Addressing a Crisis in Abortion Access
A Case Study in Advocacy

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As restrictions on abortion increase nationwide, it is critical to ensure ongoing access to abortion care throughout pregnancy. People may seek abortions later in pregnancy as a result of financial or legal barriers that delay care or because of changing circumstances, such as the status of their partner, the health of other children, employment, or a new fetal diagnosis. New York State has been a beacon for abortion access since 1970. Yet, after Roe v Wade was decided, New York State abortion law was not in compliance with federal law, and risk-averse medical institutions hesitated to provide later abortions, forcing patients out of state for care. After years of advocacy, the Reproductive Health Act was passed in 2019. Clinicians and advocates collaborated to translate policy into expanded practice at NYC Health + Hospitals, the largest public health care system in the United States. NYC Health + Hospitals conducted an internal review, identified barriers to abortion care, and addressed these through improvements in public and internal communication, strengthening of procedural skills, and a better referral system. As a result, abortion services have become visible and the system’s capacity and gestational age limit have expanded. The example of NYC Health + Hospitals is an instructive model to ensure that abortion care is provided to the most vulnerable patients, including those who need care later in pregnancy. Given the ongoing threat to reproductive rights, this example of expanded access is particularly timely.

On December 1, 2021, the U.S. Supreme Court heard arguments in a Mississippi case, Dobbs v Jackson. Experts who listened to the arguments and questions from the Justices agree that the current federal protections for abortion established by Roe v Wade (hereinafter “Roe”) will be significantly weakened. Access will be particularly restricted for people who need abortions later in pregnancy. In 2021 alone, there have been 108 abortion restrictions enacted in 19 states, the highest total in any year since the 1973 Roe decision, most of which dramatically reduce the upper gestational age for abortion care. Prohibiting abortion does not remove the need for abortion, but instead exacerbates the economic stratification between who can and cannot access care. People need later abortions for many of the same reasons people need abortions earlier in pregnancy. Studies show that many of those who seek abortion care after 20 weeks of gestation wanted an earlier abortion but faced financial hurdles and legal barriers, including the need to travel for care. For others, new information such as a fetal diagnosis may arise later in pregnancy. And for others still, circumstances change and a wanted pregnancy becomes untenable, for example when a partner leaves or dies, a young child develops a serious illness, or someone in the family loses their job or health insurance. In all of these circumstances, the ability to access later care is essential and yet has constricted over the past decade. It is anticipated that at least 22 states will quickly restrict abortion if the Supreme Court weakens federal protections, either following Texas’ example of banning abortion after an early point in
pregnancy or falling in step with a currently enjoined Alabama law banning all abortions. These bans will result in people from these states traveling long distances to access services and will place a burden on clinicians who provide abortion in neighboring states, particularly for later abortion care.\textsuperscript{9}

It is critical that facilities expand their capacity to provide abortion care to those who will travel for care wherever possible. This article highlights the effort of the public health care system in New York City to expand access to later abortion care.

\textbf{BACKGROUND}

New York State has historically been considered a beacon for abortion access. New York State permitted abortion in 1970, 3 years before \textit{Roe}. However, after \textit{Roe} was decided in 1973, New York State law fell short of constitutional protections with respect to later care. The 1970 state law criminalized care after 24 weeks from the commencement of pregnancy unless a person’s life was at risk.\textsuperscript{10} This meant that, even though \textit{Roe} and subsequent cases protected care later in pregnancy when a pregnant person’s health or life is at risk or a fetus is not viable, risk-averse medical institutions in New York State were reluctant to provide later care in those instances. As a result, pregnant people and their families were forced to travel to distant states such as New Mexico and Colorado to seek later abortion care, far from the support of family, friends, and familiar physicians and at great financial cost, stress, and additional health risks.\textsuperscript{11}

Despite the legal challenges, over the past decades, advocates and health care professionals in New York City and New York State worked to expand access to care. This included interviewing health care professionals to better understand access points and needs, convening physician roundtables, and strengthening referral networks. Furthermore, attention was given to creating residency training initiatives,\textsuperscript{12} seeking legal opinions from the New York State Attorney General to clarify health care professionals’ scope, and creating the first-in-the-nation direct municipal funding to individuals for abortion care.\textsuperscript{13} However, access to later care did not improve, as evidenced in an informal New York City physician survey done by advocates in 2015, which revealed that hospitals were not providing care after 24 weeks of gestation, except for specific maternal or fetal indications, and only one ambulatory facility was providing care up to 26 weeks of gestation. Finally, after more than a decade of advocacy, in 2019, New York State passed the Reproductive Health Act.\textsuperscript{14}

The Reproductive Health Act made three principal changes to New York State’s abortion law. It 1) removed abortion from the criminal code; 2) clarified that advanced practice clinicians such as physician assistants, nurse practitioners, and licensed midwives may provide abortion care within their scope of practice; and 3) created protections that allow for abortion up to 24 weeks from the commencement of pregnancy and throughout pregnancy when the patient’s life or health is at risk or in cases of fetal nonviability. Advocates and clinicians have been working with the New York State Department of Health to create guidance interpreting the Reproductive Health Act’s parameters. The guidance was newly released on May 6, 2022 in the form of a letter from the Commissioner of Health, and it aligns with federal policy (eg, 45 CFR § 46.102) and the “ReVITALize: Gynecology Data Definitions” endorsed by the American College of Obstetricians and Gynecologists and numerous other respected national organizations, placing the “commencement of pregnancy” at implantation of a fertilized egg.\textsuperscript{15} This will have a significant effect on clinical practice, placing “24 weeks from the commencement of pregnancy” at 27–28 weeks from the last menstrual period, as opposed to the previous interpretation of 26 weeks from the last menstrual period. Furthermore, this guidance aligns with the Supreme Court’s broad definition of health,\textsuperscript{16} which supports individualized decision making between patient and health care team throughout pregnancy.

However, policy and legal changes do not automatically result in changes to medical practice. Determined New York City advocates worked closely with hospital and ambulatory clinicians who provide abortion to mobilize expanded services allowed under the Reproductive Health Act. One example of this successful collaboration is the expansion of abortion care within NYC Health + Hospitals.

\textbf{CASE STUDY: NYC HEALTH + HOSPITALS}

NYC Health + Hospitals is the largest public health care system in the United States, comprised of 11 hospitals (see Box 1), five long-term care facilities, a certified home health agency, and more than 100 community health centers. Its mission is to deliver high-quality comprehensive health care services to all with compassion, dignity, and respect. The health care system provides essential inpatient, outpatient, and home-based services to more than 1 million New Yorkers annually. NYC Health + Hospitals recognizes abortion as an essential and necessary component of comprehensive care, and abortion care is available at all of the hospitals; however, these
services have expanded and contracted over the years, largely as a result of staffing changes, loss of institutional knowledge, competing priorities, and the evolving political landscape. Interpretations of New York State’s previous abortion law allowed for abortion care for any indication up to 26 weeks of gestation; yet, by 2019, when the Reproductive Health Act was passed, many staff were unaware of the existing legal parameters that regulated abortion, and few health care professionals had the clinical experience to provide care beyond 24 weeks of gestation, leaving a gap in care beyond that point. Furthermore, each hospital had its own organizational politics related to historical practices, unique patient communities, and current leadership views. However, NYC Health + Hospitals clinician–advocates identified strong supporters of reproductive rights at the systemwide leadership level and, with their endorsement, moved forward on expanding abortion access. Supported by policy advocates, these clinicians assessed existing barriers to care and created a strategic plan around communication, skill-building, and accessibility to expand abortion services to more fully align with the Reproductive Health Act.

COMMUNICATION

The first critical barrier identified was a lack of knowledge among patients and physicians about the abortion care NYC Health + Hospitals provided. Patients often went elsewhere for abortion care. Owing to communication challenges within the vast health care system, there was also low clinician awareness about abortion services. To improve patient awareness, clinician–advocates worked with the hospital communications team to edit patient materials to provide clear and accessible information about abortion on all websites, social media, and printed materials. To target awareness on the provider side, clinician–advocates provide ongoing presentations to give real-time clarification to clinicians and staff regarding what the Reproductive Health Act means for patient care. Additionally, the systemwide policy on abortion later in pregnancy, which was first written in 2003, was revised by a working group comprised of family planning directors from several hospitals. It was updated to align with the Reproductive Health Act and then approved by hospital legal counsel. It is being circulated to physician and nursing leadership to bring people up to date on current New York State law.

ENHANCING PROCEDURAL SKILLS

NYC Health + Hospitals clinicians also identified gaps in procedural skills that needed to be filled to expand services. Training for later abortion care is limited by the small volume of cases, the narrow specialization of care, and the misinformation and stigma about these services that exists within the medical community. To build clinician skills and participation, two educational projects are underway. The first is the development and implementation of training for physicians on administering feticidal injections. Although inducing fetal death is part of the clinical process for abortions after 24 weeks of gestation in NYC Health + Hospitals, the injection procedure is not a standard part of obstetrics and gynecology residency or family planning fellowship training. Abortion services historically have relied on maternal–fetal medicine specialists to perform this procedure; however, this depends on these specialists being comfortable participating in later abortion care. Training physicians who provide abortion services in the injection procedure will reduce the reliance on outside specialists. The second project focuses on the expansion of surgical skills needed to provide later abortion care. To facilitate training, physicians have been credentialed at multiple sites, allowing practitioners who are the sole providers of later abortion care at their facilities to find support for skill expansion outside their home institutions. Building a cadre of trained clinicians who provide abortion services who are able to administer injections and perform abortions across the pregnancy spectrum will solidify access to later abortion care within the health care system.

ACCESSIBILITY

Abortion is a time-sensitive service that requires appropriate and timely referral. The clinician–advocate team identified several obstacles within the

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**Box 1. NYC Health + Hospitals Acute Care Facilities**

| Bronx          |            |
|----------------|------------|
| NYC Health + Hospitals/Jacobi |            |
| NYC Health + Hospitals/Lincoln   |            |
| NYC Health + Hospitals/North Central Bronx |            |
| Brooklyn        |            |
| NYC Health + Hospitals/Coney Island |            |
| NYC Health + Hospitals/Kings County |            |
| NYC Health + Hospitals/Woodhull |            |
| Manhattan       |            |
| NYC Health + Hospitals/Bellevue  |            |
| NYC Health + Hospitals/Harlem    |            |
| NYC Health + Hospitals/Metropolitan |        |
| Queens          |            |
| NYC Health + Hospitals/Elmhurst  |            |
| NYC Health + Hospitals/Queens    |            |
existing referral network. There was no effective communication pathway to support timely referrals, nor a central, identifiable referral pathway for external health care professionals. In addition, because care can be cost-prohibitive for patients, seamless connections to sources of financial support such as abortion funds are a critical part of the referral system, but they were absent. To improve accessibility, NYC Health + Hospitals created a new, nimble referral system that can reduce logistical barriers to care. This referral system was built by a team comprised of physicians, administrators, members of the electronic medical record team, and data analysts. This new system integrates a patient’s geographic preference and gestational age to ensure an appropriate and timely referral. The health care system is also liaising with abortion funds to facilitate financial support for patients who face financial barriers to care.

Additionally, NYC Health + Hospitals created a new position of “Client Navigator,” following a successful model that was created in Massachusetts. The Client Navigator’s primary role will be to accompany patients who need logistic or financial support through their abortion care experience, linking them to necessary resources and ensuring timely access to care. The Client Navigator will also support health care professionals both inside and outside the public health care system who are seeking referrals for their patients. This position has been filled and onboarding is underway.

CONCLUSION

In the past 6 years, NYC Health + Hospitals has successfully made abortion services more visible to the public by citing them in public speeches, clearly explaining them on their website, and adding information about these services in patient materials. The health care system added two institutions to the list of hospitals providing abortions at more than 20 weeks of gestation and expanded systemwide capacity to provide abortion care up to 26 weeks of gestation. The number of clinicians who provide abortion care has grown with internal training and changes in hiring priorities, resulting in 10 new providers. Further, there is now a strong network of health care professionals across institutions involved in a systemwide Reproductive Health Working Group, which creates policies and cross-institutional support. This working group consists of family planning leaders from several institutions within the system and serves as a team of experts that sets medical standards for the system and liaises with individual institutions. The group has created systemwide guidance for medication abortion, later abortion, and long-acting reversible contraception. Each institution has expanded access in an individualized way depending on local politics. Future systemwide goals include expansion of abortion services to include the option of induction termination and expanding beyond 26 weeks of gestation. With this measurable progress, NYC Health + Hospitals is increasing access to abortion care for people in New York City who need this critical service.

Replication of this model in other hospital systems where allowed by law is urgent. Given the ongoing threat to abortion access stemming from the Supreme Court and state legislatures that continue to pass restrictions aiming to eliminate care, it will take a national movement of health care professionals to create sustainable abortion access. The internal advocacy by NYC Health + Hospitals clinicians, supported by state-based advocates who helped to clear legislative and regulatory barriers, is a clear example of how to provide and expand abortion care for the most vulnerable patients, including those in need of care later in pregnancy. To ensure that the right to abortion does not become a hollow promise, health care systems must evaluate and address barriers, review and expand policies, and build coalitions with local advocates, supportive lawmakers, and abortion funds so that high-quality abortion care is a reality for all our communities.

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