Your Abortion is in the Mailbox:  
A Study of Abortion Seekers’  
Understanding of their Choices in 2023

by
Sara Manns

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Approved by:

Roxana Toma, Ph.D.  
Margaret Tally, Ph.D.
ABSTRACT

On June 24, 2022, the U.S. Supreme Court issued a ruling in *Dobbs v Jackson Women’s Health Clinic*, overturning its 1973 decision in *Roe* and allowing states to regulate abortion. Twelve states immediately criminalized abortion care, precipitating chaos around the country. In Texas, abortion clinics had closed in September 2021, causing patients to travel to Oklahoma and beyond. Oklahoma’s clinics closed in May 2022. After *Dobbs*, residents of Oklahoma and Texas joined residents of three other states seeking limited clinic appointments in access states like Kansas, Illinois and Colorado. More than 50% of these appointments were for medication abortions. Due to changes in federal regulations about telehealth care, abortion pills could also be ordered online, letting prospective patients obtain the same pills available in clinics at home, without travel.

The goal of this study is to understand why abortion-seekers from Texas and Oklahoma chose to travel long distances for their pills, instead of ordering online. Clinic patients were surveyed to answer the research question: What do women who choose to travel to a clinic for medication abortion, from their homes in states where it is extra-legal or illegal, believe about telemedicine and clinic provision?

The study was approved by the Institutional Review Board of SUNY Empire State University. Data was collected April-June 2023 at a medication abortion clinic in Kansas. Adult residents of Texas or Oklahoma who traveled to the clinic for a medication abortion were offered a survey during their visit. The survey collected demographics and asked which alternatives the patient considered to end the pregnancy, which factors influenced their decision to travel to the clinic, and whether
they thought that mailing abortion pills for home use is legal in their state. If they considered a method using mail-order pills (abortion pills online or telehealth), they were asked why they decided against it.

Findings indicate that speed to appointment date was the top priority for the patients sampled; at the time of data collection, mail-order pills could take up to three weeks to arrive. Legality of the clinic appointment was also a concern for a majority. Privacy was a secondary concern. Seeing a doctor, the defining feature of a clinic visit, did not seem important. While many respondents were concerned about the legality of ordering pills for home use, most were confused about whether it was legal in their state.

Based on these findings, policy implications of the shift to self-managed abortion and the impact of abortion access on public health outcomes are explored. Policy recommendations are offered to support access to abortion, despite criminalization of abortion practice in 13 states. Further study is needed to understand what information and messaging informs potential users of at-home abortion about their options.
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1: INTRODUCTION Abortion Patients Traveling For Care, Despite Abortion Pills

On June 24, 2022, the US Supreme Court issued a ruling in *Dobbs v Jackson Women's Health Clinic*, overturning its 1973 decision in *Roe* and allowing states to regulate abortion. State laws governing abortion that had been stayed in 1973 were enforceable again, along with laws (‘trigger laws’) that had been passed in some states to criminalize abortion in this event. In many of those states, civil regulations constraining the medical practice of abortion (‘TRAP laws’) also remained enforceable. As a result, the decision precipitated chaos around the country in clinics that offered abortion services. For residents of Texas or Oklahoma who would seek an abortion after that day, how they would end their undesired pregnancy was an even more complex problem than it had been before. But their crisis in access to abortion did not begin in June 2022. In September 2021, SB 8, a law deputizing any person with knowledge of an abortion that occurred in Texas to sue anyone involved had gone into effect, followed by a similar law in Oklahoma in April 2022. These laws were the final civil restrictions on abortion practice targeting doctors and clinics to be added to each state’s extensive list of regulatory burdens designed to make abortion hard to access.

One woman’s journey in January 2023 illustrates these challenges. Tonya, a mother of two young children, was unable to end an undesired pregnancy within 350 miles of her home in Texas. Because of how Texas funds and regulates reproductive health care and criminalizes abortion practice by clinicians, she was not able to visit a nearby clinic to see a provider with prescriptive authority, get a pregnancy diagnosis, and leave that visit with the pills to end her pregnancy. Because of how the US regulates, stigmatizes and excludes abortion from the health care system, through FDA
regulations and restrictions on payments, she could not get telehealth treatment through a video visit followed by pills mailed to her home, as she might with any other medication as safe and effective as mifepristone, the pill she took to end her pregnancy in the clinic after a seven-hour car trip.

Under the previous ‘undue burden’ standard set in *Casey*, Tonya might also have been forced to travel to access abortion. While *Roe v Wade* remained federal law, politicians and policymakers who believed that human life begins at conception used a wide range of regulatory tools to restrict reproductive care that violated their beliefs. These laws and regulations were part of an effort to outlaw abortion that began in the 1976 federal budget for Medicaid funds, with Senator Henry Hyde making explicit that his intent in excluding abortion from health care payments was to use regulatory policy to impose his beliefs on poor women, only because he lacked the power to impose them on all women.

This was the start of Texas doctors and clinics’ struggle to comply with laws designed to prevent abortions. By segregating abortion from other reproductive care, requiring specialized clinics to operate outside the payment system for health care, misusing zoning rules and inventing limitations on clinical care, these policymakers acted as the insider arm of a wider movement. That movement was committed to ending legal abortion, and used violent attacks on doctors and their families in community settings, as well as terrorism against clinics, to raise the costs of providing abortions. Many Texas doctors and clinics could not manage these costs and stopped providing abortions. Because of clinic closures, the appointment Tonya needed would

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1 Not every person with the capacity for pregnancy identifies as a woman. In this document I use gender-inclusive language (person/people/they/them/patient/individual). I also use woman/women where appropriate, such as when citing the US Senate floor speech given to explain the policy to exclude abortion from indigent healthcare funding. This acknowledges the history of discrimination targeting women in US law and policy.
have been located in a distant large city and hard to schedule due to capacity limitations even in 2020. After *Dobbs*, she had to go yet further from home to get an abortion at a clinic.

In response to this crisis in access to abortion, international organizations began offering mail-at-home abortion pills to people in abortion ban states at low cost in 2018. But these services did not have large uptake in the population of abortion-seekers, who had concerns about clinical and legal safety. Nor was it clearly legal for the person ordering the pills before December 2022, when the FDA issued regulations finalizing its approval of remote provision of medication abortion, which was first permitted in August 2020 during the COVID-19 public health emergency in response to litigation by a physician association.

Despite initiatives from abortion providers, and public policy changes during the COVID-19 public health emergency, abortion clinics serving patients traveling from Texas and Oklahoma had long wait times for appointments and full schedules. An estimate using prior years’ abortion rates suggested that 36,000 people would be unable to access abortion in the 6 months following *Dobbs*. The need for more clinic appointments was evident. In January 2023, a new clinic, sited in a location accessible to a population of 2 million women of reproductive age in states banning abortion, quickly filled its schedule with patients like Tonya.

To understand why patients chose to travel long distances for their pills, instead of using a home mailing option to access them, we developed a survey to ask them what they knew about the legality of medication abortion by mail at the time they made their appointments. This study was designed to answer the following research question: What do women who choose to travel to a clinic for medication abortion, from their
homes in states where it is extra-legal or illegal, believe about telemedicine and clinic provision of medication abortion?

The purpose was to learn more about their understanding of their options, and why they decided to drive (often hundreds of miles, with an overnight stay) to a clinic for medication abortion, based on that understanding. This survey data can support policymakers and advocates as they adjust to the end of Roe, changing laws, regulations, budget allocations and messages to communicate these policies to the public. Abortion is one of the most common health care services used by women in the US. Use of abortion is distributed across the US population of women of reproductive age. This distribution reflects individuals’ odds of an unplanned pregnancy, and capacity to add a child to their family, rather than their knowledge about health policy and criminal law in their states of residence. For this reason, information about how abortion access is understood by the public in a changing legal setting is urgently needed.
Chapter 2: BACKGROUND
To understand why the regulation of abortion in the states has created a public health crisis, we must understand how individuals in the US terminate undesired pregnancies, and how state and federal policy regulates and limits their options. This chapter provides background on abortion access as public health, the impacts of delays in care, and an overview of laws and policies regulating, supporting and criminalizing abortion care provided by licensed clinicians. The introduction and regulation of medication abortion is introduced.

Public opinion and abortion policy
Abortion policies in many states are poorly fitted to the preferences of voters and the people most affected, those with undesired pregnancies. Consistent polling results from reliable measures of public sentiment over the past 50 years show that about 2/3 of voters think abortion should be legal, not criminalized, in their states. Voters have validated this statistic by keeping or making abortion legal in their states via direct democracy since June 2022, in states as different from each other as Kentucky and Michigan. However, state legislators and state courts have made great strides toward outlawing abortion in states controlled by Republicans. Data suggest that the medical and scientific facts about abortion do not influence policy positions by elected officials, but that during the Roe era of federal oversight, states moved policy on abortion access in the direction aligned with partisan polarization empowered by institutional controls in state legislatures.

For 49 years, state regulation of abortion was primarily symbolic, not material, policy. But in its Casey decision in 1992, the federal courts invited states to experiment with regulatory policy to limit abortion access. States used their power to direct medical practice in ways that materially impacted patients seeking abortions, and the doctors
who cared for them, but were not well-understood by voters. The minority who oppose abortion were unsatisfied because the clinical practice remained legal in their states, while the pro-choice majority believed that these regulations left choice available. But delays in abortion care led to public health challenges with rippling effects.

**Abortion Access As Public Health**

Access to abortion is not merely a personal crisis for those affected. Regardless of individual beliefs about abortion, abortion criminalization should be examined through a public health lens. As shown by a Colorado study from late 2021 and Kansas comprehensive data for 2022, closing abortion clinics in Texas and Oklahoma did not change the rate of undesired pregnancies in the region, nor the number of people affected who wanted to terminate those pregnancies. It only moved them to other states and other pathways to solve their problem.

Results to date show that maternal and perinatal outcomes in US states banning abortion dramatically worsened in 2022, even compared to their poor baseline relative to all US states and other developed nations. For example, after abortion was banned in Texas in 2021, maternal and fetal outcomes worsened sharply, with higher infant death rates, compared to the same measures in states that leave the decisions to expectant parents and doctors.

At the individual level, not being able to get an abortion is associated with a number of social ills. The Turnaway Study tells us what happens when women decide that they can’t have the child and seek to terminate, but are turned away from care. State laws banning abortion after a certain date in pregnancy at a particular type of clinic created this natural experiment, and its results are dramatic. The measurable impacts on abortion denied include lower incomes, higher rates of housing loss, higher odds of losing children to the child welfare system, and increased reports of domestic
abuse. Being able to end an undesired pregnancy is associated with improved developmental measures for children in the home as well as improved educational attainment and income for the pregnant woman.

Forced childbearing is not only a violation of the individual right to determine family size and child spacing, but also has immediate, measurable and lasting pragmatic consequences due to impacts on these determinants of health at the personal and family levels. In one study, states that advanced and enforced TRAP laws show suicide rates rising for women of reproductive age. Public health implications of abortion restrictions can also be observed through tracking hospital admissions from adverse outcomes related to unsafe and/or ineffective self-managed abortion, county-by-county birth rates, perinatal mortality rates, and infant mortality rates.

**TRAP Laws Making Clinical Abortion Care More Difficult to Access**

Well before *Dobbs*, abortion was wildly overregulated by some states in proportion to its risks. In 1992, the US Supreme Court's decision in *Casey v Planned Parenthood* allowed states to “impose burdens on a woman’s right to control her childbearing”.

Following this change, state lawmakers who wanted to stop abortions because of their own beliefs probed the limits of *Roe*'s bright line, a right to abortion before fetal viability. State laws added steps to the obstacle course between an undesired pregnancy and termination at a clinic by requiring doctors to enforce complex, irrational rules about abortion practice, with penalties including fines, clinic closures, or even losing their right to work in medicine. These obstacles included waiting periods after an initial request for abortion, counseling about the decision to terminate, clinically unnecessary physical exams, diagnostic tests with no medical meaning for the treatment, mandatory and misleading counseling and education, and restrictions on which licensed clinicians can perform an abortion, regardless of skill and scope of practice.
All of these regulations are out of alignment with clinical reality. Abortion before
11 weeks of gestation is much safer than carrying a pregnancy to term. Abortion is also
safer than dental surgery. Despite this, targeted regulations of abortion providers
(‘TRAP laws’) were enacted by states that wanted to make abortion harder to access
than other equally common medical procedures. That goal was accomplished. So in
2018, the year Dobbs v Jackson Women’s Health was filed in a Mississippi federal
court, women of reproductive age in Texas and Oklahoma already faced long drives to
access an abortion—even a medication abortion.

At the time of this writing, thirteen states including Texas, Oklahoma and
Mississippi have made it a crime to prescribe these pills at any stage of pregnancy.
While Texas abortion laws specify that the woman taking the pills cannot be civilly sued
or criminally prosecuted for using abortion pills, Oklahoma’s laws limiting criminal
liability for the ‘expectant mother’ remain superseded, limited subject to an opinion
issued by the state’s attorney general in June 2022, when Dobbs was issued).

Criminalization of abortion provision in 13 states has prompted abortion
advocates to propose state policy and funding that they believe will help divert patients
from waiting for scarce appointments in access states, by letting them terminate at
home using medication with telehealth support. Grassroots extralegal organizations
have worked to make safe pill distribution possible to residents of ban states, outside
the medical system, though these efforts are necessarily small in scale.

Clinical Context for Abortion Regulation before Roe
State laws forbidding abortion date to the 1840s. Contrary to the language of the Dobbs
decision, this fact does not reflect a centuries-old legal history of abortion at all stages
of gestation being regulated by the state. These laws were created to prevent
midwives, doctors and traveling patent medicine apothecaries from selling herbs, snake
oil, or a substance that might be useless or poisonous, with a claimed effect of aborting a pregnancy. These laws also intended to criminalize unsafe forms of surgical and mechanical interventions in fetal development that took place in later pregnancy, which had high rates of injury and death for their patients even compared to childbirth in hospitals as practiced before the development of hygienic practices and antibiotics.

During the 20th century, medical practice was regularized by accredited medical schools and state chapters of professional associations, bringing standards of care (assurance that the clinician is practicing as expected by her peers) to the US patient. As a result, traditional practices of midwifery in the home and community—including termination of undesired pregnancies, often referred to as bringing on late menses—were also formalized and regulated by states. This is the clinical context in which Roe v Wade (1973) was decided: doctors manage reproduction, abortion is surgery, and surgeons are licensed by states. States regulate hospitals and clinics, and over the decades between 1973 and 2022, many regulations were added to abortion care.

**Reduced Access to Abortion through Delays**
Due to the progressive nature of pregnancy, delaying or preventing access to abortion with laws regulating or criminalizing the clinical practice of abortion has a range of possible effects. The patient may be forced to continue the pregnancy until birth, a violation of her human and civil rights. She may also continue seeking an abortion until a later stage of fetal development. Delayed abortion has many negative impacts: the pregnancy can make permanent changes to the body, can negatively impact health, and the undesired pregnancy becomes more difficult to keep private.

Mathematically, calculating the demand for abortion—an inelastic rate across the population of reproductive age women that does not vary greatly from year to year—and the legal, geographic and pragmatic barriers to those abortions being provided in clinics
those women can reach, it is impossible for the majority of abortions needed each year to take place in a clinic.

While appointment scarcity is a problem throughout the US health care system, it poses unique issues for abortion-seekers learning they must stay pregnant until the next available appointment. In many states where clinical abortion practice is legal, it is also heavily regulated, and the farther pregnancy progresses, the fewer providers are available to offer the service. Before the restrictions of 2021-22, later abortions (after 12 weeks) made up about 8% of all abortions. Patients presenting after 19 weeks tend to be very young and/or had learned new information about the pregnancy, either about the fetus or about the existence of the pregnancy itself. These reasons would not be expected to vary in their prevalence in the population from year to year. But patients presenting between 13 and 18 weeks' gestation tended to be those who had encountered logistical difficulties, including appointment scarcity. For these reasons, it is reasonable to suppose that appointment scarcity is the mechanism that drove a notable rise in median gestational age for abortion in Kansas, Colorado, and New Mexico from 2021 to 2022. Despite the number of early abortions (less than 11 weeks) increasing dramatically from 2021 in these destination states for abortion travel, it appears that increased demand for early abortion appointments was impossible to meet, resulting in more late procedures across the population of ‘abortion seekers,’ not just ‘abortion seekers from Texas.’

Ironically, this causal sequence was predictable from earlier state efforts to make abortion harder to access. Studies of mandatory waiting periods, rationalized by policymakers as a consumer protection regulation giving women time to reflect on their decision to terminate, strongly correlate to an increase in later abortion within the population, but do not appear to lower overall abortion rates. This implies that people
do not change their mind due to waiting periods, but the barriers presented by them significantly delay care and cause abortions at later gestations. These later procedures must happen in clinics, unlike medication abortion.

**Development and Regulation of Medication Abortion**

A critical change in medicine after 1973, when the *Roe* decision allowed doctors to perform abortions without violating criminal laws in their states, is the advent of medication abortion (mifepristone or the abortion pill). Abortion pills do not require a clinic setting or a medical visit to be safe and effective. This pharmacologic innovation transforms the options to safely and reliably terminate undesired pregnancies. Medication abortion both widens the breadth of policy options available to promote access to reproductive choice and blunts the effectiveness of policy intended to limit it.

In 1988, France approved the use of a medication that terminates an undesired pregnancy by interfering with the hormonal signals required to continue it. This innovation in medicine arrived in the US in the 1990s, with the FDA studying RU-486 for more than 7 years before approving it for use under tightly scoped conditions.

Regardless of how much was known about mifepristone when it came to the FDA for review, it was evidently safer than pregnancy and childbirth, and also safer than procedural abortion was at the time. Had the FDA treated mifepristone like any other medication approved for prescription by U.S. clinicians, its appearance would have upended abortion policies in states. The policies described above, driven by anti-abortion beliefs, aimed to prevent abortions by limiting clinical practices. Advocates for reproductive choice petitioned the FDA to approve the new medication, and trained family medicine and women's health practices to add abortion to the range of services they offered their patients. They hoped to advance their policy preferences with ubiquitous access to medication abortion, taking abortion out of specialized clinics that
were being attacked by regulation, protest and violence and placing it in the hands of people with undesired pregnancies.

Instead of following the data about the safety and efficacy of mifepristone, the FDA’s approval of this new abortion method in 2000 required three physician visits, physician dispensing and a report on each dose to collect data on adverse events. This system, formalized as the Risk Evaluation and Mitigation Strategy in 2007, is a tool to prevent injury from high-risk medications. By 2018, 5 million women in the US had used abortion pills to end their pregnancies, with rates of complications similar to those expected for over-the-counter medications like Tylenol. Around the world, women have safely terminated pregnancies at home with medications (a combination of mifepristone and misoprostol) since the 1990s. The World Health Organization issued guidelines for self-managed use of the abortion pill regimen in 2022, after assessment of many decades of data on safety and efficacy.

**Abortion Access in 2023**

In 2013, most Americans lived within 25 miles of an abortion clinic. More than 95% of all abortions happened in one of these clinics. Over the next ten years, states passed additional laws making clinics harder to run. Clinics closed as they were unable to manage compliance with increasingly draconian laws. Travel up to 100 miles or more for abortion care became common. By July 2023, after Dobbs, thirteen states had outlawed abortion clinics altogether, with more expected to follow in this path. Access to abortion in clinics is increasingly scarce and significantly more logistically difficult than it was prior to the Dobbs decision.

But abortion pills allow safe self-management of abortions, using the same medications obtained in a clinic visit. The pregnant person can carry out that decision without a clinic or healthcare provider, seeking medical involvement only in the rare
event that something dangerous to her health happens. While self-managed abortion was uncommon in the US before 2020, it is increasingly common in states that have made clinic abortion illegal.

**Beyond Abortion Laws: Criminalizing Pregnancy Outcomes**

*Dobbs* lifted the protections *Roe* and *Casey* provided, for doctors, against criminalization related to providing abortion care. But criminalizing miscarriage and stillbirth is not new. Expectant mothers with uncommon pregnancy outcomes that conceivably could have been caused by something they did (e.g., use illegal drugs) or failed to do (e.g., attend prenatal care visits or go to a hospital for childbirth) have been charged with crimes that also could be used to prosecute self-managed abortion. In 61 cases before 2021, analyzed by reproductive justice advocates, those charges included fetal endangerment, homicide, reckless endangerment, drug abuse, or child abuse.

Child welfare interventions present a particular concern, as state authorities can deprive parents of their right to raise their children with no substantive right to appeal; the conduct of a pregnant mother scrutinized after a report of self-managed abortion can endanger the custody of her children. It is difficult to be precise in defining what makes an abortion legal because abortion laws have been regulations, targeting providers and clinics. Self-managed abortion by mail is in an ambiguous legal space, arguably fully protected by federal pre-emption (since only the FDA can regulate medications), and often absent from explicit state prohibitions (at the time of this publication, only South Carolina bans self-managed abortion). Nevertheless, users of abortion pills can be and have been prosecuted through a variety of laws never designed to refer to abortion. It is therefore important to recognize that the question posed to clinic patients in this study – ‘is mail-order abortion legal in your state?’ is not a simple one to answer.
The Experience of Abortion-Seekers in Texas and Oklahoma

For more than 49 years, abortion opponents had worked diligently in every relevant aspect of civil law and regulatory policy across the US, to make it hard to find and fund an appointment for an abortion anywhere, with Texas and Oklahoma leading the way. When the decision in *Dobbs* gave new powers to the states, all existing regulations on clinic abortion practice were left in place and criminal liability was newly imposed on clinicians. In this context, medication abortion used at home became a critical tactic to preserve abortion access.

Advocacy organizations amplified a public campaign, first launched in 2018, to promote abortion pills at home. While at the time of this study, abortion seekers in Texas and Oklahoma ordering pills at home faced long wait times and/or complex workarounds (such as mail forwarding), at-home use offered significant advantages over a clinic appointments: no need to miss work, obtain childcare, or risk loss of privacy with a one or two day absence from home. Nevertheless, large numbers of abortion seekers continued to travel long distances to clinic appointments to obtain the same pills they could have received at home. Asking those travelers what they know about ordering abortion pills is a new area of inquiry, and at the same time urgently overdue for exploration.
Chapter 3: THE STUDY

Sociologists and economists have extensively studied how women make the choice about whether to continue an unplanned pregnancy, what makes it an undesirable pregnancy to that individual, and which factors may influence the decision to terminate versus continuing a particular pregnancy. That decision is outside the scope of this project. Rather, this study focuses on the pathways to medication abortion known to and considered by patients at one clinic serving travelers whose home states outlawed abortion in 2021-22 and who had already made the decision to terminate their pregnancies.

This study was designed to answer the following research question: What do women who choose to travel to a clinic for medication abortion, from their homes in states where it is extra-legal or illegal, believe about telemedicine and clinic provision?

3.1 Methods
The study was approved by the Institutional Review Board of SUNY Empire State, and data was collected April-June 2023.

3.1.1 Setting
At the time of data collection (April to June 2023), abortion practiced by a clinician was criminalized in the states of Texas and Oklahoma. Residents of those states seeking abortion had the following options:

Option 1: Using an international reproductive rights organization’s web site to request abortion pills mailed from an overseas pharmacy. These pills typically took about 3 weeks to arrive.
Option 2: Telehealth, using an address where state law permits this practice for the doctor, then either driving to that location to pick up the pills or having the pills forwarded to the patient in her state.

Option 3: Requesting help from an extralegal distribution network to arrange hand-delivery of pills, or mailing the pills once they cross the border (such as from Mexico).

Option 4: Travel to a clinic out of state for abortion pills or a procedure.

The setting for this study was a medication abortion clinic in Kansas, a state bordering Texas and Oklahoma. Patients made appointments online, filling out standardized intake forms that asked questions about the patient’s medical history to assess whether medication abortion would be safe and effective for them. Information on mail-order pills was prominently displayed on the clinic website. In addition, during the study period, national advocacy organizations ran a campaign to promote self-managed abortion as an option for people living in states where abortion clinics had been outlawed. Thus, survey respondents had available information on the option of receiving medication by mail, but still opted to come to the clinic.

3.1.2 Sample
Our goal was to recruit a convenience sample of at least 100 patients traveling for abortion services from states where abortion is illegal, which at the time of data collection included Texas and Oklahoma.

Inclusion criteria:
1. Adult patients currently pregnant and seeking abortion services, at or under 11 weeks 6 days’ gestation.
2. Residents of Texas or Oklahoma.
3. Able to read and write in English.

Exclusion criteria:
1. Known ectopic pregnancy.
2. Inevitable abortion/spontaneous but incomplete abortion (aka miscarriage).

3.1.3 Recruitment
Between April 8 and June 4, 2023 potential participants were recruited during their clinic visit for a medication abortion. Posters in the clinic waiting room advertised the study as open to Texas and Oklahoma residents and included information about compensation of $15 for participation delivered via SMS text link. Patients spent about 45 minutes in the waiting room before their appointments. Before going to the exam room and prior to talking with the physician, they were provided with a recruitment flyer about the study. Thus, patients had time to review the flyer before their abortions.

3.1.4 Measures
This study used a survey developed by the researcher based on published literature about abortion decision-making by patients traveling outside their home state for abortion. The response format included numeric items, check boxes, and free-text fields. Requested information included demographics, specifically the patient's age, race, number of children at home, and ZIP code. Kansas statute requires vital records reporting on each abortion each physician completes, and this survey used participant self-reporting of the racial categories used in those reports; the intent was to compare responses to the clinic’s overall population, to support conclusions about generalizability of findings. A calculation from ZIP code to a data set using seven measures of community economic distress was used as a proxy for household socioeconomic status. This technique is used in public health research to monitor health disparities, because of a range of household income survey items and proxies, ZIP code is less frequently missing in completed surveys. Community measures are commonly used in child and family studies to understand how policies in health care, education and housing impact families. Gestational age was also collected.
Survey items included what alternatives were considered to end the pregnancy, which of four factors influenced participants' decision to travel to the clinic, and whether mailing abortion pills for home use is legal in their state (survey at Appendix A). If they considered a method using mail-order pills (abortion pills online, telehealth), they were asked why they did not use it.

3.1.5 Survey Administration
The survey was administered digitally, using a form that captured responses and stored them securely. After survey completion, respondents were offered a link to provide a number to receive compensation via SMS text. Patient anonymity was protected by the separation of this data from their survey response.

3.1.6 Analysis
Descriptive statistics were generated from responses in a relational database.

Residential zip code was used to calculate travel distance from the clinic, rural or urban residency and community economic distress. Survey responders were compared demographically to non-responders, to inform generalizability of findings.
Chapter 4: FINDINGS
During the study period, 195 surveys were collected. Of these, 4 had no response for patient race, and 13 others had no response for zip code, for a total of 178 surveys with all fields completed. Of all Texas patients who came to the clinic for abortions during the study period, 34% completed the survey (n = 141), as did 37% of all Oklahoma patients (n = 54).

The survey respondents in this study ranged in age from 18 to 41. Black patients were over-represented relative to clinic census on data collection days, while parents were underrepresented. Higher income communities were also over-represented relative to national figures about abortion patients. Most were early in their pregnancy: 72% at 6 weeks or less (likely because the clinic offered appointments within a few days of booking.)

4.1 Demographics
Table 1 describes participant demographics. Most reported a gestational age (GA) of 5 - 8 weeks (n = 179), with 9 participants reporting a GA of 9 weeks or greater. Many participants had children at home; 27% reported having a child less than 3 years old, and the youngest was 3 months old. The median number of children was 1.9. While 65% of those under 30 were childless, only 15% of patients older than 30 did not report children living at home.

4.2 Missing Data
In this study, 13/195 surveys were missing the ZIP code item. Responses to the 5 items about reasons for travel to obtain pills for their medication abortions were different for these 13 surveys, compared to the 182 surveys that completed the ZIP code field. Notably, just 24% of zip code omitters considered a mail-order method to get their abortions, compared to 48% of zip code disclosers. Additionally, 92% of the ZIP code
omitters believed that it is or might be illegal to order abortion pills in their state compared to 68% of zip code disclosers. Otherwise, response percentages were comparable.

### Table 1: Participant Demographics and Clinical Characteristics

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<th>Total n (%)</th>
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<th>Oklahoma n (%)</th>
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<td>35</td>
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</tr>
<tr>
<td>30-34</td>
<td>19</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>35-39</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>40+</td>
<td>4</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian American</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Black</td>
<td>30</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Latina</td>
<td>26</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>White</td>
<td>34</td>
<td>28</td>
<td>52</td>
</tr>
<tr>
<td><strong>Children living at home (N=93)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>48</td>
<td>49</td>
<td>45</td>
</tr>
<tr>
<td>No</td>
<td>52</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td><strong>Number of children at home</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>45</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>2</td>
<td>33</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>25</td>
<td>10</td>
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<tr>
<td>4</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td><strong>Income (Economic Distress Index, 1 is low, 5 is high, quintiles)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>35</td>
<td>37</td>
<td>31</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>18</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>5</td>
<td>19</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td><strong>Gestational Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than/equal to 6 weeks</td>
<td>72</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>7 weeks</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>8 weeks</td>
<td>7</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>9 weeks</td>
<td>2</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>10 weeks</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
4.3 Economic Status
Most participants were from prosperous communities, as measured by an economic
distress index ranking ZIP codes. Among participants from Texas, the largest share
traveled from the least-distressed ZIP codes, while the remaining 55% were evenly
distributed across the 4 lower quintiles. But among Oklahoma residents, this indicator
was distributed normally. Both patterns are unexpected, due to national historic data
suggesting that abortions are used more by lower-income Americans. This may reflect a
demographic skew toward higher income ZIP codes for the clinic itself. It also may
reflect the economic circumstances of the patients who self-selected for the survey.
Because the clinic does not track patient addresses at any level finer than state of
residence (required by Kansas’ abortion reporting statute), it is not possible to test
selection bias as an explanation. Comparisons on other demographic data, both at the
residence-state level and between clinic patients and survey respondents, suggest
generalizability of survey results.

4.4 Gestational age
Respondents’ mode gestational age was 6 weeks. This means they decided to
terminate a newly discovered undesired pregnancy, searched online for options, found
this clinic—most often after finding no appointments available at any other clinic location
they could travel to —scheduled the appointment, and planned their travel within about
5 days. Since clinicians serving the region in Colorado and New Mexico reported a
summer 2022 median wait time for an abortion at 27 days , that is a quick process
indeed. But these patients’ rapid progress from pregnancy discovery to termination is
aligned with prior studies on time from pregnancy discovery to termination varying
almost exclusively on wait times for an appointment, not on decision-making . Their
responses to the survey (Table 2), about reasons they traveled for their medication abortions, reflect that speed was paramount in their considerations.

4.5 Beliefs about the legality of abortion
Until September 2021, Texas doctors could comply with TRAP laws, an obstacle course making clinics expensive to operate, to provide abortion to patients able to travel to them. In September 2021 Texas enacted SB8, forbidding clinic abortions provided after 6 weeks of gestation. SB8 uses private tort actions to punish abortion provision. Another Texas law from 2013, which went into effect after Dobbs was decided in June 2023, makes providing an abortion a criminal offense for the clinician. However, both statutes specify that the person taking the pills is not committing a crime or a tort (two definitions of ‘illegal’).

In contrast, Oklahoma law has forbidden all provision of abortions by doctors since May 2022. A 1910 statute that criminalized the use of abortion pills was superseded, not repealed, by a 2021 statute that the end of Roe triggered in June 2022. That law was found unconstitutional by Oklahoma’s highest court during data collection for this study, on May 31, 2023. The legal status of a person using abortion pills in Oklahoma during this study would best be described as ‘unclear.’

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Total (%)</th>
<th>Texas (%)</th>
<th>Oklahoma (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: Alternatives considered to end this pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic visit for pills</td>
<td>78</td>
<td>76</td>
<td>81</td>
</tr>
<tr>
<td>Ordering pills online, no clinician involvement</td>
<td>42</td>
<td>43</td>
<td>41</td>
</tr>
<tr>
<td>Clinic visit for procedure</td>
<td>21</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Telehealth</td>
<td>20</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Other (self-harm, substance use)</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Q2: If telehealth or online pills considered, why did you decide to attend clinic? (N= 90)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure ordering pills is legal in my state</td>
<td>71</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>Online order process seemed sketchy</td>
<td>54</td>
<td>48</td>
<td>74</td>
</tr>
<tr>
<td>Concerned that pills would take too long to arrive</td>
<td>52</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>Concerned that someone else would see or open the mail</td>
<td>31</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Other (medication safety concerns, referral to clinic, doctor)</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Q3: Is it legal to order abortion pills through the mail in your state? (N = 193)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
<td>52</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Declined</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Q4 (a): What was the most important factor in your decision to come to the clinic for abortion pills? (N = 195)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The appointment was available quickly.</td>
<td>46</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>I was confident it is legal for me to come to this appointment.</td>
<td>28</td>
<td>25</td>
<td>37</td>
</tr>
<tr>
<td>This choice was private.</td>
<td>14</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>I knew I would see a doctor at this appointment.</td>
<td>12</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Q4 (b): What was the second most important factor, if any? (N = 195)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The appointment was available quickly.</td>
<td>27</td>
<td>25</td>
<td>31</td>
</tr>
<tr>
<td>I was confident it is legal for me to come to this appointment.</td>
<td>26</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>This choice was private.</td>
<td>16</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>I knew I would see a doctor at this appointment.</td>
<td>14</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Nothing else was important</td>
<td>16</td>
<td>16</td>
<td>15</td>
</tr>
</tbody>
</table>
As shown in Table 2, 38% of Texans [incorrectly] stated that it would be illegal for them to order abortion pills, with another 52% unsure. (There is no law in Texas explicitly prohibiting a Texan from ordering pills online; the law prohibits providers from prescribing them). 55% of Oklahomans were not sure if mail-at-home pills were legal in their state, which is arguably correct. ‘I’m not sure’ was the most commonly chosen response for residents of both states. But the share of ‘Yes’ and ‘No’ do not reflect the differences in the laws between the two states. Each option is displayed in Figure 1 as a percentage of that state’s total responses to this item, for contrast.

![Figure 1: Legality of Ordering Abortion Pills](image)

4.6 Reasons for clinic travel
If they considered obtaining abortion pills without a clinic visit (N=90), they were asked why they did not use that path. Figure 2 displays these responses by state, illustrating that concerns about legality and the reliability of online order options were more prevalent than concerns about speed or privacy, for these patients who traveled to pick up abortion pills after considering ordering those pills.
Across all participants (N=195), 71% described their reason for traveling to the clinic as 'speed' (primary or secondary reason for travel; survey design let them see both items on the same screen, to allow them to rank their reasons), while 54% chose 'legal' as primary or secondary. 29% selected 'privacy' as a primary or secondary reason they traveled to a clinic for pills.

Of course, 'seeing a doctor' is the only option in the survey describing a guaranteed result of traveling to pick up pills rather than having pills mailed. Intriguingly, this came in fourth of four primary or secondary reasons for travel at 26%, with only 12% choosing this as a primary consideration when selecting a path to obtain a medication abortion. Among that 12%, only two people selected ‘seeing a doctor’ as their only reason for travel. So for 99% of all respondents, seeing a doctor—the only certain distinguishing characteristic of the clinic visit—was not the sole reason to forego ordering abortion pills online or seeking pills through telehealth.

There was a contrast between states in these items. Legality was of greater concern to Oklahoma residents than to Texas residents, as shown in Figure 3.
Intriguingly, the participant’s belief about whether it was legal to order her pills did not connect to whether the participant considered legality as a primary or secondary concern in her decision making.

4.7 Conclusions
The study was designed to understand why patients traveled long distances for care, instead of ordering pills to be delivered to their homes. Survey responses suggest that patients seek a path to terminate their undesired pregnancy as soon as possible. This is aligned with data indicating that most abortion patients would have preferred to terminate sooner, with one-third of those stating that the reason they waited was related to clinic scheduling.
Additionally, responses suggest that patients don’t know whether the pills they can get through online ordering are legal for them to use. Laws that make it illegal for pregnant people to obtain abortion pills and use them at home are not in effect in either state under study. Despite this, ‘I was confident it was legal for me to come to this appointment’ was expected to be the most common response explaining travel. It would have been surprising if respondents were confident that ordering their pills for delivery is legal, for several reasons.

As noted in methods, the online-order alternative to get pills that was presented to these individuals before they made their appointments is a referral organization, which does not give legal advice. Questions about the law were referred to legal advice websites. Participants could understandably be confused about whether mail-order pills are legal, extralegal, or illegal in their state—which is not inappropriate, since criminalization of pregnancy outcomes can occur even where mail-at-home pills are legal for the person who ordered them.

Further, the legality of abortion pills themselves was brought into question during data collection. A federal case against the FDA’s approval of mifepristone came into the news in April 2023, when a Texas judge issued a ruling which would have withdrawn FDA approval for mifepristone. This ruling was stayed by the Supreme Court late in the month, after extensive media coverage of the legal wrangling. In May, a Nebraska teenager pled guilty to crimes related to her use of abortion pills; while the news coverage of this event emphasized how the state proved its case (Facebook messages between the girl and her mother, who illegally obtained the pills), headlines stated that the prosecution was for “abortion pills”.

While there is little data available about the role of media in public perceptions of abortion legality, there is evidence suggesting that perceptions about abortion safety are
influenced by mass media coverage of legislation and court judgments related to abortion. Therefore, we expected the salience of ‘legality’ to be highest among the four factors considered, and to rise across the study period. But the share of responses referring to legality as an explanation for why they had come to the clinic for pills was stable throughout the data collection period, and ranked after speed as a consideration.

Further studies are urgently needed to gather data from U.S. patients who travel across state lines for a medication abortion in a clinic setting, as well as from people who select a medication abortion delivered to their homes in states criminalizing the clinical practice of abortion. The findings about the centrality of speed and the irrelevancy of the medical visit, among considerations favoring travel, may not be replicated across all populations and settings. For example, it would be surprising, in light of racial disparities in child welfare investigations [85], if young Black mothers had the same level of concern about the legality or criminalization of a particular option as white mothers over 30. Similarly, many studies over decades of research suggest that patients value the care and counsel they received at the time of their clinic abortions [86], and this survey asked about the clinic visit itself (“seeing a doctor”) as a reason to travel. But in the context of criminalization for patients—through abortion bans, or as in the Roe era, through other laws regulating the conduct of pregnant people, pretextually protecting the interests of the fetus, enforced by a racially-biased justice system [87]—it may be useful to focus patient surveys on attitudes and preferences about self-managed options they can exercise privately and safely at home.

Qualitative studies, engaging traveling patients in dialogue about what they know, feel and believe about self-managed abortion are also urgently needed. The resulting data can guide best practices for advocates in public campaigns promoting access to abortion through remote provision of medications. This finding suggests that
public campaigns promoting access to abortion pills at home might emphasize the concerns prioritized by respondents: speed of delivery and legal/privacy protections for the user of abortion pills.

4.8 Limitations

Randomness
This survey does not represent a random sampling of patients who travel to Kansas from Texas or Oklahoma. This population is expected to be around 6500 for 2023 calendar year. The overall volume for abortions in Kansas tripled in 2022 because of abortion practice bans in these states. Due to changing laws in both sending states, Kansas patient totals included 370 abortions for Texas and Oklahoma residents in 2021 and 5,004 in 2022. The survey recruitment site was one of three clinics offering medication abortion in its county in Kansas.

Instrument validity
Due to changes in abortion laws in US states in 2022, and changes in clinical practice on medication abortion provision via telehealth in 2020-2023, validated survey instruments exploring patient beliefs and attitudes about the legality of medication abortion were not available. The survey for this study uses the themes that emerged from a qualitative study of abortion patients who traveled from Texas to one clinic in Colorado after the enactment of SB8 made clinic appointments for abortion infeasible in Texas. Items referring to legality used the language from a population-based survey of Ohio women assessing beliefs about abortion legality. The survey was reviewed for clarity and specificity of items by people capable of pregnancy residing in Ohio, Texas and Florida, ages 19 to 27, including native speakers of English and Spanish.
Chapter 5: POLICY IMPLICATIONS

Medication abortion has always had the potential to upend legal and policy struggles around regulating abortion. The reversal of Roe in 2022, a long-held goal of anti-abortion advocates, made medication abortion access more central to those struggles. An effective post-conception reproductive-control tool, safely be placed in the hands of individuals, shifts the debate about abortion policy. The ground Roe, Casey and Dobbs were argued on—which regulations are appropriate for the state to impose on abortion clinics, ranging from none to criminalization—becomes a clash about the appropriate level of state surveillance and criminalization of reproductive decisions made and carried out at home. In Dobbs, the federal judiciary decided that the abortion question belongs in the hands of the states, as the exercise of an individual right to choose abortion as a part of one’s medical care is not protected by the US Constitution. However, the fundamental question of how a state would derive the power to criminalize its residents’ reproductive choices outside of a medical setting is not addressed. This leaves a wide scope of opportunity for policy development on the field the courts razed by overturning Roe.

Demand for abortion in any population of women of reproductive age is fairly inelastic, because the rate of unplanned pregnancies and the share of these that are undesired do not vary widely from year to year. While abortion rates dropped annually in 2012-2021, so did pregnancy rates, most dramatically in states that expanded Medicaid and used federal family planning funds to cover contraception costs. This is exemplified by state reports on abortion from 2018-2022: about 3900 Kansas residents had abortions in clinics in the state each year, while about 55,000 Texas residents got abortions annually in the 10 years before SB8 closed Texas clinics in September 2021.
Notably, the total number of clinic abortions tracked by states dropped by 34,000 in the second half of 2022 and there were 9800 additional births in Texas in spring 2023 compared to projections based on annual trends pre-Dobbs.

This measurable outcome—more births than expected, some of them to unwilling parents, caused by the criminalization of the clinical practice of abortion—is perceived as positive by those who believe that every conception ought to result in a new person, and that therefore the state has the right to regulate the conduct of those who wish to terminate their own pregnancies.

It is perceived as negative by those who believe that people capable of pregnancy are also capable of discernment about whether they must complete a particular pregnancy, and by those who think increased births to unwilling parents, because of criminalization of choice and leading to poor outcomes for their children, is bad public policy. Fifty years of research on abortion, much of it advocacy research intended to support policymakers, can light a path toward better outcomes.

5.1 Abortion Access Policy Recommendations

Criminalization of abortion in some states creates a public health crisis in all states: increasing rates of maternal deaths, infant deaths, and rising suicide rates are everyone’s problem. Regardless of personal views on abortion, policymakers who prioritize improvement of public health outcomes should focus on three key areas:

1. **Lower the number of people seeking abortion.** Public policy in all states should make it easier to prevent pregnancy (through accessible and affordable contraception) and easier for people to continue pregnancies (for those who would choose to, with sufficient social and financial resources).
2. **Ensure easy access to at-home abortion.** Residents of all states should know that mail-order abortion is medically safe, effective and available to them without delay. Residents of states criminalizing abortion should have access to current and accurate information to weigh the benefits of mail-order abortion, compared to the legal risks for that person in that state. Even Texas, the first to criminalize abortion providers, has not criminalized taking abortion pills.

3. **Expand capacity for in-person abortion and pill-pick up sites in access states.** Not all people are medically able to have a medication abortion, and, as this study demonstrated, people will continue to travel regardless of laws. In-clinic abortion (medication and procedure) and pill-pick up access must remain widely accessible.

5.2 **Lower the number of people seeking abortion**

The political motives for state and federal legislators seizing opportunities to criminalize abortion are beyond the scope of this study. However, if we take legislators at their word that criminalizing the clinical practice of abortion is intended to lower abortion rates, it is appropriate to review state policies that are proven to do exactly this.

First, lower the state’s rate of unplanned pregnancy by expanding Medicaid coverage to increase the number of residents who can afford reproductive health care; distribute Title X federal funding to health clinics providing comprehensive reproductive health care (rather than funding anti-abortion pregnancy clinics not offering contraception); and require health plans to pay for all contraception methods, including long-acting reversible contraceptives. The abortion rate decreased in Colorado when the state improved access to long-acting reversible contraception as a Medicaid benefit. Fewer abortions are needed when there are fewer unplanned pregnancies—
this is not surprising, but should be made explicit given the emphasis on eliminating abortion in certain state legislatures.

Secondly, almost half of US pregnancies are unplanned, but not all of these are undesired. If the goal is to increase the number of continued pregnancies, states need to invest public funds to solve the kinds of challenges abortion patients name when they explain that they cannot afford another child: fund housing policies shown to keep families in stable housing; provide universal basic income for parents of young children; offer universal preschool; and reform child welfare to focus it on delivering these solutions to struggling families, instead of policing parental conduct under threat of family separation.

Criminalization of abortion is the least effective way to decrease abortion rates, for two reasons. First, it is pragmatically impossible to enforce laws against self-managed abortion using this strategy. Outlawing abortion clinics is easy; there are relatively few of them. Monitoring the daily lives and the mailboxes of women of reproductive age across a US state is not simply unethical, illegal and undemocratic, it cannot be done. There is no evidence suggesting that laws criminalizing medication abortion at home, or travel for abortion, will have a different impact on abortion rates than the civil and procedural obstacle course that TRAP laws once put between people and their reproductive decisions.

Secondly, and importantly, later abortions that require medical care will always be needed—and, as shown earlier in this study, barriers to access lead to an increase in these numbers. Criminalizing the small number of individuals who can't complete a particular pregnancy, almost always due to maternal health conditions or fetal anomalies incompatible with life, leads to suffering for everyone. Doctors will not apply to train in states criminalizing abortions, which will contribute to physician shortages in
coming decades affecting the entire population. Later abortions, which are the inevitable outcome of blocking access to early abortion, increase trauma for patients, their families, and clinicians. Abortion criminalization creates legal ambiguity for clinicians caring for pregnancy emergencies, which is expected to increase the number of doctors leaving the state. This will lead to women with pregnancy complications being forced to travel out of state for care, even for life-threatening conditions.

In summary, if legislators want to lower abortion rates, there are proven pathways to that goal: make it easier to prevent pregnancy and support people who would continue an unplanned pregnancy, if they could afford to do so. Supporting pregnant people and parents can be woven throughout social policies.

5.3 Ensure access to at-home abortion

As the 2022 surge of traveling patients becomes the normal demand for services in the states where abortion is legal, additions to provider capacity are critical to prevent a public health crisis within access states. However, it won’t be possible for health care providers to meet all the demand from states banning in-clinic abortion care, because not all people wanting to end their pregnancy can travel to another state.

Medication abortion at home is a critical tactic to manage the national public health crisis created by abortion criminalization. There is no “over there” in abortion care. All US residents are affected by abortion criminalization, regardless of state of residence.

In response to Dobbs, a national campaign leveraged social media, billboards, and mobile billboards to promote the message that abortion pills were safe, effective and available by mail in all 50 states. Community organizers and advocates have
leveraged social media to promote the safety and efficacy of self-managed abortion, even where it is illegal or extra-legal, since 2018. Yet one of the key findings of this study was that patients were confused by and concerned about the legality of at-home abortion.

This study’s results illuminate the top priorities of people driving long distances for abortion care: timely access (as soon as possible) and minimizing legal risk. Further studies are needed to understand where and how to describe the legal risks of self-managed abortion, so that people can assess whether at-home abortion is right for them. Abortion laws are often broadly written (which allows prosecutors enormous discretion). It is a challenge to accurately and clearly frame the legal risks, and to keep this messaging updated as laws change. Meeting this challenge should not be delegated to abortion providers, whose expertise is in clinical care and patient counseling about medical decisions.

As the population using self-managed abortion grows, there will be increasing demand for legal support from reproductive justice advocates. These organizations, which served people whose pregnancy outcomes were criminalized long before Dobbs, will need support to serve people seeking information about laws regulating self-managed abortion. In addition, if state legislators move from targeting providers to targeting people using medications at home, there will be a growing number of clients needing robust defense. States can support better outcomes by using the same tools they apply to other public health problems, including partnership with direct service organizations.

Finally, if abortion at home is to meet its promise as a public health solution, we need a diverse provider network to offer this care. One telehealth abortion provider
group reported in July 2023 that they had dispensed 3500 abortion pill packets into abortion ban states in 4 weeks, after NY passed new shield laws protecting interstate telehealth providers from loss of their medical licenses, civil judgments, or criminal prosecutions in their home states. But abortion access cannot and should not depend on a single organization. Five states (at the time of this publication) have passed legislation to shield providers and patients from civil and criminal penalties emerging from medication abortions via telehealth, allowing providers to prescribe to residents of states that criminalize abortion practice. A network of providers offering this service will ensure that some can withstand the predictable efforts to shut down these services.

It will also be important to study the impact of provider shield laws on patient uptake. A large share of survey responses indicated that they considered ordering their abortion pills, but were concerned about whether the vendors were reliable. Being able to schedule a telehealth visit like any other, or even exchange emails and texts with a doctor in the US, may shift that perception.

5.4 Expand capacity for in-person abortion and pill-pick-up sites
The sample in this study were all exposed to the information that they did not need to leave their home state to obtain a medication abortion. But they made an appointment at an abortion clinic and traveled long distances to arrive there. Policymakers in abortion access states can assume that people who need to end their pregnancies are coming to their states in their cars, on a plane, or by telehealth, and plan accordingly to support increased capacity to match demand—not only to meet the needs of residents of other states, but to ensure there is sufficient capacity to take care of their own residents.

Over-regulation of clinics, which made abortion expensive and hard to access, led to a grassroots response—travel support funds, practical support organizations and
patient hotlines—to help people get to clinics despite the barriers. However, the clinic system itself was designed to serve local demand, and to comply with decades of increasingly complex laws and regulations. It was not designed to rapidly shift capacity as states criminalize care and a population of abortion-seekers crosses state lines. This is a policy problem that states can respond to with strategic investment and regulatory creativity.

5.5 Conclusion: More Research Is Needed

In the rest of the US health care system, access to essential health services is protected through state and federal policy. The Centers for Medicare and Medicaid Services (CMS) ensures that its payees (state Medicaid program, Medicare managed care organizations, Medicare providers, managed care delegates) measure demand and match it with adequate supply. If abortion care were not segregated, stigmatized, and locked out of federal funding, then state and federal policy could cushion shocks to the system while the regulated entities adjusted. Since abortion is outside that system, to protect public health and ensure ongoing access to care for their own residents, policymakers in states defending essential health care must respond to the crisis in abortion access with creative solutions.

This study gathered and interpreted the perspectives and decision-making of a small sample of people who chose to travel long distances rather than take advantage of mail-at-home options for abortion. Quick access to appointments, and worries about legal risks, were the reasons they gave for travel. Given the medical fact that a doctor is not needed to have a safe abortion, and the logistical and legal facts that abortion pills can be shipped to them at home without breaking state laws against doctors performing abortions, people in their situations might make different choices. The public campaign
to make sure everyone knows that information is just beginning. More data is urgently needed.
Appendix A: Survey for clinic patients

Eligibility screening:
Do you live in Texas or Oklahoma?
Did you recently get abortion pills to end a pregnancy?
[any No, exits to Thank you statement]

Questionnaire:
These questions are about your recent process to get abortion pills.
1) What alternatives did you consider to end this pregnancy? [choose any that are right]
   • abortion pills online/Plan C (no doctor visit)
   • telehealth (seeing a doctor online who prescribed pills through the mail)
   • clinic visit for pills
   • clinic visit for procedure
   • other (please state)

If yes to considered ordering pills online (if they check ‘abortion pills online’ OR ‘telehealth’ options among their selections)
2a) Why did you choose to come to a clinic? [choose any, survey rotates on reload for randomness]
   • Online order process seemed sketchy
   • Concerned that pills would take too long to arrive
   • Concerned that someone else would see or open the mail
   • Not sure ordering pills is legal in my state

3) Is it legal to order abortion pills in your state?
   • Yes
   • No
   • I'm not sure

4) When you were considering, what mattered most to you? [choose one, survey rotates on reload for randomness]
   • The appointment was available quickly.
   • I was confident it is legal for me to come to this appointment.
   • I knew I would see a doctor at this appointment.
   • This choice was private.
   • Other (free text box, 55 characters)

5) What else did you consider? [choose one]
   • The appointment was available quickly.
   • I was confident it is legal for me to come to this appointment.
   • I knew I would see a doctor at this appointment.
   • This choice was private.
   • Nothing else
   • Other (free text box, 55 characters)

6) How far along was your pregnancy when you made your appointment?
   • Less than 6 weeks
   • 7 weeks
   • 8 weeks
   • 9 weeks
   • 10 weeks
   • I'm not sure
7-12) Demographics:
age [18-24, 25-29, 30-34, 35-39, 39+]
race
ZIP code
Do you have children living at home?
If yes: how many?

References