOULD ENCOUNTER ABORTION CARE IN THEIR EDUCATION AND TRAINING

a) Medical and nursing students should encounter abortion and reproductive care in their university education (with exceptions for those who have a conscientious objection). Junior doctors should encounter abortion and reproductive care during their internship, residency, or registrar period. Incorporating abortion care into education and training serves to destigmatise the procedure for both patients and health care professionals.

b) Since the Adelaide public clinic provides the majority of the abortion care in South Australia, formal arrangements should ensure it is offered as a site for education and training.

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[5] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "Queensland Abortion Law Reform Media Statement," 15 February 2017 https://www.ranzcog.edu.au/news/Queensland-abortion-law-reform; Williams, Plater, Burnacci, et al., "Abortion," Recommendation 25.

[6] A feticidal injection is recommended by RCOG, NAF and NAF Canada, while ACOG notes it "may be preferable to the woman or provider." See Royal College of Obstetricians and Gynaecologists, "The Care of Women Requesting Induced Abortion," 57; American College of Obstetricians and Gynecologists, "Second-Trimester Abortion," *Practice Bulletin* (2013), 1396. NAF's clinical guidelines focus on protocols for the injection rather than guidance on its use, but Canadian and US interviewees indicated that since the early 2000s, NAF has advised its members to perform a feticidal injection for later abortions. RANZCOG does not have formal clinical guidelines on feticide, but a recent article in *O&G Magazine* suggested "feticide and late termination are necessary, but difficult, parts of our profession," see Megaw and Dickinson, "Feticide and late termination of pregnancy."

[7] SA Health, "South Australian Perinatal Practice Guideline: Perinatal Loss," 7.

RECOMMENDATION 7: HEALTH CARE WORKERS WHO PROVIDE LATE TERMINATION OF PREGNANCY SHOULD BE SUPPORTED

a) Interviewees who worked at the Adelaide public clinic described a workplace with supportive processes and which offered formal and informal opportunities for staff to debrief if they were challenged by a patient or a procedure. Their greatest concerns relevant to this study were about issues such as the divergence over gestation limits, contradictory interpretations of the law, tension between public health sites, the experiences of fetal anomaly patients in public hospitals, and concern about the dignity and privacy of their second-trimester surgical patients at the administratively-linked public hospital.

b) In the 2 Adelaide public hospitals that offer induction abortion for fetal anomaly patients, doctors should receive greater departmental and institutional support and recognition for providing empathetic, time-sensitive care to people from across the state. Nursing and midwifery staff should also be institutionally supported in providing this care. In other regions visited, this was done via one or more of the following: formal 'values clarification' workshops facilitated by outside parties, one-on-one and group discussions before changes in provision of later abortion care, discussion of patient's stories at the beginning of the shift, and debriefing at the end of each shift. Interviewees and academic research also indicate that routine use of a feticidal injection in induction abortion benefits nursing staff and midwives.[8]

RECOMMENDATION 8: ABORTION SHOULD BE DECRIMINALISED

a) Abortion should be removed from the criminal law and regulated as a health matter. This is the position of RANZCOG, AMA (SA), ANMF (SA) and is also recommended in the 2019 SALRI Report. Recent academic research indicates 80% of South Australians support decriminalisation.[9]

b) Decriminalising abortion will help reduce some of the stigma for abortion care patients and providers and will ensure that doctors are more confident in providing care,

[8] Marc Dommergues, Françoise Cahen, Micheline Garel, et al., "Feticide during Second- and Third-Trimester Termination of Pregnancy: Opinions of Health Care Professionals," *Fetal Diagnosis and Therapy* 18 (2) (2003): 91-7; R. Graham, K. Mason, J. Rankin, et al., "The role of feticide in the context of late termination of pregnancy: a qualitative study of health professionals' and parents' views," *Prenatal Diagnosis* 29 (2009): 875-81.

[9] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "Decriminalising Abortion Fundamental to Effective Sexual and Reproductive Health," Moy, "AMA (SA) submission to the SALRI Review of Abortion Law and Practice in South Australia"; Australian Nursing and Midwifery Federation (SA Branch), "Law Abortion Reform – South Australia"; Williams, Plater, Brunacci, et al., "Abortion," Recommendations 1, 3, and 4; Cations, Ripper, Dwyer, "Majority support for access to abortion care including later abortion in South Australia."

particularly where there has been a fetal anomaly diagnosis later in pregnancy. It will also lessen the current institutional confusion about gestation limits and 'lawful' versus 'unlawful' abortions. The contradictory interpretation of the law and gestation limits was highly unusual when compared to every other region I visited.

c) Once abortion is decriminalised there should not be a gestation limit in law. RANZCOG opposes gestation limits in law; its November 2019 "Late Abortion statement" recognises "special circumstances where late abortion may be regarded by the managing clinicians and the patient as the most appropriate option in the particular circumstances" and outlines scenarios including maternal diagnoses, fetal diagnoses, and psychosocial circumstances.[10] The SALRI Report also recommends "no upper limit for a lawful abortion should be provided for in any new law."[11]

d) <u>However</u>, if the law has a gestation limit, it should allow for case-by-case decision making by medical professionals after that point. SALRI recommended Victoria's Abortion Law Reform Act 2008 as an alternative to no gestation limit.[12]

[10] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "Late Abortion statement."
[11] Williams, Plater, Burnacci, et al., "Abortion," Recommendations 21 and 22.
[12] Williams, Plater, Burnacci, et al., "Abortion," Recommendation 23; *Abortion Law Reform Act 2008 (Victoria), Section 5 1, 2.*

APPENDIX A

INTERVIEW SCHEDULE FOR 'LATE TERMINATION OF PREGNANCY' PROJECT

Interviewees will be asked a series of open-ended questions to get at the status of late termination of pregnancy in their region. Each interview will be semi-structured and could take a different course depending on the personality of the different interviewee, the specific nature of their involvement, their perspectives, and their professional experiences.

OPENING QUESTIONS WILL BE USED AS FRAMEWORKS AND PROMPTS

Can you tell me about how you first became involved in abortion service delivery/activism?

(when and where, background with abortion, motivation, ideological framework, expectations)

When and why did you become involved or active on late termination of pregnancy?

How do you understand your job and your place within the medical profession?

Describe the legal situation involving late termination of pregnancy in your region.

Describe the medical/public health situation involving late termination of pregnancy in your region.

What are some of the key events or developments that have influenced provision of later terminations in your region?

How do you experience these legal frameworks and public health policies?

How do your patients experience these legal frameworks and public health policies?

Describe how you think patients access information about later termination in your region.

Do you think later terminations are handled well in your region? What are the strengths of the legal and policy framework? What are the weaknesses of the legal and policy framework?

Do you have contact with other clinicians working in later termination in and outside of your region?

What is your perception of how later terminations are regulated in other regions in your country? What is your knowledge of the status of later termination outside your country?

Describe your views on abortion, gestation limits, and the law.

What do you think a model of best care would encompass for health care workers? What do you think a model of best care would encompass for patients?

BROADER ISSUES TO BE DISCUSSED

Public attitudes towards abortion services and later termination of pregnancy

Attitudes within the medical/health care community/doctors' and nurses' organisations/professional groupings towards abortion services and later termination of pregnancy

Attitudes of workers in clinics/hospitals towards later termination of pregnancy

Attitudes of politicians, government departments, public servants towards abortion/later termination of pregnancy

The law

The abortion 'industry' - which agencies are involved, new providers, loss of providers, expansion or contraction in services proved, changes in service delivery models, location within/outside public health care system, overall quality of service

Media coverage of later terminations

The women and pregnant people who seek later terminations

Fetal viability

Presence/strength/ideological position/activities of pro-choice groups and/or individuals

Presence/strength/ideological position/activities of anti-abortion groups and/or individuals

Other related matters that arise in interview, including those specific to a region/country

APPENDIX B

LIST OF INTERVIEWEES

Agatha, interview by author, Québec, 2019.

Alice, interview by author, Québec, 2019.

Anastasia, interview by author, South Australia, 2020.

Anna, interview by author, England, 2019.

Anne, interview by author, England, 2019.

Audrey, interview by author, Washington, 2019.

Bridget, interview by author, England, 2019.

Brigid, interview by author, South Australia, 2020.

Brooke, interview by author, South Australia, 2020.

Carmen, interview by author, New Mexico, 2019.

Catherine, interview by author, England, 2019.

Christopher, interview by author, Québec, 2019.

Claire, interview by author, England, 2019.

Deb, interview by author, Washington, 2019.

Diane, interview by author, British Columbia, 2019.

Donna, interview by author, Washington, 2019.

Elizabeth, interview by author, South Australia, 2019.

Helen, interview by author, Québec, 2019.

Henry, interview by author, England, 2019.

Jean, interview by author, Québec, 2019.

Joanna, interview by author, New Mexico, 2019.

Joan, interview by author, New Mexico, 2019.

Jill, interview by author, British Columbia, 2019.

John, interview by author, Washington, 2019.

Joy, interview by author, England, 2019.

Joyce, interview by author, British Columbia, 2019.

Kim, interview by author, South Australia, 2020.

Lauren, interview by author, Washington, 2019.

Lucy, interview by author, Washington, 2019.

Lynette, interview by author, New Mexico, 2019.

Mara, interview by author, England, 2019.

Mary, interview by author, England, 2019.

Mercedes, interview by author, Washington, 2019.

Natalie, interview by author, South Australia, 2020.

Patricia, interview by author, British Columbia, 2019.

Ruth, interview by author, British Columbia, 2019.

Sally, interview by author, England, 2019.

Sandra, interview by author, British Columbia, 2019.

Sarah, interview by author, British Columbia, 2019.

Shelley, interview by author, New Mexico, 2019.

Sue, interview by author, New Mexico, 2019.

Susan, interview by author, South Australia, 2019.

Wendy, interview by author, England, 2019.

Yves, interview by author, Québec, 2019.