Introduction

Each year, 56 million women around the world choose to end a pregnancy.[1] This corresponds to over 150,000 abortions a day. Access to safe and legal abortions is important for many reasons. It allows a woman an option for recourse if she falls pregnant as a result of being raped. It means doctors cannot deny treatment to women who might otherwise die from life-threatening pregnancy complications, such as ectopic pregnancies or amniotic fluid embolisms. Unrestricted access to abortion means women can choose not to have their life plans derailed by unwanted pregnancies. Women with unwanted pregnancies resort to unsafe self-managed termination practices when their access to safe abortion is curtailed, resulting in high levels of deaths and disabilities.[1]

Despite these arguments, access to abortion remains difficult in many parts of the world. The COVID-19 pandemic has led to an oversaturation of healthcare systems globally, to which some jurisdictions have responded by delaying or canceling abortions. In the United States, eleven states have taken steps to defer abortions indefinitely, deeming them ‘non-essential’. [2] While these are being challenged in court, a growing number of conservative states are questioning whether abortions should be allowed to continue.[2,3]

The crackdown on abortion is not new

In 1973, the United States Supreme Court ruled on landmark case Roe v Wade, allowing unrestricted abortions within the first trimester of pregnancy. [4] Perhaps no other court case has done so much good for public health.[5] Despite this, attempts to overturn the Supreme Court decision are ongoing. [3,4,5]

The Roe ruling itself leaves much to interpretation and state legislation.[4] While it protects a woman’s right to have an abortion under the ‘right to privacy’—a right derived to exist from the Due Process Clause of the Fourteenth Amendment to the United States Constitution—it also decided that this right to privacy should be balanced by ‘compelling state interests’, which might include the state’s interests to protect the future life of the foetus.[4] As well, the ruling allows states to regulate abortions once the foetus is deemed to be viable ex utero.[4] Consequently, women would be required to carry pregnancies to term when states deem it necessary.[4]

Beyond Roe, access to abortion is curtailed in many ways, such as funding, access to information, mandatory (but misleading) counselling, the requirement of consent from third parties and parents, waiting periods, and targeting providers and their ability to practice.[5] Three years after Roe, Congress passed the Hyde Amendment, which banned federal Medicaid funding for abortion unless a woman’s life was in danger.[5,6] This provision has been upheld by the Supreme Court in subsequent cases.[6]

In 1988, the antiabortion movement targeted Title X, the federal program funding comprehensive family planning and related preventive health services for underinsured and low-income women. [6] The Reagan administration proposed a rule that would (a) ban doctors in Title X-funded clinics from counselling patients about abortion and referring them to abortion providers, and (b) require that abortion provision be physically and financially separate from other healthcare services.[6] While this rule never came into effect, the Trump administration has recently devised and enacted a similar policy to take full effect in March 2020, reinforcing the idea that abortions are not part of comprehensive healthcare.[6] Planned Parenthood has since withdrawn from the Title X programme, with other clinics following suit.[6] Without Title X funding, however, many of these clinics risk shutting down, further limiting access to safe abortions.[6]

Last year, ‘heartbeat’ bills proposed by many conservative states dominated news cycles.[7] Signed into law by some states, these effectively prohibit abortions as early as 6 weeks, as soon as a foetal heartbeat can be detected.[7]
These ‘heartbeat’ bills are among laws that are incompatible with Roe, deliberately passed in the hope that the current conservative-majority Supreme Court judiciary revisits that precedent. Currently, the Supreme Court is hearing June Medical Services v Russo, which will decide whether abortion providers need to have the credentials to admit their patients to hospitals. While such a requirement might appear to be a step in the right direction towards making abortions and post-abortion care safer, the need for additional credentials will likely force many abortion clinics to close.

Given the attempts to undermine women’s reproductive autonomy since Roe, it should come as no surprise that some states are trying to use this pandemic as an excuse to limit access to abortions. The American College of Obstetricians and Gynecologists, along with seven other medical societies, released a statement against the categorisation of abortion as a procedure that can be delayed. Their statement highlights that abortion is a time-sensitive procedure, and delays may increase risks or even make the procedure inaccessible. As well, obstacles to obtaining an abortion can have profound impacts on a woman’s health and wellbeing.

What is it like to try to get an abortion during this pandemic?
Several news outlets have chronicled the difficulties faced by women looking to have abortions in the United States during the COVID-19 pandemic. Following social distancing guidelines, women now wait in their cars for appointments, during which time some are yelled at by antiabortion activists. Getting to appointments and paying for them has become difficult for women who now find themselves out of work.

Fifteen weeks pregnant, a 31-year-old mother of three in Houston, Texas shows up for her abortion appointment at a local clinic to find a sign taped inside the glass door: the clinic was closed.

Figure 1: Changes to abortion access in Republican-led states during the COVID-19 pandemic, as of 22 April 2020. [11,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27]
that were necessary to save women’s lives) were included on a list of elective and nonessential procedures to be cancelled during the pandemic. [10] She immediately Googles her options and lists six clinics in four different states.[10] Three weeks later, she considers driving nine hours to a clinic in Wichita, Kansas, with her infant son in the backseat. [10]

Women who are indigenous, young, or poor, or live in rural areas already face systemic barriers to abortion access.[11] In ordinary times, women in the rural reaches of Alaska have to take a snowmobile, two flights, and a bus to reach one of four abortion clinics in the state.[11] Restrictions imposed by state governments during this time compound existing barriers.[11] With abortion clinics ordered to close and social distancing measures in place, women are unable to obtain surgical abortions, or attend necessary follow-up appointments after medication abortions.[11]

Abortion access in Republican-led states has swung wildly during the pandemic, creating uncertainty and causing appointment cancellations and rescheduling.[10] While temporary restraining orders (TROs) have blocked most state abortion bans, a federal judge ruled on April 22 to restore Arkansas’ ban on surgical abortions.[12,13]

The pandemic also threatens access to medication abortions.[28] While telemedicine would be useful when abortion clinics have been forced to close or women are unable to travel to them, 18 states currently ban the use of telemedicine to provide abortion care.[28] Another obstacle to medication abortions at this time is a Food and Drug Administration (FDA) restriction, which requires that mifepristone—a drug used to induce abortions—be dispensed at a clinic or hospital.[29] It cannot be mailed to women who require it, and they cannot fill prescriptions for it at a pharmacy.[28,29]

What happens when women try to self-manage abortions?
While the pandemic increases barriers to abortion, it is likely that women will look outside formal medical care to end their pregnancies, as they have when abortion was legally or otherwise inaccessible.[30]

The World Health Organization recommends the use of mifepristone and misoprostol, or misoprostol alone, to end pregnancy.[30] These regimens have been extensively studied and have acceptable safety profiles for clinician-supervised and self-managed abortions.[30] Despite the availability of these medications, not all self-managed abortions can be carried out safely, owing to lack of access or information. [30] In the United States, women have reported using herbs, such as rue, sage, and St John’s wort, none of which have been shown to be effective.

<table>
<thead>
<tr>
<th>Arguments cited to support anti-abortion orders during the pandemic</th>
<th>Counterarguments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion is not an essential service and abortion procedures should be postponed until the pandemic ends.</td>
<td>Abortion is essential and time-sensitive healthcare. It cannot be delayed, and it becomes less accessible as time passes due to restrictions on ‘late-term’ abortions.</td>
</tr>
<tr>
<td>Stopping abortions will free up personal protective equipment (PPE), such as gloves, masks, and gowns for healthcare workers looking after COVID-19 patients.</td>
<td>Gowns and masks are usually not required to provide abortions. More PPE will be required for pelvic exams, prenatal ultrasound check-ups, and delivery if women continue their pregnancies.</td>
</tr>
<tr>
<td>Abortion will increase the strain on hospital resources.</td>
<td>Very few abortions are performed in hospitals. When abortions are safe and legal, abortion complications that require a hospital visit are rare.</td>
</tr>
</tbody>
</table>

Table 1: Arguments for and against anti-abortion bans during the COVID-19 pandemic.[28]
The use of some of these substances has been associated with toxic reactions and even death, especially so for rue. Women have also resorted to means such as vaginal insertion of implements or objects and attempts to inflict abdominal trauma.

Globally, in countries where abortion is illegal, effective post-abortion care includes outpatient uterine evacuation and management of complications. If pandemic restrictions expectedly cause a surge in self-managed (and unsafe) abortions, healthcare providers should be equipped with the skills and infrastructure required to manage abortion complications. This will prove challenging given the current widespread strain on hospital resources.

Weighing the premise behind anti-abortion orders American obstetrician and gynaecologist Daniel Grossman, MD made a case against anti-abortion orders imposed by several state governments in the Boston Review. His arguments are summarised in the table above.

Challenges to abortion access in Australia
In Australia, abortions are classified as essential and urgent. However, measures introduced to curb the spread of the coronavirus present logistical challenges for both providers and patients. Doctors who fly interstate to provide abortions are now required to quarantine for two weeks, delaying time-sensitive consultations and procedures. In rural and regional Australia, abortion providers are few and far between, making travel essential to obtain abortions. While efforts are being made to expand telemedicine services, this is not an option for those seeking to have medication abortions in South Australia, as the first dose of mifepristone is required to be administered in a clinical setting.

Conclusion
While healthcare facilities are adjusting to the bleak realities of the COVID-19 pandemic, conservative jurisdictions make efforts to halt abortion provision, citing reasons such as abortion being non-essential and the need to conserve PPE. However, these arguments are unfounded. Diversion of resources away from abortion care is expected to cause a surge in poor health outcomes, adding to the strain on resources posed by the pandemic. Sexual and reproductive health services are not a luxury and, as such, should be accessible in order to minimise preventable complications and deaths. The way forward in the COVID-19 response should be dictated by inclusion and consideration of the needs of already marginalised populations.

About the Author
Afreen Akbany is a medical student at the University of New South Wales. Currently, she is intermittently pursuing her medical studies to pursue a certificate in Data Science. She is also a research assistant at the University of Sydney School of Public Health, analysing data from past and present Sydney Women and Sexual Health (SWASH) surveys. Afreen is passionate about improving the health outcomes of socially disadvantaged communities.

Conflicts of Interest
N/A

Correspondence
a.akbany@student.unsw.edu.au

Acknowledgements
N/A

Images
N/A

References