Among U.S. states, Ohio took early and decisive action to minimize the spread of COVID-19. With the support of Governor Mike DeWine, Ohio Department of Health (ODH) Director Amy Acton ordered that all non-essential surgeries in Ohio cease, effective March 18, 2020 at 5:00 PM; this order remained in effect until healthcare access was expanded on May 1, 2020. One day prior to the initial ODH order, multiple medical societies – including the American College of Obstetricians (ACOG) and the Society for Maternal-Fetal Medicine – published a joint statement clarifying that abortion, while often performed in an outpatient setting, was “an essential component of comprehensive healthcare.” Letters from Attorney General David Yost and comments from Governor DeWine disputed the status of abortion as essential health care in the week that followed. In response, the state’s surgical abortion clinics requested protection of their services within the ongoing case challenging Ohio’s six-week abortion ban, and United States District Court Judge Michael Barrett allowed surgical abortions to continue.

As indicated by ACOG, abortions are both essential and time-sensitive, and “the consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being.” In this fact sheet, we highlight abortion and contraceptive access in our state during the COVID-19 crisis. Within the rapidly changing circumstances of a pandemic, we aim to provide a context for the importance of reproductive healthcare that will be needed during this uncertain time. We describe the benefits of timely abortion care and access to telemedicine, as well as how complications caused by restrictive Ohio abortion policies are made worse during COVID-19. Additionally, we examine how interactions between reproductive healthcare and COVID-19 restrictions differentially impact rural people and people of color.

Nine abortion clinics in Ohio remain open and people are allowed to travel to seek healthcare.

All nine abortion clinics in Ohio (some of which provide only medication abortion, and some of which provide medication and surgical abortion) remain open, and people are allowed to travel to seek healthcare. In accordance with ODH’s emergency order, patients had to use medication abortion, as opposed to surgical abortion, whenever possible and if eligible. Patients were eligible for medication abortion if they had a pregnancy that was ten weeks’ gestation or less and if the medications were not contraindicated for them. Surgical abortions were scheduled to ensure that clinics had sufficient personal protective equipment (PPE) and supplies, to give time for care providers to make case-by-case assessments about whether the surgery was essential, and to allow for social distancing in the clinics.
CONTRACEPTIVE ACCESS IN OHIO DURING AN EMERGENCY ORDER

Ohio’s COVID-19 restrictions have likely resulted in reduced access to contraceptive service provision. The physical distancing orders are particularly impactful for patients using the injectable method (Depo-Provera) or long-acting reversible contraceptives (e.g. Nexplanon, Mirena, Skyla, ParaGard, etc.) as these require ongoing contact with medical professionals. Shorter-acting methods (e.g. birth control pills) can be prescribed through telemedicine. Commercial providers of birth control pills and hormonal patches via internet ordering exist and may be used by Ohio residents who have Medicaid coverage. Surgical sterilization procedures – such as vasectomy and tubal ligation – were largely delayed under ODH’s emergency order.

Uninsured people, and people with limited internet access or unstable housing, may face additional barriers to accessing these methods than they normally would. Contraceptive safety net organizations – such as Federally Qualified Health Centers (FQHCs) and Title X Grantees – are largely ill-equipped to meet the demand for virtual services. Many publicly-funded institutions have suffered from historical disinvestment and have not yet integrated the technology and training requisite for a seamless switch to telemedical service delivery.

RACIAL DISPARITIES IN ACCESS TO REPRODUCTIVE HEALTHCARE

The risks of illness and death from COVID-19, and the consequences of reduced access to reproductive healthcare, are meaningful for all people in Ohio during a pandemic. But communities of color are at greater risk of mortality due to COVID-19,7 reflecting a larger pattern of health inequity. Because access to safe healthcare is compromised by racial and ethnic disparities, the impact of COVID-related restrictions on reproductive healthcare may fall hardest on people of color.8–10

In particular, people of color are simultaneously less able to access necessary reproductive care14,15 and more at risk of reproductive oppression (including forced sterilizations and IUD insertions).16–18 Black and indigenous people are more likely to die from pregnancy-related complications,19 and in Ohio, Black infants die at three times the rate of White infants.20 Simultaneously, reduced access to abortion care is associated with higher infant mortality rates.21 Doulas and lactation consultants, essential care providers whose work has demonstrably positive impacts on maternal and infant health,22 have been limited from being with birthing patients because of COVID-related medical restrictions.23 These disparities highlight the importance of patients’ abilities to access timely and robust reproductive care, including abortion, which remains safer than carrying a pregnancy to term.24 Increased restrictions on access to reproductive healthcare thus exacerbate racial disparities in maternal and infant health.

OHIO’S RURAL AND URBAN DISPARITIES IN REPRODUCTIVE HEALTHCARE UTILIZATION

In the United States, geographic disparities have led to the unequal distribution of reproductive health outcomes, especially between urban and rural locales. Family planning services are often less accessible in rural areas than in urban ones.25 This includes Ohio’s Appalachian regions, which are overwhelmingly rural with above-average levels of poverty.26

Because access to safe healthcare is compromised by racial and ethnic disparities, the impact of COVID-related restrictions on reproductive healthcare may fall hardest on people of color.

Policy changes in the last ten years have coincided with the closures of several abortion facilities in the state. Residents living in rural areas, where the closure of a clinic results in patients needing to travel across the state for care, have been hit particularly hard.27 From 2010-2018, the abortion ratio (abortions per 1,000 live births) in rural Ohio dropped at a faster rate than that in urban Ohio. Travel difficulties during COVID-19 – when patients may have less income (due to job loss) and less childcare (due to closures of daycare centers, pre-schools, and schools) – further limit patient access to abortion and contraceptive care, and those living in rural areas will likely face greater barriers to accessing this necessary care.

OHIO’S REQUIREMENTS FOR WAITING PERIOD AND IN-PERSON VISITS

Ohio has a 24-hour waiting period for abortions, necessitating at least two in-person visits to the clinic.28 At the first visit, the physician counsels the patient based on several state requirements that are designed to discourage people from having an abortion29 (these include, for example, mandatory ultrasound and the provision of information to the patient on the likelihood of fetal survival if the patient did not have an abortion),29 Evidence shows that waiting periods and counseling requirements are unnecessary and unjustified.30–32 The primary impact of these regulations is to increase the number of visits and to increase the time patients have to wait to obtain an abortion – in some cases for more than two weeks, such as when patients must wait for their next day off work or arrange childcare.31,32
BENEFITS OF TIMELY ABORTION CARE

State restrictions on medical care and surgeries allow exceptions for healthcare that is time sensitive. This includes abortion care, a procedure for which timely care provides considerable benefits. While second-trimester abortions are safe, abortion procedures become more complicated later in pregnancy and can sometimes require two-day procedures. Compared to earlier abortion procedures, later procedures are more costly and are less accessible, as fewer facilities offer second trimester abortions. Access to timely abortion care is associated with a range of additional benefits, including a lower risk of intimate partner violence, better socioeconomic conditions, and better overall health. Patients also report a desire for earlier access to abortion care.

If patients are forced to delay their abortion, many procedures will be pushed into the second trimester. For example, in 2018, 30 percent of abortions were obtained during the last weeks of the first trimester (9-12 weeks gestational age). Thus, a four-week delay in care would dramatically increase the number of abortions that occur after 12 weeks. Pre-existing state abortion policies, such as mandatory waiting periods, mean that patients in Ohio already receive abortion care later in comparison to the rest of the U.S. If abortion care is delayed due to COVID-19 restrictions, it may become unavailable due to cost, distance, or state gestational age limits.

Patients whose pregnancy terminations are delayed past the state's gestational limit will be required to travel out-of-state to receive their needed care. This travel will increase the risk of COVID-19 transmission if the travel requires that the patient interact with more people getting to and from their appointment(s) and/or spending the night out-of-state. Overall, ensuring timely access to care would help slow the spread of COVID-19 by reducing patient-provider exposure and would save PPE by having fewer in-person visits. Prompt access to care becomes all the more important when recognizing the racial and regional disparities in accessing timely abortion care.

BENEFITS OF TELEMEDICINE

Telemedicine uses communication technologies to deliver healthcare services and information remotely, and is especially advantageous for rural communities (about half of Ohio women live in a county with no abortion provider). The use of telemedicine in abortion care is currently allowed in Ohio in limited ways. Telemedicine is already being used across the state for primary care provision, mental healthcare, and specialty consulting, as healthcare providers work to implement social distancing policies into their practices.

Medication abortion via telemedicine is safe, effective, highly acceptable to both patients and providers, and may lower the gestational age at which patients obtain their abortion. Because telemedicine abortion is so safe and cost-effective, it has the potential to improve service delivery and quality of care because it offers “convenience and confidentiality” and can improve “safety, patient-centeredness, timeliness and geographic equity” in care. Under COVID-19 guidelines, Ohio’s telemedicine abortion care is a necessary means of administering healthcare while limiting patient and practitioner exposure, as well as PPE use. Ohio places two unnecessary limitations on telemedicine for abortion; first, the patient must have an initial medication abortion visit in-person and second, the patient must be at a clinic again for their medication abortion video conference. Evidence, however, suggests that all medication abortion care can be “no-test” using the full capacity of telemedicine: all visits (including all counseling visits) performed via teleconference from a patient’s home and medications provided by mail.

Access to timely abortion care is associated with a range of benefits, including a lower risk of intimate partner violence, better socioeconomic conditions, and better overall health.

WITHIN THE NATIONAL CONTEXT

Like Ohio, ten other states have taken action to try to limit access to abortion care under COVID-19 restrictions. Litigation is ongoing in Arkansas, where appeals courts’ decisions have severely restricted access to abortion care and forced patients to travel out of state. Texas’ initial total ban on abortions, which would have made abortion geographically inaccessible to most Texans, has recently expired so that access to surgical and medication abortions is now restored. Providers in Alabama, Iowa, Louisiana, Oklahoma, Tennessee, and West Virginia faced similar legal challenges as those in Ohio, while governors in Mississippi and Alaska claimed that abortion was non-essential, but have not taken legal action.

In comparison, a number of other states have taken proactive steps to ensure continued access to abortion and contraception care during the pandemic. At least eight states have issued executive orders specifying that abortion and contraception are essential healthcare. California Attorney General Xavier Becerra joined with 20 other attorneys general to request that the Food and Drug Administration modify the Risk Evaluation and Mitigation Strategy designation for Mifepristone, which is used in medication abortion; such a move would increase access to medication abortion. These varying approaches highlight the complex differences between states’ legislative environments, even as access to abortion and contraception is needed in all parts of the country.
REPRODUCTIVE HEALTH ACCESS IS LIMITED IN OHIO. AND COVID-19 MAKES THINGS HARDER

Ohio was an early national leader in its response to COVID-19. State leaders could do more to proactively address the reproductive healthcare needs of people of our state during this pandemic. Abortion remains available to Ohioans under current healthcare regulations, as does access to contraceptive care. Existing state restrictions on abortion already make abortion procedures difficult to access; any further limitations under COVID-19 orders would be detrimental to Ohioans' health and wellbeing.

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Furthermore, these risks are not equally distributed among Ohioans, such that patients who are made vulnerable – by racism, poverty, and disinvestment in rural health infrastructure – will be disproportionally impacted by a lack of access to safe reproductive healthcare. Overall, we urge Ohio’s decisionmakers to take actions that provide the best access to reproductive healthcare during the COVID-19 pandemic, with special attention to the needs of those whose access is already impeded.

TO CITE THIS FACT SHEET:

REFERENCES