

WOMEN'S AND PROVIDERS' EXPERIENCES OF SECOND-TRIMESTER IN THE HEARTLAND

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In the US, about 10% of abortions take place in the second trimester (after 12 weeks gestation). Many women who have later abortions do not recognize they are pregnant until later, may have trouble accessing services either because of where they live or because of financial reasons, or may decide to terminate a previously wanted pregnancy due to changes in their relationship or family status or because they receive a diagnosis of a fetal abnormality at a screening later in pregnancy. Later abortions, though safe, are more dangerous for women than first-trimester abortions, and access to later abortion services is more limited than earlier abortion services. Second-trimester providers are largely focused in urban areas and the cost of a second-trimester abortion is significant, often more than \$1,000, and may not be covered by insurance. There has also been a dramatic increase in state-level restrictions on later-abortion procedures, making them harder to obtain. Later abortions are also more challenging for providers, both because they are more technically difficult than earlier abortions and because training opportunities are limited.

We aimed to explore providers' and women's experiences with second-trimester abortion. This multi-method study included in-depth interviews with 16 providers, in-depth interviews with eight women who received second-trimester abortions, and a survey of 108 women who received second-trimester abortion services. All qualitative data was analyzed using framework analysis methods in ATLAS.TI. All survey data was analyzed in SPSS using basic descriptive statistics.

A number of themes emerged from our interviews with providers. Providers of second-trimester abortion reported a strong commitment to providing compassionate, non-judgmental care. This commitment motivated them to provide later abortion services, despite experiencing stigma, judgment, and harassment from friends, family, clinic protestors, and members of their communities. Providers noted that they rely on a number of social supports to cope with this stigma, including family, friends, and their fellow staff members. However, providers also noted that they could use more support in the form of better access to mental health care services, regular debriefings with fellow staff, and increased support from their communities.

The providers' dedication to providing high quality abortion care was reflected in the in-depth interviews and surveys with women who received second-trimester abortion services; women overwhelmingly reported receiving extremely high quality care and feeling very supported by clinic staff. However, they did have some suggestions for improving second-trimester abortion care, including better pain management, shorter wait times at the clinic, more privacy at the clinic, and closer clinic locations. Women also reported mixed knowledge about and opinions of abortion restrictions. The data from this study highlight a need for interventions to improve providers' experiences with providing second-trimester abortion; specifically, interventions are needed to mitigate the stigma providers are forced to cope with as a result of their work. Although women report receiving high quality abortion care, our results also highlight areas for potential intervention, including improved pain management, shorter waiting times, and increased privacy to improve women's experiences of second-trimester abortion.