COVID: A Silver Linings Playbook

Mobilizing Pandemic Era Success Stories to Advance Reproductive Justice

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ABSTRACT

For two centuries, reproductive health care has become increasingly medicalized[1]*—sometimes to the detriment of the health and well-being of people seeking reproductive health care.*[2] *This article surveys positive shifts during the pandemic reversing the over-medicalization of contraception, fertility, birth, and abortion care. Specifically, it analyzes the positive benefits of 1) removing bureaucratic barriers to care, 2) mobilizing telemedicine for sexual and reproductive health care (SRH) services, and 3) expanding the range of services that may be administered at home.*

Proceeding in four parts, this article will trace how COVID-era adaptations in each of these domains have transformed contraception, fertility, perinatal and

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1. In this article, the term "medicalization" refers to the process whereby fertility, pregnancy, contraception, childbirth, and abortion have been claimed and redefined by institutionalized medicine, and through which provider involvement and supervision has become increasingly prevalent across the spectrum of reproductive health services.
2. *See, e.g.*, Lois Shepherd & Hilary D. Turner, *The Over-Medicalization and Corrupted Medicalization of Abortion and its Effect on Women Living in Poverty,* 46 J. LMED. & ETHICS 672, 674 (2018); Fahimeh Ranjbar, Maryam Gharacheh & AbouAli Vedadhir, *Overmedicalization of Pregnancy and Childbirth*, 7 INT. J. OF WOMEN'S HEALTH & REPROD. SCI. 419 (July 2019); Barbara Katz Rothman, *The Costs of Medicalized Contraception: Now More Than Ever*, NYU PRESS (Mar. 2017), https://www.fromthesquare.org/medicalized-contraception/; Ann V. Bell, *The Margins of Medicalization: Diversity and Context Through the Case of Infertility*, 156 SOC. SCI. & MED. 39 (May 2016).

abortion care. It will argue that thanks to these transformations, some states have not only managed to preserve access to certain SRH services during the pandemic, but in some instances—actually increased access to care.[3] *By mapping the successes of these changes, the piece offers a potential roadmap for how pandemic-era innovation might be mobilized towards reproductive justice.*

3. *See* the discussion *infra* Sections I.B., II.B., III.B., and IV.B. about how the pandemic has expanded access, in certain respects, to contraception, fertility, birth, and abortion contexts.

INTRODUCTION

> There's some things about how we're practicing now that I don't like, and there are some things about how we're practicing that I really like, and don't want to change after sheltering in place has been lifted. . . We're even looking at this idea of no-touch abortion.[4]

These are the words of Adrienne Crawford, one of Washington D.C.'s many overworked nurse-midwives practicing at the front lines of the coronavirus (COVID-19) pandemic. With a chorus of publications examining the pandemic's detrimental impact on access to reproductive health,[5] it seems important to amplify opinions like Adrienne's. She is not alone in seeing the silver-linings of the pandemic for her field. Amidst the loss and chaos of the pandemic, there has also been stunning innovation in reproductive health. This Article does not dispute

4. Adrienne Crawford, *Part 7: Providing Abortions During COVID-19*, SELF-MANAGED: AN ABORTION STORY, at 17:26 (May 2020), https://www.smapodcast.org/podcast/part-7-providing-abortions-during-covid-19 [https://perma.cc/SUM9-33BH].

5. *See, e.g.*, Laura D. Lindberg, Jennifer Mueller, Marielle Kirstein & Alicia VandeVusse, *The Continuing Impact of the COVID-19 Pandemic in the United States: Findings from the 2021 Guttmacher Survey of Reproductive Health Experiences*, GUTTMACHER INST. (2021), https://www.guttmacher.org/report/continuing-impacts-covid-19-pandemic-findings-2021-guttmacher-survey-reproductive-health [https://perma.cc/9UF6-XAV7]; Taylor Riley, Elizabeth A. Sully, Zara Ahmed & Ann Biddlecom, *Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries,* 46 INT'L PERSP. ON SEXUAL & REPROD. HEALTH 73 (2020); Anita Makins & Sabaratnam Arulkumaran, FIGO Contraception and Family Planning Committee, *The Negative Impact of COVID-19 on Contraception and Sexual and Reproductive Health: Could Immediate Postpartum LARCs Be the Solution?,* 150 INT'L J. GYNECOLOGY & OBSTETRICS 141 (2020); Amira Ghouaibi *The Pandemic Has Hurt Women's Health. This Is Why That's Bad for Everyone*, WORLD ECON. F. (Sept. 23, 2021), https://www.weforum.org/agenda/2021/09/lessons-must-be-learned-from-covid-19-s-impact-on-women-s-health-and-rights/ [https://perma.cc/7MFE-HZ2Z].

COVID-19's devastating impacts on public health, including reproductive health. However, the pandemic has also forced the medical profession to ask itself a question that it arguably should have asked itself a long time ago: How can we scale back unnecessary medical interventions and surveillance of people with child-bearing capacity?

For two centuries, reproductive health care has become increasingly medicalized- sometimes to the detriment of the health and well-being of people seeking reproductive health care.[6] This Article surveys positive shifts during the pandemic reversing the over-medicalization of contraception, fertility, birth, and abortion care. Specifically, it analyzes the positive benefits of 1) removing bureaucratic barriers to care, 2) mobilizing telemedicine for sexual and reproductive health care (SRH) services, and 3) expanding the range of services that may be administered at home. Some states have managed to preserve access to SRH services during the pandemic as a result of these changes, and in certain instances—particularly in the abortion context—COVID-era adaptations have actually increased access to care.[7] For these reasons, this Article argues that the pandemic's pressure to restrain medical intervention and surveillance in reproductive health is one worth sustaining after the lingering consequences of the pandemic have been addressed.

This Article proceeds in four parts. Part I focuses on contraception and unpacks the ways in which harmful histories of reproductive coercion continues to mar contemporary contraception care practices. It then identifies key ways in which the pandemic has shifted these care practices away from intervention and surveillance toward greater investment in patient information and autonomy. Part II focuses on fertility care. It begins by locating contemporary fertility care protocols within broader historical trends of deeming certain parents "worthy" of having access to family building and others not. It then analyzes some of the ways in which the pandemic has transformed the settings in which fertility care can be accessed, and in doing so, reduced significant barriers. Part III focuses on perinatal care, connecting the historical criminalization of midwifery to the current overmedicalization of childbirth, and then suggests that the pandemic has transformed notions of what safety looks like in this context and significantly reduced intervention throughout the perinatal period. Finally, Part IV provides an overview of the history of criminalizing abortion, connects it to contemporary access barriers, and unpacks the ways in which the pandemic has generated

6. *See, e.g.*, Lois Shepherd & Hilary D. Turner, *The Over-Medicalization and Corrupted Medicalization of Abortion and its Effect on Women Living in Poverty,* 46 J. LMED. & ETHICS 672, 674 (2018); Fahimeh Ranjbar, Maryam Gharacheh & AbouAli Vedadhir, *Overmedicalization of Pregnancy and Childbirth*, 7 INT. J. OF WOMEN'S HEALTH & REPROD. SCI. 419 (July 2019); Barbara Katz Rothman, *The Costs of Medicalized Contraception: Now More Than Ever*, NYU PRESS (Mar. 2017), https://www.fromthesquare.org/medicalized-contraception/; Ann V. Bell, *The Margins of Medicalization: Diversity and Context Through the Case of Infertility*, 156 SOC. SCI. & MED. 39 (May 2016).

7. *See* the discussion *infra* Sections I.B., II.B., III.B., and IV.B. about how the pandemic has expanded access, in certain respects, in contraception, fertility, birth, and abortion contexts.

workarounds for those obstacles.

I. CONTRACEPTION: HOW AND WHY IT TOOK A GLOBAL PANDEMIC TO REDUCE PROVIDER INVOLVEMENT IN CONTRACEPTION ACCESS

Historical anxieties about open access to birth control and information about pregnancy prevention led doctors to becoming integral players in family planning. This section first provides a brief overview of pre-pandemic standards of contraception care, locating them within this historical context. Then, this section analyzes the ways in which COVID-19 has disrupted these standards of care and improved contraception access as a result.

A. Physician Controlled Contraception: How Anxieties About Sexual and Reproductive Autonomy Shaped Contemporary Family Planning Practices

Contemporary norms surrounding contraception counseling and care have not evolved as much as one might think they would have. Physicians have shifted toward "shared decision-making"[8] rather than unilateral physician control over which birth control methods get discussed in a consultation. These shared decision-making models, however, still place the doctor at the center of the process. Many countries (including the U.S.) still require a physician's consultation and prescription to obtain hormonal birth control.[9] The policy rationales behind these requirements depend on two assumptions: 1) that people are incapable of conducting their own risk assessments, and 2) that people should rely on a doctor's opinion, rather than their own, about which birth control method makes the most sense for their body and their lifestyle. Both assumptions are rooted in a history of social angst about reproductive autonomy.

1. History: How Anxieties Surrounding Sex Outside of Marriage Increased Doctor Involvement in Contraception Counseling and Care

The modern birth control movement coincided with the anti-obscenity movement.[10] As birth control technology emerged, and information about it began

8. *See* Christine Dehlendorf, Kevin Grumbach, Julie Schmittdiel & Jody Steinauer, *Shared Decision Making in Contraceptive Counseling*, 95 CONTRACEPTION 452, 453 (2017) ("Shared decision making is an increasingly emphasized model of health communication that has been found to be associated with increased patient engagement and improved patient outcomes, including enhanced experience of care, and, in some studies, improved health status.").
9. *See* Kate Grindlay, Bridgit Burns & Daniel Grossman*, Prescription Requirements and Over-the-Counter Access to Oral Contraceptives: A Global Review*, 88 CONTRACEPTION 91, 93 (2013).
10. *See generally* John K. Amory, *A History of the Birth Control Movement in America*, 121 J. CLINICAL INVESTIGATIONS 3782 (2011) (providing in-depth treatment of the interactions between the American birth control and obscenity movements).

to circulate, significant social anxiety attached to the idea of extramarital sex.[11] For this reason, printed material with information about contraception or family planning was banned by America's Comstock laws as "obscene."[12] The anti-obscenity movement championed the belief that increased access to information about safe sex would lead to more sex. In particular, anti-vice activist Anthony Comstock's followers believed that widespread information about birth control would lead to more extramarital sex because the risk of pregnancy would no longer serve as a deterrent.[13] Generalized fear about sex outside of marriage generated a perceived need for gatekeepers who could restrain access to birth control; physicians seemed uniquely situated to perform this role.[14] Physicians became the stopgap ensuring birth control could reach only those whom society had already deemed responsible and respectable enough to have sex: heterosexual married couples.[15]

Two separate Supreme Court precedents granted physicians the legal authority to prescribe contraceptives. In 1965 *Griswold v. Connecticut* allowed married people to use contraceptives.[16] Seven years later, *Eisenstadt v. Baird* allowed unmarried individuals to do so.[17] These precedents reveal that whether someone had access to contraception was fundamentally about whether they could be trusted to make their own decisions about the circumstances under which they had sex. Neither court held that the decision to use contraception belonged exclusively to the person seeking it.[18] Rather, the Court deemed doctors to be most suitable for the task. After all, at least one of the parties challenging birth control bans in both *Griswold* and *Eisenstadt* was a physician or clinical director.[19] While there is useful language in both cases surrounding privacy and a person's right to equal protection, these cases depended on a doctor's right to *prescribe* contraception rather than a person's right to *consume* it. Thus, each opinion further

11. *Id.*
12. *See* Helen Lefkowitz Horowitz, *Victoria Woodhull, Anthony Comstock, and Conflict over Sex in the United States in the 1870s*, 87 J. AM. HIST. 403, 426 (2000).
13. *See* Jessica L. Furgerson, The Battle for Birth Control: Exploring the Rhetoric of the Birth Control Movement 1914–2014, at 200–01 (2015) (Ph.D. dissertation, Scripps College of Communication of Ohio University) (on file with author).
14. *See* Desirée Martinelli, *Sex, Drugs, Trump and Birth Control,* 24 WM. & MARY J. WOMEN & L. 295, 327–29 (2018) (providing a history of how doctors came to be so involved in birth control access).
15. *Id.*
16. *Griswold v. Connecticut,* 381 U.S. 479, 486 (1965) (holding that state restrictions on contraception use violated the right of marital privacy).
17. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (holding that the Equal Protection Clause of the Fourteenth Amendment protected unmarried individuals' right to use contraception).
18. *See Griswold,* 381 U.S. at 481-86; *Eisenstadt*, 405 U.S. at 452-55.
19. In *Griswold,* the defendants were the Executive Director of the Planned Parenthood League of Connecticut and a licensed physician and professor at Yale Medical School who served as Medical Director for the League at its Center in New Haven. 381 U.S. at 480. They were arrested for giving "information, instruction, and medical advice to married persons as to the means of preventing conception." *Id.* In *Eisenstadt*, the defendant was the clinical director of a vaginal foam company who distributed vaginal foam to an unmarried woman. 405 U.S. 438, 444.

endorsed the role of doctors as gatekeepers in birth control access.

This history impacts contemporary contraception counseling and prescription laws. Modern policy rationales behind mandatory counseling and prescriptions are still anchored in the belief that doctors should have a role in deciding who should be given access to birth control.[20] In today's internet age, however, people can access the information they need in order to self-screen for risks associated with each of their potential birth control options.[21] This has consistently proven true for the more than one hundred countries that have legalized over-the-counter access to birth control.[22]

2. Current Practice: Understanding the Role of Medical Providers in Contemporary Contraception Care

While every country's contraception policy varies to some extent, important constants exist regardless of geographic location. Namely, even in the most "liberal" countries, access to contraception often remains constrained by requirements for provider involvement.[23] This is true in the U.S., Canada, and most of Western Europe.[24] This section argues that contemporary counseling and prescription practices for contraception are not medically necessary and do not serve the interests of many people who need contraception. This section then locates these practices within historical context, arguing that contemporary policy rationales are rooted in harmful, inherited anxieties about reproductive autonomy.

a. Contraception Counseling

Why do certain States require contraception counseling in order to access hormonal birth control? A research review of global standards for contraception counseling noted that contraception counseling is usually mandatory because of an articulated need to ensure "informed decision making" on the part of the patient.[25] On its own, this point makes sense. The authors of the review, however, proceeded to elaborate on this rationale, explaining that countries implement

20. *See* Martinelli, *supra* note 14, at 308–16 (further elaborating upon contemporary policy rationales behind mandatory contraception counseling and prescriptions).
21. *See* Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception*, 134 OBSTETRICS & GYNECOLOGY e96 (2019) [hereinafter ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception*] ("Several studies have demonstrated that women are capable of using self-screening tools to determine their eligibility for hormonal contraceptive use.").
22. *See Statement of Purpose*, ORAL CONTRACEPTIVES OVER-THE-COUNTER WORKING GRP., https://ocsotc.org/ [https://perma.cc/UWF5-YNNZ] (last visited Apr. 1, 2022).
23. *See id.*
24. *See Glob. Oral Contraception Availability*, ORAL CONTRACEPTIVES OVER-THE-COUNTER WORKING GRP., https://ocsotc.org/world-map/ [https://perma.cc/2GPA-VNDN] (last visited May 7, 2021).
25. Christine Dehlendorf, Colleen Krajewski & Sonya Borrero, *Contraceptive Counseling: Best Practices to Ensure Quality Communication and Enable Effective Contraceptive Use*, 57 CLINICAL OBSTETRICS & GYNECOLOGY 659, 665 (2014).

shared decision-making models because "women's selection of a new contraceptive method is influenced by whether providers mention or recommend specific methods,"[26] and that "women who report experiencing higher quality care have higher rates of contraceptive continuation."[27] These two assertions warrant unpacking. First, "informed decision-making" and "shared decision-making" are distinguishable models. An "informed decision-making" model stresses the importance and value of health care providers sharing only information about contraception methods, and discourages providers from participating in the selection of the method itself, so as to ensure that women are not inappropriately influenced.[28] A "shared decision-making" model, on the other hand, focuses on "eliciting and responding to patient preferences and [using]specific task-oriented communication strategies [to] enhance the process of method selection [and to] facilitate correct use of a chosen method."[29] Ensuring that people know what their contraception options are is a distinct goal from influencing their contraceptive selection or continuation. While the former is about connecting patients to information, the latter two are about controlling how that information is used. Attempting to control the type and duration of a patient's contraceptive choices is rooted in a broader constellation of historical initiatives to control people's reproductive autonomy,[30] and does not ultimately serve the interests of the person seeking care.

This variety of medical paternalism disproportionately targets people who face additional forms of discrimination that contribute to their providers' perception that they cannot make their own contraceptive choices. Studies in both the U.S. and the U.K. have found that racist and classist biases led providers to disproportionately prescribe more long-term and invasive forms of contraception such as LARCs ("Long-Acting Reversible Contraception" including intra-uterine devices and NuvaRings) to low-income people of color.[31] These same groups are more likely to encounter discrimination and coercion when seeking removal of their LARCs.[32] In fact, multiple state Medicaid programs fund the insertion of

26. *Id.* at 661.
27. *Id.*
28. *Id.* at 665.
29. *Id.* at 669.
30. *See* discussion *infra* Section I.B. (providing an overview of why reducing provider involvement in contraception counseling opens up access for many).
31. *See generally* Jenny A. Higgins, Renee D. Kramer & Kristin M. Ryder, *Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Adult Women* 106 AM. J. PUB. HEALTH 1932 (2016) (finding that survey participants reported that their preferences regarding contraceptive selection or removal were not honored and that many participants believed that providers recommend LARC disproportionately to socially marginalized women). *See* Christine Dehlendorf, Rachel Ruskin, Kevin Grumbach, Eric Vittinghoff, Kirsten Bibbins-Domingo, Dean Schillinger & Jody Steinauer, *Recommendations for Intrauterine Contraception: A Randomized Trial of the Effects of Patients' Race/Ethnicity and Socioeconomic Status*, 203 AM. J. OBSTETRICS & GYNECOLOGY 319.e1 (2010); Jeffrey Wale & Sam Rowlands, *The Ethics of State-Sponsored and Clinical Promotion of Long-Acting Reversible Contraception*, 47 BRIT. MED. J. e11 (2021).e11 1
32. *See, e.g.*, Kelsey Holt, Reiley Reed, Joia Crear-Perry, Cherisse Scott, Sarah Wulf & Christine

LARCs, but place additional restrictions in order to be reimbursed for their removal.[33] Because mandatory contraception counseling exists in order to influence the choice and duration of people's contraception methods, it inevitably opens the door to these coercive practices. With access to contraceptive information online, people today are perfectly capable of performing their own risk assessments, weighing their options, and making the right choice for themselves. Mandatory contraception counseling should be repealed, and COVID-era policy changes in this area (discussed below) should be sustained long-term.

b. Mandatory Prescriptions

Many countries, including the U.S., still require a health care provider's prescription to obtain oral contraceptives.[34] The primary policy rationales that typically justify these mandatory prescriptions are that 1) oral contraceptives may not be advisable for everyone and 2) permitting over-the-counter access to birth control pills will mean that people will forgo screening and other preventive services.[35] Neither of these policy rationales are supported by credible evidence. First, it has been clinically shown that people are entirely capable of self-screening for risks associated with hormonal birth control.[36] Provider screening, therefore, cannot be a justification for mandatory prescriptions. Second, pelvic and breast examinations, cervical cancer screenings, and sexually transmitted infection screenings—the screening and preventative services that providers tend to administer at other reproductive health care appointments—are rarely, if ever, necessary before initiating hormonal contraception.[37] It therefore does not make

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Dehlendorf, *Beyond Same-Day Long-Acting Reversible Contraceptive Access: A Person-Centered Framework for Advancing High-Quality, Equitable Contraceptive Care*, 222 AM. J. OBSTETRICS & GYNECOLOGY S878, S881 (2020) (citing Jennifer R. Amico, Ariana H. Bennett, Alison Karasz, Marii Gold, *"She Just Told Me to Leave It": Women's Experiences Discussing Early Elective IUD Removal*, 94 CONTRACEPTION 357 (2016)).

33. *See* Sarah Christopherson, *NWHN-SisterSong Joint Statement of Principles on LARCs*, NAT'L WOMEN'S HEALTH NETWORK (Nov. 14, 2016), https://nwhn.org/nwhn-joins-statement-principles-larcs/ [https://perma.cc/BVB9-VATW]; Jenna Walls, Kathy Gifford, Usha Ranji, Alicia Salganicoff & Ivette Gomez, *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, KAISER FAM. FOUND. (Sept. 15, 2016), https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey-reversible-contraception/ [https://perma.cc/QBA9-NBGP].

34. *See* Glob. Oral Contraception Availability, ORAL CONTRACEPTION OVER THE COUNTER WORKING GRP., *supra* note 24.

35. ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception*, *supra* note 21.

36. *See id.*

37. *See id.* (citing KATHRYN M. CURTIS, TARA C. JATLAOUI, NAOMI K. TEPPER, LAUREN B. ZAPATA, LEAH G. HORTON, DENISE J. JAMIESON, MAURA K. WHITEMAN, U.S. SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE , 2016, 65 MORBIDITY AND MORTALITY WKLY. REP. 1, 51 (2016)); ACOG, *Committee Opinion No. 615: Access to Contraception*, 125 OBSTETRICS & GYNECOLOGY 250 (2015); Naomi K. Tepper, Kathryn M. Curtis, Maria W. Steenland & Polly A. Marchbanks, *Physical Examination Prior to Initiating Hormonal Contraception: A Systematic Review*, 87 CONTRACEPTION 650 (2013)); Naomi K. Tepper, Maria W. Steenland, Polly A. Marchbanks & Kathryn M. Curtis, *Laboratory Screening Prior to Initiating Contraception: A Systematic Review*, 87 CONTRACEPTION 645

sense to rely on a preventative care rationale for requiring prescriptions for hormonal birth control. Moreover, it seems untenable to argue that these types of screenings and preventative care methods should be necessary in order to obtain contraception, given that they are not related to the risks that one might incur from taking hormonal birth control.[38] While mandatory prescriptions create an unnecessary additional hurdle for everyone, they have a disparate impact on people who may not be able to get a prescription for administrative reasons (for example, a lack of parental consent in the case of minors in many countries, or undocumented immigrant status).

Each of the rationales that has been advanced for mandatory contraception counseling and prescriptions is rooted in the misguided assumption that people cannot perform their own risk assessments or decide for themselves what care options will work best for them. The following section demonstrates how COVID-era transformations have taught us that this physician-centered contraception regime can, and should, be dismantled.

B. Contraception in a Pandemic: How Lockdown Reduced Surveillance of People with Childbearing Capacity.

Many jokes were made about COVID babies when stay-at-home orders began proliferating in March 2020. "This will mean more sex, with less protection," was a common perception surrounding pregnancy prevention during this time.[39] While the pandemic has limited contraceptive access in some key respects,[40] one cannot tell the story of contraception care during the COVID-19 pandemic without acknowledging the many innovative ways in which certain states have since adapted to address, secure, and in some instances, *increase* access to contraception between March 2020 and today. This section will argue that the pandemic has proven that prior mandatory counseling and prescription requirements were not medically necessary, and that reducing provider involvement in contraception care is in the ultimate interests of many, regardless of the future of the pandemic.

(2013).

38. *See generally* ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception, supra* note 21.
39. *See, e.g.*, Maria Puente, *Will Coronavirus Cause a Baby Boom? Prepare for Jokes, If Not Babies!,* USA TODAY (Apr. 2, 2020, 3:52PM), https://www.usatoday.com/story/life/parenting/2020/04/02/coronavirus-fact-check-could-covid-19-cause-baby-boom/5105448002/; Beata Mostafavi, Researchers Predict COVID Baby Boom, Michigan Health Lab (June 3, 2021), https://labblog.uofmhealth.org/rounds/researchers-predict-covid-baby-boom#:~:text=Study%20suggests%20the%20pandemic%20initially,a%20baby%20surge%20this%20summer.&text=A%20different%20type%20of%20surge,the%20pandemic%20%E2%80%93%20a%20baby%20surge.
40. *See* Jasmine Aly, Kristin O'Haeger, Alicia Christy & Amanda Johnson, *Contraception Access During the COVID-19 Pandemic*, 5 CONTRACEPTION & REPROD. MED. 17 (Oct. 2020).

1. Removing Administrative and Procedural Barriers to Care

On March 23, 2020, the French government made it possible to buy hormonal contraceptives without needing to renew one's prescription and made new prescriptions available via telemedicine.[41] This welcome change is part of a larger global movement to liberalize access to contraception during the pandemic.[42] France is one of several countries that have made efforts to cut back procedural barriers to hormonal contraception during the pandemic. Like Portugal, France has sought to make birth control prescriptions available through telemedicine,[43] and is one of sixty countries that have made emergency hormonal contraception (EHC) available over the counter.[44] Other countries have extended free access to contraception for certain key populations. Belgium, for example, has made emergency contraception free for anyone who needs it, and is now completely reimbursing any contraceptive for people under 25 years old.[45] In the past, this reimbursement was available only for those under age 18.[46]

In-person screenings for many methods of contraception are often neither necessary, nor best practice.[47] In fact, many argue that physicians should not

41. *See* Olivier Véran & Marléne Schiappa, *Pilule Contraceptive, I.V.G.: le Gouvernement Mobilisé pour Assurer les Droits Sexuels et Reproductifs des Femmes,* MINISTÈRE DES SOLIDARITES ET DE LA SANTÉ (Mar. 23, 2020), https://solidarites-sante.gouv.fr/actualites/presse/communiques-de-presse/article/pilule-contraceptive-et-ivg# [https://perma.cc/WV2T-LZNY].
42. *See Joint Press Statement Protecting Sexual and Reproductive Health and Rights and Promoting Gender-Responsiveness in the COVID-19 Crisis*, GOV'T OFFICES SWED. (May 6, 2020), https://www.government.se/statements/2020/05/joint-press-statement-protecting-sexual-and-reproductive-health-and-rights-and-promoting-gender-responsiveness-in-the-covid-19-crisis/ [https://perma.cc/8NRY-E2F6].
43. *See* EUR. PARLIAMENTARY F. FOR SEXUAL AND REPROD. RTS. & INT'L PLANNED PARENTHOOD FED'N EUR. NETWORK, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC 6 (Apr. 22, 2020), https://www.epfweb.org/sites/default/files/2020-05/epf_-_ipff_en_joint_report_sexual_and_reproductive_health_during_the_covid-19_pandemic_23.04.2020.pdf [https://perma.cc/HKU6-MUG7] [hereinafter IPPF, JOINT REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC].
44. *See Emergency Contraceptive Pills: Map of the Registration Status of Dedicated Progestin-Only ECPs Worldwide*, INT'L CONSORTIUM FOR EMERGENCY CONTRACEPTION, https://www.cecinfo.org/ [https://perma.cc/V7AS-9ULE] (last visited May 11, 2021).
45. EUR. PARLIAMENTARY F. FOR SEXUAL & REPROD. RTS., EUROPEAN CONTRACEPTION POLICY ATLAS 2020—BELGIUM, https://www.epfweb.org/node/704 [https://perma.cc/H2HY-HEQ5] (last visited Mar. 1, 2022).
46. IPPF, JOINT REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC *supra* note 43.
47. *See* ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception, supra* note 21. ACOG enumerates the following reasons why over-the-counter access to hormonal birth control should be guaranteed: it has continuation rates of hormonal contraception comparable to prescription-only access and has the potential to decrease unintended pregnancy; evidence demonstrates that patients want over-the-counter access to hormonal contraception because it is easier to obtain; data support that progestin-only hormonal methods are generally safe and carry no or minimal risk of venous thromboembolism (VTE); the VTE risk with combined oral contraceptive use is small compared with the increased risk of VTE during pregnancy and the postpartum period; pelvic and breast

require any screening for certain methods of pregnancy prevention, such as EHC.[48] Because EHC is most effective when taken as early as possible after sexual intercourse, time is of the essence.[49] Given how safe these medications are, requiring screenings creates unnecessary barriers to access.[50] Making EHC available over the counter ensures that people can access it as soon as possible following unprotected sex, maximizing its effectiveness. Clare Murphy, Chief Executive Officer at the British Pregnancy Advisory Service (BPAS) notes, however, that in many countries including the UK, "over the counter" still means the medicine can only be obtained after consulting with a pharmacist.[51] Her organization argues that the medication ought to be reclassified as a General Sales List item so that it can be sold directly from the shelf of a pharmacy or supermarket without a consultation.[52] "The pandemic has made us question whether face-to-face interactions are really necessary, and access to emergency contraception is a case in point," says Murphy. Further,

> It's ridiculous for women to have to undergo a consultation even in normal times, as all the evidence shows women are capable of understanding when and how to take this medicine, and do not need further interventions. [. . .] We are hopeful the pandemic will finally push this essential medicine out from behind the counter and onto the shelf.[53]

In the United States, EHC has been available on drug store shelves, albeit at a high price, in many states since 2006. The pandemic has renewed calls for a wider range of self-administered hormonal contraceptive methods. Efforts to make

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examinations, cervical cancer screening, and sexually transmitted infection screening are not required before initiating hormonal contraception and should not be used as reasons to deny access to hormonal contraception; several studies have demonstrated that consumers are capable of using self-screening tools to determine their eligibility for hormonal contraceptive use. *Id.*

48. *See* Krishna Upadhya, *Policy Updates Guidance on Emergency Contraception*, *Advocates for Access*, AM. ACAD. PEDIATRICS (Nov. 18, 2019), https://www.aappublications.org/news/2019/11/18/contraception111819 [https://perma.cc/68HG-8QSS] ;ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception, supra* note 21; Natasha Schimmoeller & Alix Perry, *Pandemic Perspective: OTC Hormonal Contraception Needed*, 65 CONTEMP. OB/GYN J. 18, 18–19 (2020).
49. *Emergency Contraception*, WORLD HEALTH ORG. [WHO] (Nov. 9, 2021), https://www.who.int/news-room/fact-sheets/detail/emergency-contraception [https://perma.cc/44Z5-NA8S].
50. *See generally* Chanapa Tantibanchachai & Lauren Nelson, *Experts Find Strong Case for Over-the-Counter Oral Contraceptives for Adults and Teens*, JOHNS HOPKINS MED. (Mar. 14, 2017), https://www.hopkinsmedicine.org/news/media/releases/experts_find_strong_case_for_over_the_counter_oral_contraceptives_for_adults_and_teens [https://perma.cc/DR4Q-DMD8] (finding the switching the pill from pr will benefit adults and teens).
51. Telephone Interview with Clare Murphy, Chief Exec. Officer, Brit. Pregnancy Advisory Serv. (Apr. 2020).
52. *See id.*
53. *Id.*

oral contraceptive pills, the contraceptive patch, contraceptive vaginal rings, and depot medroxyprogesterone acetate injections available over the counter have doubled-down during the pandemic.[54] This would eliminate the need for prescriptions and permit consumers to self-screen for eligibility.[55] Based on the current evidence, the American College of Obstetricians and Gynecologists (ACOG),[56] Ibis Reproductive Health, and many others support over the counter access to hormonal contraception without age restrictions.[57] Increasing the availability of methods without prescription would expand access to care and by doing so, encourage uninterrupted use of birth control, potentially reducing the rates of unwanted pregnancy worldwide.[58]

2. Expanding Telemedicine

Many medical providers agree that the harms of prescriptions and screenings for oral contraception outweigh their potential benefits.[59] However, if they are mandated, they should be available online as well as in person—regardless of the status of the pandemic. This is because requiring in-person screenings is both medically unnecessary and creates barriers that contribute to inconsistent or nonuse of contraception.[60]

Several countries, including France and the United Kingdom, have authorized providers to issue contraception prescriptions via telemedicine.[61] This circumvents the obstacles posed by in-person screenings. A recent study by the American Medical Association (AMA) found that in-person screenings were not accessible to many patients because of cost barriers or lack of insurance; challenges obtaining an appointment or getting to a clinic; the clinician requiring a clinic visit, examination, or Pap test; not having a regular doctor or clinic; and

54. *See, e.g.*, Sarah Toler, *Will Coronavirus Impact Access to Contraception?*, CLUE (Apr. 16, 2020), https://helloclue.com/articles/birth-control/will-coronavirus-impact-access-to-contraception [https://perma.cc/X7SR-BNDE].
55. *See id.*
56. *See* ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception, supra* note 21.
57. *See* BRIT. PREGNANCY ADVISORY SERV., ACCESS TO CONTRACEPTION: BPAS SUBMISSION TO THE APPG ON SEXUAL AND REPRODUCTIVE HEALTH 2 (Mar. 2019), https://www.bpas.org/media/3147/bpas-submission-srh-appg-access-to-contraception.pdf [https://perma.cc/2CFZ-32PV]; ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception, supra* note 21; IBIS REPROD. HEALTH, *Free the Pill: Moving Oral Contraceptives (OCs) Over the Counter (OTC) in the US*, https://www.ibisreproductivehealth.org/projects/moving-oral-contraceptives-over-counter [https://perma.cc/6CGR-Z4LX] (last visited Mar. 30, 2021).
58. *See* ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception, supra* note 21.
59. *See id.*
60. *See id.*
61. *See generally* IPPF, JOINT REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC, *supra* note 43 (discussing how France even allows women to buy contraceptives without renewing their prescriptions).

difficulty accessing a pharmacy.[62] Although it is true that birth control consultations have historically been an access point to preventive reproductive health screenings such as Pap smears and breast exams,[63] one's access to contraception should not hinge on being able to attend an in-person visit. The expansion of telemedical screenings for hormonal birth control during COVID is therefore a positive change that should remain in place after the pandemic.

When policymakers look to expand the scope of telemedicine to encompass contraception counseling, they can, and should, take steps to ensure that a wide range of providers can provide these consultations. Policymakers should look to France's reform as a model. France now authorizes midwives as well as doctors to conduct screenings via telemedicine. Midwives have the training and expertise necessary to consult on both birth control options and abortion.[64] Indeed, midwifery is associated with "improved psycho-social outcomes" and "increased birth spacing," and increased "contraceptive use."[65]Authorizing midwives and other providers like doulas and nurses to provide telemedical contraception counseling optimizes patient choice not just in terms of which contraception method they use, but also which providers they engage with and the circumstances in which they engage with them. By increasing the range of options available, policymakers can empower people to manage their fertility in the way that works best for them. This, in turn, results in greater consistency in contraception use and better health outcomes overall.[66] Governments worldwide should therefore implement and maintain telemedical infrastructure and services for contraception after the pandemic, as well as authorize a broader spectrum of providers to conduct telemedical consultations for contraception.

3. Relocating Services to the Home Setting

The COVID-19 pandemic has changed the geography of reproductive health. While certain services were already being administered in the home setting

62. *See* Brandi Ring, Telemedicine and Mobile Apps: Accessing Birth Control Without Stepping Foot in a Clinic, at 13, educational session at Interim Meeting of the House of Delegates of the American Medical Association (Nov. 16, 2019), https://www.ama-assn.org/system/files/2019-11/i19-telemedicine-birth-control.pdf [https://perma.cc/AJ7T-4CXN] (presentation slides).

63. *See* Kristine Hopkins, Daniel Grossman, Kari White, Jon Amastae & Joseph Ptter, *Reproductive Health Preventative Screening Among Clinic vs. Over-the-Counter Oral Contraceptive Users*, 86 CONTRACEPTION 376, 377 (Oct. 212).

64. *See* NURSING & MIDWIFERY COUNCIL, STANDARDS FOR PRE-REGISTRATION MIDWIFERY EDUCATION 29 (2009), https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-preregistration-midwifery-education.pdf [https://perma.cc/LXE8-P6Q2].

65. *See generally* HOLLY POWELL KENNEDY, THE LANCET SERIES: THE INTERSECTION OF GLOBAL AND LOCAL MIDWIFERY, https://www.wilsoncenter.org/sites/default/files/media/documents/event/Kennedy_Lancet_Series.pdf [https://perma.cc/95ZT-PMAJ] (examining how midwives can improve the care of women and infants internationally). *See* Jane Sandall, Hora Soltani, Simon Gates, Andrew Shennan & Declan Devane, *Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women*, COCHRANE DATABASE OF SYSTEMATIC REVS. (2016).

66. *See generally* Dehlendorf et al., *supra* note 25 (improving the quality of contraceptive use prevents unintended pregnancies).

before the pandemic, lock-down measures have incentivized health systems to expand access to information and support for self-managed reproductive health care options.[67] For years, growing numbers of reproductive health care products have become available outside medical settings, including home pregnancy tests, testing and treatment for sexually transmitted infections (STIs), and some longer acting contraceptives.[68] In 2019, the WHO described these developments as "among the most promising and exciting new approaches to improve health and well-being, both from a health systems perspective and for people who use these interventions."[69] Of course, reproductive justice advocates must continue to prioritize access to clinical care because there will always be certain forms of care for which the home setting is inappropriate or unsafe. But expanding legal access to services that can be safely managed outside of clinical settings is an exciting development that should continue beyond the pandemic era.

Today, self-help technologies are available across the reproductive health spectrum. In the context of contraception, methods like condoms and cervical caps have been supplemented by longer acting contraception options that people can control on their own with reduced clinical intervention, such as self-injections of Sayana Press[70] and vaginal rings.[71] People can also perform their own home-based STI testing, including human papillomavirus (HPV) testing, which reduces the need for invasive Pap smear tests as a first-line approach.[72] Fertility care is also becoming increasingly self-manageable. Ovulation predictors, home pregnancy and sperm-count tests, home insemination kits, and phone-based apps allow people to monitor their fertility on their own, and from home.[73] In the context of childbirth, in-home fetal monitors, ultrasounds, and blood pressure cuffs now allow people to monitor their pregnancies at home.[74] Finally, in the abortion context, medication abortion with mifepristone and misoprostol enables people to

67. *See, e.g.*, Elsa Ohlen, *Pandemic Seen Changing How Women Get Reproductive Health Care*, REUTERS (Aug. 11, 2020, 5:54 PM), https://www.reuters.com/article/us-health-women-abortion/pandemic-seen-changing-how-women-get-reproductive-health-care-idUSKCN2572SL [https://perma.cc/6VRH-UJY8].
68. *See* Marjorie Murray, Martha Brady & Jennifer Kidwell Drake, *Women's Self-Care: Products and Practices*, OUTLOOK ON REPROD. HEALTH, Nov. 2017, at 3–5; Michelle Remme, Manjulaa Narasimhan, David Wilson, Moazzam Ali, Lavanya Vijayasingham, Fatima Ghani & Pascale Allotey, *Self-Care Interventions for Sexual and Reproductive Health and Rights: Costs, Benefits, and Financing,* 365 BRIT. MED. J. 1, 1 (2019).
69. *See* WHO, WHO CONSOLIDATED GUIDELINE ON SELF-CARE INTERVENTIONS FOR HEALTH: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (2019), https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf?ua=1 [https://perma.cc/2YL6-HNZX].
70. *DMPA-SC* (brand name Sayana Press) is an injectable contraceptive. *See* Path, *The Power to Prevent Pregnancy in Women's Hands: DMPA-SC Injectable Contraception* (Sept. 12, 2018), https://www.path.org/articles/dmpa-sc/.
71. *See id*. at 66.
72. *Id.* at 69.
73. *Id.* at 61.
74. *See* Gabriela Weigel, Brittni Frederiksen & Usha Ranji, *Telemedicine and Pregnancy Care*, KAISER FAM. FOUND. (Feb. 26, 2020), https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/ [https://perma.cc/94ZF-JP33].

end their own pregnancies without medical intervention.[75] Each of these self-managed care options represents promising developments that have the potential to radically expand access to reproductive health care, especially for people who cannot access care in clinical settings.[76]

While innovation in each of these arenas predates COVID, changes made during the pandemic should remain in place because they increase access to reproductive health care for groups that have been historically under-served or unable to access care with dignity.[77] As researchers have argued, "self-care interventions could enable health systems to get 'more health for the money' through technical and productive efficiency gains."[78] Efforts to increase access to, and the quality of, home care are therefore worth sustaining beyond the current moment of crisis.[79]

II. FERTILITY CARE: HOW AND WHY IT TOOK A PANDEMIC TO SERIOUSLY RECONSIDER STRUCTURAL BARRIERS TO CARE & THE POSSIBILITIES OF SELF-MANAGED FERTILITY OPTIONS.

For centuries, a troubling principle guided many Western reproductive health systems: the belief that the state has a role in controlling who should, and should not, have access to family building. This section will argue that the COVID-19 pandemic has proven that it is possible to significantly reduce structural and cultural barriers to fertility care by reducing the role that doctors play in it.

A. Regulating (In)fertility Care: How Mythologies Surrounding "Suitable" Parenthood Have Shaped Infertility Care.

Though access to fertility care varies significantly across countries and regions, some universal norms exist. Before addressing legal and economic barriers to fertility care access, this Article will outline and historically contextualize each of these norms.

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75. *See generally* Murray et al., *supra* note 68 (illustrating how people around the world can safely manage at-home abortions through medical abortion);, Remme et al., *supra* note 68.
76. This could be because of any variety of reasons including, but not limited to, cost and transportation barriers, a lack of gender affirming and culturally safe care availability, trauma associated with negative experiences with health care in the past, and others.
77. *See id.* at xiii.
78. *See also* Remme et al., *supra* note 68 (examining and proposing reforms to the financing of health care to improve efficiency and equity); WHO, HEALTH SYSTEMS FINANCING: THE PATH TO UNIVERSAL COVERAGE (2010), https://www.who.int/whr/2010/10_summary_en.pdf?ua=1 [https://perma.cc/9894-FMN6].
79. *See, e.g.,* Roger Pebody, *HIV Self-Testing Has Several Advantages, but Some Barriers to HIV Testing Likely to Remain*, AIDSMAP (June 7, 2016), https://www.aidsmap.com/news/jun-2016/hiv-self-testing-has-several-advantages-some-barriers-hiv-testing-likely-remain [https://perma.cc/NSM5-66YG].

1. Harmful Parenting Mythologies

Racism, classism, and heteronormativity have profoundly shaped policies that restrict fertility care access across the globe.[80] In the United States, the government has historically pronounced certain communities "unfit" for parenthood and used that as the basis for denying them access to family building. The legacies of slavery, the eugenics movement, the forced removal of Native American children, the use of LGBTQIA+ status as a disqualifier in custody proceedings, and the mass sterilization of people of color and people with disabilities all lurk behind U.S. refusal to make fertility care affordable for everyone. These histories inform the cultural biases that people hold about "good" and "bad" parenthood, and the degree of necessity and worthiness that they attach to the idea of fertility care.[81] Policymakers are not immune to these misconceptions, and often let them drive regulatory and budgetary decision-making.[82] For this reason, we can understand forced sterilization, family separation, and the denial of equal access to fertility care as part of a State effort to control who gets to parent.[83] Giving some people a positive right to care and not others, or providing government assistance to some and not others, is discrimination.[84] When unequal treatment stands on the shoulders of centuries of

80. *See generally* Ethics Comm. of the Am. Soc'y for Reprod. Med., *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54, 54 (2021) (explaining how disparities in access to effective treatment in reproductive medicine are tied to many factors, including socioeconomic status, geography, race, ethnicity, religion, sexual orientation, gender identity, marital status, and conscious or unconscious discrimination).

81. *See id.*; Lynn White, Julia McQuillan & Arthur L. Greil, *Explaining Disparities in Treatment Seeking: The Case of Infertility*, 85 FERTILITY & STERILITY 853 (2006); Chris Duke & Christine Stanik, *Overcoming Lower-Income Patients' Concerns About Trust and Respect from Providers*, HEALTH AFFAIRS (Aug. 11, 2016), https://www.healthaffairs.org/do/10.1377/forefront.20160811.056138/full/ [https://perma.cc/6BPP-JA85].

82. *See generally* David Orentlicher, *Discrimination Out of Dismissiveness: The Example of Infertility*, 85 IND. L. J. 143, 181 (2010) (arguing that infertility not being considered a disability negatively impacts policymaking, insurance, and access to fertility care, and that "[r]eproductive policies in the United States have long favored procreation by whites and wealthier persons and disfavored procreation by minorities and poor individuals");Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 30 (2008); Deborah L. Steinberg, *A Most Selective Practice: The Eugenic Logics of IVF,* 20 WOMEN'S STUD. INT'L' F. 33 (1997); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy,* 104 Harv. L. Rev. 1419, 1436-50 (1991) (discussing the history of public policies in the United States that devalued black motherhood); Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 937-42 (1996).

83. *See* Maya Manian, *Immigration Detention and Coerced Sterilization: History Tragically Repeats Itself*, ACLU (Sept. 29, 2020), https://www.aclu.org/news/immigrants-rights/immigration-detention-and-coerced-sterilization-history-tragically-repeats-itself/ [https://perma.cc/9N2W-QKHU] ("Over the course of this long history, both public and private actors in the U.S. targeted the poor, the disabled, immigrants, and racial minorities for forced sterilization.").

84. *See* Ethics Comm. of the Am. Soc'y for Reprod. Med., *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54, 58 (2021) ("Legal scholars have argued that the lack of insurance coverage for

reproductive oppression, we should not consider it facially neutral. Active steps are necessary in order to re-align fertility care with broader principles of health equity and human rights.

2. Current Practice: How Law & Policy Determines Who Gets to Parent

Currently, most countries create legal and economic barriers to fertility care access by restricting things like sexuality and partnership. Though it varies by cultural context, most countries currently restrict legal access to fertility care based on sexual orientation, marital status, and socioeconomic status.[85] While the U.S. does not have a federal prohibition on same-sex couples and single people using assisted reproductive technology (ART), subtle legal and policy obstacles nevertheless hinder the ability of low income people and LGBTQIA+ families to access the care they need to have children.[86] For example, many insurance plans do not cover the cost of surrogacy (which is necessary for many LGBTQIA+ families) or require couples to undergo a period of infertility prior to being able to access care.[87] In addition, the public insurance programs of Medicaid and Medicare do not cover fertility care in most states and many jurisdictions use parentage and medical licensure laws to criminalize home-based fertility care options, which tend to be less expensive and more gender-affirming.[88] The failure

infertility in the United States operates to discriminate against significant groups of people and prevents them from obtaining medical assistance to reproduce.").

85. *See Infertility*, WHO (Sept. 14, 2020), https://www.who.int/news-room/fact-sheets/detail/infertility [https://perma.cc/URZ5-W9WK] (naming cost barriers and bans on third-party reproduction as common trends worldwide); C. Calhaz-Jorge, Ch De Geyter, M.S. Kupka, C. Wyns, E. Mocanu, T. Motrenko, G. Scaravelli, J. Smeenk, S. Vidakovic & V. Goossens, *Survey on ART and IUI: Legislation, Regulation, Funding and Registries in European Countries*, 2020 HUM. REPROD. OPEN 1, 3 (2020) (finding that eleven surveyed countries only permit heterosexual couples to access ART care, while five allow ART and IUI for both "single women and same sex couples," with most others surveyed falling "somewhere between these two extremes with … 30 offering treatments to single women and 18 to female couples"). *See also* Willem Ombelet, *Global Access to Infertility Care in Developing Countries: A Case of Human Rights, Equity and Social Justice*, 3 FACTS, VIEWS & VISION OBGYN 257 (2011) (providing a cross-cultural analysis of barriers to fertility care access in developing countries, such as legal and cultural barriers, as well as those stemming from lack of funding and capacity); Marie Thoma, Jasmine Fledderjohann, Carie Cox & Rudolph Kantum Adageba, *Biological and Social Aspects of Human Infertility: A Global Perspective,* OXFORD RES. ENCYCLOPEDIAS, GLOB. PUB. HEALTH 35–41 (2021).

86. *LGBTQ+ Legislation Initiatives*, RESOLVE, https://resolve.org/get-involved/become-an-advocate/our-issues/lgbtq-legislation-initiatives/ [https://perma.cc/22NA-ZPBY] (last visited May 17, 2021); *LGBTQ Patients Face Discrimination and Erasure When Seeking Reproductive Healthcare*, BIXBY CTR. GLOB. REPROD. HEALTH, https://bixbycenter.ucsf.edu/news/lgbtq-patients-face-discrimination-and-erasure-when-seeking-reproductive-health-care [https://perma.cc/2KPB-WY84] (last visited May 17, 2021).

87. *See id.*

88. *See, e.g.*, Emily Kazyak, Brandi Woodell, Kristin S. Scherrer & Emma Finken, *Law and Family Formation Among LGBQ-Parent Families*, 56 FAM. CT. REV. 364 (2018) ; David Kaufman, *The Fight for Fertility Equality*, N.Y. TIMES (July 24, 2020), https://www.nytimes.com/2020/07/22/style/lgbtq-fertility-surrogacy-coverage.html [https://perma.cc/TV94-SQSE] (providing an overview of the fertility equality movement,

to cover fertility care also disproportionately impacts people of color, who researchers have found have "higher rates of infertility and lower rates of accessing fertility care than their white contemporaries," in part because economic inequality resulting from institutionalized racism.[89] Indeed, when ART treatment is not covered, it is especially likely to be prohibitively expensive for people of color.[90] By keeping fertility care unaffordable and restricted to clinical settings, the state prevents those who cannot access mainstream health care—for personal or financial reasons— from becoming parents.[91]

B. Fertility in a Pandemic: How Lock-Down Transformed Care Access

Fertility services were quickly deemed "non-essential," and largely suspended as coronavirus outbreaks emerged across the globe.[92] This has been

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which tackles each of the areas articulated above); Gabriela Weigel, Usha Ranji, Michelle Long & Alina Salganicoff, *Coverage and Use of Fertility Services in the U.S.*, KAISER FAM. FOUND. (Sept. 15, 2020), https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/ [https:perma.cc/77KQ-ASQJ].

89. *Inequality in Infertility: Black, Indigenous and People of Color*, PROGYNY (Dec. 29, 2020), https://progyny.com/blog/lets-talk-fertility/inequality-in-infertility-black-indigenous-and-people-of-color/ [https://perma.cc/WM7K-CA9X].

90. *See, e.g.*, Molly Quinn & Victor Fujimoto, *Racial and Ethnic Disparities in Assisted Reproductive Technology Access and Outcomes*, 105 FERTILITY & STERILITY 1119, 1120-21 (2016) ("The cost of care has been identified as the greatest barrier to access to infertility care in the U.S. and likely explains a significant amount of the shared contribution of ethnicity/race, education level, and income toward disparities in access.").

91. *See*, *e.g.*, Ethics Comm. of the Am. Soc'y for Reprod. Med., *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54 (2021); Nechama Moring, *I Can't Afford Sperm. So I Did DIY Fertility Treatment In My Bathtub*, TALK POVERTY (Dec. 15, 2021), https://talkpoverty.org/2021/12/15/cant-afford-sperm-diy-fertility-treatment-bathtub/ [https://perma.cc/HL6A-MF3D]; Liza Mundy, *A Special Kind of Poverty,* WASH. POST (Apr. 20, 2003), https://search-proquest-com.proxygt-law.wrlc.org/hnpwashingtonpost/docview/2263600506/AB75E70D69E54DBCPQ/1?accountid=36339 [https://perma.cc/D2CP-YEL7] (discussing significant financial barriers low-income individuals face when seeking fertility care).

92. *See generally* Lilach Marom Haham, Michal Youngster, Adi Kuperman Shani, Samantha Yee, Reut Ben-Kimhy, Tamar R. Medina-Artom, Ariel Hourvitz, Alon Kedem & Clifford Librach, *Suspension of Fertility Treatment During the COVID-19 Pandemic: Views, Emotional Reactions and Psychologic Distress Among Women Undergoing Fertility Treatment,* 42 REPROD. BIOMED. ONLINE 849 (2021); Carlo Alviggi, Sandro C. Esteves, Raoul Orvieto, Alessandro Conforti, Antonio La Marca, Robert Fischer, Claus Y. Andersen, Klaus Bühler, Sesh K. Sunkara, Nikolaos P. Polyzos, Ida Strina, Luigi Carbone, Fabiola C. Bento, Daniela Galliano, Hakan Yarali, Lan N. Vuong, Michael Grynberg, Panagiotis Drakopoulos, Pedro Xavier, Joaquin Llacer, Fernando Neuspiller, Marcos Horton, Matheus Roque, Evangelos Papanikolaou, Manish Banker, Michael H. Dahan, Shu Foong, Herman Tournaye, Christophe Blockeel, Alberto Vaiarelli, Peter Humaidan & Filippo M. Ubaldi, *COVID-19 and Assisted Reproductive Technology Services: Repercussions for Patients and Proposal for Individualized Clinical Management*, 18 REPROD. BIOLOGY & ENDOCRINOLOGY 45 (2020) (discussing the suspension of most fertility care and, writing in late April 2020, examining the implications of a potential prolonged stoppage in fertility care). *See also* Nathalie Vermeulen, Baris Ata, Luca Gianaroli, Kersti Lundin, Edgar Mocanu, Satu Rautakallio-Hokkanen, Juha S. Tapanainen & Anna Veiga, The ESHRE COVID-19 Working Group, *A Picture of Medically Assisted Reproduction Activities During the COVID-19 Pandemic in Europe*, 2020 HUM. REPROD. OPEN 1 (2020) (examining pauses in fertility care in European countries in spring

devastating for many people seeking infertility treatment world-wide, in particular those approaching age cut-offs for clinical care.[93] However, some governments have enacted noteworthy changes with the potential to increase access to care. Fewer procedural hurdles, paired with more widespread access to telemedical consultation and home-based care, ultimately have made the landscape of fertility care more patient-centered than it was prior to COVID-19.

1. Removing Administrative & Procedural Barriers to Care

The pandemic has influenced providers to remove certain barriers to access, despite fertility care being a highly regulated form of reproductive health care. Many governments have cut back on the number of in-person procedures and screenings prior to commencing treatment. For example, the Human Fertilisation and Embryology Authority (HFEA) in the United Kingdom issued guidance directing all fertility clinics to implement a COVID response strategy that complied with "requirements relating to . . . social distancing." [94] This, in turn, increased interest in and use of telemedicine (see Part II.B.2) and encouraged clinics to cut back on the number of in-person screenings. Clinics worldwide pared down in-person clinical intervention and increased their use of telemedicine.[95] The CARE Fertility clinic group in the UK, for example, offers a "minimal-contact drop-off service for sperm providers to bring their semen samples to the clinic for analysis," offers home kits for a key hormone test, and "only ask[s] you to come

and summer 2020).

93. *See, e.g.*, Zeynep B. Gürtin, Ephia Jasmin, Philomena Da Silva, Carmel Dennehy, Joyce Harper & Shirin Kanjani, *Fertility Treatment Delays During COVID-19: Profiles, Feelings and Concerns of Impacted Patients*, 14 REPROD. BIOMED. & SOC'Y ONLINE 251 (2022); Kimberley Molina, *Fertility Treatments Should Be Considered Essential, Say Patients*, CBC NEWS (May 3, 2021, 4:00 AM), https://www.cbc.ca/news/canada/ottawa/ivf-clinics-necessary-patients-say-1.6011195 [https://perma.cc/V2B2-MJFD] (discussing the impact of delays in fertility treatments in Canada due to COVID-19 public health orders to stop "non-emergent and non-urgent surgeries and procedures").

94. HUM. FERTILISATION & EMBRYOLOGY AUTH., DIRECTIONS GIVEN UNDER HUMAN FERTILISATION AND EMBRYOLOGY ACT 1990 (AS AMENDED): COVID-19 TREATMENT COMMENCEMENT STRATEGY 3 (2020), https://portal.hfea.gov.uk/media/1543/2020-04-28-general-direction-0014-version.pdf [https://perma.cc/XJ4J-6HTK].

95. *See, e.g.*, Elizabeth Cutting, Sally Catt, Beverley Vollenhoven, Ben W. Mol & Fabrizzio Horta, *The Impact of COVID-19 Mitigation Measures on Fertility Patients and Clinics Around the World*, REPROD. BIOMED. ONLINE (Dec. 27, 2021), https://www.rbmojournal.com/article/S1472-6483(21)00616-7/fulltext [https://perma.cc/R45A-S9W5]; Carlo Alviggi, Sandro Esteves, Raoul Orvieto, Alessandro Conforti, Antonio La Marca, Robert Fischer, Claus Andersen, Klaus Bühler, Sesh K. Sunkara, Nikolaos Polyzos, Ida Strina Luigi Carbone, Fabiola C. Bento, Daniela Galliano, Hakan Yarali, Lan N. Vuong, Michael Grynberg, Panagiotis Drakopolous, Pedro Xavier, Joaquin Llacer, Fernando Neuspiller, Marocs Horton, Matheus Roque, Evangelos Papanikolaou, Manish Banker, Michael H. Dahan, Shu Foong, Herman Tournaye, Christophe Blockeel, Alberto Vaiarelli, Peter Humaidan & Filippo M. Ubaldi, *COVID-19 and Assisted Reproductive Technology Services: Repercussions for Patients and Proposal for Individual Case Management*, 18 Reprod. Biology & Endocrinology 45 (2020).; John C. Schoen, *Providers, Patients Alike Embrace Telehealth for Fertility Services*, HEALIO (Oct. 20, 2021), https://www.healio.com/news/womens-health-ob-gyn/20211020/providers-patients-alike-embrace-telehealth-for-fertility-services [https://perma.cc/RKE4-VWG3].

into the clinic for vital monitoring."[96] On its website, the clinic group states: "We can reassure you that we won't compromise your treatment by making these changes."[97] If measures exist to increase the convenience of treatment to patients without sacrificing quality of care, providers should implement those measures permanently. Providers should use this time as an opportunity to explore creative ways to meet patient needs, including how to minimize administrative and procedural obstacles to accessing care.

2. Expanding Telemedicine

"What many people don't realize is that returning to a fertility clinic after a loss can itself be a re-traumatizing experience."[98] Tracey Chester is a counselor who works with people experiencing infertility in the U.K.[99] She feels that expanded access to telemedicine in the realm of fertility care has been a positive and well-received change through the COVID-19 pandemic.[100] By conducting all appointments not involving a medical procedure online, fertility services have made these meetings more accessible, increased patient privacy,[101] and reduced the anxiety that many infertility patients experience from the physical space itself. In addition to the many people who experience anxiety in fertility clinics because of previous losses or negative experiences relating to failed procedures, fertility clinics are often gendered spaces that can be triggering for LGBTQIA+ people.[102]

Fertility care is also often construed as a luxury. "People think: You're breeders anyway. They think: You already have too many children," Sunyatta Amen, a Maryland-based doctor and fertility specialist, told the *Washington Post*.[103] The *Post* summed up the "persistent myth" that lower-income groups do not suffer from infertility: "[T]he myth is that the less money a person has, the more babies a person has: that the poor are unstoppably fertile, popping out baby after baby that they cannot afford to clothe or educate or feed."[104] Society perceives poor people as having too many children for their own good, and the

96. *IVF During the Coronavirus Pandemic (COVID-19)*, CARE FERTILITY, https://www.carefertility.com/where-to-start/ivf-during-the-coronavirus-pandemic-covid-19/ [https://perma.cc/C5BW-2ZFG] (last visited May 11, 2021).
97. *Id.*
98. Virtual Interview with Tracey Chester, Fertility Counselor, British Infertility Counseling Ass'n. (June 2, 2020).
99. *Id.*
100. *Id.*
101. *Id.* According to Tracey Chester, this is possible because patients no longer have to provide an excuse to a supervisor for why they are missing work or run the risk of encountering someone they know at the clinic. *Id.*
102. *See generally* Abirami Kirubarajan, Priyanka Patel, Shannon Leung, Bomi Park & Sony Sierra, *Cultural Competence in Fertility Care for Lesbian, Gay, Bisexual, Transgender and Queer People: A Systematic Review of Patient and Provider Perspectives*, 115 FERTILITY & STERILITY 1294 (2021) (finding that a lack of gender-affirming and culturally competent care prevents many LGBTQ people from accessing fertility care).
103. Mundy, *supra* note 91.
104. *Id.*

State frequently views their children as unplanned and unwanted.[105] "The flip side of the myth," as the *Post* put it, is that infertility only plagues the rich.[106] We imagine fertility patients as wealthy, probably white working women who chose to delay pregnancy just a little too long for the sake of their career.[107] This vision of infertility shapes people's experiences of fertility clinics and can render them both stigmatizing and uncomfortable spaces for many.

Telemedical appointments for fertility care significantly alleviate patient discomfort. The U.K., U.S., and Canada have expanded telemedicine services for fertility counseling.[108] Patients in all three countries have reported positive experiences with video conferencing.[109] None report feeling that conferencing has compromised the patient-provider relationship.[110] On the contrary, Chester insists that patients feel more able to speak openly when "in their 'own private and confidential space.'"[111] While key aspects of fertility care may still require an in-person visit, fertility clinics should continue to offer counseling and psychological screenings remotely.

3. Relocating Services into the Home Setting

On March 17, 2020, the American Society for Reproductive Medicine (ASRM) issued guidance for patient and clinical management during the pandemic.[112] Key recommendations were to:

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105. *Id.*

106. *See* Ethics Comm. of the Am. Soc'y for Reprod. Med., *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54, 57 (2021) ("The status of fertility treatment as being available mainly to non-Hispanic whites and the economic elite perpetuates the unfair dismissal of fertility treatment as a lifestyle choice or as a luxury comparable to elective cosmetic surgery.").

107. *See* Liza Mundy, *A Special Kind of Poverty,* WASH. POST (Apr. 20, 2003), https://search-proquest-com.proxygt-law.wrlc.org/hnpwashingtonpost/docview/2263600506/AB75E70D69E54DBCPQ/1?accountid=36339 [https://perma.cc/D2CP-YEL7]

108. *See, e.g.*, John C. Schoen, *Providers, Patients Alike Embrace Telehealth for Fertility Services*, HEALIO (Oct. 20, 2021), https://www.healio.com/news/womens-health-ob-gyn/20211020/providers-patients-alike-embrace-telehealth-for-fertility-services [https://perma.cc/RKE4-VWG3]; Goldi Gill, *CFAS Communication on COVID-19*, CANADIAN FERTILITY & ANDROLOGY SOC'Y, https://cfas.ca/CFAS_Communication_on_COVID-19.html#february25 [https://perma.cc/FN23-TLLK] (last visited Apr. 1, 2022).

109. *See, e.g.*, Ivy L. Lersten, Angela Fought, Christina Julia Yannetsos, Jeanelle Sheeder & Cassandra Roeca, *Patient Perspectives of Telehealth for Fertility Care: A National Survey*, 116 FERTILITY & STERILITY E375 (2021); Einav Kadour-Peero, Ido Feferkorn, Ranit Hizkiyahu, Ezgi Demirtas, *The Effect of Telemedicine During the COVID-19 Pandemic on IVF Treatment*, 116 FERTILITY & STERILITY E297 (2021).

110. *See id.*

111. It is important to note that there are many circumstances where this may not be the case, such as in circumstances where the home is a site of interpersonal or inter-partner violence.

112. AM. SOC'Y FOR REPROD. MED., PATIENT MANAGEMENT AND CLINICAL RECOMMENDATIONS DURING THE CORONAVIRUS (COVID-19) PANDEMIC (2020), https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/covid-19/covidtaskforce.pdf [https://perma.cc/V6UJ-8B7C].

1. Suspend initiation of new treatment cycles, including ovulation induction, intrauterine inseminations (IUIs), in vitro fertilization (IVF) including retrievals and frozen embryo transfers, as well as non-urgent gamete cryopreservation;
2. Strongly consider cancellation of all embryo transfers whether fresh or frozen;
3. Continue to care for patients who are currently ''in-cycle'' or who require urgent stimulation and cryopreservation;
4. Suspend elective surgeries and non-urgent diagnostic procedures; and
5. Minimize in-person interactions and increase utilization of telehealth.[113]

The United States was one of many governments that deemed infertility treatment and fertility services as non-essential.[114] This left many infertility patients stranded. However, in the words of Marta Jansa Perez, Director of Embryology at BPAS, "when people are determined to try to have children, they will do anything to access treatment."[115] When obstacles to care proliferate, people do not abstain from care; instead, they get creative. In addition to self-tracking fertility at home, people around the globe are self-administering hormonal injections for assisted reproduction[116] and even managing insemination procedures at home.[117]

A lesser-known subculture of midwives began branching out from delivering babies to helping create them over a decade ago.[118] However, COVID-19 has increased public awareness of—and reliance on—midwifery support for fertility treatment in the United States.[119] Fertility care is increasingly incorporated into the scope of midwifery practices in the U.S., and midwives can administer a remarkable number of these services in the home, from tracking and testing services to more complex insemination procedures. Intrauterine insemination (IUI), for example, is a form of insemination that places washed sperm[120] inside

113. *Id.*
114. Giulia Cavaliere, *Non-essential Treatment? Sub-Fertility in the Time of COVID-19 (and Beyond)*, 41 REPROD. BIOMED. ONLINE 543, 543 (2020). "Essential health care" services were understood as those which respond to life-threatening, emergency health situations. *Id.* For a more in-depth discussion and critique of why fertility care was deemed non-essential, *see id.*
115. Virtual Interview with Marta Jansa Perez, Director of Embryology, Brit. Pregnancy Advisory Serv. (Apr. 6, 2020).
116. *See* Laura Ferguson, Susana Fried, Thabo Matsaseng, Sundari Ravindran & Sofia Gruskin, *Human Rights and Legal Dimensions of Self Care Interventions for Sexual and Reproductive Health*, 365 BRIT. MED. J. 1941 (2019).
117. *See* Jillian Keenan, *Beyond the Turkey Baster,* SLATE (Aug. 26, 2013, 2:58 PM), https://slate.com/human-interest/2013/08/intrauterine-insemination-at-home-midwives-are-performing-iuis-without-formal-education-or-regulation.html [https://perma.cc/GC4H-ZZJ5].
118. *See id.*
119. *See generally* Adelle Dora Monteblanco, *The COVID-19 Pandemic: A Focusing Event to Promote Community Midwifery Policies in the United States*, 3 SOC. SCI. & HUMAN. OPEN 100104 (2021).
120. Sperm washing is the process of separating healthy, motile (swimming) sperm from the rest

the uterus to facilitate fertilization, increasing the number of sperm that reach the fallopian tubes and thus the chance of fertilization.[121] IUI is roughly two to three times more successful than intracervical insemination, where sperm is inserted inside the cervix.[122] A growing number of midwifery practices now offer the service in-home. Kristin Kali, a Seattle-based midwife who specializes in fertility and LGBTQIA+ family building, explained:

> Intrauterine insemination is a simple, low-tech procedure that can easily be performed by a midwife at home. In fact, many clients who have previously experienced IUI in a clinic tell me that not only do they feel more relaxed at home, they are surprised to find that IUIs can be painless. I believe this is because I take the time to ensure that they are comfortable, and I rely on gentleness and finesse to navigate the cervix rather than forcing my way through with instruments.[123]

Indeed, a midwife's formal training already includes the skills required to safely perform IUIs, such as how to insert a speculum, navigate obstetric and gynecological anatomy, and ensure a sterile environment, making in-home IUI a natural and logical extension of the home birth movement.[124] Michelle Borok, a San Francisco-based midwife who offers home IUI services, described the home birth midwife as "the ideal provider to offer IUIs to those on a conception journey."[125] She argued that "access to a provider that can show up at your home, day or night, weekend or holiday, is critical to getting the timing just right. And with IUIs, timing is vital."[126] In addition, the lower cost of home inseminations relative to in-clinic inseminations could make fertility care more accessible to lower- and middle-income families. In-home inseminations also create a work-around for people who may feel othered or unwelcome in their local fertility clinic. For example, hetero-centric messaging often pervades fertility care; too often, clinics fail to provide gender affirming care that upholds the dignity of LGBTQIA+ people who seek their services.[127] While we must ensure that anyone who wishes to undergo treatment in a clinical setting may feel comfortable doing so, offering care in-home enables people to access care without ever having to

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of the semen specimen. Fertility Ctr. of Oregon, *What Is Sperm Washing?*, FERTILITY CTR. OF OREGON, https://fertilitycenteroforegon.com/sperm-washing-and-intrauterine-insemination-iui/.

121. *See* Nina Carroll & Julie R. Palmer, *A Comparison of Intrauterine Versus Intracervical Insemination in Fertile Single Women*, 75 FERTILITY & STERILITY 656 (2001).

122. *See id.*

123. Virtual Interview with Kristin Kali, Licensed Midwife, MAIA Midwifery & Fertility (Apr. 7, 2020).

124. *See* Michelle Borok, *Home Sweet Home … Insemination: A midwife's Journey*, BUILD NURTURE RESTORE (Jan. 6, 2017), https://buildnurturerestore.com/midwife-home-iui/ [https://perma.cc/CY3T-ZKLR].

125. *Id.*

126. *Id.*

127. *LGBTQ Patients Face Discrimination and Erasure When Seeking Reproductive Healthcare*, *supra* note 86.

engage in a health care system that has not been affirming for them in the past. Sustaining midwifery practices that offer in-home insemination is therefore worthwhile beyond the COVID-19 context.

It would be a mischaracterization to claim that COVID-19 has expanded fertility care access. Some fertility services are simply not available at home—those in need of egg collection or in vitro fertilization, for example, cannot proceed if clinics are closed. In countries like the U.K. where fertility services may only be administered in clinical settings, the pandemic has generated a significant backlog of fertility patients desperate for treatment.[128] There, the Human Fertilisation and Embryology Authority (HFEA) does not permit providers to offer IUI services outside of licensed facilities.[129] While the HFEA does permit individuals to self-inseminate without the help of a provider, this comes with serious legal risks—including imposed paternity status on the sperm donor—that deter home care and increase reliance on clinical providers.[130] Therefore, while COVID-19 has impacted fertility services in some positive ways, access to fertility services have not generally increased during the pandemic.

III. PERINATAL CARE: HOW BIRTH BECAME AN EMERGENCY, AND WHY IT TOOK A PANDEMIC TO SCALE BACK PERINATAL MEDICAL INTERVENTION.

Over-medicalization occurs when more medical care is applied to a health condition than is recommended or required to achieve better health outcomes.[131] While only fifteen percent of pregnancies will include some level of medical complication, traditional obstetric models of care—including that of the U.S.—treat most pregnancies as if they are at high risk of complications.[132] While some pregnancies may require advanced medical care to deliver healthy babies to healthy parents, most require more basic skilled perinatal care to ensure safe outcomes.[133] This section will explain how medical and cultural practices began to treat birth as an emergency, and how such policies compromise birth outcomes. Then, it will argue that the COVID-19 pandemic proved that it is possible to scale back medical intervention in childbirth, and that this improves outcomes for both pregnant people and their babies.

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128. *See Intrauterine Insemination (IUI)*, NAT'L HEALTH SERVS. [NHS] https://www.nhs.uk/conditions/artificial-insemination/ [https://perma.cc/FNL2-E8TP] (last visited May 11, 2021).

129. *See id.*

130. *Id.*

131. *See Over-Medicalization of Maternal Health in America*, EVERY MOTHER COUNTS (Sept. 11, 2014), https://blog.everymothercounts.org/over-medicalization-of-maternal-health-in-america-40e20e6b4171 [https://perma.cc/M5DD-FW22]; Note, *The Legal Infrastructure of Childbirth*, 134 HARV. L. REV. 2209, 2211-2212 (2021).

132. *See id.*

133. *See, e.g.*, Note, *supra* note 131, at 2211-2212; Rebecca Dekker, EBB 175 — Evidence on Midwives, EVIDENCE BASED BIRTH (May 5, 2021), https://evidencebasedbirth.com/evidence-on-midwives/ [https://perma.cc/PLZ7-RQCR].

A. Medicalized Birth: Mapping the Criminalization of Midwifery & Home Birth and Its Impact on Perinatal Care.

The U.S. spends more on health care than any other country but is ranked sixtieth in the world in maternal health outcomes.[134] Currently, about seven hundred people die each year in the U.S. from pregnancy- and childbirth-related complications.[135] That number is rising and closely connected with the over-medicalization of maternal health care.[136] Indeed, for the first time in history, a birthing person is twice as likely to die from pregnancy related complications than was true a generation ago.[137]

Maternal mortality rates are not evenly distributed across communities. Black and Indigenous birthing people are two to three times more likely than white birthing people to suffer or die from pregnancy complications.[138] Black, Latinx and Indigenous birthing people are both more vulnerable to coerced procedures and significantly more likely to be denied respectful care in clinical settings.[139] A recent study surveyed 2,138 birthing people in the U.S. and found that one in three people of color giving birth in a hospital setting reports experiencing disrespectful care or mistreatment.[140] The study also found that Black, Lantine/x and Indigenous people are significantly more likely to be treated with condescension, disregard, neglect, and fear-based coercion.[141] These patterns of mistreatment are consistent with broader patterns of institutionalized racism and state violence inflicted on communities of color.[142] For example, when asserting their rights to informed consent, bodily autonomy, and self-determination, birthing people of color are

134. *See Over-Medicalization of Maternal Health in America*, *supra* note 131.
135. *Pregnancy-Related Deaths*, CDC (Feb. 26, 2019), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm#:~:text=The%20death%20of%20a%20woman,of%20pregnancy%20or%20delivery%20complications [https://perma.cc/LXD8-X3QL].
136. *See* Richard Johanson, Mary Newburn & Allison Macfarlane, *Has the Medicalisation of Childbirth Gone Too Far?*, 324 BRIT. MED. J. 892 (2002) (providing a history of the medicalization of childbirth and when it stopped correlating with better health outcomes).
137. Associated Press, *An American Mom Today is Twice as Likely to Die in Childbirth than Her Own Mother Was*, MARKETWATCH (May 9, 2019, 4:35 PM), https://www.marketwatch.com/story/heres-why-us-pregnancy-deaths-are-three-times-more-likely-among-some-minority-groups-2019-05-09 [https://perma.cc/N59D-74BA].
138. *See Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths: Black, American Indian/Alaska Native Women Most Affected*, CDC (Sept. 5, 2019, 1:00 PM), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html [https://perma.cc/HK3U-APSB].
139. *See* Saraswathi Vedam, Kathrin Stoll, Tanya Khemet Taiwo, Nicholas Rubashkin, Melissa Cheyney, Nan Strauss, Monica McLemore, Micaela Cadena, Elizabeth Nethery, Eleanor Rushton, Laura Schummers & Eugene Declercq, *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH 77, 85 (2019).
140. *See id.*
141. *See id*.
142. *See generally* Dána-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor and Birthing*, 38 MED. ANTHROPOLOGY 560 (2018).

disproportionately likely to be treated as incompetent[143] and subjected to surveillance and criminalization in the same way that they are outside of health care settings.[144] Before examining contemporary care practices that contribute to over-medicalization and how they impact health outcomes, it is important to locate them within their historical context.

1. History: How "Home" Became Unsafe for Childbirth.

Prior to the Civil War, midwives were the primary providers of full-spectrum reproductive health care.[145] Most midwives at the time were Black or Indigenous women, and they held both legally and socially sanctioned roles in society.[146] When slavery ended, skilled Black midwives—sometimes referred to as "granny midwives"—presented serious competition to white men who sought to enter the practice of family medicine and obstetrics.[147] As the field gained popularity in the second half of the nineteenth century, physicians sought to eliminate pre-existing networks for obstetric care.[148] Physicians viewed granny midwives as "unwelcome interlopers" in their field.[149] Smear campaigns were used in order to push them out of the profession, some of which proliferated racist messages about the "barbaric" and "primitive" practitioners.[150] Others focused on abortion, reframing it, and the midwives who provided it, as criminal.[151] This is when birth began to be framed as a medical emergency warranting a hospital setting.

The professionalization of medicine, beginning in the late 1800s and continuing into the 1900s, gave legal license to health professionals to claim authority over obstetric care through the erection of a legal monopoly.[152]

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143. *See* Tressie McMillan Cottom, *I was Pregnant and in Crisis. All the Doctors Saw Was an Incompetent Black Woman*, TIME (Jan. 8, 2019, 7:57 AM) https://time.com/5494404/tressie-mcmillan-cottom-thick-pregnancy-competent/ [https://perma.cc/J2LX-GCU6].

144. *See* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299, 333 (2013).

145. *See* Michele Goodwin, *The Racist History of Abortion and Midwifery Bans*, ACLU (July 1, 2020), https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans/ [https://perma.cc/46S7-QXXL].

146. *See* Keisha La'Nesha Goode, Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism (2014) (Ph.D. dissertation, City University of New York) (CUNY Academic Works).

147. *See* Goodwin, supra note 145.

148. *See id.*

149. *See* Alicia D. Bonaparte, The Persecution and Prosecution of Granny Midwives in South Carolina, 1900–1940, at 129 (2007) (Ph.D. dissertation, Vanderbilt University) (Vanderbilt University Institutional Repository) [hereinafter Bonaparte, The Persecution & Prosecution of Granny Midwives].

150. *Id.* at 82, 132.

151. *Id*. at 17.

152. *See id.* at 130 (first citing PAUL STARR, THE SOCIAL TRANSFORMATION OF MEDICINE (1982); then citing JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA (Temple U. Press 1985); then citing Judith Walzer Leavitt, *The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics*, 1 MED. ANTHROPOLOGY Q. 230 (1987); and then citing Alyson Reed & Joyce E. Roberts, *State Regulation of Midwives: Issues and*

Circulating new fears about non-hospital births, physicians and other health care lobbyists advocated for medical practice regulation and criminalization of other healers with whom they competed—like midwives.[153] This coincided with the "Great Sanitary Awakening,"[154] a nineteenth century movement that identified poor hygiene as a main vehicle of transmission for disease.[155] Those who ascribed to this line of reasoning promoted public health materials that portrayed illness as "an indicator of poor social and environmental conditions, as well as moral and spiritual conditions . . . . Cleanliness, piety, and isolation were seen to be compatible and mutually reinforcing measures to help the public resist disease."[156]

Playing off these anxieties and beliefs, the passage and promotion of medical practice acts and licensure laws positioned doctors as the only legitimate source of obstetric care.[157] These laws framed midwife-attended births as dangerous and criminalized providers who could not obtain licenses that legalized their work. According to professor and sociologist Alicia Bonaparte, the proliferation of medical licensure laws was a strategic, and effective, way of eliminating granny midwives and abortion providers.[158] In her doctoral thesis, *The Persecution & Prosecution of Granny Midwives*, she explained that initially, these acts ensured that practitioners had attended socially sanctioned schools of medical instruction.[159] Over time, however, they began to require that those individuals practicing medicine were under the auspices of a governing body, such as the State Board of Medical Examiners, which explicitly excluded people of color and implicitly excluded women from membership at the time.[160] The following excerpt from a 1905 issue of the Journal of American Medicine discusses the passage of the 1905 Construction of Practice Act:

> The statutes do not attempt to discriminate between different schools of medicine or systems for the cure of disease. No method of attempting to heal the sick, however occult, is prohibited. All that the law exacts is that, whatever the system, the practitioner shall be possessed of a certificate from the State Board of Medical Examiners, and shall exercise such reasonable skill and care as are usually possessed by practitioners in good standing of that system in the vicinity

Options, 45 J. MIDWIFERY & WOMEN'S HEALTH 130 (2000)).

153. *See* Bonaparte, The Persecution & Prosecution of Granny Midwives, *supra* note 149, at 130.
154. *See* CHARLES-EDWARD AMORY WINSLOW, THE EVOLUTION AND SIGNIFICANCE OF THE MODERN HEALTH CAMPAIGN 12 (Yale U. Press 1923).
155. *See* COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, THE FUTURE OF PUBLIC HEALTH 58 (1988).
156. *Id.*
157. *See, e.g.*, Alicia D. Bonaparte, *"The Satisfactory Midwife Bag": Midwifery Regulation in South Carolina, Past and Present Considerations*, 38 SOC. SCI. HIST. 155, 160 (2014).
158. Bonaparte, The Persecution & Prosecution of Granny Midwives, *supra* note 149, at 132.
159. *See id.*
160. *See* Robert B. Baker, *The American Medical Association and Race*, 16 AMA J. ETHICS 479 (2014).

where they practice.[161]

As the passage reveals, the purpose of the Act was neither to prescribe safer or better care nor "to make any particular mode of effecting a cure unlawful," but to make a medical license a prerequisite for administering care, which in turn stripped medical authority from healers who did not—or could not—obtain certification by state boards.[162] It reserved the practice of medicine exclusively to practitioners who "possessed . . . a certificate from the State Board of Medical Examiners."[163] Requiring licensure to establish one's professional legitimacy gravely affected community healers like midwives.[164] Many state and local medical associations refused to accept Black applicants until the 1960s, and state medical boards were similarly hostile.[165] As a result, licensure laws, though neutral on their face, effectively prohibited birth work by Black midwives and other providers of color. Through these licensure laws, states were able to impose fines, fees, and in some cases, incarceration upon providers of color, thereby establishing the near total dominance of white men over the field of obstetrics.[166]

These laws were eventually accompanied by outright bans on the practice of midwifery.[167] Licensure laws are used to criminalize midwives today,[168] and continue to legitimize the view that home birth, and providers who administer care in the home setting, are dangerous. They drive pregnant people into hospitals and ensnare them in the web of over-medicalized care described above. The following section will argue that COVID-19 has transformed mainstream attitudes surrounding home birth for the better and ushered in welcome changes to the ways in which perinatal care is administered.

2. Current Practice: Over-medicalization & Maternal Mortality.

While the over-prescription of pain medication and the over-representation of OBGYNs compared to midwives illustrate over-medicalization in the United States, the country's over-medicalization is most evident from its 31.7% cesarean

161. *See* Bonaparte, The Persecution & Prosecution of Granny Midwives, *supra* note 149, at 132-33.
162. *Id.* at 133.
163. *Id.*
164. *See id.*
165. *See* Robert B. Baker, Harriet A. Washington, Ololade Olakanmi, Todd L. Savitt, Elizabeth A. Jacobs, Eddie Hoover & Matthew K. Wynia, *African American Physicians and Organized Medicine, 1846-–1968: Origins of a Racial Divide*, 300 J. AM. MED. ASS'N 306, 312 (2008); Jonathan Sidhu, *Exploring the AMA's History of Discrimination*, PROPUBLICA (July 16, 2008, 10:22 AM), https://www.propublica.org/article/exploring-the-amas-history-of-discrimination-716 [https://perma.cc/NM3B-NTB8].
166. *See* Bonaparte, The Persecution & Prosecution of Granny Midwives, *supra* note 149, at 133.
167. *See* Goodwin, supra note 145.
168. *See* Jennifer Block, *The Criminalization of the American Midwife*, LONGREADS (Mar. 10, 2020), https://longreads.com/2020/03/10/criminalization-of-the-american-midwife/#:~:text=New%20York%20midwife%20Elizabeth%20Catlin,counts%20at%20her%20upcoming%20trial.&text=Politics%20and%20patriarchy%20make%20the,of%20women%20and%20underserved%20communities [https://perma.cc/AL6F-7Q4T].

section rate.[169] This is more than twice what the World Health Organization considers to be advisable.[170] Cesarean sections are major surgeries that are medically indicated in just ten to fifteen percent of cases.[171] Based on the World Health Organization's systematic review, increasing the rates of cesarean section above fifteen percent does not reduce fetal or maternal mortality.[172] On the contrary, numerous research reviews have found that a cesarean rate above fifteen percent correlates with increased maternal mortality."[173] The American College of Obstetricians and Gynecologists (ACOG) has noted that "the rapid increase of cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality rates raises significant concern that cesarean delivery is overused."[174] Though most striking in the U.S. context, cesarean sections are over-performed in many countries around the world.[175] However, because the drivers of cesarean rates and over-medicalization more generally vary significantly depending on the region, this section will focus primarily on the U.S. context.

There are many factors that contribute to the over-medicalization of birth. One of the primary drivers is the cultural perception that pregnancy is medically complicated and dangerous.[176] Providers and pregnant people alike receive pervasive social and cultural messaging that more medical tests and treatments guarantee healthier babies and births. This vision is rooted in historic efforts to make hospitals seem like the only safe places to have babies.[177] Framing birth as an emergency is in the financial interests of both doctors and pharmaceutical companies.[178] Both have much to gain from encouraging the full spectrum of

169. Joyce A. Martin, Brady E. Hamilton, Michelle J.K. Osterman & Anne K. Driscoll, *Births: Final Data for 2019*, 70 NAT'L VITAL STAT. REP. 1 (Mar. 23, 2021), https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf [https://perma.cc/UXS2-68TW].

170. WHO, *WHO Statement on Cesarean Section Rates* (2015).

171. *See Over-Medicalization of Maternal Health in America*, *supra* note 131; ACOG, Soc'y for Maternal-Fetal Med., Aaron B. Caughey, Alison G. Cahill, Jeanne-Marie Guise & Dwight J. Rouse, *Safe Prevention of the Primary Cesarean Delivery*, 210 AM. J. OBSTETRICS & GYNECOLOGY 179 (2014); WHO, *supra* note 170.

172. *See* WHO, supra note 170.

173. *See, e.g.*, Jiangfeng Ye, Ana Pilar Betrán, Miguel Guerrero Vela, João Paulo Souza & Jun Zhang, *Searching for the Optimal Rate of Medically Necessary Cesarean Delivery*, 41 BIRTH 237 (2014); Keila Cristina Mascarello, Bernardo Lessa Horta & Mariângela Freitas Silveira, *Maternal Complications and Cesarean Section Without Indication: Systematic Review and Meta-Analysis*, 51 REVISTA DE SAÚDE PÚBLICA 105 (2017).

174. ACOG, *supra* note 171.

175. *See* Ana Pilar Betrán, Jianfeng Ye, Anne-Beth Mollar, Jun Zhang, A. Metin Gülmezoglu & Maria Regina Torloni, *The Increasing Trend in Caesarean Section Rates: Global, Regional, National Estimates: 1990-2014*, 11 PLOS ONE e0148343 (2016).

176. *See* Hindi Stohl, *Childbirth is Not a Medical Emergency: Maternal Right to Informed Consent Throughout Labor and Delivery*, 38 J. LEGAL MED. 329, 329–331 (2018) (explaining how framing birth as an emergency gets manipulated to justify excessive, and sometimes forced, medical interventions).

177. *See* Note, *supra* note 131.

178. *See, e.g.*, Elizabeth Kukura, *Obstetric Violence,* GEORGETOWN L.J. 721, 767 (2018); Alexandria Gesing, The Medicalization of Childbirth Within the United States 34 (2016) (B.A.

interventions, given that cesarean sections are more costly procedures, involving more medication and follow-up care than vaginal deliveries.[179]

Insurance providers likewise reinforce the highly medicalized model of care by paying providers more when more treatment is performed. Medical malpractice insurance for obstetricians is among the most expensive in the country.[180] When a provider or hospital is sued for maternal or fetal death or injury, their legal defense depends on the extent of medical care provided to prevent or reduce harm.[181] If a provider can document that every medical treatment available was provided, they are less vulnerable to malpractice claims and more legally defensible.[182] Many providers therefore practice high-intervention obstetric care to offset malpractice suits.[183] Thus, insurance companies, the pharmaceutical industry and providers themselves benefit from the cultural perception that birth is an emergency.

B. Birth in a Pandemic: How Lockdown Revolutionized Care, and Righted Historical Wrongs.

As COVID-19 spread throughout the United States, birthing people began to rethink hospitals as ideal sites for childbirth.[184] American legal regimes have become friendlier to midwifery and home birth than ever before as COVID-19 has forced people to increasingly associate hospitals with the risks that many birthing people of color have been factoring into their birth planning for generations. The following section provides examples from the U.S. and other regions that illustrate how these changes have taken place, as well as how perinatal care has become more accessible and safer for many people who have been historically underserved and actively harmed by mainstream medical systems.

1. Streamlining Perinatal Care

Rather than reverting to pre-COVID care norms as the pandemic wanes, providers and policymakers should evaluate the benefits and the drawbacks of the traditional approach. Early in the pandemic, the United Kingdom's Royal College of Obstetricians and Gynecologists (RCOG) recommended that maternity care providers "reduce routine appointments, provide more home visits or deliver some care and support over the phone or by video to reduce the number of times you need to travel and attend hospital/clinics."[185] One RCOG recommendation was

thesis, Union College) (on file with the author).

179. *Over-Medicalization of Maternal Health in America*, *supra* note 131.

180. *See* Colin Nabity, *How Much Does Medical Malpractice Insurance Cost?*, LEVERAGERX (May 14, 2018), https://www.leveragerx.com/blog/medical-malpractice-insurance-cost/ [https://perma.cc/HG2D-CPXP].

181. *Over-Medicalization of Maternal Health in America*, *supra* note 131.

182. *See* Kukura*, supra* note 178.

183. *See id.*

184. *See generally* Jennifer C. Nash, *Home Is Where the Birth Is: Race, Risk, and Labor During COVID-19*, 32 YALE J. L. & FEMINISM 103, 106 (2021).

185. *See* ROYAL COLL. OBSTETRICIANS & GYNAECOLOGISTS, CORONAVIRUS (COVID-19)

that "wherever possible, scans, antenatal appointments and other investigations should be provided within a single visit, involving as few staff as possible."[186] This echoes official guidelines in France, which urge providers to reduce the number of times pregnant people must visit a clinic.[187] Streamlining care and limiting the number of times that a pregnant person must take off work, find childcare, or pay for an antenatal visit is a modification that should outlast the COVID-19 pandemic. It is a waste of time and other valuable resources to require multiple in-person appointments for people who prefer telemedical support.

Moreover, certain forms of pregnancy surveillance historically carried out during mandatory in-person consultations have been eliminated during the pandemic, without leading to negative outcomes. England, for example, has dropped carbon monoxide testing, a formerly routine component of pre-natal care, during the COVID-19 pandemic.[188] These tests are administered to determine whether the pregnant person has been smoking during their pregnancy.[189] Although concerns have been expressed that this may increase health inequalities because younger and low income people are more likely to smoke,[190] providers and advocates alike have raised strong ethical reservations about the use of this test, which assumes pregnant people cannot be trusted to speak truthfully about how much they smoke and therefore must be objectively "tested."[191] The WRISK project, a public engagement collaboration between BPAS and Cardiff University exploring women's[192] experiences of risk communication in pregnancy, found that

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INFECTION IN PREGNANCY (2022), https://www.rcog.org.uk/globalassets/documents/guidelines/2022-01-11-coronavirus-covid-19-infection-in-pregnancy-v14.3.pdf [https://perma.cc/2FYU-EJGP].

186. *See id.*

187. *See COVID-19: Recommandations à l'Usage des Gynécologues Médicaux et Gynécologues Obstétriciens de Ville*, CADUCEE (Mar. 17, 2020), https://www.caducee.net/actualite-medicale/14784/covid-19-recommandations-a-l-usage-des-gynecologues-medicaux-et-gynecologues-obstetriciens-de-ville.html [https://perma.cc/VJ2E-U3ZJ] (recommending that providers privilege telehealth consultations whenever possible to limit in-person clinical visits); Anissa Boumediene, *Coronavirus: Grossesse, Pilule… Comment S'organise le Suivi Gynécologique des Femmes Pendant le Confinement?*, 20 MINUTES (Mar. 19, 2020, 5:28 PM), https://www.20minutes.fr/sante/2743251-20200318-coronavirus-grossesse-pilule-comment-organise-suivi-gynecologique-femmes-pendant-confinement [https://perma.cc/JJ4N-U99D] (describing recommendations to privilege telehealth in cases of gynecological and obstetric care to avoid in-person visits).

188. *Appendix H: COVID-19 and CO Monitoring in Pregnancy*, NHS https://www.england.nhs.uk/wp-content/uploads/2020/04/C0121-SBLCBv2-Appendix-H-Testing-info-COVID19_FINAL-002.pdf [https://perma.cc/6MD5-QFZB] (last visited May 8, 2021).

189. *See* Zara C. Usmani, Pauline Craig, Deborah Shipton & David Tappin, *Comparison of CO Breath Testing and Women's Self-Reporting of Smoking Behaviour for Identifying Smoking During Pregnancy*, 3 SUBSTANCE ABUSE TREATMENT, PREVENTION & POL'Y 4 (2008).

190. *See* Maxine Myers, *COVID-19 Changes to NHS Services May Lead to Worsening Health Inequities,* IMPERIAL COLL. LONDON (May 15, 2020), https://www.imperial.ac.uk/news/197534/covid-19-changes-nhs-services-lead-worsening/ [https://perma.cc/M35X-RHAD].

191. *See* Catherine Bowden, *Are We Justified in Introducing Carbon Monoxide Testing to Encourage Smoking Cessation in Pregnant Women?*, 27 HEALTH CARE ANALYSIS 128 (2019).

192. BRIT. PREGNANCY ADVISORY SERV., *Inaccuracies in Science Reporting on Pregnancy Linked*

many participants strongly objected to carbon monoxide testing. As one pregnant person explained,

> "I always thought it's bizarre asking someone for their subjective answer and then you are almost like, 'Right, well that means absolutely nothing because we need to do a test of the carbon monoxide in your blood anyway.' I think that's rubbish, really, because the relationship between midwife and mother is really, really important. I think we should be making sure that's as strong as possible throughout pregnancy . . . I think [testing] strengthens that power imbalance between clinician and patient."[193]

The temporary suspension of the test during the COVID-19 pandemic provides a useful opportunity to re-evaluate its role in pre-natal settings.

Models of prenatal care that limit in-person interactions are working. An international study, conducted by the American Journal of Obstetrics and Gynecology, compared different countries' approaches to prenatal care.[194] The study found that fewer visits, greater intervals between visits, and less reliance on obstetrician-gynecologists for routine, low-risk prenatal care did not negatively impact patient outcomes.[195] Lifting restrictions on telemedicine before and during the pandemic appears to produce benefits and has significantly reduced the number of missed appointments.[196] Karen Dale, R.N., M.S.N., market president for AmeriHealth Caritas in Washington, D.C., explained that "many providers have told [her] their no-show rates plummeted to zero after they began offering telehealth, including audio-only calls. When combined with remote patient monitoring and health coaching, these visits have helped to increase health literacy among patients."[197] These developments represent exciting shifts that could bolster successful birth outcomes, patient autonomy and health literacy.

2. Expanding Telemedicine

On March 4, 2020, U.S. Congress passed an 8.3-billion-dollar coronavirus response bill that gave health care practices the ability to bill patients' insurance

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to Academic Press Releases, New BPAS Research Finds (May 18, 2021), https://www.bpas.org/about-our-charity/press-office/press-releases/inaccuracies-in-science-reporting-on-pregnancy-linked-to-academic-press-releases-new-bpas-research-finds/ [https://perma.cc/M6FE-CF3K]. This study was open to trans men and gender non-conforming individuals, but all participants self-identified as women. *Id.*

193. *Id.*

194. *See* Alex Friedman Peahl, Michele Heisler, Lydia K. Essenmacher, Vanessa K. Dalton, Vineet Chopra, Lindsay K. Admon & Michelle H. Moniz, *A Comparison of International Prenatal Care Guidelines for Low-Risk Women to Inform High-Value Care*, 222 AM. J. OBSTETRICS & GYNECOLOGY 505 (2020).

195. *See id.*

196. *See* Brenda Gleason & Laurie Zephyrin, *Improving Access to Telematernity Services After the Pandemic*, COMMONWEALTH FUND (Aug. 17, 2021), https://www.commonwealthfund.org/blog/2021/improving-access-telematernity-services-after-pandemic [https://perma.cc/XV68-4PRR].

197. *Id.*

plans (including state-funded Medicare plans) for telehealth care.[198] Providers nationwide quickly shifted many pre- and post-natal visits to teleconsultations.[199] *New York Times* reporter Emily Goligoski predicted that this shift is likely to outlive the pandemic. "Dissuaded from visiting clinics but armed with blood pressure cuffs, fetal heart rate Doppler monitors and smartphones, many women are learning to self-monitor. For many parents-to-be, it's the first time we have been involved in collecting our own data or had direct communication with our care teams outside of face-to-face appointments."[200]

For some, self-managing the tracking of one's pregnancy symptoms, blood pressure, weight and fetal heart rates can feel powerful and exciting. In a recent interview with the *New York Times*, Niha Zubair, a Seattle-based data scientist, explained that she signed up for a TeleOB program for this reason.[201] The program provides patients with a blood pressure cuff and fetal monitor, along with instructions and telehealth consultation access.[202] It also predates the coronavirus. This is because many prefer video consultations to in-person visits.[203] "It's a huge time saver. I have a full-time job and two small children, and it means not having to drag kids to an appointment if I don't have child-care," Zubair said.[204]

The normalization of telehealth has real potential for serving the needs of pregnant people who might normally be cut off from prenatal care because of demanding work schedules, transportation barriers and childcare needs. Telehealth can also be preferable for people who have received disrespectful or discriminatory care in the past, or who fear it in the future.[205] Dr. Peahl at the University of Michigan said that, in the long term, "reduced-visit models and televisits will be advantageous: Patients won't have to miss work, or will be able to have kids in their lap."[206] For people living in rural areas, telehealth could revolutionize access to prenatal health care. In the United States, for example, there is a dearth of reproductive health providers in rural areas. However, most American obstetric practices require a minimum of a dozen (and frequently more)

198. *See* Emily Cochrane, *House Passes $8.3 Billion Emergency Coronavirus Response Bill*, N.Y. TIMES (Mar. 9, 2020), https://www.nytimes.com/2020/03/04/us/politics/coronavirus-emergency-aid-congress.html [https://perma.cc/ZF3E-UPGE].

199. *See* Emily Goligoski, *Prenatal Care May Look Very Different After Coronavirus*, N.Y. TIMES (May 1, 2020), https://www.nytimes.com/2020/04/28/parenting/pregnancy/coronavirus-prenatal-care.html [https://perma.cc/5895-WREM] [hereinafter Goligoski*, Prenatal Care May Look Very Different After Coronavirus*].

200. *Id.*

201. *Id.*

202. *Id.*

203. *See, e.g.*, Duncan Stewart, Ariane Bucaille, Bill Fera & Ken Abrams, *Video Visits Go Viral: COVID-19 Sparks Growth in Video Doctor's Visits*, DELOITTE (Dec. 7, 2020), https://www2.deloitte.com/xe/en/insights/industry/technology/technology-media-and-telecom-predictions/2021/virtual-doctor-video-visits.html [https://perma.cc/6F83-W6LP].

204. Goligoski*, Prenatal Care May Look Very Different After Coronavirus*, *supra* note 199.

205. *See generally* Ben Kaplan, *Access, Equity, and Neutral Space: Telehealth Beyond the Pandemic*, 19 ANNALS FAM. MED. 75 (2021).

206. Goligoski, *supra* note 199.

in-person office visits during pregnancy.[207] Expecting all pregnant people to be able to take off work, find childcare, access transportation, and pay for a doctor's visit is neither reasonable nor best practice when telemedicine is available for patients who would prefer to forgo the in-person visit.

While in-person care must remain an option—especially for those experiencing higher risk pregnancies—telehealth consultations may be a safe and effective stand-in for clinical visits. One large-scale study evaluated the efficacy of coupling text-based communication with self-monitoring of the pregnant person's weight, their blood pressure, and the fetus's heart rate. This text-based communication connected the pregnant person with their care team in addition to an online community forum—moderated by a nurse—where cohorts of pregnant people could consult with one another and their providers.[208] The study found many benefits of the telemedicine model, including increased sense of control and reassurance, lower cost of care, increased access for high-acuity patients, supportive partnerships between care team and pregnant person, increased patient satisfaction, increased patient engagement and continuity of care, less time away from work, facilities savings, and increased provider engagement and satisfaction.[209] The study concluded that telehealth aided in anticipating the needs of patients and provided access to care in a way that better accommodates the lives of many patients.[210] Indeed, research demonstrates that telemedical prenatal care provides comparable health outcomes to traditional methods of health care delivery without compromising the patient–physician relationship, and can in fact enhance patient satisfaction and engagement.[211]

Telemedicine also limits unnecessary utilization of costly medical resources, such as clinic time and nursing support.[212] For countries with limited health care resources, telemedicine could revolutionize access. This was the case in rural Hangzhou, China, for example, which enacted telemedicine provision of prenatal care.[213] Launched in 2012, their program predates the pandemic, and was initially designed to monitor people experiencing high-risk pregnancies in rural areas.[214] Pregnancies are considered "high risk" if one or more factors are present that

207. *See* Elena Muller, *What to Expect When You're Expecting With Telehealth*, HEALTH RECOVERY SOLS., https://www.healthrecoverysolutions.com/blog/what-to-expect-when-youre-expecting-with-telehealth [https://perma.cc/2M2G-5ARS] (last visited Apr. 1, 2022).

208. *See* Yvonne S. Butler Tobah, Annie LeBlanc, Megan E. Branda, Jonathan W. Inselman, Megan A. Morris, Jennifer L. Ridgeway, Dawn M. Finnie, Regan Theiler, Vanessa E. Torbenson, Ellen M. Brodrick, Marnie Meylor de Mooij, Bobbie Gostout & Abimbola Famuyide, *Randomized Comparison of a Reduced-Visit Prenatal Care Model Enhanced with Remote Monitoring*, 221 AM. J. OBSTETRICS & GYNECOLOGY 638.e1 (2019).

209. *See id.*

210. *See id.*

211. *See* ACOG, *Committee Opinion 788: Over the Counter Access to Hormonal Contraception*, *supra* note 21.

212. *See id.*

213. *See* Xu-Hong Zhu, Jing Tao, Li-Yuan Jiang & Zhi-Feng Zhang, *Role of Usual Healthcare Combined with Telemedicine in the Management of High-Risk Pregnancy in Hangzhou, China*, 6 J. HEALTHCARE ENG. 1, 1 (2019).

214. *Id.* at 2.

increase the risk of complication, including high blood pressure, multiple births, gestational diabetes, or an age over 40.[215] Hangzhou's program helps those experiencing such risk factors to consistently attend their prenatal visits with specialists who might otherwise have been unavailable in their area. Hangzhou is one of the many rural areas around the world that lack access to specialists, in particular high-risk obstetricians.[216] At-home monitoring improves access to care by eliminating transportation barriers to see specialists, and patients reported that it increases the quality of their experiences because it allows for active participation in their care and promotes self-efficacy.[217] Telemedical consultation also permits providers to "dynamically observe the health information of all high-risk pregnant women in real-time . . . [and] improve their work efficiency."[218]

Telemedicine should be extended to consultations after birth as well. Drawing from pandemic-era adjustments, postnatal care schedules in the U.S. could change from in-person appointments six weeks after delivery to tele-visits two to three weeks post-birth to check in with parents in this high-anxiety period.[219] This could lead to better postpartum experiences for parents and babies. Indeed, the COVID-19 pandemic offers an invitation to redesign maternal health infrastructure—at all stages of the pregnancy process.

3. Supporting Home Births

There are many reasons why the pandemic has deterred people from hospital births. These include—but are not limited to—the possible risk of infection, the inability to have loved ones present, and the risk that the baby may not be able to come home on schedule because of possible exposure to COVID.[220] However, there are many reasons why people might choose home birth even under normal circumstances. According to Rebecca Brione, who works in research and policy at Birthrights UK:

> The women who contact our advice service seeking support for home birth have often thought very carefully about what is important to them, including weighing up the evidence on the outcomes for both fetuses and birthing people choosing home birth, and the evidence that suggests that those who give birth at home often report more positive care experiences than those in hospital. These are

215. Mayo Clinic Staff, *High Risk Pregnancy: Know What to Expect*, MAYO CLINIC, https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/high-risk-pregnancy/art-20047012 [https://perma.cc/JT4S-RVJQ] (last visited Feb. 8. 2020).
216. *See generally* Xu-Hong Zhu et al., *supra* note 213 (explaining health care in Hangzhou, China).
217. *Id.*
218. *Id.*
219. *See* Goligoski, *supra* note 199.
220. *See* Jaenique Hurlock, *With Hospitals Full of COVID-19 Patients, She Chose to Give Birth at Home,* NAT'L GEOGRAPHIC (May 8, 2020), https://www.nationalgeographic.com/history/2020/05/inside-a-home-birth-in-the-time-of-coronavirus/ [https://perma.cc/LPB4-URYA].

decisions that should be heard and respected.[221]

People seek home births for a variety of reasons: they want less medical intervention, such as labor induction; they want the freedom to control their birthing environment; they feel a midwife would be more respectful of their cultural or religious values; or they feel dissatisfied with the hospital system.[222] As Brione explains, providers should respect all of these reasons.

Home birth has become more widely accessible during the pandemic. On March 29, 2020, the International Confederation of Midwives recommended that "in countries where the health systems can support homebirth, healthy women experiencing a normal pregnancy and with support from qualified midwives, with appropriate emergency equipment, may be safer birthing at home or in a primary maternity unit/birth centre than in a hospital where there may be many patients (even non-maternity patients) with Covid-19."[223] The U.K.'s Royal College of Obstetricians and Gynecologists published guidance supporting home births in July 2020, acknowledging the increased demand for these services.[224] Nevertheless, a number of NHS funding recipients have suspended their home birth services during COVID-19's "lockdown" period due to insufficient staff and concerns about the availability of ambulances in the event of transfer. At the same time, patient-requested caesareans—surgeries performed without medical indication—have also been restricted or reviewed in some areas. Thus, while the pandemic theoretically presented an opportunity to expand options in the birth context, options were largely restricted in practice.

Patient dissatisfaction with hospital births is often deserved. In 2015, the WHO called on the international human rights community to address the prevalence of disrespect and abuse during childbirth,[225] a phenomenon that is increasingly referred to as "obstetric violence" or "obstetric racism."[226] Research shows that many people across the globe experience disrespectful, abusive, or

221. Virtual Interview with Rebecca Brione, Res. & Partnerships Officer, Birthrights (June 19, 2020).

222. *See* Hurlock, *supra* note 220.

223. *See* WOMEN'S RIGHTS IN CHILDBIRTH MUST BE UPHELD DURING THE CORONAVIRUS PANDEMIC, INT'L CONFEDERATION MIDWIVES (2020), https://www.internationalmidwives.org/assets/files/news-files/2020/03/icm-statement_upholding-womens-rights-during-covid19-5e83ae2ebfe59.pdf [https://perma.cc/3YHE-3DCS].

224. *See* ROYAL COLL. MIDWIVES & ROYAL COLL. OBSTETRICIANS & GYNAECOLOGISTS, GUIDANCE FOR PROVISION OF MIDWIFE-LED SETTINGS AND HOME BIRTH IN THE EVOLVING CORONAVIRUS (COVID-19) PANDEMIC (2020), https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-10-guidance-for-provision-of-midwife-led.pdf [https://perma.cc/9B8N-8WB5].

225. WHO, THE PREVENTION AND ELIMINATION OF DISRESPECT AND ABUSE DURING FACILITY-BASED CHILDBIRTH (2015), https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1 [https://perma.cc/T84S-KZ2U].

226. *See, e.g.*, Kukura, *supra* note 178 at 726; Dána-Ain Davis, *Reproducing While Black: The Crisis of Black Maternal Health, Obstetric Racism and Assisted Reproductive Technology*, 11 REPROD. BIOMED. SOC'Y ONLINE 56 (2020).

neglectful treatment during childbirth in facilities, and that birthing people of color are disproportionately the targets of this abuse.[227] Such abuse may be motivated by patriarchal power dynamics rooted in sexist preconceptions about the decision-making capabilities of birthing people, racial animus has also been at the root of many people's experiences of obstetric violence.[228]

Many contemporary gynecological protocols were developed on the bodies of unconsenting, enslaved, Black pregnant and birthing people.[229] For these reasons, scholar Dána-Ain Davis coined the term "obstetric racism" to better articulate the particularities of Black birthing people's experiences of abuse during childbirth.[230] Regardless of the discriminatory basis that underlies violence and abuse during the perinatal period, it constitutes a violation of trust between patients and their health-care providers. It can also be a powerful disincentive to seek and use maternal health care services.

Such practices may have direct adverse consequences for both the person giving birth and the infant.[231] Obstetric violence is seen as one cause of disparities in maternal mortality and morbidity.[232] It has been pointed to as one of the explanations for why Black birthing people in the United States are about three times as likely to die of pregnancy-related causes as white birthing people.[233] Home birth has been associated with fewer maternal health interventions and higher patient satisfaction rates.[234] COVID-inspired interest in home birth support

227. *See id.*; Sheetal P. Silal, Loveday Penn-Kekana, Bronwyn Harris, Stephen Birch & Diane McIntyre, *Exploring Inequalities in Access to and Use of Maternal Health Services in South Africa*, 12 BMC HEALTH SERVS. RES. 120, 120 (2012); Rhonda Small, Jane Yelland, Judith Lumley, Stephanie Brown & Pranee Liamputtong, *Immigrant Women's Views About Care During Labor and Birth: An Australian Study of Vietnamese, Turkish, and Filipino Women,* 29 BIRTH 266 (2002); Ana Flávia Pires Lucas D'Oliveira, Simone Grilo Diniz & Lilia Blima Schraiber, *Violence Against Women in Health-Care Institutions: An Emerging Problem,* 359 LANCET 1681 (2002).

228. Davis, *Obstetric Racism*, *supra* note 226.

229. *See* C. RILEY SNORTON, BLACK ON BOTH SIDES: A RACIAL HISTORY OF TRANS IDENTITY, 17–53 (Univ. of Minn. Press 2017).

230. Davis, *Obstetric Racism*, *supra* note 226.

231. WHO, THE PREVENTION AND ELIMINATION OF DISRESPECT AND ABUSE DURING FACILITY-BASED CHILDBIRTH, supra note 225.

232. *See, e.g.*, Vanessa Grubbs, *Researchers Seek Reproductive Justice for Black Women*, CAL. HEALTH CARE FOUND. (Sept. 25, 2020), https://www.chcf.org/blog/researchers-seek-reproductive-justice-black-women/#related-links-and-downloads [https://perma.cc/D5HN-9P7F]; Ziba Taghizadeh, Abbas Ebadi & Molouk Jaafarpour, *Childbirth Violence-Based Negative Health Consequences: A Qualitative Study in Iranian Women*, 21 BMC PREGNANCY & CHILDBIRTH 572 (2021) (finding that experiences of mistreatment during childbirth contribute to adverse health consequences); Anita Raj, Arnab Dey, Sabrina Boyce, Aparna Seth, Siddartha Bora, Dharmendra Chandurkar, Katherine Hay, Kultar Singh, Arup Kumar Das, Amit Chakraverty, Aparajita Ramakrishnan, Mrunal Shetye, Niranjan Saggurti & Jay G. Silverman, *Associations Between Mistreatment by a Provider during Childbirth and Maternal Health Complications in Uttar Pradesh*, *India*, 21 MATERNAL CHILD HEALTH J. 1821 (2017) (finding that mistreatment of women is associated with increased risk for maternal health complications, such as obstructed labor and postpartum hemorrhage).

233. Rachel Jones, *Why Giving Birth in the U.S. is Surprisingly Deadly*, NAT'L GEOGRAPHIC, Jan. 2019, at 10.

234. *See, e.g.*, Ruth Zielinski, Kelly Ackerson & Lisa Kane Low, *Planned Home Birth: Benefits,*

is therefore worth maintaining after the pandemic, yet the evidence thus far suggests that people's childbirth choices are still far from being respected.[235]

IV. ABORTION: HOW DOCTORS TOOK CONTROL OVER ABORTION CARE, AND HOW THE PANDEMIC LOOSENED THEIR GRIP

The hyper-medicalization of birth parallels that of abortion. This convergence might be because the two share a common history—one that is inextricable from the racist criminalizion of midwifery. This section will provide a brief history of the ways doctors claimed control over abortion care, as well as the ways that the COVID-19 pandemic has transformed the geography of abortion care, rendering it more accessible for many as a result.

A. Regulating Abortion: How Home Abortion Became a Crime.

Before the Civil War, abortion was legal in the U.S. and primarily provided by midwives.[236] When slavery ended, these providers—predominantly Black and Indigenous women—became serious competition for white men who sought to enter the practice of family medicine and obstetrics.[237] As the field of obstetrics gained popularity, smear campaigns were used in order to push them out of the profession. While some of these campaigns relied heavily on racist messages (see Part III. A. above),[238] others focused on casting abortion and the midwives who provided it as criminal.[239]

Outlawing abortion was an effective proxy for criminalizing midwives because it enabled medical associations to disguise their project of eradicating a class of trusted medical practitioners as a religious and moral crusade. States began by passing licensure laws that forbade non-licensed abortion practitioners, colloquially known as "granny midwives," from providing care. Eventually, these laws were accompanied by outright bans on midwifery and abortion.[240]

Beginning with the American Medical Association in 1859, organized medical societies began to lobby against legal abortion and campaigned for restrictive laws that would give physicians full control over the decision of

Risks, and Opportunities, 7 INT'L J. WOMEN'S HEALTH 361, 374 (2015); Casey Bernhard, Ruth Zielinski, Kelly Ackerson & Jessica English, *Home Birth After Hospital Birth: Women's Choices and Reflections*, 59 J. MIDWIFERY & WOMEN'S HEALTH 160 (2014); ACOG, *Committee Opinion Number 697: Planned Home Birth*, 129 OBSTETRICS & GYNECOLOGY e117 (2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/planned-home-birth [https://perma.cc/4ZLY-PQ7K].

235. *S*ee Daniela Rea, Lydiette Carrión & Diana Cariboni, *Women Across Latin America 'Under Pressure' to Have C-sections During COVID-19*, OPENDEMOCRACY (July 16, 2020, 12:00 AM), https://www.opendemocracy.net/en/5050/women-latin-america-pressure-c-sections-covid/ [https://perma.cc/3YGT-HG7D].

236. *See* Goodwin, *supra* note 145.

237. *See* Goodwin, *supra* note 145.

238. *See* Bonaparte, The Persecution & Prosecution of Granny Midwives, *supra* note 149, at 129.

239. *Id*. at 17.

240. *See* Goodwin, supra note 145.

whether or not to provide an abortion.[241] By 1910, all but one state in America had criminalized abortion, except in cases when the judgment of a doctor deemed it necessary to save a woman's life; thus transforming legal abortion into a "physicians-only" practice.[242] The same sorts of licensure laws used to criminalize midwives in the context of home birth were thus used to criminalize abortions, particularly those that took place outside of hospital settings.[243]

Many of these laws remain on the books in the United States, and prosecutors not only manipulate them against midwives who perform abortions, but against people who end their own pregnancies outside of a clinical setting.[244] The following section will provide an overview of some of the ways in which the pandemic transformed the legal landscape of abortion care, expanding access for many.

B. Abortion in a Pandemic: How Lockdown Revolutionized Care

The greatest victories—and losses—of access during the COVID-19 pandemic have arguably occurred in the abortion context. While some states have capitalized on the coronavirus crisis to deny people access to care, others have developed innovative solutions that make abortion more accessible than ever. This section will provide an overview of how eliminating procedural and administrative barriers to abortion, expanding access to telemedicine, and increasing the availability of home abortion all have opened radical new pathways to abortion care.

1. Removing Administrative & Procedural Barriers to Care.

Some countries have used COVID-19 as an opportunity to extend time limits previously placed on medication abortions and align their state policies more closely with the World Health Organization's guidelines, which state that medical abortions at home with misoprostol may be safely performed up to thirteen weeks.[245] In France, for example, the French National Health Agency (HAS)

241. *See* NAT'L INST. REPROD. HEALTH, WHEN SELF-ABORTION IS A CRIME: LAWS THAT PUT WOMEN AT RISK 10 (2017), https://www.nirhealth.org/wp-content/uploads/2017/06/Self-Abortion-White-Paper-Final.pdf [https://perma.cc/EL87-D6LA] (first citing ROSALIND P. PETCHESKY, ABORTION AND WOMAN'S CHOICE: THE STATE, SEXUALITY & REPRODUCTIVE FREEDOM 80 (1985); then citing JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY 157, 161 (1978); and then citing ALEXANDER SANGER, BEYOND CHOICE: REPRODUCTIVE FREEDOM IN THE 21ST CENTURY 26 (2004)).

242. *See* Harmon Leon, *Abortion Ban in Alabama: A Brief History of How America Got Here,* OBSERVER (May 15, 2019, 3:55 PM), https://observer.com/2019/05/abortion-ban-alabama-american-reproductive-rights-history/ [https://perma.cc/A8D8-8AP5].

243. *See* Block, *supra* note 168.

244. *See generally* FARAH DIAZ-TELLO, MELISSA MIKESELL & JILL E. ADAMS, SIA LEGAL TEAM, ROE'S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL (2017) (providing a history of the criminalization of abortion in the U.S., current laws on the matter, and a path forward).

245. *See WHO Launches New Guideline to Help Health-Care Workers Ensure Safe Medical Abortion Care*, WHO (Jan. 8, 2019), https://www.who.int/reproductivehealth/guideline-

recommended the performance of medical abortion at home between seven and nine weeks of gestation and the use of telemedicine for abortion consultations.[246] In England, early medical abortion at home is now allowed up to ten weeks.[247]

Wales adopted a particularly novel approach to abortion care. There, a repurposed ambulance is currently bringing abortion pills directly into communities. When COVID-19 hit Wales, health centers across the country faced space and staffing shortages. Several such centers were managed by reproductive health care provider Swansea Bay University Health Board (SBUHB).[248] The pandemic had already led the U.K. to operate a pills-in-the-post program as the standard alternative to in-clinic abortions during the pandemic. But faced with infrastructure barriers and privacy concerns, the providers at SBUHB developed an alternative approach. They equipped an unused ambulance with health center staff and abortion pills. Now, when a resident of Wales needs an abortion, they can call the clinic and set up an appointment to get the pills in a convenient location. According to Amanda, one of the providers at SBUHB:

> It allows for more privacy for people who might not want their family members knowing that they ordered abortion pills. Now patients can simply show up at the ambulance, ask any further questions they might have, and then they go take the pills at home. People seem to really like it. We are getting such a positive response from patients that we plan to keep the ambulance after COVID, and even equip it with contraception and do coil and implant fittings on board as well.[249]

This innovative model of abortion provision has significant potential to increase both privacy and convenience for patients, especially for those living in rural areas without easy access to clinical care. Because these advantages are independently salient, it is worth expanding similar programs even after the pandemic ends.

2. Expanding Telemedicine

Telemedicine has made a remarkable difference in abortion care throughout the COVID-19 pandemic. While many people safely self-manage their abortions without any medical supervision, in the words of full spectrum doula Antonia Piccone, "self-managed doesn't have to mean alone."[250] Teleconsultation can play

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medical-abortion-care/en/ [https://perma.cc/A7T4-LU3C].

246. Karen Gibelin, Aubert Agostini, Michèle Marcot, Hélène Piclet, Florence Bretelle & Laura Miquel, *COVID-19 Impact in Abortions' Practice, a Regional French Evaluation*, 50 J. GYNECOLOGY OBSTETRICS & HUM. REPROD. 1 (2021).

247. IPPF, JOINT REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC, *supra* note 43.

248. Virtual Interview with Amanda Davies, Health Bd. Serv. Improvement Manger, Swansea Bay U. Health Bd. (June 6, 2020).

249. *Id.*

250. Interview with Antonia Piccone, Full Spectrum Doula and Exec. Producer, Self Managed: An

a key role in facilitating access to mandatory consultations and in making self-managed abortion feel safe and supported.[251] Many countries require patients obtain screening before accessing abortion care to ensure that the patient has made their decision free from coercion, to explain the risks and obtain informed consent, or to ensure the person meets the legal criteria for abortion access in that country. But such mandatory consultation should be available via telemedicine. Transportation, cost, and childcare barriers often stand in the way of in-clinic attendance. These factors become even more prohibitive if multiple visits are required, as they are in certain countries where abortion is heavily restricted, including parts of the United States.[252] Requiring that mandatory consultation be in-person can sometimes make the difference between access to a wanted abortion and being forced to carry an unwanted pregnancy to term.

Belgium, Germany, Catalonia, and the United States have begun using telemedicine for prescriptions and abortion consultations, a practice that has been in place in the U.K. and Sweden for years.[253] Even patients for whom the in-person consultation does not present a barrier to access appreciate the option to consult with their provider via telemedicine.[254]

Telemedicine makes is not only helpful for pre-abortion consultation, but also for the provision of abortion medication, accompaniment, and follow-up care. Molly Dutton-Kenny, a Canada-based midwife, made the case for telemedicine provision of abortion:

> We know, statistically, that the majority of abortions are uncomplicated, first trimester abortions. That means that many abortions at this time could easily be achieved completely over telemedicine, where a care provider support a client in gathering knowledge about abortion options, supports home pregnancy tests for confirmation of pregnancy, skips lab work and ultrasound, helps the client access the medications, makes available contact in case of complications, debriefs the abortion over the phone, and confirms completion at home. A client would actually never have to go into a clinic or see a provider in person. They could manage their abortion at home, with their chosen supports, and backup medical care. Frankly, in most cases, this is how it always should have been.[255]

Abortion Story Podcast (May 15, 2020).

251. *See* Katherine Ehrenreich, Shelly Kaller, Sarah Raifman & Daniel Grossman, *Women's Experiences Using Telemedicine to Attend Abortion Information Visits in Utah: A Qualitative Study,* 29 WOMEN'S HEALTH ISSUES 407, 410 (2019).

252. *See* Megan K. Donovan, *Improving Access to Abortion via Telehealth*, 22 GUTTMACHER POL'Y REV. 23 (2019).

253. *See* IPPF, JOINT REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC, *supra* note 43, at 1, 8–9; Pam Belluck, *Abortion by Telemedicine: A Growing Option As Clinics Wane*, N.Y. TIMES (June 29, 2020), https://www.nytimes.com/2020/04/28/health/telabortion-abortion-telemedicine.html [https://perma.cc/Q2EZ-5885].

254. *See* Ehrenreich et al., *supra* note 251, at 410–13.

255. Molly Dutton-Kenny, *Abortion Care Changes During the COVID-19 Pandemic*, MOLLY DUTTON-KELLY (Feb. 25, 2020), http://www.mollyduttonkenny.com/blog-mdk/abortion-

Not only does home abortion eliminate many access barriers, but many people also have more positive experiences with home abortions than clinical ones. A recent scoping research review, for example, found that survey respondents in Poland, Northern Ireland, and Thailand report positive emotions in the wake of a self-managed abortion including gratitude and relief.[256]

In late March 2020, the United Kingdom's Secretary of State for Health and Social Care authorized the home use of mifepristone in England during the COVID-19 pandemic, enabling people to manage every step of their abortion at home. The same measure was introduced in Wales and Scotland.[257] Earlier that week, BPAS had announced that 44,000 women in the U.K. would have to leave their homes to access abortion care over the upcoming thirteen weeks.[258] With the COVID-19 pandemic raging, that meant risking their lives. BPAS and other health experts called on U.K. health ministers to take action to curtail COVID exposure by enabling people to undergo early medical abortion at home. When the new regulation was passed, the landscape of abortion care in England, Scotland, Wales and parts of Northern Ireland changed radically. Now, when patients wish to terminate a pregnancy in the first ten weeks, they may do so by calling health care providers like BPAS and requesting the abortion pills to be sent to their home.[259] Telemedical abortion is also now available in the Republic of Ireland.[260] These changes may allow patients to schedule their consultations at a time that is more convenient for them, avoid transportation costs and barriers, and obtain information about the procedure. Other countries have followed suit. France, Sweden, and Catalonia have each taken steps to increase access to home abortion.[261] Of all the silver linings that COVID has offered, increased access to abortion at home is one of the most essential.

Abortion pills are also now available for low or no cost online, allowing patients to bypass the cost of getting an in-clinic abortion (often upwards of five

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care-changes-during-covid [https://perma.cc/Q72A-3WQU].

256. Heidi Moseson, Stephanie Herold, Sofia Filippa, Jill Barr-Walker, Sarah E. Baum & Caitlin Gerdts, *Self-Managed Abortion: A Systematic Scoping Review*, 63 BEST PRAC. & RES. CLINICAL OBSTETRICS & GYNAECOLOGY 87, 102 (2020).

257. *See* Jim Connolly, *Coronavirus: Home Abortions Approved During Outbreak,* BBC (Mar. 31, 2020), https://www.bbc.co.uk/news/newsbeat-52092131 [https://perma.cc/4ME4-HJF7].

258. *See Healthcare Professionals Call on Boris Johnson to Intervene to Protect Women's Health - Reckless Failure to Listen to Scientific Advice is Putting Vulnerable Women at Severe Risk,* BRIT. PREGNANCY ADVISORY SERV. (Mar. 25, 2020), https://www.bpas.org/about-our-charity/press-office/press-releases/healthcare-professionals-call-on-boris-johnson-to-intervene-to-protect-women-s-health-reckless-failure-to-listen-to-scientific-advice-is-putting-vulnerable-women-at-severe-risk/ [https://perma.cc/7P46-PS5G].

259. *Coronavirus (COVID-19) Essential Information*, BRIT. PREGNANCY ADVISORY SERV., https://www.bpas.org/contact-us/covid-19 [https://perma.cc/D7GX-HZ52] (last visited Apr. 1, 2022).

260. *See* Alison Spillane, *Permanent Use of Telemedicine in Abortion Care Is a Positive, Patient-Centred Step*, IRISH EXAM'R, (May 24, 2021, 7:30 PM), https://www.irishexaminer.com/opinion/commentanalysis/arid-40297127.html [https://perma.cc/AQ3U-4WW7].

261. *See* IPPF, JOINT REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 PANDEMIC, *supra* note 43, at 8–9.

hundred dollars).[262] A recent study found that misoprostol abortions are successful ninety-nine percent of the time if taken during the first nine weeks of pregnancy.[263] Abortion using mifepristone and misoprostol together has been proven to be effective 93.8% of the time if the medications are taken during the first nine weeks of pregnancy.[264] Of the medical abortions that are unsuccessful, only 0.001% have resulted in death of the pregnant person.[265] The health risks involved with taking abortion pills are therefore significantly fewer than those entailed by taking minimally regulated and easily accessible medications like aspirin, Tylenol (paracetamol), or Viagra.[266]

Although telemedicine abortion presents several possible complications including infection and blood loss, the risks are identical to those of spontaneous miscarriage, which occurs naturally in fifteen to twenty percent of pregnancies.[267] This means that any average health clinic or emergency room is able to treat complications stemming from abortions performed outside of a clinical setting. In the unlikely event that a person experiences complications, they would be able to access treatment simply by going to their nearest provider and telling them that they were having a miscarriage. There is currently no medical test capable of distinguishing between a medication abortion and a miscarriage when abortion pills are taken orally.[268] This makes medication abortion an invaluable option for people living in areas where abortion is criminalized or stigmatized.[269] Abortion pills have significantly reduced the number of deaths caused by unsafe abortions

262. *See The Plan C Guide to Abortion Pills*, PLAN C, https://plancpills.org/reportcard [https://perma.cc/642T-SNTK]; Charlotte Cowles, *How Much Does An Abortion Cost? Learn the Facts*, CUT (Nov. 20, 2018), https://www.thecut.com/2018/11/how-much-does-an-abortion-cost.html [https://perma.cc/87XK-CFQX] (last visited Mar. 2020).

263. *See* Heidi Moseson, Ruvani Jayaweera, Ijeoma Egwuatu, Belén Grosso, Ika Ayu Kristianingrum, Sybil Nmezi, Ruth Zurbriggen, Relebohile Motana, Chiara Bercu, Sofía Carbone & Caitlin Gerdts, *Effectiveness of Self-Managed Medication Abortion with Accompaniment Support in Argentina and Nigeria (SAFE): A Prospective, Observational Cohort Study and Non-Inferiority Analysis with Historical Controls*, 10 LANCET GLOB. HEALTH e105, e111 (2022).

264. *Id.*

265. *See* Mitchell Creinin, Paul Blumenthal & Lee Shulman, *Mifepristone-Misoprostol Medical Abortion Mortality*, 8 MEDSCAPE GEN. MED. 26, 27 (2006).

266. *See* ADVANCING NEW STANDARDS IN REPROD. HEALTH, ANALYSIS OF MEDICATION ABORTION RISK AND THE FDA REPORT: "MIFEPRISTONE U.S. POST-MARKETING ADVERSE EVENTS SUMMARY THROUGH 12/31/2018" (2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf [https://perma.cc/4P4W-AWSJ].

267. *Using Abortion Pills for Safe Abortions in the USA. Self-Managed Abortion; Safe and Supported (SASS)*, WOMEN HELP WOMEN, https://consult.womenhelp.org/en/using-abortion-pills-for-safe-abortion-usa [https://perma.cc/S6EQ-P2X2] (last visited Apr. 1, 2022).

268. *See id.*

269. It is worth noting that the inexistence of such a test has not prevented people, in the US, in particular, from being arrested and charged for pregnancy loss. *See* Anna Reed, *A Future From the Past: The Legal Landscape of Ancient Care and Modern Medicines for Self-Managed Abortion,* in WHOSE CHOICE IS IT? ABORTION, MEDICINE AND THE LAW (David F. Walbert & J. Douglas Butler, eds., 7th ed. 2021).

in South America and have huge potential if made accessible worldwide.[270]

Though meaningful access to clinical abortions remains important, self-managed abortion is uniquely equipped to meet the needs of underserved populations and those living in rural environments. Retaining COVID-era measures that ensure regulated and supported access to home abortion is critical to preserve the expansions in access to self-sovereignty and economic mobility that broadened access has made possible. In turn, this would assist in reducing health, economic, and social disparities and increase equality across the board.

CONCLUSION

The COVID-19 pandemic has been a profoundly dark time marked by devastating loss. However, we should not lose sight of the pandemic's silver linings. By easing procedural and administrative requirements for accessing care, increasing access to telemedicine, and supporting those who wish to self-manage their care at home, some governments have changed the landscape of reproductive health for the better. We must think critically and carefully about which measures have paved new pathways to care access and insist that they remain in place even in a future where the pandemic recedes. Some people have always lived with the challenges the pandemic imposed upon us all, in which administrative burdens and health care regulations are insurmountable barriers to care, clinical settings are unsafe, and home care options are preferable to clinical care. The pandemic has demonstrated that these barriers *can* be reduced; now it is time for advocates to argue why they must, and for policymakers to listen.

270. *See* Nina Zamberlin, Mariana Romero & Silvina Ramos, *Latin American Women's Experiences with Medical Abortion in Settings Where Abortion is Legally Restricted*, 9 REPROD. HEALTH 1, 3 (2012).