

9-21-2020

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Carrie N. Baker

Smith College, cbaker@smith.edu

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Recommended Citation

Baker, Carrie N., "Abortion Regulation in the Age of COVID-19" (2020). Study of Women and Gender: Faculty Publications, Smith College, Northampton, MA.
https://scholarworks.smith.edu/swg_facpubs/27

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Opinion | Health | Sep 21, 2020

Abortion Regulation in the Age of COVID-19

Carrie N. Baker



Both abortion advocates and opponents have used the COVID-19 crisis to further their policy goals.

The gendered dimensions of the political response to the COVID-19 crisis are manifesting clearly in efforts to close abortion clinics, as well as in campaigns led by doctors, lawyers, and reproductive rights advocates to expand access to telemedicine abortion during the pandemic and beyond.

Anti-abortion politicians in states across the country have used the COVID-19 pandemic to attempt to restrict abortion, [arguing](#) that abortion is not essential health care and that banning the procedure will [conserve](#) personal protective equipment for COVID-19 cases. In March and April of 2020, 12 states [tried](#) to [restrict](#) abortion, including Alaska, Iowa, Louisiana, Mississippi, and West Virginia, among others. Legislators in Kentucky passed a bill to allow the state's Attorney General to block abortion access during COVID-19, but the Kentucky governor [vetoed](#) the bill.

Advocates for abortion rights have condemned these actions and sued to keep clinics open. The [National Abortion Federation](#), a professional association of abortion providers, issued a statement [declaring](#) that abortion care is an essential health service and that “denying or deferring abortion care places an immediate burden on patients, their families, and the health system, and can have profound and lasting consequences.” The [Center for Reproductive Rights](#), the [American Civil Liberties Union](#), and clinics in states with abortion bans have [brought](#) legal challenges to [protect](#) abortion access during the pandemic.

In response, courts have [blocked](#) the bans in Alabama, Ohio, Oklahoma, and Tennessee. In Louisiana, the state [lifted](#) the ban after clinics sued. Texas finally [lifted](#) its ban on April 22 after multiple court decisions see-sawed back and forth for weeks, forcing pregnant people to travel hundreds of miles to other states to obtain abortion care.

But restrictions prevailed in some states. The [U.S. Court of Appeals for the Eighth Circuit](#) [upheld](#) an abortion ban in Arkansas, although the [Arkansas Department of Health](#) later [issued](#) a directive permitting providers to resume elective procedures. Bans—some of which were [lifted](#) or have since expired—have not been challenged in Alaska, Indiana, and Mississippi, whereas a clinic in West Virginia [challenged](#) a ban in the state, which the Governor later [lifted](#).

In addition to filing lawsuits challenging the bans, abortion advocates are [calling](#) for greater access to telemedicine abortion to provide safe, accessible, socially distant abortion health care.

Telemedicine abortion [combines](#) medication abortion—which uses pills to end a pregnancy—and telemedicine—which allows providers to supervise the use of abortion pills through videoconferencing or telephone consultations. Approved by the [U.S. Food](#)

and Drug Administration (FDA) for use during the first 10 weeks of pregnancy, medication abortion uses two types of pills: mifepristone, which interrupts the flow of the hormone progesterone that sustains the pregnancy, and misoprostol, which causes contractions. Misoprostol alone, or in combination with mifepristone, is an extremely safe way to end a pregnancy in the first 12 weeks of gestation. According to the Guttmacher Institute, medication abortion accounted for approximately 40 percent of all recorded abortions and 60 percent of abortions performed up to 10 weeks' gestation in 2017. The actual rate is likely higher because of the growing number of people who are self-managing their abortions using medication purchased on the internet or obtained in other ways.

The growth in the use of medication abortion has dovetailed with expansion of telehealth to provide new opportunities for pregnant people to access abortion in a safe and private way. As abortion restrictions have increased over the last several years and harassment of people entering health clinics persists—even during the COVID-19 crisis—pregnant people are increasingly turning to medication abortion and telehealth to increase their safety and privacy when obtaining abortion care. Reproductive health advocacy organizations, such as Aid Access, Plan C, and the Self-managed Abortion; Safe and Supported Project, provide pregnant people with information and support on how to use abortion pills safely, especially with the recent proliferation of abortion bans in conservative states.

Nevertheless, numerous legal and regulatory barriers limit the reach of telehealth abortion. Many states prohibit patient access to the abortion pill through telemedicine, despite the pill's proven safety and efficacy. Eighteen states currently require the prescribing clinician to be physically present when prescribing the abortion pill. Thirty-two states require the clinician prescribing the abortion pill to be a physician.

Another significant barrier to telemedicine abortion is that FDA restricts the distribution of mifepristone. When FDA initially approved the drug in 2000, the agency blocked easy access to the pill using its Risk Evaluation and Mitigation Strategies (REMS) due to pressure from anti-abortion forces. REMS is a drug safety program that allows FDA to restrict the circulation of certain medications with serious safety concerns to help ensure that the benefits of the medication outweigh its risks. Under the REMS program, mifepristone must be dispensed in person at a clinic, medical office, or hospital under the supervision of a health care provider registered with the drug manufacturer.

In light of COVID-19 and the need for social distancing, advocates are challenging FDA's REMS restriction on the abortion pill. On March 30, California Attorney General [Xavier Becerra](#) sent a strongly-worded [letter](#) to the [U.S. Department of Health and Human Services](#) and FDA, urging the Trump Administration to waive or use its discretion on enforcement of its REMS designation.

“Forcing women to unnecessarily seek in-person reproductive health care during this public health crisis is foolish and irresponsible,” Attorney General Becerra [stated](#) at a press conference. “That is why we are calling on the Trump Administration to remove red tape that makes it more difficult for women to access the medication abortion prescription drug.”

On the same day, New York Attorney General [Letitia James](#) spoke out in favor of removing the FDA restriction on mifepristone. “Control over one’s reproductive freedom should not be limited to those able to leave their homes as we battle the coronavirus,” Attorney General James [said](#). She [highlighted](#) that a coalition of state attorneys general “is calling on the federal government to make mifepristone more easily accessible so that no woman is forced to risk her health while exercising her constitutional right to an abortion.”

Reproductive health groups are also pressuring the government to remove the REMS restriction on the abortion pill. The [National Women’s Health Network](#), for example, [created](#) a petition and social media campaign with the slogan, “Get the pill where you take the pill—at home!”

In addition to lobbying FDA, medical providers and advocates are filing lawsuits to remove the REMS restriction on mifepristone. On May 27, the [American College of Obstetricians and Gynecologists](#) (ACOG) filed a [lawsuit](#) challenging the FDA restriction. Joined by the [Council of University Chairs of Obstetrics and Gynecology](#), the [New York Academy of Family Physicians](#), and [SisterSong](#), ACOG is [asking](#) a federal district court to order FDA to lift the REMS restriction on mifepristone during the COVID-19 crisis.

In July, Judge [Theodore Chuang](#) of the [U.S. District Court for the District of Maryland](#) issued a decision temporarily suspending enforcement of FDA’s restriction on the abortion pill, [ruling](#) the FDA requirement of in-person visits during the pandemic imposes a “substantial obstacle” to abortion health care that is likely unconstitutional.

Judge Chuang's order allowed patients to receive mifepristone from their doctors through the mail. The Trump Administration [asked](#) the district court, and then the [U.S. Court of Appeals for the Fourth Circuit](#), to reinstate the in-person requirements while FDA appeals the decision, but both courts [rejected](#) the Administration's request. The Administration has now [taken](#) its request to the [U.S. Supreme Court](#).

Some reproductive health advocacy organizations have also promoted self-managed abortion, a process by which people order abortion pills online and [use](#) them independently of any direct medical supervision. Plan C maintains an updated [list](#) of safe websites from which to [order](#) abortion pills and also has information about how to [self-manage](#) abortion safely using the pills. Although self-managing abortion [involves](#) some legal risks, for many people it might be safer than traveling long distances to access abortion health care or risking further delay in securing an abortion.

Research shows that self-managed abortion has [increased](#) during the coronavirus, especially in conservative states that have enacted restrictions on abortion. The legal advocacy organization [If/When/How](#) has a new [campaign](#) and an online [petition](#) pushing for the decriminalization of self-managed abortion, which the organization argues is critical during the coronavirus epidemic. In a campaign fact sheet on self-managing abortion during the COVID-19 crisis, If/When/How [argues](#) that “during times of heightened societal fear, overzealous police, prosecutors, and anti-abortion politicians may— more than usual—rely on a racist, classist criminal legal system to punish people for their pregnancy outcomes.” The group also [expresses](#) concern that international postal delivery and transit across international borders could be slowed, interrupted, or suspended as countries around the world enact safety measures, affecting the distribution of abortion medication.

Another way to increase abortion access during the pandemic, as well as afterwards, is to expand a research exception to the REMS restriction. Since 2016, the women's reproductive health care organization [Gynuity](#) has operated a research study on telemedicine abortion, [TelAbortion](#), which allows clinicians participating in the study to provide medication abortion care by videoconference and mail without an in-person visit. The study is currently [running](#) in Washington, D.C. and 13 states, including Hawaii, Washington, and Oregon, among others. This study has [shown](#) that telemedicine abortion is safe and effective. Advocates are working to expand the TelAbortion program to more states.

Both advocates for and opponents of abortion have used the COVID-19 crisis as an opportunity to advance their political agendas. Although anti-abortion politicians have tried to ban abortion as a non-essential medical procedure, women's health advocates have pressed for increased access to the abortion pill and telemedicine abortion.

These abortion policies have gendered impacts. Restrictions on abortion impose on female, transgender, and nonbinary people unwanted pregnancies and medical risks, especially during a pandemic, while removing these restrictions frees pregnant people from the burdens, costs, and risks of unwanted pregnancy and parenthood during dire economic times.



Carrie N. Baker is a professor in the Program for the Study of Women and Gender at Smith College.

Tagged: [Abortion Care](#), [COVID-19](#), [telehealth](#), [Telemedicine](#)