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COMMENTARY

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MORE THAN A JOURNAL

Access to later abortion in the United States during COVID-19: challenges and recommendations from providers, advocates, and researchers

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Access to abortion throughout pregnancy is an important reproductive health, rights, and justice issue. In 2016, 9% of abortions occurred at or beyond 13 weeks of gestation in the United States.[1] Later abortion (abortion after the first trimester) procedures become more complex as pregnancy progresses. Clients seeking later abortion face barriers in accessing care, including high procedure costs, delays in finding a clinic, travelling for care, and logistical challenges in arranging for accommodation and childcare while receiving care.[2] Delays exacerbate financial and logistical challenges as the number of available providers decreases (in 2014, only 25% of US abortion providers offered abortion at 20 weeks, and only 10% at 24 weeks)[3] and procedure costs increase, with gestational age.[2]

Impact of COVID-19 on abortion access

COVID-19 has rapidly upended social support systems and financial security for millions of people in the United States and around the world. Stay-at-home orders are in effect in many states, which may result in additional barriers in accessing contraception, and potentially increased risk of experiencing domestic violence, both of which may result in unintended pregnancies. In addition, travel restrictions, quarantine measures, additional caregiving responsibilities, fear of exposure to the virus, and fewer appointments due to reduced provider and staff availability may limit people's ability to access first-trimester abortion. Changes in economic stability due to furloughs and layoffs, concerns about personal or family members' health, and distress around birthing and parenting during a pandemic are all likely to impact decision-making and access to abortion care.

Since the start of the pandemic, 13 states (Alaska, Alabama, Iowa, Indiana, Kentucky, Louisiana, Mississippi, Ohio, Oklahoma, Texas, Tennessee, Utah, and West Virginia) have attempted to halt abortion services by deeming abortions "non-essential" or "elective" procedures.[4] Injunctions, temporary restraining orders, and unclear legal definitions of "essential" and "elective" have created a confusing landscape where clinics may be open one day and closed the next. In addition to temporary restrictions that deem abortion as non-essential care, previously existing state-imposed

method and/or gestational age bans, mandatory waiting periods and/or ultrasound scanning, and restrictions to telehealth, among other politically motivated measures, may result in clients having to travel long distances to receive later abortion care.

Impact of COVID-19 on later abortion clients

Those traveling for later abortion now face several new challenges in receiving care. With clients having to travel long distances for care, finding safe accommodation has become challenging as many hotels are closed or operating with limited capacity, and options to stay with volunteer networks are limited due to physical distancing measures. Travel by air, bus, and train is difficult. Even for those who have access to a reliable vehicle, some may be deterred from driving to their appointment, especially if out-of-state, due to fear of needing to interact with police; in some states, for example, police have set up border checkpoints to question out-of-state drivers and mandate two-week quarantine. Anxieties about interacting with police may be magnified for people of colour[5] and undocumented people[6] who have historically and disproportionately been targeted and detained by law enforcement. Some clients may also feel anxious about travelling longer distances and receiving care in areas of widespread COVID-19 transmission, especially those who have never travelled outside of their state or community. Difficulties in reaching clinics are compounded by quarantine measures for people travelling across some state borders, requiring financial and logistical preparation for longer, out-of-state trips. Due to quarantine measures, volunteer groups that have supported abortion clients by coordinating and/or funding rides and housing have had to pause their work, leading to gaps in necessary care. Minors, undocumented people, individuals with disabilities, people experiencing intimate partner violence, rural populations, and others who already face challenges in accessing health care, may now face additional barriers.

Impact of COVID-19 on later abortion providers

Clinics and hospitals that provide later abortions have had to overcome challenges in securing personal protective equipment for staff. For some facilities, this challenge is compounded by severely restricted funding and resources. As finances are an extreme barrier to access, abortion clinics necessarily keep costs low for clients and therefore operate on slim margins and cannot stockpile supplies. Staff may need to quarantine themselves and travelling abortion providers may be needed in their home states or may face travel challenges themselves, further reducing the already small pool of later abortion providers. Clinics may also be spacing out appointments to accommodate shifts in provider availability and physical distancing measures. Hospitals that provide a variety of healthcare services, including abortion care, may need to reallocate space for COVID-19 clients, which may impact their ability to continue providing abortion services. Cervical preparation prior to a later abortion procedure may require an additional visit or may prolong the abortion visit, increasing risks of COVID-19 exposure.

Later abortion facilities are responding to these challenges in innovative ways. Intake processes that screen clients for respiratory symptoms prior to the appointment are being implemented and client temperatures taken upon arrival. Clinics are restricting the number of people who accompany clients and requiring them to wait in a separate room. Clients and visitors are encouraged to wear facemasks and adhere to handwashing hygiene and respiratory precautions. In addition, clinics are minimising the total number of staff caring for clients and switching to split as telehealth for remote intake and follow-up sessions.

Recommendations

Several strategies could be adopted to meet the potential increased demand for later abortion while combating the risk of infection from COVID-19. Abortion providers can increase the gestational age up to which they provide services by consulting with other providers experienced in providing later care; this could help clients get the care they need closer to their homes. Evidence-based techniques with shorter pre-procedure cervical preparation times for later abortion could be adopted.[7,8] Those providing first-trimester and later abortions in the same facility could transition as much first-trimester volume out of the clinic as possible by using telehealth, and minimal contact medication abortion service, and raising the gestational age for medication abortion. These measures would help to regulate clinic flow, shorten visit times for clients having later abortions, and decrease the risk of exposure for clients and staff. However, it is critical that clinics continue to balance safety with client abortion method preference in order to facilitate client autonomy and confidentiality, especially for those who may not have access to secure and private

space at home to have their abortion (such as lack of privacy at home, risk of domestic violence, need for discretion, and/or method preference). Providers who do not currently provide dilation and evacuation could consider providing medication (induction) abortion, which is safe and effective for later abortion care and might be an easier adaptation for family planning physicians; this could result in an increase in the number of later abortion providers in the country.[9] Family planning and maternal-fetal medicine specialists can also work together to develop new or improved referral systems. Practical support organisations and abortion funds could work with clinics to provide clients travelling long distances with letters explaining their need to seek care. Fact sheets with information on rights while travelling for care during COVID-19, and language to use when asserting one's rights to police, may help to prepare and empower clients who need to travel. Practical support organisations can also build relationships and contracts with trustworthy rental car companies so that clients can avoid public transportation and rideshare apps.

These strategies may make abortion a reality for some, but others may be left out due to lack of knowledge about abortion legality and its status as an essential service, challenges accessing clinics during the pandemic, and other factors. Providing abortion care now, even when health care is limited, ultimately decreases the future burden on the health system when the pandemic subsides. It is imperative that all possible strategies are pursued to reach all people, especially those seeking later abortion care, to ensure their ability to protect their reproductive health and exercise their right to decide when and whether to parent.

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Author contributions

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