# Abortion Toolkit

Almost half of all pregnancies in the US are unintended. Healthy People 2010, an initiative of the U.S. Department of Health and Human Services, established a national goal to reduce unintended pregnancy (U.S. Department of Health and Human Services, 2000), and access to reproductive health care, including pregnancy options counseling and contraceptive counseling, is critical for reaching this goal. Despite this understanding, abortion continues to be a contentious issue in the US.

Nurses play a unique role in providing access to abortion services. A growing number of nurse-practitioners and nurse-midwives are including abortion services in the wide range of health services that they offer. Even if not actively providing abortion services, nurses play a critical role in offering referrals, information, and emotional support to patients seeking abortion or who are pregnant and unsure of their options.

Understanding the full scope of issues connected with abortion will help you provide comprehensive, supportive patient care at any level.

This toolkit will cover the historical and current status of abortion in the US, focusing specifically on policies and factors which restrict access to abortion, provide an overview of advanced practice nurses as abortion providers, an introduction to the common pathways by which people access abortion, and information on how to be a competent abortion referral provider.

# HISTORICAL BACKGROUND

Abortion services were legal in the US until "quickening" (typically defined as first movement) until the mid-1800's, when the first anti-abortion laws were passed.

Abortion in the US was finally criminalized in the 1880's under the Comstock laws, which also banned contraception. Abortion remained illegal until the landmark Supreme Court decision *Roe v. Wade* in 1973, which asserted that abortion was protected as a private health decision under the Constitutional right to privacy. In the decade before *Roe v. Wade*, one third of states liberalized or decriminalized abortion laws, however, abortion was not federally protected until the 1973 Supreme Court decision.

Prior to the legalization of abortion, it is estimated that rates of illegal abortion averaged at about 1.2 million per year. People accessed these abortions through a variety of sources, some from private doctors either in the US or abroad, some from untrained practitioners, and some self-induced. Many people died or suffered serious medical complications from self-induced abortion or procedures from untrained practitioners. Typically, only people with substantial financial means were able to access abortion from trained physicians. Physicians who did provide illegal abortion faced increasing risk as the 20th century wore on.

After Roe v. Wade, anti-abortion activists quickly mobilized, employing a diversity of tactics. Some worked on a legal level, working to prohibit state and federal funding for abortion, as well as other tactics to prevent access to abortion. Others chose to focus on physically disrupting clinics by demonstrating, blocking access, and harassing patients. Over time, anti-abortion violence increased resulting in clinic bombings, physical attacks, and murder.

In 1992, under Planned Parenthood v. Casey, the Supreme Court ruled that restrictions could be placed on first trimester abortions in ways that are not medically necessary, so long as it does not put "undue burden" on the patient. This resulted in numerous state laws, restricting abortion access including mandatory waiting periods, parental involvement, and biased counseling.

During the 1994 International Cairo Conference on Population and Developments, governments explicitly acknowledged reproductive rights as human rights covered by other human rights provisions as outlined in the Universal Declaration of Human Rights (Universal Declaration), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These standards guarantee, as human rights, the right to make decisions about one's body and family, access to reproductive services, and the right to decide the number and spacing of one's children.

In response to a rise in clinic violence, Congress passed the Freedom of Access to Clinic Entrances (FACE) Act in 1994. This act made it a federal crime to use force, the threat of force, or physical obstruction to prevent individuals from obtaining or providing reproductive healthcare services.

## CURRENT STATUS OF ABORTION IN THE US

Although recognized domestically and internationally as a human right, over half of people ages 15-44 with the ability to become pregnant in the US currently live in states that are hostile to abortion rights. Access to abortion has been increasingly compromised over the past 5 years. Over 25% of the laws restricting access to abortion since 1973 have been passed since 2010.

Targeted Regulation of Abortion Providers (TRAP) laws specifically single out the medical practices of practitioners who provide abortion and, "...impose on them requirements that are different and more burdensome than those imposed on other medical practices. For example, some TRAP laws require that abortions be performed in far more complicated and expensive facilities than are necessary to ensure the provision of safe procedures, such as in ambulatory surgical facilities. Compliance with these requirements may require costly and unnecessary facility modifications, which may not even be feasible in existing facilities, or impose unnecessary staffing requirements that are expensive or impossible to meet. Another example is TRAP laws requiring that physicians who perform abortions have admitting privileges in a local hospital, a requirement that is not medically justified and severely reduces women's access to abortion services." (Center for Reproductive Rights)

This targeted restriction of abortion providers and clinics has resulted in record closing of abortion clinics. Since 2011, 162 abortion clinics have closed while just 21 have opened. In 5 states, there is only 1 abortion clinic left in the whole state.

Some regulations specifically target patients. These include state-mandated counseling, mandatory waiting periods, and parental involvement in a minor's decision to have an abortion.

**From the Guttmacher Institute:**

- *State-Mandated Counseling:*
  17 states mandate that women be given counseling before an abortion that includes information on at least one of the following: the purported link between abortion and breast cancer (5 states), the ability of a fetus to feel pain (12 states) or long-term mental health consequences for the woman (9 states)

- *Waiting Periods:*
  27 states require a woman seeking an abortion to wait a specified period of time, usually 24 hours, between when she receives counseling and the procedure is performed. 14 of these

states have laws that effectively require the woman make two separate trips to the clinic to obtain the procedure.

- *Parental Involvement:*
  37 states require some type of parental involvement in a minor's decision to have an abortion. 25 states require one or both parents to consent to the procedure, while 12 require that one or both parents be notified.

Access to abortion is also compromised through funding restrictions. Since 1977, the Hyde Amendment has prohibited federal funding from covering abortion, except in cases of maternal life endangerment, rape, or incest. States are required to follow this federal standard but may choose to cover abortion through state-funded health coverage. However, only 17 states currently cover most or all costs of medically necessary abortions.

The intersection of these issues can create a perfect storm in some areas, prohibiting access to abortion through a combination of geographical, financial, and emotional barriers.

Imagine that you are a low income person in a state like Mississippi, with no state-funded coverage of abortion services and only one abortion clinic left. This clinic is forced to require two separate in-person visits, one for in-clinic counseling and one for your procedure after the mandatory 24 hour waiting period, which begins after counseling. Suppose that you do not live in the city in which the clinic is located. You must arrange for transportation, housing, and food for yourself for 1-2 days. Perhaps you must also take work off and arrange for childcare. You must also find some way to pay for your abortion if it is not covered by private insurance or some other funding source. Your provider may be required to offer you a picture of the ultrasound image and the opportunity to listen to fetal heart tones and you must sign a form verifying that you were offered these options. This does not take into account other substantial barriers which may exist like lack of access to accurate information, lack of services in the language you speak, lack of support from family/friends/partner, and your own decision-making process. The intersection of all of these issues can make it exceptionally difficult to access abortion services, especially within a sensitive time window.

# NURSES AS ABORTION PROVIDERS

Most abortions are currently provided by obstetrician-gynecologists. However, a growing number of primary care providers, including nurse practitioners (NP), certified nurse-midwives (CNM), and physician assistants (PA), collectively known as advanced practice clinicians (APCs) are including abortion services in the comprehensive range of services they offer. An increasing body of research supports the safety of non-physician clinicians providing abortions.

*Providing Abortion Care: A Professional Toolkit for Nurse- Midwives, Nurse Practitioners, and Physician Assistants (APC Toolkit)* is a toolkit which includes in-depth comprehensive information for practitioners interested in expanding their scope of practice to include abortion services. While certain excerpts from it are included in the course of this document, the APC Toolkit can be found in full on the Nursing Students for Sexual and Reproductive Health website.

The ability of APCs to offer abortion services varies state by state. From the APC Toolkit:

- "Abortion laws, many of which were enacted before the statutory recognition of advanced practice clinicians roles and the development of newer and simpler abortion technologies, create confusion for clinicians who want to offer abortion care. After the 1973 Roe v. Wade Supreme Court decision legalizing abortion, many states enacted physician-only laws presumably to protect women from unsafe, untrained, and unlicensed abortion providers.
- Unfortunately, these laws have become a de facto restrictive legacy to the evolution of APC scope of practice for two reasons: (1) hesitation by some health professionals and reproductive rights organizations to address the issue of women's access to abortion care from all qualified women's health care providers, and (2) uncertainty whether these laws apply to demonstrably "safe and competent" providers who are not physicians.

Even in states where APCs have a broad scope of practice including prescriptive authority, they must abide by abortion-specific limitations that prevent them from offering either aspiration or medication abortion services. For example, although in Arizona PAs have broad physician-delegated authority to diagnose, treat, prescribe, and perform minor surgery, a statute specifically prohibits them from providing abortions (Ariz. Rev. Stat. § 32-2501.11 (2007)). Similarly, in Ohio PAs' prescriptive authority specifically excludes abortion-inducing medications (Ohio Rev. Code § 4730.02 (2009)).

However, in a number of states, including those with physician-only laws, APCs with additional training are providing medication and, in some cases, aspiration abortions as a result of Attorney General opinions, regulatory clarifications, and other mechanisms (Joffe & Yanow, 2004; Advancing New Standards in Reproductive Health, 2007). This demonstrates that even in states where abortion is restricted by law to licensed physicians, non-legislative strategies have provided APCs with opportunities to incorporate abortion services into their practices. (See Section IV.D and IV-E for an overview of these statutory and regulatory examples.)

These state-specific abortion laws must be considered within the context of nursing, midwifery and physician assistant practice acts which also vary from state to state."

To review the specific policy in your state, see the Guttmacher Institute's State Policy on Abortion database.

For more information, see APC Toolkit Module One supplemental handout.

# UNDERSTANDING SCOPE OF PRACTICE

Scope of practice establishes guidelines within which healthcare providers operate and dictate which kinds of healthcare practices providers are authorized to provide. Ideally, scope of practice would be consistent across states and would both encompass and build upon a profession's definition of its practice base, while also staying sufficiently broad enough to include the dynamic nature of an evolving scope of practice. As we've reviewed, scope of practice for APCs varies markedly across the US. However, APCs and nurses in particular, represent a growing organizing base, with the potential for expanding scope of practice and increasing the availability of abortion services across the US.

# PATHWAYS FOR ACCESSING ABORTION

Even when not working as primary providers of abortion services, nurses are able to play an important role in supporting patient access to abortion. Given increased restrictions on abortion and resultant limitation in services, abortion-referral making, the process by which a patient is connected to an appropriate service provider, is a critical service for any frontline healthcare worker.

People access abortion in a variety of ways. Once a person has determined that they are pregnant and made the decision to consider or to have an abortion, their experience locating and accessing abortion services will vary, from seamless to challenging, depending on existing knowledge of abortion providers, circumstances, and the resources both available and known. It is important to have an intersection analysis of people's varied experiences and needs. Access to abortion is severely limited by geographical location and financial limitations, as well as other issues of oppression. Delays in accessing abortion services are disproportionately experienced by folks of low income, people of color, and young people.

At its most seamless, a person will find out that they are pregnant through a private physician who is also able to provide an abortion. However, less than 1% of abortions are provided in this way. More likely, a person will need to find an abortion clinic after learning that they are pregnant, either through a home pregnancy test or through another healthcare provider. This requires the ability to locate an abortion clinic and arrange an appointment, presuming either access to telephone book or internet and the language abilities and emotional capacity to arrange an appointment.

Factors which may affect this include the number of clinics, public visibility and proximity of abortion providers, as well as the number and visibility of anti-abortion centers (i.e. Crisis Pregnancy Centers), some of which falsely present as abortion providers in order to deliberately delay or deter people from accessing abortion. Additionally, if abortion is not covered by public or private insurance, ability to pay for an abortion may present a serious barrier for accessing abortion, particularly in a timely

fashion. Some funding may be available through non-profits which exists to help people fund abortion procedures.

Navigating cultural stigma adds an additional barrier, as a person seeking abortion services may need to overcome significant personal dilemma, as well as the opinions and advice of family, peers, partner, and other significant support or authority figures. A minor may face additional barriers if the state in which they reside requires parental involvement, which may or may not be safe for that individual.

An informed care provider can make a great deal of difference in connecting someone with abortion services. Provide, an organization working to ensure access to abortion, particularly in low-resource rural and Southern communities, found that of 429 providers surveyed in 3 southeastern state, 50% felt that they lacked the skills and information needed to make an abortion referral if needed. Some providers, for example those working in religious institutions, may be prohibited from discussing abortion services by their employer.

## CONFRONTING STIGMA AND VALUES CLARIFICATION

An individual care provider may need to navigate personal bias when supporting a patient seeking an abortion. It is important to develop a critical understanding of your own personal value set and clarify your ethics in regards to patient care pertaining to pregnancy choices.

Every care provider is informed by their own values to one degree or another. Eliminating personal bias in favor of evidence-based practice is lifelong work as a healthcare provider. It begins by developing awareness of your own values and identifying the ways that they may show up in your work. Important questions to ask yourself are:

- What beliefs do I have about pregnancy?
  Examples: Pregnancy is a joyous event to be celebrated, even under difficult circumstances…Some people just shouldn’t be parents…I support a person’s right to choose if, when, and how they become parents.
- How would I support a patient who disclosed that they were pregnant and unsure of what they wanted to do?
- How would I support a patient who disclosed that they were pregnant and did not want to be?
- What kinds of behaviors do I consider completely unacceptable during pregnancy?

- How would I support a patient who was choosing to do something I found completely unacceptable during pregnancy?
- Under what circumstances is it okay for a nurse to let a personal reaction affect the care that they provide?
- What values do I bring into my work? Make a list of values that inform and affect your work.

Culturally, abortion continues to be a highly stigmatized and contentious issue. Perhaps the religious community you are a part of does not support abortion. Perhaps your family or community of origin also does not support abortion. Perhaps your colleagues or the institution in which you work doesn't. Perhaps you as a practitioner do not. It is critical that you consider how these beliefs will impact the care you provide before you are actively working with a pregnant patient who is trying to decide what pregnancy choice is best for them.

## MAKING COMPETENT ABORTION REFERRALS

Competent referral providers play a critical role in helping people access abortion, as safely and easily as possible. Specifically, they can provider accurate, evidence-based information to help clear up common misconceptions and deliberate misinformation about the legality and safety of abortion, as well as assist people with the complex social and/or medical circumstances they may face while accessing abortion services. Comprehensive referral providers extend their support beyond providing a list of abortion providers and may include assistance scheduling an appointment; assistance in accessing supportive services such as transportation, childcare, and abortion funding or insurance; follow-up on service utilization and outcomes; and assessment of patient satisfaction with the referral and with the care received. This also includes the ability of abortion providers to refer people who exceed gestational limits within their facility and/or who have unique health needs that require care to be obtained elsewhere (Provide).

# WHAT YOU NEED TO KNOW TO MAKE AN ABORTION REFERRAL

## About the patient

- Desired outcome
- Emotional status, which may include hopes/fears and personal feelings about abortion
- Natural support network, including partners, family, friends, and other community support
    - Is the patient able to safely disclose pregnancy status to any or all?
    - Are there safety issues, including intimate partner violence, domestic violence, or danger from the community? Some people rely on a close-knit community for numerous resources and may lose this community if pregnancy status and decision to seek abortion becomes known, which may be a primary concern of your patient.
- Needs around scheduling an appointment
- Financial status including if patient insurance (public or private) covers abortion services and possible other funding sources
- Needs around arranging for work coverage, childcare, and transportation
- After-care plan
- Any other concerns

## About your workplace

- Specific policies restricting abortion referrals
- Any safety concerns for you or your employment when making an abortion referral

## About the area/state where you live/work

- Abortion providers in the area
    - Specific services offered, medical/surgical abortion, up to what gestational period
    - Appointment process, availability
- Presence and practices of anti-abortion centers (crisis pregnancy centers) that may manipulate and provide misinformation to clients
- Specific state policies restricting access to abortion (mandatory counseling, mandatory waiting period, mandatory ultrasound/fetal heart tones auscultation, etc.)

- Coverage of abortion
- Abortion funding sources
    - Some areas have nonprofits or independent charities that exist specifically to fund abortions, you may be able to help your patient connect with these to meet funding needs
- Abortion support organizations
    - Some areas have organizations that exist specifically to provide accompaniment and emotional support to people seeking abortion services
    - Some areas have organizations that exist specifically to assist with transportation and housing for folks who must travel far from home to receive an abortion
- Abortion providers in nearby states if patient cannot find services in home state

## About yourself

- Your own boundaries, limitations, and scope of practice
    - It is essential that you do not offer to assist a patient in ways that you know you are truly unable to. Setting reasonable and realistic expectations is critical in establishing a trusting, ethical relationship with your patients.
- Personal risk you may be taking by providing abortion referrals and support, either in your workplace or community
- Your personal values and biases and the ways that these may influence your ability to provide patient care
- Your natural support network
    - When supporting someone through any kind of difficult or emotionally stressful event, it is important that you also have access to appropriate care and support, particularly if you are going against the grain in your community or workplace.

# RESOURCES

https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/comparison_first_trimester.pdf

http://apctoolkit.org/

https://www.prochoice.org/pubs_research/publications/downloads/about_abortion/medical_abortion.pdf

http://prochoice.org/wp-content/uploads/abortion_option.pdf

http://www.pregnancyoptions.info/whichmethod.htm

http://www.reproductiverights.org/project/targeted-regulation-of-abortion-providers-trap

http://www.bloomberg.com/news/articles/2016-02-24/abortion-clinics-are-closing-at-a-record-pace

https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid

https://www.plannedparenthood.org/planned-parenthood-southeast/shadow-pages/mississippi-laws

https://www.guttmacher.org/about/gpr/2008/08/abortion-and-women-color-bigger-picture

Finer, L.B., Frohwirth, L.F., Dauphinee, L.A., Singh, S., and Moore, A.M. Timing of steps and reasons for delays in obtaining abortions in the United States. Contraception. 2006; 74: 334–344 ([PubMed PMID: 16982236. Epub 2006/09/20 09:00. Eng

https://www.arhp.org/publications-and-resources/contraception-journal/january-2015