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Exploring Barriers to Performing Abortion Past 24 Weeks Among California Abortion Providers

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spiritual resources (including doulas and support groups) and detailed aftercare instructions to be included with product and/or through an affiliated hotline/textline. Participants also discussed how it could be useful to be able to ask questions to a trusted and trained pharmacist.

Conclusions: Findings from this study build on existing findings that show growing interest in a potential OTC medication abortion model. Participants' perspectives about benefits, concerns, and resources needed for OTC medication abortion can help inform ways that we can begin building toward a future where everyone has access to the abortion care they want. While there are immediate threats to medication abortion in the United States, this formative research can help us lay the groundwork for a more inclusive and accessible future for abortion care, as well as highlight strategies to improve medication abortion experiences in this current moment.

Poster Abstract 15: Exploration of Post-Abortion Contraception Choice by Insurance Status

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Introduction: Providing patients access to contraception post-abortion is safe, is effective, can help better meet patients' fertility preferences, and can minimize the burden of multiple appointments. Federal Medicaid regulations make prescription contraception broadly available. However, using Medicaid for post-abortion contraception is more complex to navigate and presents billing issues, questions of which rules to apply when patients travel to states with different policy environments, and unclear reimbursement guidelines for contraception given during telehealth abortion. In this study, we assess differences in post-abortion contraception uptake by insurance type and state Medicaid policy for abortion patients across Midwest states.

Methods: This retrospective cohort study uses electronic health record data from January 1, 2019, to December 31, 2024, of abortion patients at Planned Parenthood North Central States clinics (Minnesota, Iowa, South Dakota, and Nebraska). We excluded patients if their pregnancy ended in miscarriage, was ectopic, or if they were receiving treatment for a failed abortion. We hypothesized that abortion patients who qualify for Medicaid are more likely to choose non-prescription and prescription methods of contraception such as condoms and oral contraceptive pills over methods that require additional clinic visits to obtain, such as methods of long-acting reversible contraception (LARC). We compared people who do not qualify for Medicaid (control) with people who qualify for Medicaid (comparison) and performed within-state comparisons. We report demographics and chi-squared tests to describe the population sample and estimate between-group post-abortion contraception choice differences.

Results: A total of 63,477 patient records were analyzed. Minnesota allows Medicaid coverage of abortions while Iowa, South Dakota, and Nebraska prohibit it. Forty-seven percent of the sample did not qualify for Medicaid while 53% did qualify for Medicaid in their state of residence. More than half of the sample (58%) received an abortion in Minnesota followed by Iowa (11.5%), Nebraska (7%), and South Dakota (1%). Approximately 76% live in the Midwest and > 1% live in some other region. Patients who qualified for Medicaid were mostly 18–24 years old (16.5%), white (18%), single (35%), and English speaking (38.5%). Eleven percent of the sample has a country of origin outside the United States. There were statistically significant differences (< 0.0001) in contraception choice between patients who did and did not qualify for Medicaid and type of abortion. Patients who qualified for Medicaid chose methods of LARC more often than those who did not qualify for Medicaid. Abortion patients who did not qualify for Medicaid chose pills, rings, fertility awareness, partner methods, and no method more often than their Medicaid qualifying counterparts.

Conclusions: Despite the varying policy environments in the sample, Medicaid qualifying patients chose LARC methods more often than those who don't qualify for Medicaid across all abortion delivery modalities. Non-Medicaid qualifying patients more often chose prescription methods and non-hormonal, non-prescribed methods. This difference potentially signals the ability and preferences of populations who exceed the Medicaid income limits to choose methods that require more continuous upkeep (e.g., renewing prescription, picking up contraception from pharmacy, tracking cycles) compared to methods of LARC. More research is needed to investigate the social structures that influence these decisions among those who do and do not qualify for Medicaid.

Poster Abstract 16: Exploring Barriers to Performing Abortion Past 24 Weeks Among California Abortion Providers

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Introduction: In the United States (US), 14 states, including California, have laws that define limits on abortion care based on fetal "viability." Although the laws often define viability in a legal context, specific medical definitions of fetal viability are lacking. As a result, viability is often operationalized as 24 weeks gestation, and those seeking abortion beyond this point in states without explicit gestational limits often still encounter barriers. We conducted a qualitative study of how obstetrician/gynecologists (Ob/Gyns) in California approach abortion beyond 24 weeks to explore how fetal viability interpretation affects clinical decisions

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about abortion in a state with viability-based legislative restrictions.

Methods: This is a sub-analysis of semi-structured interviews with generalist and Complex Family Planning (CFP)-trained Ob/Gyns in California. We excluded physicians in training. The research team developed a semi-structured interview guide using a socioecological model. We reviewed existing qualitative literature on peri-viable pregnancy to inform the interview guide which was refined after pilot testing. We recruited through online physician specialty organization message boards and purposive email outreach to capture a diversity of participants. Interviews began with questions about participants' personal and clinical approach to peri-viable pregnancy care and ended with a discussion of the institution and state abortion policy. Participants provided oral consent and received a USD50 gift card. We digitally recorded audio-only interviews conducted between October 2024 and March 2025; we then transcribed, de-identified, and analyzed thematically. Investigators independently reviewed all transcripts and inter-coder agreement ensured consistency until we reached thematic saturation.

Results: Among 21 interviewees, 12 (nine CFP-trained and three generalists) routinely provided abortion care. Most were cisgender white women under age 50 years practicing in urban settings. All abortion providers acknowledged that California law recognizes viability as a flexible concept rather than a fixed gestational point. However, several themes regarding provision of abortion past 24 weeks emerged: (1) no conflicts; (2) externally imposed conflicts; (3) internally imposed conflicts; and (4) facilitators of expanded abortion care. Shaped by clinical experience with later abortion patients, Ob/Gyns routinely providing over 24-week abortion viewed viability as a legal, not medical, construct. Institutional restrictions at 24 weeks reduced demand and motivation to expand skills or advocate for institutional change to expand care. Many rationalized 24-week limits by citing the rarity of encountering later patients and concerns about potential professional backlash. Although all participants emphasized the importance of centering reproductive autonomy, several described internal tension between this value and their comfort providing abortion over 24 weeks given personal viability interpretations. Many acknowledged a need to define their own gestational limits if external constraints were removed. Participants often suggested that stronger institutional support and a widely accepted clinical standard among California clinicians might facilitate expansion of abortion care beyond 24 weeks.

Conclusions: In this study, California Ob/Gyns' perspectives on later abortion care were often shaped by institutional definitions of viability that limit abortion at 24 weeks. For many, this threshold served as a personal and practical boundary rather than a medical one. Expanding access beyond 24 weeks will require confronting later abortion stigma, challenging viability as a restrictive proxy, and fostering values clarification among clinicians. Strengthening institutional advocacy and legal clarity can help establish new community standards that support abortion providers in offering comprehensive later abortion care and reaffirm reproductive autonomy across all gestational ages.

Poster Abstract 17: Exploring Interest in Doula Support for In-Office Osmotic Dilator Placement Prior to Dilation and Evacuation

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Introduction: Full-spectrum doulas provide emotional, physical, informational, and logistical support during pregnancy, abortion, and pregnancy loss. Prior research regarding abortion doula services demonstrates that most patients value doula support and would recommend it to others. Notably, existing data have been collected from clinical settings where personal support people were not permitted during procedures. At our academic medical center in Northern California, patients undergoing dilation and evacuation (D&E) may have a personal support person present during outpatient osmotic dilator placement. This study examines patient interest in doula support during in-office dilator placement where a personal support person may already be present.

Methods: We conducted an anonymous web-based survey about support during placement of in-office dilators prior to D&E. Participants provided oral informed consent and completed the survey after the procedure. We excluded individuals younger than 18 years and those who did not speak English. Participants received a USD10 gift card as compensation. Based on an estimated 70% interest in doula support, 10% margin of error, and 10% allowance for incomplete surveys, we aimed to enroll 90 participants. We analyzed survey data using descriptive statistics.

Results: Of 127 individuals approached for the study, 90 (71%) completed the survey. Of respondents, 84 (93%) indicated a visit for abortion and 6 (7%) for fetal demise. All identified as cisgender women, and mean age was 30. Participants primarily identified as Hispanic/Latinx ($n = 36$; 40%), white ($n = 39$; 43%), other/multiracial ($n = 29$; 32%), or Black ($n = 15$; 17%). Most ($n = 81$; 90%) had not previously heard of doula support for abortion and miscarriage. In total, 46 of 90 respondents (51%) expressed interest in the option for doula support during dilator placement. Interested respondents commonly expressed a desire for help with pain management and emotional support. Of 43 of 90 respondents (48%) without personal support at their appointment, 22 (51%) expressed doula interest. Common reasons patients cited for not having support present were as follows: privacy, support was unnecessary or unavailable, and desire to avoid burdening others. Of 47 of 90 respondents (52%) with personal support at their appointment, 24 (51%) expressed doula interest. Twenty-nine (62%) brought their partner, 13 (28%) a family member, and five (11%) a friend. Only 26 of 47 (55%) had personal support physically present during dilator placement. Seventeen of those 26 (65%) expressed interest in doula support in addition to personal support, and 5 (11%) expressed interest in doula support instead of personal support.

Conclusions: Our data demonstrate patient interest in the option for doula support during dilator placement prior to D&E with similar rates regardless of whether personal support is already present. Patients commonly expressed a desire to use

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