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Providers' Perspectives of Georgia's 22-Week Abortion Ban and its Sociocultural and Political Implications

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Abstract

Providers' Perspectives of Georgia's 22-Week Abortion Ban and its Sociocultural and Political Implications

By Awa Youm

Background: In 2015, the Georgia legislature passed House Bill 954 (HB954) which implements a gestational age limit on abortion at 22 weeks from last menstrual period. This study sought to analyze the social, cultural and political contexts and consequences of HB954 from the perspective of abortion clinic personnel in Georgia.

Methods: 20 semi-structured, in-depth interviews were conducted with a diverse set of service delivery stakeholders from 4 abortion clinics in Georgia. Using an iterative process, and principals of grounded theory, transcripts were annotated and coded in MAXQDA. The analysis used both inductive and deductive approaches.

Results: Participants reported a disconnect between the medical and legal communities, particularly due to the presence of medically inaccurate language in HB954, as well as lawmakers' insertion of their own personal beliefs and ideas of morality. Participants also described the stigma they experienced within a hostile service delivery environment. Participants expressed that HB954 disregards patients' bodily autonomy and intrudes into the provider–patient relationship. The state's intrusion into the provider-patient relationship created a heavy emotional and mental burden on participants because they reported having to deny some patients care and/or refer patients to other states.

Conclusion: Providers viewed HB954 as posing a threat to patients' bodily autonomy, perpetuating and legally codifying medical misinformation, and contributing to mental and emotional burnout among personnel. Future research is needed to further evaluate abortion providers role in legislation and the impact recent restrictive abortion regulation creates on patients as a study population.

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Table of Contents

Chapter 1: Introduction

Introduction & Rationale

In 2012, Georgia introduced House Bill 954 which would restrict abortions occurring after 20 weeks post fertilization (22 weeks from last menstrual period) [1],[2], [3]. The bill specified that abortions post 20 weeks must be performed in a way that would maximize the potential for neonatal survival [1],[2], [3]. Proponents of bans on abortion at or around 22 weeks after the last menstrual period (LMP; the dating criterion used hereafter) generally rely on unscientific claims [4] for support. These evidence-free claims include that a fetus can feel pain and that terminating a pregnancy will result in mental health complications [4]. Antiabortion rhetoric uses misleading terms, such as "20-week bans", to date pregnancy from the date of conception instead of dating pregnancy using standard medical practice language such as last menstrual period (LMP) [4]. Gestational age bans such as HB954 are harmful at any stage of pregnancy because they infringe upon people's reproductive decision making and further make securing abortion rights difficult [4]. After the introduction of the bill, a judge issued an injunction while the courts decided on the legality of the proposed bill, the law partly went into effect in January of 2013[69]. Since 2013 the injunction has been lifted and the full law went into effect in October of 2015[70],[73]. This law presents implications for reproductive health systems such as obstetric care and family planning.

Problem Statement

Georgia was the first state to pass a ban where a relatively large percentage of abortions after 20 weeks were being provided (9% of all U.S. abortions after 21 weeks were performed in Georgia in 2009 versus 5% combined in all other states with 20-week bans) [5],[6],[7]. Given the persistently high rates of unintended pregnancy and maternal-infant morbidity and mortality in the Southeast of the country, especially among Black and low-income women [1]. Georgia's 20-

week ban presents serious implications for abortion clinic personnel's ability to provide care especially for marginalized communities.

Purpose Statement

The purpose of this research to document the contexts and consequences of Georgia House Bill 954 on abortion providers. This will be achieved by the qualitative analysis of 20 in-depth interviews with abortion providers in Georgia. The perspective of abortion providers is one that is often not represented. However, providers' perspectives are critical in assessing the status of our health care delivery and system. Decisions that are made at the policy level impact both providers and patients.

Research Question

What are the social, cultural and political contexts and consequences of House Bill 954 on abortion providers in Georgia?

Significance Statement

Findings from this research will help in informing future research related to gestational age limits, abortion providers and making policy and program recommendations.

Chapter 2: Background and Literature Review

Reproductive Health, Rights & Justice

The traditional framework of reproductive health is focused on the providing services and improving access to facilities, education and healthcare [8]. This framework is narrow in scope because it does not typically take into account structural inequalities that contribute to patients' differences in accessing these services [8]. Reproductive rights as a framework is more focused on the legal protection of reproductive health care services, particularly abortion [8]. The legal foundation for reproductive rights comes from the protection of privacy derived from *Roe*

v.Wade [9]. However, within the reproductive rights framework, a governmental role in removing social inequities which contribute to health disparities is not present [8], [10].

Given the limitations of both of these frameworks, a comprehensive and inclusive framework can be found within reproductive justice. Reproductive justice, a term created by Black women in 1994 [11], can best be described as a combination of social justice and reproductive rights. This framework rests on intersectionality, which states that people can have a series of different experiences based on the interplay of their specific gender, sexuality, race, religion, etc. [11],[71], thereby creating a set of distinct human experiences [11]. Intersectionality also emphasizes intersectional oppressions, a term that describes the interplay of systems of oppressions within one's identity such as racism, heterosexism, capitalism, etc. [12] Researchers using the reproductive justice believe in the human right of exercising autonomy over one's own body, life, sexuality and gender [11]. This autonomy includes the decision to have children, not to have children, and to parent children had in sustainable and safe communities [13]. This right is not inherent to all nor is it equally distributed because of the presence of systems of oppression which further inequities in our sociocultural environment [11].

The values that reproductive justice advocates support are not practiced universally. Barriers complicate creating an equal and just reproductive environment for many, particularly those who have historically been marginalized [14]. Marginalization is an ever-present threat that has been shaped by a combination of historical, sociocultural and political factors [11], [14]. For example, gynecology and our present-day understanding of women's health exists as a direct result as the experimentation on Black bodies [15]. Instances of coercive behaviors towards women of color, forced sterilization and the experimentation of scientific practices remain as the backdrop of women's health [14]. Recognizing this past and how it shapes present-day decisions

requires evaluating and reflecting on ways to better align reproductive health with the principles of reproductive justice.

Abortion Procedure & Pregnancy Dating

An induced abortion is a procedure or medication that terminates a pregnancy [27]. Most induced abortions take place during the first trimester of pregnancy (i.e., up to 13 weeks) [27]. Two methods can be employed during the first trimester, medication or suction curettage [27][2]. Gestational age is a clinical dating method that helps describe how far along a pregnancy is. This measure is taken from the first day of last menstrual period (LMP) to the current date [29]. As mentioned previously, *Roe* did not actually establish at what gestational age viability is achieved [9], instead leaving that decision to individual states; some states have, consequently, have decided on an upper limit, or absolute last gestational age point at which an abortion can take place [24]. Most commonly this upper limit is observed after 24-28 weeks from LMP [24].

Global Health Context of Abortion

Globally, abortion is a highly stigmatized and contested practice, and, as a result, the legality of the medical practice varies. *Abortion* is simply the termination of a pregnancy [22]. However, the definition of abortion can vary depending on the community and is a key component in the way the subject is discussed and legislated about. Notably, this variation adds complexity to the topic of abortion as I will discuss later in the Results and Discussion sections. Together, unintended pregnancies and abortion stand as two areas that operate together and present variability in their practices globally.

The right to legal and safe abortions is recognized by various regional and international treaties and national-level treaties [16]. These treaties specify that accessing safe, legal and comprehensive abortion care including post-abortion care is an essential element in attaining the

highest level of sexual and reproductive health [16]. Globally, 970 million women (59% of women of reproductive age) reside in countries that generally allow abortions, whereas the other 41% live in legal environments that restrict their abortion rights [16]. The inability to gain access legal and safe abortion care affects 700 million reproductive-aged women. Moreover, the WHO estimated that 23,000 women die each year from complications of unsafe abortions and thousands more experienced serious health issues as a result of their inability to access safe abortions and post-abortion care [17]. Unsafe abortions are defined by the WHO as abortions that 1) are carried out in environments that do not have the minimal medical standards or 2) when a person lacks the necessary medical training and skill to perform it [17]. Barriers to accessing safe abortions include stigma, cost, restrictive laws and unnecessary/strenuous requirements [17]. Abortion restrictions fall into multiple categories, from prohibiting the procedure altogether to limits based on gestational age. The general trends that are observed are that in settings and countries where abortion access is restricted and penalized the rates of unintended pregnancies rates are the highest [20]. Worldwide, the rates of unintended pregnancies have declined, and a possible explanation is the advancement of family planning services, and the increase in the use of contraception and their access [19]. Legal restrictions placed on abortion do not decrease abortion rates. Instead, people still seek abortions, but the only abortion and post-abortion care they can access endangers them [21]. Each year, 4-13% of maternal deaths result from unsafe abortions, which means that each of those deaths was preventable [17].

History of Abortion Legislation in the United States

The history of abortion legislation in the United States can be traced back to the early 19th century, where the 1873 Comstock law criminalized selling or distributing materials that could be used for abortion or contraception [23]. About a hundred years later, abortion was illegal in 30

states and in allowed only in very specific conditions in the other 20 [9]. In 1973, the United States Supreme Court decided *Roe v. Wade*. In *Roe*, a woman in the state of Texas wanted an abortion but an existing state statute, passed in 1857, outlawed abortions unless it they were necessary to save the mother's life [9]. The court sided with *Roe* that the Texas law was an unconstitutional violation of her right to privacy present under the 9th and 14th amendments [9]. The United States Supreme Court inferred in *Roe* and other decisions a right to privacy. However, a citizen's right to privacy is not a specifically enumerated right in the United States Constitution [9]. Rather, this court decision combined pieces from the Bill of Rights and the Due Process Clause of the Fourteenth Amendment to assert a right to privacy [9]. This right to privacy was deemed to be qualified, meaning that it can be regulated by each state [9]. Consequently, states were required to balance their interest in protecting the potential of human life with the health of an existing human life [9]. To delineate when a state could intervene, the Supreme Court divided pregnancy into a timeline of twelve-week trimesters [9]. The point of fetal viability, the ability of a fetus to survive outside the uterus, was used as the baseline for the point at which states could begin to impose limitations on access to abortion [24].

The trimester-based timeline for when states can intervene in pregnant peoples attempts to seek abortions and post-abortion care are as follows. In the first trimester of pregnancy, states cannot prevent women from accessing abortion, nor can states regulate abortion. The only thing states can do is require that the procedure is performed by a licensed clinician and in a safe medical environment. The second trimester becomes vague; states can regulate abortion procedures as long as the primary intent is to promote the mother's health. Finally, in the third trimester, the state's interest lies in protecting the potentiality of the life of the fetus. The court held that the fetus is not actually a person as set by a judicial precedent defined by the Fourteenth

Amendment. Thus, abortions can be prohibited except to preserve the health or life of the mother. Ultimately, *Roe v. Wade* does not guarantee that one has a right to an abortion, which means that although a right privacy is recognized, states are still able to impose their own regulations on abortion.

The same day that *Roe* was decided, *Doe v. Bolton* emerged from Georgia [25]. *Doe v. Bolton* was born out of a 1968 statute that only allowed abortions if it was to save a women's life if 1) a pregnancy resulted from rape or incest or 2) the fetus had a high chance of being born with a birth defect [25]. Along with these requirements came procedural requirements such as the requirement to obtain a committee's approval to have an abortion, the agreement of two doctors, accreditation of the hospital, and, finally, Georgia residency [25]. The Supreme Court decided that the statute and its procedural requirements were unconstitutional because it violated personal liberty and privacy [25]. Following *Roe* and *Bolton,* the Supreme Court continued to struggle with cases pertaining to the constitutionality of a women's right to privacy and how that lines up with proposed legislation. Finally, the federal Hyde Amendment, passed in 1976, prohibited the use of federal Medicaid funds to pay for abortions unless the pregnancy is a result of rape or incest or the pregnant women's life is in danger [26].

The previously highlighted court cases are not a comprehensive list of all abortion-related Supreme Court or general court cases but serve the purpose of providing an understanding of the ambiguity in abortion-related legislation. Currently, an ongoing issue is what state-imposed obstacles to accessing the procedure and challenges to those obstacles. These obstacles contribute to and reveal access gaps present at different points of entry into our health care system. These obstacles eliminate peoples' autonomy over their bodies and health.

State-level Abortion Restrictions in the United States

Many restrictions against abortion have proliferated at the state level in the past decade. These include physician and hospital requirements, waiting periods, parental involvement mandates and gestational age limits [28]. In 2019, a wave of antiabortion legislation happened in Midwestern and Southeastern states [30]. Six states, including Georgia, passed laws that ban abortions at the first sign of a fetal heartbeat (also known as "heartbeat bills"), which occurs at approximately 5-6 weeks [30]. These bills have been temporarily or permanently blocked by courts in most of these states [30]. Other states, including Illinois, banned abortions at "viability," or the point at which a fetus can survive outside of the womb, but do not indicate at what week viability would be reached [31]. These policies increase barriers to abortion care (e.g., getting time off of work, securing travel, accommodations and childcare) and disproportionally affect socially disadvantaged populations [32]. And although abortion restrictions are not new, legislation has increasingly included components that criminalize the patient, physician or both [33]. The practice of family medicine anchors itself in trust established via the doctor–patient relationship, and restrictive laws harm the patient-centered care that is a critical component of family medicine [33].

Abortion Disparities

To further understand abortions and how legislation that restricts abortions upholds systems of social inequalities, it is important to pay attention to who seeks abortions, who can access to abortion services, and the disparities in seeking and obtaining such access. Rates of abortions are 11 per 1,000 for non-Hispanic White women, 28 per 1,000 for Hispanic women and 50 per 1,000 for Black women [26], [34]. These disparities also persist by socioeconomic status: Those with an income of less than 100% of the federal poverty level have an abortion rate of 52

abortions per 1,000 [35]. In comparison, those with incomes greater than 200% FPL have a rate of 9 per 1,000. Black and Hispanic and low-income women are also more likely to have abortions take place in the second trimester than White women or more affluent counterparts [35].

Minority-identifying and poor women face challenges and barriers in accessing abortion services. Abortion-associated cost increases with gestational age; the average charge for a non-hospital abortion at 10 weeks is $523 while at 20 weeks is $1,339 [26]. Even with insurance, 12 states restrict abortion coverage under insurance for public employees [26]. The presence of disparities in abortion are reflective of other systemic inequalities such as worse health outcomes for communities from underserved and historically marginalized backgrounds.

The Turnaway study, conducted by researchers at the University of California, San Francisco, provided a good understanding of the profile of individuals seeking abortion care after 20 weeks gestation since last menstrual period despite it being more expensive for them to do so [36]. The Turnaway study is the largest study of women in the United States seeking abortions at 20 weeks or later. The inclusion criteria for participation in the study was anyone that presented for an abortion near or just past the gestational limit [36]. The study found that patients are more likely to seek abortion after 20 weeks if they are lower income, unemployed, younger, or non-White [37], [36]. Patients seeking abortions after 20 weeks were reported to face a series of challenges ranging from procedure and travel cost, lack of childcare support and inter-partner relationship conflict [38].

Another (albeit smaller) group of individuals seeking abortions after 20 weeks' gestation are those whose fetuses were diagnosed with severe anomalies [32]. The most common severe congenital anomalies are heart defects, neural tube defects and Down Syndrome [39]. Fetal anomalies can vary in their detection period. Some, such as fetal health, urinary tract, placenta

and others can be identified at 10-11 weeks of gestation [40]. Others, such as spina bifida and heart defects, are difficult to detect before 13 weeks of gestation [40]. During the second trimester, screenings for structural anomalies are the most common screening. These include maternal serum screen, fetal echocardiogram and an anomaly ultrasound [41]. Most patients whose fetuses have anomalies after 20 weeks choose to terminate their pregnancies and the legislative restrictions on abortions increases the risk of mortality and morbidity for both mother and fetus [42], [43]. Continuing or terminating a pregnancy should be a decision left to the individual, especially when considering the mental, emotional, and physical implications of carrying a fetus with a known anomaly may present. In addition, the presence of legislative restrictions alone do not always deter people from seeking abortions and can push patients toward terminating their pregnancies via unsafe and/or self-induced methods [42].

Abortion in the Southeastern United States and Georgia

The South of the United States has a unique social and political history that has been shaped by the institution of slavery, the Civil War, Reconstruction and Jim Crow, and the Civil Rights Movement [44]. This area is often referred to as the "Bible Belt" due to the strong societal and political influence socially conservative evangelical Protestantism plays [45]. This conservatism spills over into many putatively secular areas, including health legislation and abortion. Religious values tend to be the compass for morality and set the standard for decision making [46]. Another example of religious intrusion is the presence of crisis pregnancy centers [78]. These are organizations that provide prenatal services and counseling from an antiabortion perspective [78]. Many of these centers are affiliated with national antiabortion organizations and intentionally seek to persuade teens and pregnant people with unplanned pregnancies to choose "motherhood" or "adoption" [76],[77]. Often times these centers are staffed by employees and

volunteers who lack training and licenses, and individuals who seek care at crisis centers tend to be young, poorly educated or poor [78].

To further contextualize abortion in the Southeast, it is important to understand the landscape of sexual and reproductive health in the state of Georgia. As of 2009, data provided on abortion at later gestational ages from eight Southeastern states (Alabama, Arkansas, Georgia, Kentucky, Louisiana, South Carolina, Virginia, and West Virginia) revealed that 81% of abortions after 21 weeks of gestation took place in Georgia [5]. Prior to 2013, abortion was permissible up to 26 weeks, and with certain exceptions, after 26 weeks. [1],[5], [47].

Georgia continues to uphold a set of restrictions on abortion that researchers and providers have called medically unnecessary [42]. However, in comparison to other Southeastern states, Georgia' abortion restrictions do not stand out as unusually restrictive. Georgia's current abortion restrictions are a waiting period of 24 hours, mandatory parental notification for minors seeking abortion care, and a gestational age limit of 22 weeks from last menstrual period [28], [49]. As of 2017, an estimated 26 facilities were providing abortions in Georgia, 15 of which were clinics [50], [42]. This number is the highest in the region, but the geographic distribution of the clinics do not allow for wide accessibility. Most of the clinics are clustered around the Atlanta Metropolitan area, which means that about 95% of counties in the state that are not in or near Atlanta do not have an abortion facility [50]. Indeed, in 2014, only 4% of Georgia counties had clinics that provided abortion, leaving 58% of women in Georgia without a clinic in their county. The need to travel to access abortion services can be observed across many different communities in the United States; in 2014, patients had to travel a median distance of 10.79 miles to reach the nearest abortion clinic [19], [48]. However, in the Southeast, one in four women have to travel more than 50 miles to reach an abortion clinic [48], [49]. And as mentioned earlier,

individuals seeking abortions who have to travel, also have extra cost and potential loss of wages.

Further, in Georgia, despite abortion being common, most people face sociocultural and systemic barriers that limit access to services. The attitudes that condemn abortion are found in policies, systems and at the community level [51],[45]. The presence of abortion stigma is a concern [51],[52],[45] as it may influence people's ability to exercise their health and reproductive autonomy [53], [54], [45]. Researchers have suggested that "abortion stigma confounds a woman's decision to terminate a pregnancy due to worries about judgment, isolation, self-judgment, and community condemnation" [55], [45]. When looking at maternal mortality rates in the United States, Georgia has one of the highest, [56],[45] yet access to obstetric services is limited by a decline in the number of obstetrician/gynecologists in the workforce, especially in rural areas [57], [45]. Additionally, half of all counties in Georgia do not have even one obstetrician/gynecologist or hospital where pregnant people can give birth or access basic services [58],[45].

In 2012, the Georgia Assembly passed House Bill 954 (HB954) which bans abortions at 22 weeks or more from last menstrual period. Prior to this bill, abortions were legal up to 26 weeks from LMP [3],[42]. This ban does have exceptions to the 22-week limit, such as to "avert death… or serious risk of substantial and irreversible physical impairment of the pregnant woman" or to "preserve the life of an unborn child" [3], [42], [40]. The bill was partially implemented in 2013 as a result of a temporary injunction that changed the gestational age limit to 24 weeks from last menstrual period [3], [42]. HB954 was fully implemented in October of 2015 and reduced the limit to 22 weeks [3], [42].

Findings in a 2021 paper demonstrated that if Georgia restricted abortion in a severe manner more than 80% of the study participants would continue to seek an abortion [49]. This

would happen either by seeking care in another state, self-harming, or taking harmful substances [49]. This study further highlighted the fact that the criminalizing abortion is not an indication that the practice will cease.

Evidence-based Patient Care

In order for clinicians to make the best decision regarding patient care, they rely on reliable and valid information about prevention, diagnosis, prognosis and treatment [59]. This is reflected by the framework of evidence-based medicine (EBM) [59]. EBM integrates clinicians' experience, patients' values, and the best available scientific information to guide decision making about clinical management [59].

Medicine as a practice is focused on physicians providing to patients [60]. The code of medical ethics further emphasizes this dynamic [60]. The relationship between a patient and physician is based on trust, which contributes to physicians having an ethical obligation to put the welfare of a patient above their own self-interest, to use sound medical judgment on the behalf of a patient, and to advocate for the welfare of their patients [60]. Abortion-related legislation has posed a threat to this essential dynamic between a patient and a physician [33]. Laws aimed at restricting care or criminalizing the patient and/or the physician undermine care and create a threat to the ethical principles of the patient–physician relationship [33]. More recently, the impact of legislative interference has been explored as it pertains to topics that intertwine the medical and legal community. Physicians and other clinicians have warned over the overstepping occurring between legislators and clinicians [33].

When a physician serves the medical needs of a patient, they enter a patient–physician relationship [60]. The American College of Obstetricians and Gynecologists has expressed oppositions to legislation that interfere with patient–physician relationships [61]. The College

describes this relationship as essential to the providing patients safe and quality medical care and has to remain protected against unnecessary governmental intrusion [61].

Chapter 3: Methods & Results

Study Setting

This study recruited personnel from abortion clinics in the state of Georgia that provide second-trimester abortions. In-depth interviews were conducted on site and via phone.

Study Population, Sample Size, and Data Collection

Beginning in Spring 2018, twenty service delivery stakeholders were interviewed at four abortion clinics in Georgia. Staff roles ranged from clinical care, support staff/patient care to more administrative roles. Breakdown of the characteristics of those interviewed can be found in Table 1 below. In order for staff to participate, they had to be currently employed in one of the four target clinics. Interviews ranged from 38 to 78 minutes; the semi-structured guide focused on personnel experiences providing abortion care in their organizations, and included questions and probes around staff roles, abortion care generally, later abortion care, and abortion legislation and HB954.

Table 1. Breakdown of characteristics of abortion personnel from qualitative interviews in Georgia, 2018-2019

Characteristic	Number (n=20)
Age, years	
24-34	7
35-44	6
45-54	4
≥ 55	3
Role at clinic	
Director/Administrator	3

Clinical Care	6
Patient Care/Support Staff	11
Years working in sexual/reproductive health* (n=19)	
< 4	7
4–14	5
≥ 15	8
Years in current position	
< 4	11
4–14	6
≥ 15	3

Ethics

Emory University's Institutional Review Board approved this study. Participating abortion facilities provided Letters of Support, and the study team obtained a federal Certificate of Confidentiality and a waiver of documentation of oral consent to further protect confidentiality. Participant involvement was completely voluntary; they could leave the study at point in time. With participants' permission, interviews were audio recorded, and then professionally transcribed under a non-disclosure agreement, and finally de-identified and cleaned by the study team. Data remained secure and confidential throughout the duration of the study period.

Data Analysis

This data was previously coded by four researchers on the study team using an iterative process within MAXQDA. The categories of these codes where overarching codes which were not level specific, followed by external/macro level, provider/clinic level, and patient level codes. These categories encompassed subcodes, and using the agreed upon codebook,

researchers coded individually then met and discussed until 100% agreement was reached. For the goal of my research, I took a focused coding approach, also using MAXQDA.

Principles of grounded theory anchored the data analysis of this project [62], [63]. The transcripts were first read through and annotated by reflecting on the data. Annotating data provided the foundation to identifying codes. After annotating the data, the team codebook from the first round of analysis was compared to the created memos. This allowed for exploration of patterns and any potential areas of interest. Three new codes were developed and two codes from the original research codebook were included, adapting to fit the context of the research question. These codes were: Abortion Evidence, Intent of Requirements, Reproductive Autonomy/Agency, Policy Differences and Patients Turned Away (see Appendix 2 for full list of codes).Once the codes were finalized, I coded the full set of 20 transcripts.

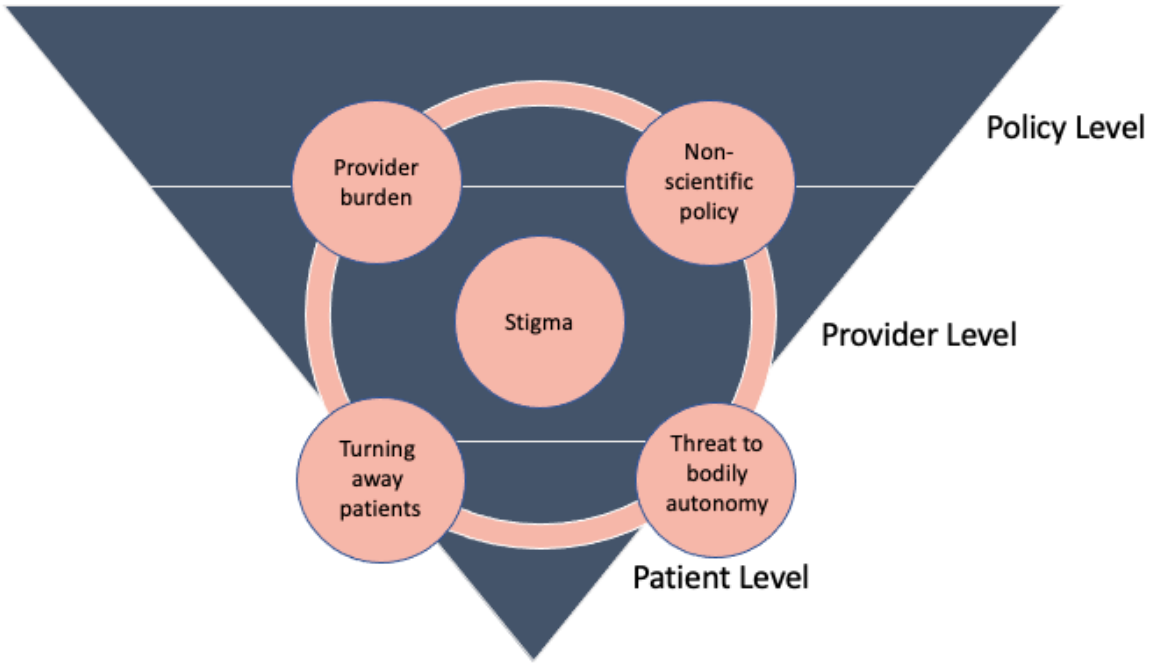
After the first round of coding, I used the summary grid feature of MAXQDA to summarize segments within specific codes. Segments were then compared and thematically organized. This organization was via a matrix setup and allowed for analysis across the transcripts. An additional two codes were added as reservoirs for information that emerged but did not directly fit into the predetermined codes. These additional codes were: Unintended Consequences and Attitude Towards Bill. The complex query feature of MAXQDA was used to help determine coded segments that overlapped. Themes were drafted based on the pairing and comparison of coded segments. These themes were then used to create a conceptual model of HB954 themes across a socio-ecological model (Figure 1).

Chapter 4: Results

Overview & Framework

The results (as described in the conceptual framework depicted in Figure 1) fit into three main levels with themes that are interconnected and interact in a cyclical way. Two main overarching domains emerged that were related to experiences of the health providers following HB954: These were 1) provider-level challenges to the provision of care and 2) patient-level challenges. These domains interacted with one another, and the 4 main themes spanned both domains. The themes that correspond to each overarching were as follows: 1) HB954 is not a scientific evidence-based policy, 2) HB954 is a threat to patients' bodily autonomy, 3) After HB954, providers turn away patients with great consequence, and 4) After HB954, providers experienced more emotional and mental burden

Figure 1. Conceptual model of HB954 themes across the socio-ecological model



House Bill 954 is not a scientific evidence-based policy

The first theme that emerged was that the implementation of this gestational age ban illustrates a disconnect between the medical and legislative community. This primarily stemmed from concern that members of the legislature do not base their decision making on established scientific information. Instead, regulation is political in nature rather than related to clinical decision-making. One participant stated that *"I think that they put all these requirements on us as clinicians to follow based on their – that their sense of morality, not on any medical data driven basis" (Nurse).* This sentiment was echoed when asked about the specific language of House Bill 954. *"[T]hat statement is ridiculous. I feel that it's absurd and in no way founded in any sort of medical science. And I think that is anti-abortion stigma being placed in public policy, where it doesn't belong" (Director/Administrator).*

Essentially, participants felt that language used was often rooted in anti-abortion stigma and pushed an inaccurate narrative. In addition, many discussed that legislators let their personal opinions and morals impact what they vote and stand for. This merging of personal and political ideology creates a dangerous political environment that leaves constituents subject to the varying personal beliefs of their representatives. The perspective of these providers presents important considerations for public policy. How much emphasis should be placed on balancing the presence of morality and science, and is there room for both of these to coexist? Further in terms of stigma, these quotes demonstrate the way that stigma can be perpetuated at the structural/policy level. These beliefs then transpire into laws and continue to exist without scientific support.

When asked about specific pieces of the bill, providers had a hard time understanding word choices or were surprised by what was in the bills. Participants also commented on the use

of misleading non-scientific terminology about biological and medical processes: *"I think that using language such as 'unborn child' is misleading. Nowhere in that sentence did I hear anything about the health of the mother or the pregnant person. That's all I have to say. I think it's more important to discuss the existing life, the mother and her health and her outcomes" (Director of Nursing).* The term "unborn child" is often pushed forward by anti-abortion proponents and creates an image that characterizes the fetus as being an alive being. This further complicates the abortion discussion and can create real emotional distress for both the pregnant person and the public at large.

The previous participant mentioned that if we are discussing a fetus, conversations also need to include the pregnant person and their life. This stands as an important point because the separation of the fetus from the pregnant woman encourages discussion where fetal survival is prioritized over the autonomy and well-being of the pregnant person. Autonomy and well-being remain important components of the abortion discussion.

Participants also questioned this aspect of the terminology in HB954, specifically related to the statement: *"The method of abortion used at 22 or more weeks from LMP was one that, in reasonable medical judgment, provided the best opportunity for the unborn child to survive" (GA HB954, 2012).* Participants were confused as to how an abortion—an intentional pregnancy termination procedure— is supposed to provide the best chance of survival for the fetus. Clearly perplexed, one participant reflected, "*To survive? So, that's – you want it to live but you want to do a procedure so that it won't live, but you're – that's like a backward – that doesn't – I don't get that. That is weird. So, you're still forcing. You're trying to say that you're implementing so that they can – the fetus not survive, but you're setting it up so that it survives. I don't – is that the bill for real? Oh. Does that make – like, how could you do that? What kind of – who – so, that – So,*

again, you're trying to prevent abortion. Slick-handedly" (Health Educator). Once again here we see lawmakers prioritizing of fetal survival over the autonomy and health of the pregnant person, another example of blatant intrusion of politics and individual beliefs about morality into medical and scientific discussions and decisions.

Similarly, participants described the lack of involvement medical professionals play in the policy drafting process: *"I wish we had some leadership in [drafting the bill]… Like I said, they allow the doctors to come talk, but they weren't listening because they don't understand it. They're not willing to let down that barrier of this false morality to listen and be educated. And I think we have to require that of our legislators. If they are gonna make laws that govern us, they need to be educated in what that means"(Nurse).* This brings to the table an important consideration when it comes to medical-related legislation: to what extent should clinicians participate in drafting policies?

HB954 is a Threat to Patients' Bodily Autonomy

The second theme that came forward was the threat to patients' bodily autonomy, which emerged when discussing the purpose and outcomes of abortion regulations. As reflected in the quotes above, participants described how lawmakers were projecting their own beliefs and feelings into policy and healthcare practice, which participants felt stemmed from a desire to control women. *"I think there are folks that want to have power and control over women and poor people and people of color, and regulate what they do with their bodies, and I think sometimes they put that in the name of religion, which maybe they feel that way. I think they have a lot of influence over legislators, some of which agree, some are just kowtowing to political pressure. Yeah. I'll leave it at that" (Director/Administrator).*

In addition, participants felt lawmakers regulate abortion in an attempt to discourage

patients from making autonomous decisions about their health which includes abortions. Participants also mentioned the impact of religious and cultural factors in the South, for instance, being in the "Bible Belt"— a culture and environment with a lot of Conservative and Christian representation. *"We're a tad more liberal than our west and east and northern neighbors, so a lot of them come to us. But, you know, we still have plenty of crisis pregnancy resource centers out there. I had to go to one, and, you know, a lot of people depend on them for, you know, STI services and stuff like that, because they're free, because they're still government funded, whereas we are not" (Phone Advocate).* The impact of being in the southeast creates an obstruction by conservatives particularly those that are Christians which leads to barriers to abortion care. The identity of lawmakers in terms of being primarily men and of the dominant racial/ethnic group (white) was of concern. Providers questioned their ability to truly relate to individuals of color that are primarily being affected by these gestational bans.

Georgia was described as a state of importance in abortion care because in comparison to neighbors in the southeast there is relatively better abortion access. Lastly, in the participant mentioning crisis pregnancy centers, we see this reliance on government-funded, non-evidence-based crisis pregnancy centers for basic sexual and reproductive health services.

Lastly, concern emerged over the emotional and mental health impact on pregnant people whose bodily autonomy is denied. Participants described how the decision to have an abortion is already emotionally charged and restrictions create additional psychological consequences for patients. Participants urged consideration of the environment these kinds of regulations create for patients: *"This kind of legislation only further reinforces that stigma of shame in a patient's mind. Even if they don't know about this specific bill, they know about restrictions about abortion. Even if it's not something that consciously weighs on them, I would imagine it's*

something that subconsciously does, because that's your literal government telling you that what you're doing is wrong, so wrong that I'm going to now tell you what you can and can't do with your body"(Health Educator).

On the provider level emotional and mental burden was the most apparent. Policies like HB954 reinforce stigma and shame providers often feel from working in abortion care. This described burden was connected to not being able to provide the best health care. Additionally, external conditions such as the presence of protestors outside the clinic and being surrounding by anti-abortion rhetoric contributed to the described mental and emotional toll. This impacts the environment of the clinic, the patients and the providers. Providers were forced to adapt accordingly, because noncompliance with the bill would be criminal. Fear of criminalization poses a direct threat to our quality of care and type of medical attention given to patients.

After HB954, Providers Turn Away Patients with Great Consequence

Participants frequently described having to "turn away" patients who were over the gestational limit, particularly the challenges that arise when a patient has to be referred out of state or denied care altogether. Participants also noted that patients may need to secure the means to travel, which often presented additional financial burdens. *"What I notice, once the patient scans too far… they have to get that referral to proceed, it becomes more of a financial issue, because the price goes up. Then they have to incorporate travel fees to be able to proceed with the procedure. Once you're under 22 weeks, often, a lot of times, there's a facility that isn't far out the way from the patient or it's within their scope to be able to get to that facility to proceed"* (Medical Coordinator). A sense of helplessness among participants also emerged, because legally there is not much providers can do. Participants described that some neighboring states have higher limits, but that it is not realistic for every patient to seek that care elsewhere. *"Like I*

said, it affects us in the sense that if a woman measures up, then there's nothing we can really do. The only care that they got that day was just being in front of going through the ultrasound. I think that puts us in a pickle with having to explain or refer them to another state that goes higher, because they don't have the means to travel to that state…"(Health Educator/Admissions).

Abortion care and more broadly health care as described by participants is highly state dependent. If abortion regulation was operating under scientifically guided evidence, then a level of standardization would be present. Variability is concerning because the type of care you receive in one geographical location should be comparable to one in another. But we know that due to the presence of structural inequities this not the case. If better care is only available at a distance, then we see how restrictions are inequitable for communities without the economic means to travel out of state for care.

Providers also called patients telling them that they would take matters into their own hands. One participant explained they *"had somebody on the phone once ask, "How many weeks do you all go up to?" and I said, "21 weeks and 6 days, which is the maximum number in the state of [State 1]." She was like, "I'm living in another state. What about this state?" I was like, "I can give you a number. Unfortunately, in your state you're not going to be able to be seen there, but I can provide you a number." She was like, "If I drank bleach, would that terminate the pregnancy?" So, like you see desperation. You hear desperation" (Health Educator).* This quote and others like it demonstrate how abortion restrictions can cause self-managed abortion. The desire to terminate a pregnancy does not stop at the provider level and can include the use of unsafe potentially lethal methods like drinking poisonous bleach.

After HB954, Providers Experienced More Emotional and Mental Burden

A final theme was the emotional and mental burden faced by abortion healthcare providers. As described in the previous section, many participants mentioned they know that women will take matters into their own hands, and talked about the impact this had on themselves. Providers described very vivid memories of patients pleading for care: *"I would just say it just takes an emotional toll on us, having to turn women away. There are just really difficult, heartbreaking circumstances, and we all know that morally, we think the right thing to do would be to provide care to patients seeking it, and our hands are tied, and we can't. And we feel heartbroken for the patients and their circumstances. And it's also stigmatizing to us"* (*Director)*.

As providers, the patients' well-being is at the forefront of their practice and to have policies that intervene with this goal makes it incredibly difficult to provide high-quality care. This once again also stigmatizes providers and not just their patients. Another participant explained, *"Putting physicians into a position where they, instead of making decisions to protect the lives of pregnant people and their choices, versus having to make a choice that – For example, if they think that the safest thing to do for this person's life would be to terminate the pregnancy so that the mother is safe, it's unfortunate that because they're making a decision to save someone's life, they may have to serve time in jail. It's just absurd, makes me angry that there are any laws coming between a physician and her patient" (Director of Nursing).* This final quote echoes themes of political and legislative interference into the health care system. The risk of criminalization creates serious implications to delivering healthcare and de-prioritizes medical practice based on scientifically established safest practice.

Chapter 4: Discussion

Summary of Findings

The results of this study indicate that House Bill 954 created observed impacts on providers and their provision of abortion related services. Providers were concerned about the threat to patients' bodily autonomy such legislation creates and expressed their experienced emotional and mental strain. In some instances, this strain was related to having to turn patients away and in others was due to the environmental nature of abortion work. Stigma existed as a big component of the difficult environment abortion provider navigate. Further, the lack of consensus between legislation and science was discussed as a point of frustration and fear for the perpetuation of medical misinformation. It was lastly found that decisions made at the policy level were interconnected to both the provider and patient experience. Despite the mentioned challenges, providers continue to display extreme commitment and advocacy for the health of their patients. These findings parallel and add to knowledge from the current literature, specifically around our understanding of how abortion legislation affects abortion providers; findings also indicate gaps in the literature and needs for future research.

Legislative Interference

In a 2015 qualitative analysis of abortion providers in North Carolina exploring the women's right to know law, provider level challenges closely resembled those found in this study [64]. For example, providers expressed resentment towards the regulation of medicine as a practice by politicians that have little to no medical knowledge [64]. This was also reflected in the results of this many providers expressed a large disconnect present between the legal and medical community.

Mercier et al.[64] also described finding that providers felt the intention of the law was to

discourage women from obtaining abortions. By restricting access and providing misleading information. The interviewed providers also felt that the North Carolina law was highly intrusive and politically motivated. The study authors described a change in the way providers administered health care after the implementation of the law, resulting in this described burden. Mercier et al. [64] describe that the burden the law places shifts from the patient to the provider, ultimately resulting in a degree of personal and professional strain. As a way to remain adaptable and up to the date with the law, providers start to adopt a form of "normalization." They warn that normalization may result in desensitization of providers. The burden expressed by providers in North Carolina is similar to that described in the current study, particularly the mental and emotional burden of having to deny or withhold care. Given the potential for desensitization and the similar burdens, found in Georgia providers this presents serious implications. Georgia providers may also be at risk for increased strain and burnout, and there needs to be supports to help providers' resilience and continual focus on patient centered care

Abortion Providers' Role in Abortion Laws

Providers in this study expressed concern with the direct threat to patients' bodily autonomy such legislation imposes. Despite this concern, there was intense optimism and determination to continue doing what they can to provide quality care. The ongoing threat caused by restrictive legislation has given rise to a wave of activism that has been community and provider based. Advocates are finding ways to advocate for the rights of their patients to make decisions regarding their own health. Limitations are however present to the extent in which providers can advocate, particularly when there is the threat of criminalization. A 2019 commentary paper by a series of Family Medicine physicians convey that fear [33]. They explain that laws with criminalization present discourage providers and future clinicians to even practice

in abortion care. This ties into limiting patents access to comprehensive reproductive health care especially in a system that already faces a lot of strain [33]. This fear also ties to this idea of normalization mentioned previously and was a component of the study findings. Ultimately patients have to maintain control of their own health and providers serve the purpose of supporting them through that decision process. Without the recognition of people and patients as autonomous, we risk external individuals and decisions dictate the outcome of such an important topic.

United States Political Environment

Providers in this study pointed to the political climate of the South as part of the reason the HB954 exists. The southern United States, as mapped out by the Guttmacher Institute, is comprised of many states labeled as "hostile" grounds for reproductive health care [65]. The political hostility and hinderance in medical practice described by providers in this study aligns with Guttmacher's findings and reveal the harm such environments poses on medical practice and the delivery of quality services of health. This hostility towards abortion has existed as a wave across the United States and continues to present a different set of challenges each year. Limitations are put in place that continue to move the needle closer to achieving a total ban on abortion. This progressive restriction was noted by the interviewed providers and presents a challenge in making sure patients and providers stay up to date with current practices.

Gestational age limits and similar restrictions contribute to the need to turn patients away at time. When patients have to be turned away discussion has to happen over the lack of support especially financially in abortion funds. Abortion funds and lack thereof play an important role in mitigating access to abortion care. In the Southeast particularly where there are increases in restrictive abortion policies. Organizations such as ARC-Southeast distribute funds and other

abortion care support services in states that are categorized as “hostile” to reproductive health [66]. Their capacity is however limited and there is need for comprehensive support both for these types of organizations and patients being turned away.

Abortion Stigma

Abortion stigma as defined by Kumar et al. [51] is a negative attribute that is ascribed to people who seek to terminate a pregnancy and in turn marks them as inferior to set ideals of “womanhood”. From this definition came the work of Norris et al., [67] which looked into how abortion stigma begins to impact abortion providers and more generally those that support abortion rights. Norris et al., [67] identified four other causes of abortion stigma those being 1) attributing personhood to fetus 2) Legal restrictions 3) the idea that abortion is dirty or unhealthy and 4) the use of stigma as a tool for anti-abortion efforts. The attribution of fetus to personhood was reflected within this study and is a primary component of the language of HB954. Such attribution pushes the image of a fetus as fully alive human and creates a separation of the fetus from the pregnant person on which it depends. This also contributes to this prioritization of fetal survival over autonomy and wellbeing of the pregnant person.

Moreover, stigma of abortion providers creates marginalization and isolation within the medical community which further fuels violence and harassment aimed at abortion care providers [68]. This contributes to an inadequate number of providers in many areas of the United States, and this described stigma contributes to the training-provision gap and reluctance of health care providers to pursue some form of abortion care in their practice [68]. The combination of the lack of enough providers compounded with pervasive stigma and experienced harassment all contribute to burnout and mental and emotional toll. The abortion stigma literature explains stigma is enacted from the individual level all the way to the structural level. And the findings of

this study demonstrate how that mechanism works.

Strengths & Limitations

A primary strength of this study was the variety of abortion provider types that were interviewed. Types ranged from nurses, techs, and physicians to those in more administrative positions. This allowed a glimpse into different points of entry into the healthcare system and demonstrates the extent to which HB954 was felt. In addition, the presence of qualitative in-depth interviews allows for a detailed narrative of these individuals and gives us personalized stories. Another strength is this context-specific information that adds another layer to our understanding of abortion in the Southeast and particularly Georgia. However, as a result of the nature of qualitative work the findings are not generalizable to the population at large, either in Georgia or with similar gestational age bans in other states. Moreover, given that these interviews were collected from healthcare providers we cannot draw extensive connections or assumptions about the patient experience. Interviewing patients would allow for exploration of direct implications at the patient level.

Chapter 5: Conclusion and Recommendations

Policy & Program Recommendations

Given the unlikelihood of a complete reversal of the ban, our recommendations focus on how to decrease harms perpetuated and exacerbated by the ban. These results, taken in tandem with previous research, indicate a need to change the language utilized in gestational age bans. For instance, terms such as “unborn child” should be removed and replaced with medically utilized language such as “fetus.” Language like “unborn child” is often used by anti-choice individuals and further stigmatizes abortion. Another example of medical terminology is the use of “Last Menstrual Period” as a standard way to determine gestational age. Some state laws

consider “fertilization” the point when pregnancy begins, but fertilization is two weeks before LMP[4]. Abortion legislation should also incorporate medical providers in the drafting and writing of bills. This collaboration would help ensure that what is voted into law is supported by scientific evidence.

Next, a programming recommendation that stems of funding would be the expansion of funding sources that can be used towards abortion services. These would help reduce access to care. Lastly, given the impacts on providers the provision of resources and support systems are imperative. Support has to be present while providers are training in order to incentivize entry into abortion care. Moreover, resources have to accompany to assist in navigating the known stigmas and potential presence for backlash. We have to consider how to train providers that are motivated and supported to continue working in this area.

Future Studies

Future studies could build off the limitations of this study by first interviewing patients, to examine direct narratives related to the implications of the bill on patient experiences. Future research could also examine legislator perspectives on research findings, and processes that accompany the drafting of such bills. Another study could examine differences between types of gestational age limits across different states, looking at similarities and differences in implementation and subsequent health care level effects. Next, given the lack of research in the role abortion providers have in abortion legislation. A study could qualitatively investigate provider involvement in legislative drafting or advocacy. The study could also look at the extent to which providers want to be involved in the process. This would help in understanding how much potential there is for the collaboration between legislators and providers. Finally, research could employ additional methodologies to strengthen and supplement findings; for instance,

making use of focus group discussions according to abortion provider type to gain a collective narrative on differences in implications by provider role.

Conclusion

In conclusion, interviewed participants primarily discussed House Bill 954 from a place of concern and frustration, with detrimental impacts described at patient, provider and political levels, and the largest concern the disconnect present between the legal and medical community. This type of disconnect contributes to the incorporation of medically inaccurate information in bills. Ultimately, the situations and stories shared by providers do not exist in silos; this heaviness carries on as they continue to see other patients and has real consequences to the type of care that is provided. Abortion providers are also subject to a hostile environment from protesters outside of their clinics and others that lobby against their practices. By observing the patient and provider level implications of HB954, we can start to contextualize what it means on a social, cultural and political level.

Appendices

Appendix 1: In-Depth Interview Guide

Abortion Clinic Staff

In-Depth Interview Guide, 22WB

[Start recording on both devices]

Do you consent to participate in this interview?

Do you consent to be recorded?

Date:

Start time:

End time:

Thank you again for taking part in this study. As a reminder, our discussion will be completely confidential. In this interview, we use the term later abortions to refer to abortions that take place after 22 weeks from last menstrual period (LMP). Interviews will take approximately one hour. All responses will be confidential, and there are no right or wrong answers. Participating in this interview will not impact your work, either positively or negatively.

Abortion Care Generally

First, I'd like to know a bit about your professional background, experience at [*clinic*], and your experiences with providing abortion care.

1. *Introduction/warm-up*
    a. What's your current role or title here at [*clinic name*]?
        i. Probe: Do you hold any different jobs or titles here (for example, clinic administrator and Director of Nursing)?
    b. What are your main responsibilities in this position (-*OR*- these positions)?
    c. How long have you been working in reproductive health care?
        i. How long have you worked at [*clinic name*]?
    d. How long have you been working in abortion care specifically?
        i. How long have you been working in abortion care at this particular organization?
        ii. Probe: Have you always held the same position here? If not, what other positions have you held?
    e. Please describe the patients that you serve at your clinic.
        i. Probe: For example, could you tell me about patients' ages, race and ethnicities, and languages spoken?
        ii. Probe: What percentage of patients would you say come from out-of-state?
    f. Do you work at any other facilities that provide reproductive health care?
        i. [*If yes*] Probe: Please tell me more about the role you held in those facilities.
    g. Have you provided reproductive health care in other states besides GA?

i. [*If yes*] Probe: How did that experience compare with your work here in GA? Were there any similar/different challenges to providing reproductive or abortion care?

2. *Experience in providing abortion care*

    a. What made you decide to work in abortion care?

    b. Why have you continued working in abortion care?

    c. What is a typical day like for you providing abortion care?

        i. Probe: What are the major tasks you complete in your job on a typical day?

    d. What challenges do you face in your job?

    Probes: Are these challenges related to your schedule? Patient-specific issues?

    Probe (**for director/administrator**): What financial challenges do you face in your job?

    e. What makes your job rewarding?

    Probes: Your colleagues, the patients, etc.?

    f. What are some reasons that you think patients choose to come to this clinic for abortion care?

Later Abortion Care

Thank you so much for sharing these details with me. I am now going to ask you some questions related to your perspectives and experience with providing later abortion care.

1. *Perceptions of and attitudes toward later abortions*

    a. How do you feel about clinics providing abortions at later gestational

ages?

i. Probe: Do you see benefits or drawbacks for the clinic? For patients?

b. What challenges do women face when seeking later abortions?

i. Probes: Access to abortion facilities? Cost of abortion? Emotional issues? Support from family or friends?

c. What factors make it easier for women who seek later abortions?

i. Probes: Facility-specific factors? Support and other emotional factors?

d. What challenges do healthcare professionals who offer later abortion care face?

i. Probes: Facility-specific challenges, such as security, location of facility, etc.?

ii. Probes: Personal issues, such as pay, feeling of being unsafe on the job, lack of family or social support for providing abortion care?

e. What factors make it easier for healthcare professionals who offer later abortion care?

i. Probes: Facility-specific factors, such as location of clinic, strong security measures?

ii. Probes: Personal factors, such as good pay, strong family, or social support?

f. How do patients who seek abortions after 22 weeks compare to patients who seek abortions before 22 weeks?

i. Probe: How are they similar?

ii. Probe: How are they different?

g. Do you think that women seeking later abortions receive the same quality of care that women seeking earlier abortions receive? Please explain why or why not.

h. In terms of legal differences, how do you think later abortion care in GA differs from other states?

2. *Experiences providing later abortion care*

a. [*If staff member involved in or knowledgeable about appointment-making process*]: Please walk me through the process of assisting a woman who is seeking an abortion at or past 22 weeks.

i. [*Participant may respond that they cannot make these appointments in their clinic; if so, use the probes below as needed to get more details on how any referrals are made*]

ii. Probe: What information is provided to the woman?

iii. Probe: Who in the clinic makes this appointment for her?

iv. Probe: How long must she typically wait before an appointment is available?

b. How is providing abortions after 22 weeks similar to or different from providing abortions before 22 weeks?

i. Probe: Are there special requirements, considerations, or practices?

ii. Probe: How is it different for your patients? For you?

c. Are there specific circumstances that make you more or less comfortable providing later abortions?

Abortion Legislation and HB 954

1. *General abortion legislation*
    a. What is your understanding of laws related to regulating abortion care in GA? How about in other surrounding states?
        i. Probe: For instance, are there laws that affect women? Laws that affect providers/organizations?
    b. From your perspective or understanding, how, if at all, have the laws regulating abortion care in GA changed in the last 5 years or so?
    c. Why do you think GA regulates abortion?
        i. Probes: Are these reasons motivated by clinical decision-making? Ethical concerns? Religious concerns?
    d. How do you feel about these laws?
        i. Probes: What are the negative or positive consequences of these laws on your patients? On your clinic? On you?
2. *HB 954*
    a. What is your understanding of HB 954 (i.e. 22-week ban)?
    b. How much do you think your patients seeking later abortion care know about HB 954 and its requirements?
    c. What is your perception of how HB 954 affect your patients?
        i. Probe: Patient satisfaction?

ii. Probe: Patient physical health? Mental health?

iii. Probe: Relationships with family/partners?

iv. Probe: Financial status/employment?

v. Probe: Social well-being?

d. Please describe how your clinic implements the requirements of HB 954.

i. Probe: Have clinic staff/providers found it easy to implement?

ii. Probe: Have clinic staff/providers found it difficult to implement?

e. Please describe the administrative and reporting requirements around HB 954.

i. Probe: What are the benefits associated with these requirements?

ii. Probe: What are the challenges associated with these requirements?

f. The bill requires that, (and I quote) "the method of abortion used [at 22 or more weeks from LMP] was one that, in reasonable medical judgment, provided the best opportunity for the unborn child to survive." How do you feel about this statement?

i. Probe: How would you interpret this statement? How do you interpret it as it affects your work?

g. The bill defines "criminal abortions" as those provided outside of the acceptable scope of abortions according to HB 954. HB 954 specifies that, "a person convicted of the offense of criminal abortion shall be punished by imprisonment for not less than one nor more than ten years." What do you think about the language in the bill regarding punishing providers who

provide “criminal abortions”?

3. *Changes in service delivery and practice with HB 954*

    a. How does HB 954 affect your and your organization’s ability to provide abortion care?

        i. Probe: What are the financial or operational consequences of HB964 on your clinic?

        ii. Probe [*if not already described*]: How does HB 954 affect your patients?

        iii. Probe [*if not already described*]: How does HB 954 affect your providers/staff?

        iv. Probe: How, if at all, has HB 954 changed your clinic’s practice?

            1. Number or type of patients?
            2. Distribution of types of services provided?
            3. Clinical and administrative practices?
            4. Clinic work environment?
            5. Financial viability of clinic?

    a. Have you noted any additional changes to the clinic or your work since HB 954 was passed?

        i. Probe [*if not already described*]: Any specific changes in clinical protocols?

    b. Have you had to turn away later abortion patients as a result of HB 954?

        i. [*If yes*] Probe: What were the reactions from the patients?

ii. [*If yes*] Probe: What kind of follow-up was done with these patients, if any?

iii. [*If no*] Probe: Why not?

c. Have your organization's relationships with other healthcare providers (e.g. publicly-funded, private, safety-net, etc.) changed since HB 954 was passed?

i. Probe: Referrals?

ii. Probe: Interactions with different types of providers/organizations?

4. Is there anything else you think is important for us to know related to GA's abortion ban that we haven't already discussed?

Okay. That completes the interview. Thank you for taking time to talk with me today and taking part in our study.

Appendix 2: Codebook

Code	Patients Turned Away
Brief Description	This code captures references to: • Inability to provide patient care or services as a result of gestational age • Referral to out of state or other facilities
Use for	Descriptions of turning away a patient (either themselves, a provider they work for, or the facility)

Code	Intent of Reqs
Brief Description	• Perspectives on why GA, other states, and/or the US regulates abortion care
Use for	Discussions on the purpose of abortion regulation (E.g. to protect residents, to make abortion more difficult to attain)

Code	Abortion Evidence
Brief Description	This code captures references to: • Medical or scientific information or lack thereof that informs policies on abortion care
Use for	Impact and connection of medical and scientific information on abortion care policies
Do Not Use for	Personal patient misinformation, misinformation that is specific to the abortion experience

Code	Reproductive autonomy/agency
Brief Description	This code captures references to: • Observed influence policy has on bodily autonomy and agency • Power and ability to decide pregnancy and childbearing
Use for	Internal and external factors related to patient decision making

Code	Policy Differences
Brief Description	This code captures references to: • Comparisons of policies and regulations based on facility or state
Use for	Direct comparisons made between abortion provision context

Code	Attitude Towards Bill
Brief Description	This code captures references to: • Abortion clinic personnel's personal attitude and beliefs towards the bill
Use for	Discussion of emotions related to the legislation

Code	Unintended Consequences
Brief Description	This code captures references to: • Aftermath of the bill
Use for	Implications that have been derived from the bill

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