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Original Research Article

Seeking abortion care in Ohio and Texas during the COVID-19 pandemic☆,☆☆

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ABSTRACT

Objectives: Political and public health responses to the COVID-19 pandemic changed provision of abortion care and exacerbated existing barriers. We aimed to explore experiences of individuals seeking abortion care in 2 abortion-restrictive states in the United States where state policies and practice changes disrupted abortion provision during the pandemic.

Study design: We conducted 22 semistructured interviews in Texas (n = 10) and Ohio (n = 12) to assess how state executive orders limiting abortion, along with other public health guidance and pandemic-related service delivery changes, affected individuals seeking abortion care. We included individuals 18 years and older who contacted a facility for abortion care between March and November 2020. We coded and analyzed interview transcripts using both inductive and deductive approaches.

Results: Participants reported obstacles to obtaining their preferred timing and method of abortion. These obstacles placed greater demands on those seeking abortion and resulted in delays in obtaining care for as long as 11 weeks, as well as some being unable to obtain an abortion at all.

Conclusions: Political and public health responses to the COVID-19 pandemic - exacerbated pre-pandemic barriers and existing restrictions and constrained options for people seeking abortion in Ohio and Texas. Delays were consequential for all participants, regardless of their ultimate ability to obtain an abortion.

Implications: During the COVID-19 pandemic, state executive orders and clinic practices exacerbated already constrained access to care. Findings highlight the importance of protecting timely care and the full range of abortion methods. Findings also preview barriers individuals seeking abortion may encounter in states that restrict or ban abortion.

1. Introduction

The COVID-19 pandemic changed health care provision significantly as health systems, public health authorities, and state governments attempted to mitigate the spread of the novel coronavirus. Public health responses and politically motivated measures that limited abortion in 12 U.S. states, including Ohio and Texas, uniquely impacted abortion care [1]. Prior to the pandemic, Ohio and Texas imposed numerous restrictions on abortion, including a 24-hour waiting period, state-directed counseling designed to discourage abortion, ultrasound requirements, and a gestational limit

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of 22 weeks from the first day of the last menstrual period (LMP); Texas also restricted medication abortion by telemedicine [2,3].

In Ohio, an executive order halting non-essential surgeries went into effect on March 18, 2020, which the state attorney general interpreted to include procedural abortions [4]. After legal challenges, the executive order was rescinded on May 1, 2020 [5,6]. In Texas, the attorney general issued a statement on March 23, 2020 that included abortion among the procedures that needed to be postponed because they were not "immediately medically necessary" according to the governor's executive order [7,8]. Subsequently, legal challenges to the order resulted in a series of 6 different court decisions, contributing to ambiguity about the legal status of abortion until the order expired on April 22, 2020 [9].

Recent studies have shown how both executive orderss and the COVID-19 pandemic affected abortion provision in the U.S and other Global North countries [10–14]. A survey of independent abortion facilities found executive orders significantly disrupted services, and roughly 70% of independent facilities in states that deemed abortion "non-essential" temporarily closed, canceled, or postponed services [10]. In Ohio, there was a sharp decline in procedural abortions during the early months of the pandemic, as clinics were required to provide medication abortion unless a patient had a contraindication [6]. In Texas, while use of medication abortion also increased (relative to the previous year), the overall number of abortions decreased [11]. Additionally, out-of-state travel for abortion increased during the period the order was in effect and second-trimester procedures increased after the order expired, reflecting delays in access to care [11].

In this study, we report findings from in-depth interviews with individuals who sought abortion care in Ohio and Texas in the first year of the pandemic. The interviews explored how the political and public health responses, together with existing restrictions, altered the abortion-seeking process, including method and timing of abortion.

2. Materials and methods

2.1. Study design

In both states, we recruited people who sought abortion care during the pandemic. In Ohio, we recruited participants through advertisements on various social media platforms, in-clinic surveys, and flyers in abortion clinics. In Texas, facility staff referred participants to the study and posted flyers. Eligibility criteria in both states included being over age 18 and speaking English. Participants in Ohio were eligible if they sought an abortion between March 2020, after the executive order was in place, and November 2020. Participants in Texas were eligible if they sought an abortion during the executive order period (March 23–April 22, 2020). As part of their larger efforts to capture the experiences of people in Ohio seeking abortion care during the pandemic, the Ohio study team continued to collect data after the executive order period, as pandemic-related disruptions continued after the executive order was no longer in effect. The University of Cincinnati and University of Texas at Austin Institutional Review Boards (IRBs) approved this study.

2.2. Data collection

Informed by prior research about patients' experiences seeking abortion in restrictive settings following clinic closures, the semi-structured interview guide used by both sites included questions about abortion seekers' experiences finding a clinic, decision-making following facility closures and appointment delays, and other barriers to obtaining care [15]. A sociology graduate student (KLB), a research assistant trained in gender studies (HG), and a staff member (EV) trained in public health conducted all interviews. All interviewers received qualitative methods training from their graduate programs or from senior researchers on their project teams. Participants provided oral consent and were compensated with a gift card for their time ($40 in Texas, $100 in Ohio). The rapid-response nature of the research prevented us from amending our IRB protocols to make the compensation amounts the same. We conducted all interviews by phone, audio-recorded the interviews for transcription, and de-identified transcripts.

Table 1
Self-reported demographics of participants seeking abortion in Texas and Ohio, 2020.

	Ohio (n = 12)	Texas (n = 10)
Race/ethnicity		
Hispanic	0	4
Black	6	1
White	4	4
Asian	2	0
Declined to report	0	1
Education		
Some high school	1	0
High school	2	3
Some College	5	6
College degree	2	1
Advanced degree	2	0
Relationship status		
Single	5	6
In a relationship, non-cohabiting	4	3
Cohabitating	2	1
Separated	1	0
Parity		
0	8	1
1	1	3
2+	3	6
Abortion method		
Unable to obtain	0	5
Medication abortion	7	0
Procedural abortion	5	5

2.3. Data analysis

We developed a codebook using both an inductive approach that identified themes in the transcripts and a deductive approach based on our knowledge of the existing literature. Once we reached agreement on the codebook, a coding pair, consisting of an author from Ohio (HG or DC) and Texas (EC or KLB), coded each transcript and met to resolve any discrepancies. The lead author (EC) crafted thematic summaries based on coding reports, and the remaining team members reviewed and provided feedback. The finalized thematic summaries serve as the basis for the results.

3. Results

3.1. Participant characteristics

We interviewed 10 respondents from Texas and 12 from Ohio who sought abortion services (Table 1). In Texas, five participants obtained an abortion, 3 were unable to obtain care and resolved to carry their pregnancy to term, and 2 were unsure about continuing the pregnancy. In Ohio, all participants had either obtained an abortion or had an appointment scheduled at the time of the interview. While we did not systematically collect participants' gender identity, we use she/her pronouns for most of our respondents. However, one Ohio participant disclosed their gender identity as trans and specified they use they/them pronouns. Participant quotes are presented with their state of residence, race/ethnicity, age, estimated gestational duration at the

time when they sought an abortion (if known), and abortion outcome or plan at the time of interview. Below, we show how the executive orderss and institutional responses to the pandemic altered the process of seeking an abortion, specifically, the unique burdens of navigation during this time of delayed care, leading to physical and emotional distress and constrained accessibility of participants' preferred abortion method and timing. For some, delays and lack of preferred method affected their abortion decision.

3.2. Participants experienced delays and a more complex abortion-seeking process

Disruptions in clinic operations following the executive orders left participants unsure about the legal status of abortion, and they struggled to find information about appointment availability and to reach clinics by phone. These disruptions, coupled with the public health response measures that existed everywhere, forced respondents to delay care, with delays ranging from a few days to over 11 weeks. A participant from Ohio who was unable to obtain an appointment for several weeks described calling numerous clinics when she first found out she was pregnant; however, many were not scheduling new appointments or did not answer her calls.

> I'm completely in the dark…A lot of [clinics] weren't answering or had weird hours because of COVID or just had too many customers calling them or something. When I finally got to reach someone, they told me that they were only doing abortions at one of the three clinics. (Ohio, Asian, age 23, uncertain about gestation, but estimated 7-8 weeks when initially sought care, appointment scheduled at time of interview*).*

A Texas respondent relayed:

> When I called that first [clinic], they gave me an appointment for next Saturday. This was in late March. The day before the appointment, they [called] and [said], 'Hey, we canceled all the appointments right now because the State of Texas, they're putting a hold on what we're doing'. (Texas, age 29, race/ethnicity not provided, estimated 5-6 weeks when initially sought care, uncertain about plans for pregnancy)

Approximately 8 weeks after the appointment had been cancelled, this participant was still unsure whether she was going to be able to get an abortion.

Desperate to find information, several participants unintentionally contacted crisis pregnancy centers (CPCs). Three participants in Texas and 2 participants in Ohio first visited CPCs, which remained open, before finding an abortion facility. In some instances, these participants thought they had scheduled an appointment at an abortion clinic, only to learn that CPCs do not offer abortion services. In addition to experiencing emotional distress and deception, participants had to start the process of obtaining an abortion all over again, which further delayed their care, as a Texas participant who had already spent at least 2 weeks searching for care reported

> I went asking for an abortion, and they didn't tell me upfront that they didn't do that. They just said, 'Don't worry, we're going to get you a sonogram. We're going to get you set up.' Then when I got back into the room, where they did the sonogram, they told me how far along I was. I think I was 13 weeks, 12 weeks. After I asked them like three or four times, when can I schedule the abortion, they finally told me they don't do abortions. (Texas, age 31, white, 9-10 weeks when sought care, obtained an abortion at 14-15 weeks)

Given the uncertainty and lack of availability of in-state care, respondents also considered traveling out of state. Respondents worried about the health risks of traveling, in addition to the significant logistical burdens and financial costs. Texas' large geographic expanse made travel to New Mexico or Colorado particularly daunting. Ultimately, one participant from Ohio traveled roughly 200 miles one way to Michigan to obtain their abortion, and 2 participants from Texas traveled over 700 miles one way to New Mexico for care. Despite the complexity of getting clinic-based care, only 2 of the 22 participants reported considering self-managing their abortion.

3.3. Physical and emotional consequences of delayed care

Delays forced participants to shoulder significant physical and emotional burdens. Participants noted the exhaustion, nausea, and other physical symptoms of pregnancy were difficult to manage and the delays prolonged these symptoms. For example, an Ohio participant was very ill with hyperemesis gravidarum, a condition that results in severe nausea and vomiting during pregnancy, while waiting 3 weeks for her appointment:

> It just sucked, I just wanted to sleep [until] it was time for my abortion date, but I couldn't. I had to get up, do things, be a mom still… I was just trying to lay in bed those last few days until my appointment…I was vomiting, couldn't keep nothing down. I didn't know how I was even going to make it. (Ohio, age 29, Black, obtained an abortion at 9 weeks)

For others, the uncertainty around whether they would be forced to carry a pregnancy to term led to depression, fear, and hopelessness, which were exacerbated by the uncertainty around COVID-19. The emotional distress of planning for abortion care was particularly pronounced for a Texas participant, who had been sexually assaulted prior to the pandemic and struggled to acknowledge her pregnancy. Once she was ready to make an appointment, the executive order had been issued, and her options for obtaining an abortion became much more limited.

> I guess I was trying to act like it [pregnancy] just wasn't true…It was a very hard choice. It took me a long time to ultimately make one…. It was March, and by the time I had made that decision, when I went to [clinics'] Facebook pages and they had a dark post about how they were closing down for a while, and that's when I thought that I didn't have any options. (Texas, white, age 35, obtained an abortion at 23 weeks out-of-state)

After several weeks of searching for options, she ultimately traveled out-of-state for care.

3.4. Delayed care affected participants' preferred timing and method of abortion

Because access to abortion care was constrained by both executive orders and changing clinical practices, participants reported difficulties obtaining their preferred timing and abortion method. No Texas participants were able to obtain a preferred medication abortion, in part due to delays pushing them beyond the limits. For example, a Texas respondent sought a medication abortion early in pregnancy but was unable to get an in-state appointment until after the order was lifted. She ultimately needed a dilation and evacuation procedure. To obtain this procedure, she had to go to a different clinic and repeat the mandatory consultation visit and the 24-hour waiting period requirement.

> When they finally did reopen, [the clinic] had called me. I went, and they told me I was too far along to be at that clinic. So, they had to send me to a different clinic for people who were further along in their pregnancy, which wasn't the way that I wanted to do it because I originally wanted to do the medi-

cal one, not the surgical one. (Texas, age 23, Hispanic, 8 weeks when initially sought care, obtained an abortion at 17 weeks)

Although seven Ohio participants obtained a medication abortion, this was not always in line with their preferences. One respondent preferred a procedural abortion but ultimately obtained a medication abortion to avoid further delays.

"At that point, [I] just wanted the surgical, but it did take a delay because of the um anesthesiologist was only in... the next time that she was available to take me was going to be like a week or so after. I didn't want to wait so I just ended up just deciding to do the medical abortion. [...] but I had really wanted to the surgical because you know it's gone. (Ohio, age 26, Black, 4 weeks when initially sought care, obtained an abortion at 6 weeks).

Other participants were unable to obtain a medication abortion, despite their preference, due to a variety of reasons, including delays pushing them outside of eligibility, their health conditions, or clinic availability. One such participant scheduled a medication abortion because it would lessen their risk of exposure to COVID-19 owing to a shorter clinic visit. However, this participant, who identified as trans, had their appointment cancelled. They traveled out of state to receive timely care and avoid further challenges finding care in Ohio. They were able to obtain neither their preferred method nor gender-inclusive care, as they endured being misgendered by both clinics.

I would've [preferred a medication abortion] just because I wouldn't have had to spend so much time in the clinic…that's where the resentment comes from, feeling like I didn't [have] full agency. Abortion is a very time-sensitive procedure… [the executive order] honestly felt irresponsible to me, so I do resent that…. It was not gender inclusive. So, I was misgendered…But for me being trans, it's not exactly the full care that I need. (Ohio, age 24, Black, 6 weeks when initially sought abortion care, obtained an abortion at 9 weeks)

Barriers to the preferred timing or method of abortion prevented five Texas respondents from getting an abortion at all. For example, one Texas participant sought an abortion early in pregnancy, but once the executive order was lifted, she no longer felt comfortable obtaining an abortion due to the stage of pregnancy. She had numerous concerns about having another child during the pandemic, especially given her lack of economic stability. However, her discomfort about having an abortion in the second trimester outweighed those concerns.

I'm 14 weeks, and I decided to go ahead and go through with the pregnancy. I was going to get an abortion when I was four weeks, but then when they closed everything down, meaning I was 12 weeks when I could make an appointment…that's already too far along [for my comfort], and I wouldn't feel comfortable anymore. (Texas, age 28, race/ethnicity not provided, 4 weeks when initially sought care, decided not to get an abortion at 12 weeks)

Similarly, in Ohio, some participants reported they would have opted to continue a pregnancy rather than use a method not in line with their preference. When asked about method preference, one Ohio participant reported she would have continued the pregnancy rather than have a procedural abortion.

I don't think I am brave enough to go through with a surgical procedure. It sounds really scary to me [….] I probably would not do it. I was so very frightened to go through with the surgical procedure. (Ohio, age 23, white, 4 weeks when initially sought abortion care, appointment scheduled at time of interview)

Pandemic-related delays resulted in respondents enduring a stressful process of scheduling care, being unable to obtain their preferred method, and emotional and physical distress. These factors led some respondents to change their abortion decision.

4. Discussion

In this study, we describe the experiences of individuals who sought abortion care in Ohio and Texas, 2 abortion-restrictive states where state action and clinic-level changes limited abortion provision in the first year of the COVID pandemic. Although clinic-level changes and the scope of the executive orders and their impacts on access to abortion care differed, individuals in both Ohio and Texas encountered many of the same barriers and disruptions in seeking abortion care. These findings add to emerging literature about the impact of the pandemic on abortion care by highlighting the increasingly complex process individuals navigated in the first year of the pandemic. Executive orderss deeming abortion as non-essential likely intensified challenges, as accessing abortion even in less restrictive environments was increasingly complex due to public health-related responses [12–14].

Consistent with the growing evidence on the impact of the COVID-19 pandemic on abortion provision, participants in our study experienced delays in care, leading to abortions later than desired, out-of-state travel, or an inability to receive care [6,9]. Although it is difficult to disentangle the effects of the executive orders versus the public health response, especially in Ohio where medication abortion remained an option, the combined impact likely heighted delays, which affected participants' physical and mental health and the options for care that were available to them. Exacerbating delays were other restrictions on abortion, including mandatory ultrasound and waiting period requirements, which imposed medically unnecessary visits and increased exposure to the virus, and gestational limits on abortion. Further, participants who at first sought care at CPCs faced additional delays in accessing abortion care. In both Texas and Ohio, CPCs were allowed to remain open, revealing the politicized nature of abortion care during the early days of the pandemic. Together, these factors made the process of seeking care in Ohio and Texas more complex and costly.

Our findings highlight how the political and public health response to the pandemic in Ohio and Texas compromised participants' access to abortion care aligned with their preferences and desires. Some abortion methods were not offered, or participants were no longer eligible for them by the time of their appointment. Of our 22 participants, at least 11 were unable to obtain their preferred method. Previous work has highlighted that delays can prevent individuals from obtaining medication abortion, regardless of their preference [16]. Some participants were unwilling to use a method not aligned with their preferences. Although some participants were willing to use a different method, their decision-making was still compromised. This is particularly concerning given that the majority of people seeking care in these states are Black, Hispanic and people living on low incomes, groups that experience multiple structural oppressions [17,18]. This also further demonstrates how abortion restrictions have a pronounced effect on the reproductive autonomy of already-marginalized groups.

This study, and others, offer a preview of the barriers that are already becoming more widespread now that the United States Supreme Court has overturned *Roe v. Wade* with the final decision in *Dobbs v. Jackson Women's Health Organization* [19,20]. The hardships associated with out-of-state travel, delayed care, and inability to obtain one's preferred method - or any abortion - will be more common in the 26 states that have lost or are expected to lose access to legal abortion [21]. Efforts such as strengthening connections to clinics in the states where abortion remains legal, mini-

mizing the complexities of travel, and sharing information about self-managed abortion, are needed to protect some access to abortion care, particularly in already restrictive environments.

4.1. Limitations

Our findings should be interpreted in context of the study limitations. Both Ohio and Texas have highly restrictive policy environments and issued executive orders s aimed at halting abortion care during the pandemic; however, the scope and implementation of the orders and effect on service delivery differed, contributing to differences in outcomes and ability to get abortion care between the Texas and Ohio participants. Notably, the demographics, geographic context, and availability of abortion services prior to the enactment of the executive orders likely also impacted access to care for residents in these states. While the data sets are complementary, they are not identical and differences between study sites, including, IRB-approved study design, recruitment modalities and periods, and participant compensation may have led to differences in who decided to participate in the study and the barriers they faced. Additionally, the pandemic prevented us from entering clinics, meaning we had to rely on passive recruitment strategies. Our sample does not reflect the experiences of individuals who could not make it to a clinic or who self-managed abortion. Finally, given the recruitment timeline, our study does not capture the longer-term impacts of the pandemic on abortion seekers' experiences.

COVID-19 significantly impacted most aspects of health care, including abortion care. The political and public health response to the pandemic compromised timely abortion care for individuals in Texas and Ohio. Findings from our study highlight the increasingly complex process individuals were forced to navigate and the subsequent delays to care and reduction in abortion options available to those who were subject to these restrictions.

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