COMMENTARY



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# Consequences of gestational age limits for people needing abortion care during the COVID-19 pandemic

Silvia De Zordo [a], Joanna Mishtal [b], Giulia Zanini [c], Caitlin Gerdts [d]

a Ramón y Cajal Researcher and ERC Stg PI, Department of Anthropology, University of Barcelona, Barcelona, Spain. *Correspondence*: silviadezordo@ub.edu

b Professor, Department of Anthropology, University of Central Florida, Orlando, FL, USA

c Post-doctoral Researcher, Department of Anthropology, University of Barcelona, Barcelona, Spain

d President for Research, Ibis Reproductive Health, Oakland, CA, USA

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As the global COVID-19 pandemic unfolds, risks to sexual and reproductive health rights have rightly been at the forefront. Abortion access, in particular, should remain essential, with the reduction of burdensome, non-evidence-based requirements, such as in-person visits for early medical abortion. The Republic of Ireland, France and Britain (i.e. excluding Northern Ireland) have led the way in Europe since early pandemic confinement by allowing medical abortion at home via telemedicine in the first trimester. Such measures are critical to safeguard early abortion care but insufficient to address the need for later abortions, which under normal circumstances account for 10–20% of cases.[1] With healthcare systems overwhelmed, delays in abortion care are compounded worldwide by clinic closures, provider shortages and politically motivated efforts to curtail abortion access. US and European studies demonstrate that exceeding specified gestational age (GA) limits makes travel across borders to seek care in another state or country necessary and can result in a serious burden. The pandemic has severely restrained mobility and travelling abroad (including for health reasons) has become complicated. Governments now have the option of expanding or removing GA limits and specifications (such as the number of health professionals required to sign approvals) for the provision of abortion care, which are arbitrary from public health and human rights perspectives[2] and negatively impact the health and rights of pregnant people.

## *The burdens of seeking abortion care beyond the first trimester*

In a seminal US study of the consequences of receiving vs. being denied an abortion, those seeking abortion at or after 20 weeks were more likely to: be young; have discovered their pregnancy after 8 weeks gestation; have experienced logistical delays finding a provider or covering the costs of travel/abortion procedure; and have personal and/or financial challenges.[3] In a European study, participants who had a second trimester abortion reported discovering their pregnancies near the end of the first trimester, and facing barriers to abortion access.[4] Those who had an abortion at 18 or more weeks gestation were more likely to experience delays when seeking to make an abortion appointment. Those aged under 18 years were more likely to experience delays due to decision-making struggles. A study in the Netherlands showed that delays in accessing care were associated with being young, recognising pregnancy later, experiencing relationship turmoil, and ambivalence towards pregnancy. Non-Dutch women residing in the Netherlands were more likely to seek care in the second trimester than Dutch women.[5]

## *Gestational age limits as a barrier to care in "normal" and pandemic times*

For decades, pregnant people in the US, Europe and Canada have travelled to seek abortion care within

their own countries as well as across borders.[6] Travel is vital when abortion is illegal, however, recent data demonstrate that pregnant people continue to travel far from where they live even after abortion "legalisation", in its various forms.[7] A study has shown that women from countries where abortion is legal on broad grounds or on request (e.g. France and Italy) frequently sought services in England because of GA limits in their own countries.[8] GA limits for abortion on broad grounds vary in Europe from 10 to 14 weeks, while only a few countries, such as the Netherlands and Britain, allow it up to 22–24 weeks.

We conducted a mixed-methods study on barriers to legal abortion and abortion travel in Europe, funded by the European Research Council (ERC), showing that GA limits are the first reason why participants from countries where abortion is legally accessible in the first trimester travel abroad.[9] Data collected in abortion clinics in the Netherlands, Britain and Spain (2017–2019), show that pregnant people travelled to these destination countries from eight other European countries where abortion is legal, mostly from Germany and France. Most respondents who learned they were pregnant and chose to have an abortion at 14 weeks gestation or later, had to travel abroad after exceeding local GA limits. A variety of reasons for exceeding local GA limits were reported, including lack of clear pregnancy signs, irregular periods, distressing life circumstances, misinformation by health professionals about pregnancy signs and contraception problems. A third of respondents had considered abortion while within the GA limits in their country of residence, but reported being delayed by difficulties in accessing information on abortion services in their area, or in obtaining referral to a provider. In a few cases, doctors miscalculated GA, misleading people into thinking they had more time than they did. In Italy, some participants said they were refused care. We believe that conscientious objection, which is claimed by most gynaecologists working in public hospitals, was a possible reason.[9] In our study, travelling abroad and covering the cost of the procedure was difficult for most of the participants, with 18% reporting moderate to severe financial insecurity. Many were delayed in seeking or receiving care due to logistical challenges, particularly work-family arrangements. The participants presented for abortion care at an average of 17 weeks and six days gestation, and approximately 20% of them arrived at the destination clinic after 20 weeks gestation.[9]

These findings are alarming when considered in the context of COVID-19 restrictions on travel. Travel for abortion care exposes people to the risk of contagion, and is challenging due to mobility restrictions and difficult daily work-family arrangements resulting from loss of support usually provided by schools and relatives. Job losses or insecurity may also affect the ability of pregnant people to cover costs. Barriers to abortion care and delays in access increased during the COVID-19 pandemic, particularly in regions with extensive outbreaks.[10] More people than before may exceed GA limits. Although some countries have simplified access to medical abortion in the first trimester, including via telemedicine, GA limits have not been modified anywhere, making it especially difficult to find care in later gestation. In France, at the behest of abortion providers and family planning organisations, Parliament and the Senate discussed expansion of the GA limit, but this was ultimately rejected.

## *Conclusion: gestational age limits on abortion care are harmful*

People seeking later abortion, even those who live in countries where the abortion law is ostensibly liberal, have to travel far from where they live, including across borders.[7–8] Travelling and covering costs are a significant burden and can lead to delays, health risks and social and gender inequalities.[9] Travelling during a pandemic is more challenging and imposes further risks for people's health. Potential legal complications can be serious for those whose legal status and rights are precarious, like migrants and refugees. Accessing information on abortion abroad while being confined at home, with domestic violence on the rise and increased care responsibilities, can also be arduous. GA limits therefore seriously harm pregnant people's health and rights, and even more so in pandemic times. There are profound and lasting implications for public health, human rights and public policy. While also needing to improve the access and availability of early medical abortion, we urge governments to revise and expand GA limits in abortion and revisit conditions and requirements (e.g. signatures for approval by health professionals, disclosures for approving travel, exemptions for quarantine). Concurrently,

efforts are also needed to expand the number of providers able and willing to carry out later procedures when needed and to improve the quality of medical training and services in abortion techniques beyond the first trimester.[11]

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### ORCID

*Silvia De Zordo* http://orcid.org/0000-0002-8956-6566
*Joanna Mishtal* http://orcid.org/0000-0002-3292-7236
*Giulia Zanini* http://orcid.org/0000-0002-3031-7282
*Caitlin Gerdts* http://orcid.org/0000-0002-2488-5072

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