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# How Expansive is Essential? Restriction of Abortion Services in the United States During the COVID-19 Pandemic

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# How Expansive is Essential?

## Restriction of Abortion Services in the United States During the COVID-19 Pandemic

**by**

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## Introduction

The World Health Organization officially declared a global pandemic on March 11th, 2020 as the novel coronavirus spread worldwide. As COVID-19 unfurled throughout the United States, the Trump administration failed to put in place a national policy to fight the effects of this virus and identify essential health services for persons during a public health crisis. The Federal Centers for Medicare & Medicaid Services moved swiftly in their recommendation that states and health care providers defer all non-essential medical, surgical, and dental procedures as the pandemic and its implications grew exponentially in the United States. This measure was put in place with the intention of reducing the spread of COVID-19 as well as conserving medical resources including personal protective equipment for those health care workers required to be on the front lines of the pandemic (Planned Parenthood, 2020). However, as states moved to set their own policies after the realization that a national response plan was not coming, several states set restrictions on access to abortion and other reproductive health services under the guise of an unprecedented public health crisis. These limitations have had the effect of virtually banning and/or blocking any and all access to crucial abortion services (Sobel et. al, 2020).

This paper will discuss U.S. state responses to the COVID-19 pandemic in the context of restricting women's access to reproductive health care and bodily autonomy. The majority of states delivered executive orders where governors made clear their plan to either uphold the principles related to reproductive health care and freedom or attack them. Almost half of the states discussed reproductive health services in either their stay-at-home orders or essential procedures orders. While the right to an abortion exists at the national level, states

vary widely in their regulation of the procedure. For the purposes of this project, I will focus on those states that moved to restrict access to abortion under the cover of a protective COVID-19 health measure. I establish the historical background of ensuring legal access to abortion granted by the landmark Supreme Court case *Roe v. Wade,* which legalized abortion access from a standpoint of the constitutional right to privacy, as well as *Planned Parenthood of Southeastern Pennsylvania v. Casey,* which established the principle of the undue burden standard. Further, I discuss the implications and importance of the Affordable Care Act in improving women's health care by including and thus normalizing reproductive care as essential health care. Lastly, I examine and discuss those state actions that sought to restrict women's access to health care during a global pandemic.

These actions have significant medical and legal consequences. Although a number of states made an attempt to restrict access to abortion services or ban the procedure altogether, the medical community is unified in the recognition of abortion as an essential health care service, thus creating a necessity for these services to be provided even in times of public health emergencies. Further, suspending abortion services through the end of COVID-19 pandemic will make it impossible for women to utilize their constitutional right to obtain a pre-viability abortion. These short-term impediments in the attempt to access abortion services during the COVID-19 pandemic will likely have long-term effects. Longitudinal research consisting of American women who wanted to terminate a pregnancy but were unable to obtain an abortion found these women to suffer more debt, have lower credit scores, and have poverty-level incomes comparatively. They were also faced with more chronic pain, had worse health, and were more likely to experience sustained physical violence from the man involved in the pregnancy (Jones, 2020).

This inquiry will advance research related to women's reproductive health care by examining and assessing the decisions by states to restrict reproductive rights and bodily autonomy even in the context of a global pandemic. At a time where much is still unknown about the coronavirus and the nation has failed to adequately address its implications, women's reproductive health care is still under swift attack. The initial federal response to COVID was a failure to act and, as such, left each individual state in charge of determining health care policy. As such, several states took the absence of federal guidance on defining what essential health services means in a global pandemic as an invitation to restrict full access to women's reproductive health care. Research on the impact of COVID-19 in the U.S. has revealed that women have suffered significant, negative economic impacts from COVID-19. The pandemic has affected women deeply as a result of their concentration in both low-wage and face-to-face jobs. Further, COVID-19 has greatly increased the pressure on working mothers. Mothers of children under the age 12 lost 2.2 million jobs between February and August of 2020 (Bateman & Ross, 2021). Thus, the decision by many states to restrict women's access to essential health services during a pandemic makes clear that the impact of COVID-19 on women will also have a negative health impact.

## Review of Literature

### *Overview*

Here, I open with the rhetoric that has surrounded reproductive health care including the term "reproductive politics," which is particularly noteworthy because it shows how politics remains the focal point of the abortion debate as opposed to health care or bodily autonomy. Next, I establish the historical background of ensuring legal access to abortion granted by the

landmark Supreme Court case *Roe v. Wade* (1973), which legalized abortion access from a standpoint of a constitutional right to privacy and remained precedent for over 20 years. This precedent was replaced by the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992), which established the principle of undue burden, thus placing varying conditions and stipulations related to a woman's right of choice. Lastly, I discuss the implications and importance of the Affordable Care Act in improving women's health care by including and thus normalizing reproductive care as essential health care, which is critical in establishing reproductive health care as essential health care in a COVID-19 context. The pieces within this literature review establish the background necessary to demonstrate that the restriction of abortion services under the guise of the COVID-19 pandemic is problematic because the existing precedent holds that abortion services are an essential and time sensitive right.

### *Reproductive Politics*

The term "reproductive politics" was notably formulated by second wave feminists and women's right advocates in the 1960's as they fought for rights related to sexuality, contraception, and abortion. This term is particularly noteworthy because it accurately encompasses how politics – not health care nor bodily autonomy – sit at the center of this debate. In the era before *Roe v. Wade*, state legislatures constructed and implemented legislation regarding abortion. As such, abortion procedures were extremely limited and virtually illegal in most states across the nation. It was not until the late 1960's, when women increasingly entered the workforce, that the need for a legal pathway to abortion made true headway (Solinger, 2013). At this time, abortion advocates and opponents debated whether sex and reproduction were a public matter or a private matter. The majority of Americans are of the opinion that one's

reproductive decisions are a private matter and thus the choices made during a pregnancy fall under the jurisdiction of a pregnant woman. However, a minority of Americans do consider reproduction to be a public concern, thereby causing this intimate decision of whether or not to bear a child to be subjected to legislation (Solinger, 2005). This public versus private debate has shaped federal and state regulation of women's reproductive health care for decades, affecting issues such as family leave, health insurance, and access to contraception and abortion procedures (Solinger, 2005). Laws and policies enacted as a result of this debate have wrestled with the idea of when a woman's authority to make a decision regarding her own body becomes a state matter of interest and regulation, as was the question put before the Supreme Court with the case of *Roe v. Wade.*

***Roe v. Wade (1973)***

*Roe v. Wade* (*Roe)* entered the scene in March of 1970 when two Texan lawyers, Sarah Weddington and Linda Coffee, sought to confront and dispute the state's dangerous anti-abortion laws. Filing a claim on behalf of Norma McCorvey under the pseudonym "Jane Doe" as well as all other women similarly situated, Weddington and Coffee argued that a woman's constitutional rights are infringed upon by the state's laws which criminalize abortion procedures. The Fifth Circuit Federal Court ruled in favor of McCorvey, asserting that the Texas law concerning abortion is unconstitutional (Solinger, 2013).

McCorvey's case was appealed to the Supreme Court and heard in December of 1971. Their decision was issued January 23rd, 1973. In a 7-2 decision, the Court once again ruled in favor of McCorvey. Thus, the ruling made in *Roe* nullified any state law restricting a woman's

access to abortion during the first trimester of a pregnancy. According to the majority opinion, the legalization of abortion access was rooted in four primary constitutional principles:

(1) Women have a constitutional right to reproductive privacy and proposed governmental regulation of that right must be subject to strict scrutiny – the most stringent review used by United States' courts.

(2) The government must remain neutral in regard to a woman's decision of whether to have an abortion.

(3) In the period before viability, the government may restrict abortion only in the interests of protecting the woman's health.

(4) After viability, the government may prohibit abortion, but laws must make exceptions that permit abortion when necessary to protect a woman's health or life.

(Solinger, 2013, p. 29)

This 1973 ruling by the Supreme Court expanded the principle of due process and its protections to a woman's right to choose to terminate a pregnancy. Although the Constitution does not explicitly reference privacy, the Court acknowledged that a woman's decision to end a pregnancy lies within the realm of privacy secured by the liberty component of both the Fifth and Fourteenth amendments' due process clauses. The substantive due process doctrine reaffirms the Fifth and Fourteenth amendments assurance that the state cannot deprive any person of life, liberty, or property without due process of law; this is paramount to the abortion debate because it addresses those rights which are not specifically enumerated in the Constitution, but that are nonetheless deemed worthy of protection by the Court. The ability to terminate a pregnancy during the first trimester is included among these rights. The spehcific instances in which these parameters have been applied has changed over time, to be sure, but the fundamental basis that

the Court follows in distinguishing due process rights has not. The doctrine was founded upon the premise that the government does in fact have the power to make and pass laws for the purpose of preserving the public good; however, there are specific limits to the state's authority as certain actions would be in direct conflict to the principles related to democratic governance. Thus, due process essentially upholds the balance necessary to manage the state's power with the private sphere's liberty (Tanka, 2015). This landmark ruling in the case of *Roe* remained precedent for over 20 years and was the preeminent legal standard for abortion regulation. This model of *Roe* was replaced only when the Supreme Court established the undue burden standard in the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992.

***Planned Parenthood of Southeastern Pennsylvania v. Casey (1992)***

Though the legal precedent established in *Roe* is certainly important, the legal metric changed with the Supreme Court's 5-4 ruling in the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) (*Casey)* wherein the Court moved away from the trimester framework established by *Roe* in favor of what was dubbed the undue burden standard. Agreed upon by the majority, the undue burden standard essentially invited interested parties – chiefly anti-choice advocates – to legislate restrictions on the practice of abortion. What was considered to be an undue burden and what was not was ultimately a subjective decision left to the courts. *Casey* surfaced as a constitutional challenge to numerous provisions of the Pennsylvania Abortion Control Act of 1992. This Act required that:

> (1) all women seeking abortions be provided with certain specific information at least twenty-four hours before the abortion was performed;

(2) all minors seeking abortions obtain the consent of either their parents or a judge before the abortion takes place;

(3) all married women notify their spouses prior to obtaining abortions; and

(4) facilities that offered abortion-related services were bound to the State for distinctive reporting requirements (Maltz, 1992, p. 11).

The Court upheld the majority of the provisions of the Pennsylvania Abortion Control Act of 1992 with the exception of the spousal notification provision. Further, it completely abandoned the trimester approach that was established previously in *Roe*, which had fundamentally shaped the basis of abortion jurisprudence until now. Justices Sandra Day O'Connor, Anthony Kennedy, and David Souter issued a jointly signed majority opinion to maintain *Roe*'s essential holding, which reaffirmed that a woman may choose to have an abortion before fetal viability in the first trimester, and further should be able to acquire the medical procedure without superfluous interference on behalf of the state as long as said interference did not constitute an undue burden on the woman. Thus, the ruling in *Casey* essentially invited anti-abortion advocates to enact various requirements and stipulations related to abortion so long as they did not inflict a so-called undue burden on the women's right to choose to terminate a pregnancy (Maltz, 1992). The problem with this undue burden standard, however, is that it has proven difficult to settle on exactly what abortion restrictions constitute an undue burden. Thus, the ruling essentially invited states and the federal governments to pass restrictive abortion measures to test what constitutes a so-called undue burden.

Although the Court's ruling in *Roe* generated a distinctive trimester framework to follow in order to set forth how the state could and could not regulate a woman's right to terminate a pregnancy, *Casey* rejected that precedent. Although *Casey* did affirm the fundamental principle

established in *Roe* that a woman does have rights related to the termination of a pregnancy, this new case pinpointed two countervailing principles: the state's concern regarding the potential for human life and the health of the mother. Before *Casey,* a woman's right to privacy was paramount in the first trimester when compared to the state's interest in protecting the potential for human life. This case established that, prior to fetal viability, the state can neither outlaw abortion procedures nor place an undue burden on a woman's right to access the service. Courts should consider a given law related to reproductive health care to be an undue burden if its motive or effect is to place considerable barriers in the path of a woman pursuing an abortion before the fetus reaches independent viability. Following fetal viability, however, the scales tip massively in favor of the state over the woman and her bodily autonomy. The capacity for human life allows the state to not only restrict, but proscribe abortion except in cases of absolute necessity, appropriate medical judgment, or instances in which the life or health of the mother is placed at risk (Tanka, 2015).

Although *Casey* upheld the principle that a woman has an initial, fundamental right of choice in seeking reproductive health care related to ending a pregnancy previously established in *Roe,* it placed varying conditions and stipulations related to a woman's right of choice. For instance, the Court established that a given state may appropriate its resources in a way that accentuates its preference for childbirth over abortion. In subsequent legal challenges to federal and state abortion regulations, the Court has further maintained that both state and federal statutes which allocate funding for childbirth but not abortion or outrightly ban government funding from being used for abortion procedures do not in any way curtail a woman from accessing her fundamental reproductive rights. Instead, the Court lists the woman's poor decision making and destitute nature – which the state has no obligation to restore – as the aversion

present in her inability to obtain an abortion. Unfortunately, this reasoning follows, as previously established due process clauses typically do not grant any right to accessing governmental aid. Thus, while women theoretically maintain a fundamental right to abortion, extensive limitations severely limit that right's efficacy in practice. Although the government technically is not permitted to place barriers that unduly burden a woman's right of choice, it is legally permitted to suppress and withhold funds, facilities, and personnel needed to carry out the medical procedure (Maltz, 1992). The idea of Targeted Restriction on Abortion Provider (TRAP) laws are a contemporary, relevant example of this. The conclusion here is that the right of a woman to terminate a pregnancy if she so chooses is a flimsy right, at best.

"Liberty finds no refuge in a jurisprudence of doubt" (O'Connor, 1992). With these words etched into the *Casey* opinion, the Supreme Court set the scene for a novel era of abortion regulation. This matter of an undue burden settles nothing in regard to the ongoing abortion debate as it is an invitation for interested parties – anti-choice parties – to test where the line for the standard lies. The controversial debate has grown in recent years as multiple Justices explicitly demonstrated their inclination to overturn the 1973 *Roe v. Wade* decision constitutionalizing abortion. However, in some ways, *Casey* was shown to have the opposite effect. The joint opinion that resulted from this case made abundantly clear that the Constitution affirms a woman's fundamental right in the choice of obtaining an abortion prior to viability of the fetus. On the other hand, though, the range and scope of this protection was uncertain and thus remained unresolved as the Court provided no concrete mechanism for which to dictate what constitutes an undue burden on abortion (Metzger, 1994).

The undue burden standard established in *Casey* marked a distinctive shift from a clearly defined bright-line test to a more subjective practice where individual judges were left to

determine what constitutes an undue burden on women seeking abortion services. As opposed to clearly and directly nullifying those restrictions which inflicted more than a minimal burden on first trimester abortions, when adjudicating legal challenges to legislation, judges are now required to assess the burden imposed by a regulation and make an individual determination concerning whether or not burden is too substantial to be necessary. The case further stipulates that this evaluation regarding the weight of burdens concerning abortion should use the framework of regulatory context. Consequently, a notable change in what is considered to be an acceptable state purpose and the degree of scrutiny by which restrictions on abortion services are reviewed takes root. Thus, the Court essentially permitted states to not only to convey a preference for childbirth, but also allowed states to actively coerce a pregnant woman to carry an unwanted pregnancy to term as opposed to seeking out abortion services. This constitutes a notable divide from the *Roe* instruction that those restrictions whose purpose is to influence a woman's choice related to her pregnancy and whether to carry to term or obtain an abortion are unfounded. Further, *Casey* stoutly curtailed the review process pertaining to abortion services from the approach of strict scrutiny that was established in *Roe.* Those regulations put in place on pre-viability abortions were fully legal so long as a judge ruled that the restriction does not constitute whatever they, as an individual, considered to be an undue burden (Metzger, 1994). Thus, the subjective nature of the undue burden standard gives the government a fair amount of room to maneuver in the realm of setting regulations. *Planned Parenthood of Southeastern Pennsylvania v. Casey* and the undue burden standard continues to be the current legal standard for abortion regulation. In a COVID-19 context, this standard allows pro-choice advocates to argue that pandemic-imposed restrictions on abortion procedures are indeed posing an undue burden on women seeking those services.

### *The Affordable Care Act & Women's Health*

Beyond the legal framework, the medical component should be of consideration when adjudicating access to abortion services. The Affordable Care Act, enacted in 2013 under the Obama administration, extended access to health care and enhanced the quality of that care. For women in particular, new insurance refinements which banned gender rating, exclusions related preexisting conditions, and required coverage of maternity care as well preventive services granted more women more access to higher quality insurance coverage. These clauses of the Affordable Care Act allowed for health care that better addressed the health needs of women, thus making health care more accessible for this cohort. The Affordable Care Act was successful in its intended purpose, as the rate of uninsured women between ages 18 and 64 years was cut in half, dropping to a rate of 10.8% by the year 2015 (Wood, 2017).

One of the most innovative concepts to come out of Affordable Care Act was its directive concerning prevention. For women particularly, ensuring that critical women's preventive health services made the list of covered services was challenge, but this fight allowed for an opportunity to bring women's health care into the spotlight. The Affordable Care Act specifically appended a women's health care amendment, titled the Mikulski Women's Health Amendment, which instructed the United States Department of Health and Human Services to produce and publish a list of women's health preventive services in an attempt to fill the spilled over gaps and loopholes present in the United States Preventive Services Task Force. To accomplish this task, the Department of Health and Human Services requested that the Institute of Medicine assist in the identification of those preventive services pertaining to women's health that were currently absent from this framework. Subsequently, eight services were added to the list for coverage

including at least one wellness visit per year, screening services for HIV, human papillomavirus, and other sexually transmitted diseases, lactation support, gestational diabetes screenings for pregnant women, and screening and counseling for interpersonal and domestic violence. Though the stipulation regarding coverage of preventive services without cost sharing was a controversial one as it was a reversal of traditional insurance principles, it proved its worth as the United States witnessed a significant increase in the use those preventive services offered by the act (Wood, 2017).

Moreover, the Affordable Care Act expanded insurance coverage to all USAFDA–approved contraceptive methods as well as counseling. This requirement of coverage for contraception, however, resulted in a multitude of legal challenges. Though the Obama administration lobbied for this birth control coverage, the culminating Supreme Court rulings sided with the grievances of opponents and granted certain employers the ability refuse coverage of contraceptives as can be seen in the case *Burwell v. Hobby Lobby.* Here, the Court ruled that privately held corporations are legally allowed to refuse to provide health care coverage of contraceptives for its employees. Though a loss for reproductive rights advocates, this ruling does not fundamentally restrict insurance coverage of contraceptives. Millions of women have benefited from insurance coverage of contraception and its effect on lower out-of-pocket expenses related to it. This expansion of coverage further included over-the-counter contraceptives including emergency contraception at both the federal and state levels. Further, a crucial aspect of increasing the quality of women's health care is ensuring that women and couples are presented with the appropriate range of choices related to family planning, including whether and when to have children. A framework to ensure this principle is upheld, published jointly by the Centers for Disease Control and Prevention and the Human Health Services Office

of Population Affairs on Quality Family Planning, put forth a new standard for primary care providers and family planning specialists. In requiring coverage for contraceptives with no out-of-pocket costs, the Affordable Care Act greatly expanded a women's access to a wide range of contraceptives. As a result, 62.4 million women now have insurance that covers contraception without having to pay a dime in out of pocket expenses (Wood, 2017).

On the other hand, however, enduring endeavors to deliver an emergency contraceptive pill like Plan B in an over-the-counter format for all women who need it – a venture that was stoutly blocked by the W. Bush administration – was not quickly reconciled with the switch in political leadership to a Democratic Obama administration. Instead of upholding the measures of scientific and medical evidence, the Obama administration sided with the continued efforts to block approval. Ultimately, judicial intervention became necessary; a ruling by Judge Edward Korman of the District Court of Eastern New York the mandated that these safe and effective emergency contraceptive medications be available in a fully over-the-counter manner. Data collected since 2013 has shown that this approval did not result in any negative or unintended consequences. Instead, the Court's ruling simply created an additional means by which women may prevent an unintended pregnancy (Wood, 2017).

Though the Obama administration and its efforts put forth in Affordable Care Act undoubtedly encompassed strong values related to supporting preventive services for women, the administration remained passive concerning issues of abortion specifically. As a result of the Affordable Care Act's regulations concerning abortion coupled with already existing funding bans, accessible options for the most vulnerable populations of women persisted. Though leaders in areas of reproductive health, rights, and justice called upon the Obama administration to eliminate those obstacles regarding women's informed decision making and access to abortion

services, the administration failed them (Wood, 2017). Regardless of these missed opportunities, the importance of the Affordable Care Act in improving women's health by means of normalizing women's health care and including reproductive care as essential health care has a felt impact in the United States. However, the Trump administration along with a Republican dominated Congress continually attacked the premises set forth by the Affordable Care Act, especially those related to women's health and reproductive rights. Though the expansion of access to affordable and effective contraception has been among the top landmark accomplishments established by the Affordable Care Act, the Trump administration worked to limit these gains with the discharge of regulations that would allow any employer, insurance plan, school, or individual to deny access to no-cost contraception based on moral objection (Long, 2020).

In a COVID-19 context, the Affordable Care Act is extremely useful in ~~a~~ffirming that reproductive care is in fact essential health care. Though the Trump administration coupled with a Republican dominated Congress worked to overturn those premises set forth by the Affordable Care Act, these efforts were overwhelmingly unsuccessful; that said, the precedent set by the Act still remain in place. The new Biden Administration coupled with a Democratic majority Congress has differed from the Trump administration insofar as the Administration has a plan to address COVID-19 at a federal as opposed to leaving states to act or flounder on their own. As the pandemic persists, the Biden administration has moved to apply those premises of the Affordable Care Act to an America experiencing an unprecedented global health crisis, including the protection of reproductive health care at this time. The Biden Administration got off to a strong start, issuing nearly 40 executive orders, memoranda, and presidential proclamations in its first 10 days. On January 28, it announced an executive order to strengthen Medicaid and the

Affordable Care Act's marketplaces with special consideration paid to the memorandum on women's health. Here, it states that "it is the policy of [the Biden] Administration to support women's and girls' sexual and reproductive health and rights in the United States, as well as globally" (Biden, 2021). Though the Biden administration has acted quickly to address the COVID-19 pandemic, the inaction of the Trump administration and failure to institute a federal policy to address the pandemic has left lasting negative impacts, including a push by some states to restrict access to abortion services under the guise of protecting public health. As such, it is important to consider how some states moved to define and restrict policy on abortion to suit the preferences of state leaders.

## Case Studies

### *National Overview & Trends*

The emergence of COVID-19 in the U.S. prompted many states to quickly enact policies intended to impede the course of the virus and maintain the function and quality of health care. As such, many states delivered executive orders in which state officials specified whether or how the COVID-19 pandemic would impact a woman's ability to seek an abortion. Almost half of the states discussed abortion and other reproductive health services in either their stay-at-home orders or essential procedures orders, where policies fluctuated from reassuring, to concerning, to dangerous. By mid-April of 2020, a total of 23 governors had made the move to safeguard the principle of timely access to reproductive health services in their states,[1] 12 of which protected abortion procedures specifically (Guttmacher Institute, 2020).

[1] California, Delaware, Hawaii, Illinois, Indiana, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New York, North Carolina, Ohio, Oregon, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin

However, anti-choice politicians in 11 states across the country including Texas, Oklahoma, Arkansas, Mississippi, Louisiana, Alabama, Tennessee, Iowa, Ohio, West Virginia, and Alaska have used the COVID-19 pandemic as an attempt to hinder access to abortion services by categorizing abortion procedures as elective or non-essential (Bayefsky et al., 2020). While a number of states including Iowa, Ohio, and Tennessee, constrained their enforcement strictly to surgical abortions, other states such as Arkansas, Oklahoma, and Texas, imposed their orders in a way so as to delay or ban all abortions services, including medication abortion (Donley et al., 2020). Currently, 29 U.S. states are considered to be hostile towards abortion rights according to an abortion policy landscape study by the Guttmacher Institute. Of the 11 states that attempted to restrict abortion access in some way during the COVID-19 pandemic, 10 are categorized as either hostile or very hostile to abortion access (Nash, 2020). Furthermore, in 2020, 10 of these 11 states had Republican governors. All 11 states that sought to restrict access to abortion services during the COVID-19 pandemic also had Republican majorities in both House and Senate state chambers. In addition, 10 of the 11 states retain Republican Attorney Generals – a position for which the officeholder serves as the state's top law enforcement official (Kaiser Family Foundation, 2020). Thus, actions taken to restrict access to abortion services in the initial months of the COVID-19 pandemic were taken almost exclusively by states led by Republican policymakers.

For the purposes of this project, I examined 3 states that moved to restrict access to abortion services under the guise of the COVID-19 pandemic: Arkansas, Alabama, and Alaska. These states were chosen based on their hostility ranking by the Guttmacher Institute's abortion policy landscape study. The chosen states are considered to be very hostile, hostile, and lean in support of abortion right respectively. All 3 chosen states have Republican governors,

Republican majorities in both House and Senate state chambers, and Republican Attorney Generals. The 3 states differed in their approaches taken to limit access to abortion services, which are examined below.

### *Arkansas*

Arkansas is a state considered to be very hostile toward abortion rights according to the Guttmacher Institute's abortion policy landscape study (Nash, 2020). Only 38% of adults in the state believe that abortion should be legal in all or most cases (Pew Research Center, 2020). The state of Arkansas has a long history of limiting access to abortion services, having its first abortion ban set by 1900. Further, the state constitution was amended in 1988 to condemn abortion procedures, stating that "the policy of Arkansas is to protect the life of every unborn child from conception until birth, to the extent permitted by the Federal Constitution." Abortion restriction bills, coupled with partial-birth bans, took root in the state throughout the 1990s as unconstitutional pre-*Roe* laws remained intact in Arkansas (Arndorfer, 1998). Arkansas was at the forefront of those states that enacted a comprehensive abortion-specific informed consent requirement, which was put in place in 2007 (Nash & Benson, 2007). In 2013, a fetal heartbeat bill, designed to ban abortion procedures from occurring after twelve weeks of pregnancy, was passed by the state. A fetal heartbeat bill is a contentious form of legislation practiced in the United States which seeks to make abortion procedures illegal once the embryonic heartbeat is perceptible which is, oftentimes, before a woman even realizes she is pregnant. Though the bill was vetoed by former Governor Mike Beebe (D), his veto was overridden. The law was struck down a year later after being ruled unconstitutional by a federal judge (Parker, 2013).

In the present, Arkansas has instituted a multitude of restrictions on women seeking to terminate a pregnancy, including state-directed counseling that contains information intended to discourage the patient from obtaining an abortion, a 72 hour waiting period between pre-abortion counseling and the procedure that serves no medical purpose, and parental consent for minors seeking abortion services (Guttmacher Institute, 2021). Health plans provided by Arkansas's state health exchange under the Affordable Care Act prohibit the coverage of abortion procedures except in certain circumstances of life endangerment, rape, or incest. Abortion procedures in the state of Arkansas are limited by gestational periods and are completely banned after twenty weeks of pregnancy. This is based on a claim that a fetus can feel pain at that point in pregnancy. This postulation has been disproven by scientific evidence and thus has been repudiated by the medical community (Guttmacher Institute, 2021). There is only one clinic in the state of Arkansas – located in the capital city of Little Rock – that offers abortion services, meaning 97% of counties in Arkansas do not contain a clinic where abortion services are provided (Jones et al., 2019). The state requires this singular clinic to meet medically unnecessary standards related to their physical building, equipment usage, and staffing protocols. Dubbed Targeted Restrictions on Abortion Providers, or TRAP laws, the clinic is required to meet medical and facility standards that are targeted to affect them as an abortion provider and are not extended to other medical facilities that provide outpatient medical care which does not include abortions. In a COVID-context, the use of telemedicine appointments to manage medication abortion is not permitted despite a study by the National Academies of Sciences, Engineering and Medicine finding that there is no evidence that the taking of medication abortion pills requires the physical presence of a health care provider (Guttmacher Institute, 2021).

At the emergence of COVID-19 in the United States, Arkansas had a Republican governor, Republican attorney general, and Republican majorities in both the state House and Senate ("Arkansas Election Results", 2018). On April 3rd, 2020, one month after the World Health Organization officially declared a pandemic as the novel coronavirus spread globally, the Arkansas Department of Health issued an elective surgery directive in response to the growth of the COVID-19 pandemic in the United States. This directive instructed all health care facilities to suspend procedures that could be safely delayed in order to conserve personal protective equipment for frontline workers. It should be noted that this directive did not include a specific reference to abortion procedures (Hutchinson & Smith, 2020). However, just days later on April 10, 2020, a cease and desist[2] order was delivered to the state's only procedural abortion provider by inspectors from the Arkansas Health Department (Planned Parenthood, 2021). The inspectors, who claimed that the clinic was in violation of the Department's April 3rd ban on elective surgeries, demanded that the clinic promptly put a stop to all procedural abortions (Planned Parenthood, 2021). As a result, The American Civil Liberties Union and the law firm of O'Melveny & Myers took direct action and sued the state as representatives of the clinic, requesting a blockage of the abortion ban by a district court (American Civil Liberties Union, 2020). The case was successful, as a federal judge issued a temporary restraining order the following day which granted the clinic the authorization needed to proceed with abortion procedures (United States Eastern District Court of Arkansas, 2020).

This victory was brief, though, as the U.S. Court of Appeals for the Eighth Circuit restored the abortion ban, thereby reversing the lower court's ruling. In its amicus curiae, the Eighth Circuit judges cited the Arkansas Department of Health directive as a simple interlude –

[2] A cease and desist document is dispatched to either a particular business or certain individual with the intent of ordering the cessation of alleged illegal activity occurring (Trimble, 2010).

as opposed to a ban – due to the fact that the directive would be terminated in a month's time unless the state of emergency was renewed by Governor Asa Hutchinson (U.S. Court of Appeals for the Eighth Circuit, 2020). By April 27, 2020, a new elective surgery directive was put in place by the Arkansas Department of Health. Under the revised mandate, elective surgeries were permitted to restart with the stipulation that a patient must acquire and present a negative COVID-19 test within 48 hours of their scheduled procedure date (Arkansas Department of Health, 2020). At a time where the United States was experiencing a scarcity of coronavirus test kits, women pursuing abortions services were required to locate a health care facility that would test asymptomatic persons who were not in contact with COVID-19 and yield the results in a high-speed fashion. As a result, The American Civil Liberties Union filed an additional emergency lawsuit on behalf of the Little Rock Family Planning clinic on May 1, 2020, petitioning for exemption from the testing provision due to the fact that that there was a select group of women seeking abortion services who were days away from the Arkansas's state cut-off for the procedure and who had been unable to secure a COVID-19 test (American Civil Liberties Union, 2020). On May 7, 2020, a federal judge refused the plea, citing the Eighth Circuit opinion which asserted that a state is authorized to take actions that violate constitutional rights in times of public health crises (Satter, 2020). By May 18, 2020, the Arkansas Department of Health reported there would be a relaxation of testing qualifications, and patients now had 72 hours prior to the elective procedure date to secure a negative COVID-19 test. The following month, on July 6, 2020, the timeframe was once again adjusted and now sat at 120 hours prior to the date of the elective procedure. By August 1, 2020, the Arkansas Department of Health issued a directive completely repealing the requirement for a negative COVID-19 test in advance of scheduled elective procedures (Arkansas Department of Health, 2020).

Through the strict regulations put in place by the state of Arkansas, the essential health care service of abortion procedures was heavily restrained at the onset of the COVID-19 pandemic. This was demonstrated through the Arkansas Department of Health's elective surgery directive, which instructed all health care facilities to suspend procedures that could be safely postponed. Though abortion services were not listed among those procedures, a cease and desist order was delivered to the state's only procedural abortion provider with the claim that the clinic was in violation of the Department's ban on elective surgeries. After weeks of tit-for-tat, litigation efforts were successful and abortion services became more accessible in the state. However, these actions taken by Arkansas showcase how the state does not deem abortion to be essential health care regardless of the unified medical and legal stance that abortion services are a timely and essential right. This theme of restricting access to abortion services under the guise of the COVID-19 is not unique to just Arkansas; many other states – predominantly southern and almost exclusively Republican-led – followed suit.

### *Alabama*

Alabama is a state considered to be hostile toward abortion rights according to the Guttmacher Institute's abortion policy landscape study (Nash, 2020). Issues related to abortion are polarized within the state, with 58% of adults believing the procedure should be illegal in all or most cases (Pew Research Center, 2020). There have been laws pertaining to abortion services active in Alabama active since the 1800's when the state legislative body outrighly banned abortion procedures. In the time before *Roe v. Wade*, abortion was legal only if a pregnant woman's physical health was placed in jeopardy as a result of the pregnancy (Arndorfer, 1998). Alabama's state legislature was heavily involved in attempts at passing cardiogenesis or fetal

heartbeat detection date abortion bans beginning in 2014, with efforts proceeding unsuccessfully for years due to legal challenges. In May 2019, governor at the time Kay Ivey, Alabama's second female governor and first female Republican governor, signed The Alabama Human Life Protection Act. Under this law, performing an abortion would be classified as a Class A felony, meaning doctors who perform the procedure could be sentenced to life imprisonment (Alabama HB314, 2019). Class A felonies are the most heinous category of crimes in Alabama and include violent crimes that typically entail danger committed against another person such as murder, arson, and kidnapping (Alabama Code § 13A-5-6, 2020). The objective of The Human Life Protection Act was to enforce an almost absolute ban on abortion services in the state beginning in November 2019. Various amendments proposed that would have permitted abortion procedures in the event of a pregnancy resulting from rape or incest were rejected. The bill was passed in both chambers of the Alabama Legislature in a party-line vote of 73-3 in the state's House of Representatives and 25-6 in the state Senate (Alabama HB314, 2019).

In the present, Alabama is similar to the state of Arkansas insofar as the state places restrictions on those women seeking to terminate a pregnancy including state-directed counseling that contains information intended to discourage the patient from obtaining an abortion, a 72 hour waiting period between pre-abortion counseling and the procedure that serves no medical purpose, and parental consent for minors seeking abortion services. In addition, a patient must submit to an ultrasound before scheduling an abortion procedure and is obligated by law to view the image. Health plans provided by Alabama's state health exchange under the Affordable Care Act prohibit the coverage of abortion procedures except in certain circumstances of life endangerment, rape, or incest. Abortion procedures in the state of Alabama are limited by gestational period, being prohibited after twenty weeks of pregnancy. There are three clinics in

the state of Alabama that offer abortion services, meaning 93% of Alabama's counties have no clinics that provide abortion services. The state requires these clinics to meet medically unnecessary standards related to their physical building, equipment usage, and staffing protocols. In a COVID-context, the use of telemedicine appointments to manage medication abortion is not permitted (Guttmacher Institute, 2021).

At the emergence of the public health emergency of COVID-19 in the United States, the state of Alabama had a Republican governor, attorney general, and Republican party control in both their state Senate and state House of Representatives. On March 27, 2020, just weeks after the World Health Organization officially declared a pandemic, Alabama's Department of Public Health issued an Order of the State Health Officers deferring public gatherings in an attempt to mitigate the risk of infection of COVID-19 in the state. In this declaration, the Alabama Department of Public Health stated that all medical, surgical, and dental procedures should be suspended pending further information. Exceptions were put in place by the Department where necessary to address inevitabilities such as emergencies, to circumvent serious injury, and retain ongoing and active treatments (Alabama Department of Public Health, 2020). In the same day, Alabama Attorney General Steve Marshall verified that abortion services would be barred under the Department of Public Health's directive (Attorney General's Office, State of Alabama, 2020). Following this order, Attorney General Marshall issued a news release on March 30, 2020, in which he rendered that the order by the Department of Public Health applied without exception, and went on to make false and misleading assertions regarding the risks posed by abortion clinics in the transmission of COVID-19 such as the claim that abortions require hospitalization post-procedure and that abortion clinics are exhausting personal protective equipment. To conclude this news release, Attorney General Marshall stated that he would

enforce the order against all violators and threatened prosecution against Alabama's three abortion clinics – a clear signal of aggressive enforcement and sanction for violation of this directive (Attorney General's Office, State of Alabama, 2020).

In the same day of Attorney General Marshall's news release, the American Civil Liberties Union, representing Dr. Yashica Robinson, an abortion provider in Alabama, in conjunction with the Alabama Women's Center, Reproductive Health Services, and West Alabama Women's Center – the state's three abortion clinics – filed an emergency complaint in the United States District Court for the Middle District of Alabama (United States District Court for the Middle District of Alabama, Northern Division, 2020). In the following weeks, on April 12, 2020, Alabama's federal district court issued a preliminary injunction, which is a court order presented at the outset of a lawsuit that forbids parties involved from doing that action of dispute until a final judgment has been presented and the trial has ended in an attempt to maintain the status quo (Cornell Law School, n.d). This injunction allowed abortion providers to independently calculate if the procedure was an essential service needed in order to avoid additional danger, costs, or legal hurdles on a case by case basis. U.S. District Judge Myron Thompson, who issued the preliminary injunction and is responsible for blocking Alabama's near-total abortion ban from going into effect previously in 2019, cited the undue burden placed on a woman's right to access critical abortion services during a public health emergency in his twelve page ruling (District Court of the United States for the Middle of Alabama, Northern Division, 2020). The Eleventh Circuit Court of Appeals upheld the preliminary injunction on April 23, 2020, permitting doctors the continued use their medical judgment in decisions of whether an abortion was a timely necessity to avoid further threats and/or whether a woman seeking to terminate a pregnancy would lose the legal right to do so in the event the procedure

was delayed. Effective April 30th, 2020, medical, surgical, and dental procedures were permitted to resume in Alabama with the provision that procedures would immediately cease should the State Health Officer determine that performing said procedures would diminish access to personal protective equipment or other materials needed to combat COVID-19. (Sobel et. al, 2020).

Accessing abortion services at the onset of the COVID-19 pandemic was made to be increasingly difficult by the state of Alabama. This is demonstrated by Attorney General Steve Marshall verification that abortion services would be barred under the Alabama's Department of Public Health Order of the State Health Officers deferring public gatherings. Attorney General Marshall went on to make false and misleading assertions regarding the risks posed by abortion clinics and threatened prosecution against Alabama's three abortion clinic. Litigation efforts were successful and abortion services became more accessible in the state as a result of a preliminary injunction. Though 8 of the 11 states that restricted access to abortion services under the guise of the COVID-19 pandemic were located in the southern United States, this theme is not unique to southern states exclusively; nor is it unique to states considered to be hostile towards abortion rights.

***Alaska***

Alaska is a state considered to lean in support of abortion rights according to the Guttmacher Institute's abortion policy landscape study (Nash, 2020). 63% of adults in the state believe that abortion should be legal in all or most cases (Pew Research Center, 2020). Alaska was one of four states to legalize abortion between 1967 and 1970, before the United States Supreme Court's ruling in *Roe v. Wade* in 1973. By 2007, however, the state of Alaska had

implemented a consent requirement that mandated abortion providers to alert patients of an apparent connection between abortion and breast cancer, which is a claim proven to be scientifically unsupported and medically unfounded (Guttmacher Institute, 2019). In the same year, the state also imposed a provision stating that women attempting to terminate a pregnancy must be informed that a fetus is capable of experiencing pain at 20 weeks despite the conclusion by the medical community following scientific research that pain sensors do not develop in a fetus until at least 23 weeks and may develop as late as 30 weeks as published in Journal of the American Medical Association (Nash, 2007). In 2017, a bill was introduced in Alaska's House of Representatives by David Eastman (R) that would have would have banned abortion in the state. The bill did not make it out of committee (Alaska HB250, 2017). Representative Eastman introduced a piece of legislation in 2019 similar to that of his previous bill, which defined abortion as the murder of an unborn child. This bill has since failed (HB178, 2019). Though anti-abortion efforts have been made in the state, these efforts have largely failed as a result of a largely pro-choice legislature as well intervention by the courts.

In the present, abortion services are much more permissible in Alaska compared to that of Arkansas and Alabama. State-directed counseling that contains information intended to discourage the patient from obtaining an abortion are in place. There are three clinics in the state of Alaska that offer abortion services, meaning 86% of Alaska's counties have no clinics that provide abortion services (Guttmacher Institute, 2021). Though the state of Alaska has historically been supportive of abortion rights, it should be noted that Alaska is currently led by anti-choice Governor Mike Dunleavy. In 2019, Dunleavy blocked $334,700 in funds to the judiciary – the exact amount the state spent funding abortion services in 2018 – in response to a court ruling defending Medicaid funds spent on abortion procedures. Dunleavy explicitly

admitted that this veto was an act of direct retaliation against the Alaska Court System for their ruling, which was in conflict with his own political views (American Civil Liberties Union, 2019). Thus, the state of Alaska is moving in a more anti-choice direction.

At the emergence of the public health emergency of COVID-19 in the United States, the state of Alaska had a Republican governor, attorney general, and Republican party control in both their state Senate and state House of Representatives. On March 16, 2020, just days after the World Health Organization officially declared a pandemic, Alaska's chief medical officer published a health alert strongly recommending that Alaska follow the guidance of United States surgeon general in postponing or canceling all non-urgent and elective procedures for three months in an attempt to mitigate the spread of COVID-19 throughout the state. This alert explicitly stated that this was a request, and not a mandate (Dr. Zink, 2020). Days later, on March 19, 2020, Governor Mike Dunleavy issued a health mandate ordering all non-urgent and elective procedures to be deferred until June 15, 2020 or cancelled. The following month, on April 7, 2020, a revised COVID-19 response policy was put in place by the joint forces of the governor, the Alaska Department of Health and Social Services, and the chief medical officer for the state, which explicitly declared surgical abortions to be non-urgent procedures, thus ordering them postponed. In this revised health mandate addressing non-urgent and elective procedures, a specific section exists for gynecological surgeries. Under the subheading of gynecological surgeries that could be safely delayed for several weeks, surgical abortion it listed. The mandate states that surgical abortion procedures must be deferred indefinitely except in cases where the life or physical health of the pregnant woman is placed at risk by continuance of the pregnancy during the period of forced deferment (Dunleavy et al., 2020). This revision came shortly after Alaska Attorney General Kevin Clarkson signed an amicus brief, which is typically filed by

persons with the objective of asserting support for a particular side in a case, backing the state of Texas for its anti-abortion response amidst the COVID-19 pandemic (Planned Parenthood, 2021). Kevin Clarkson has since resigned from his post as attorney general following the publication of a series of inappropriate text messages Clarkson sent to a junior state employee decades younger than him (Paybarah, 2020). By mid-April, the American Civil Liberties reported that abortions were occurring in the state and that Alaska's COVID-era abortion ban lasted less than one week (2020).

Though the state of Alaska leans in support of abortion rights, abortion services were made to be inaccessible at the onset of the COVID-19 pandemic as a result of an anti-abortion governor. This is demonstrated through Governor Mike Dunleavy, the Alaska Department of Health and Social Services, and the chief medical officer for the state explicitly declaring surgical abortions to be non-urgent procedures. Alaska's COVID-era abortion ban lasted less than one week, as the American Civil Liberties reported that abortions were occurring in the state by mid-April. Of the 11 states that moved to restrict abortion services under the guise of COVID-19, no bans are currently still in effect (Sobel et al., 2021).

## Discussion

The emergence of COVID-19 in the United States propelled many states into quickly enacting policies intended to impede the course of the virus as well as maintain the function and quality of health care. As such, many states delivered executive orders in which state officers made clear their plan to either uphold the principles related to reproductive health care and freedom or attack them. Almost half of the states discussed abortion and other reproductive health services in either their stay-at-home orders or essential procedures orders,

where policies fluctuated from reassuring, to concerning, to dangerous. By the time of mid-April, a total of 23 governors had made the move to safeguard the principle of timely access to reproductive health services in their states. However, 11 anti-abortion governors exploited this global health crisis in a way so as to use the COVID-19 pandemic as an opportunity to deem abortion non-essential health care, thereby unconstitutionally limiting access to the service. These 11 states made stringent efforts to ban all or some abortion procedures.

Just days after a pandemic was officially declared in the United States, the American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine issued a joint statement reaffirming the essential nature of continued abortion services. According to this statement, "abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impacts a person's life, health, and well-being." This coalition of medical groups stressed the fact that they do not support those COVID-19 responses which postpone or cancel abortion procedures and urged community-based and hospital-based clinicians to combine efforts in the attempt to make certain abortion access is not limited during this time (American College of Obstetricians and Gynecologists, 2020).

Although many states with Republican leaders and legislative majorities piled on restrictions to abortion to further reduce the agency that women have in deciding whether or not

to terminate a pregnancy in a political move, the medical community is unified in the recognition of abortion as an essential health care service, thus creating a necessity for these services to be provided even in times of public health emergencies. Many states who sought to bar abortion procedures from occurring did so with the insistence that the objective of doing so was an attempt to expand the availability of personal protective equipment for those frontline workers treating cases of COVID-19. This argument, however, is nonfactual. Women who are incapable of acquiring an abortion will either remain pregnant, thus requiring prenatal care for the duration of the pregnancy as well as medical support during delivery, or may revert to unsafe and high-risk methods in an attempt to abort on their own – as was the typical case in instances where abortion care was inaccessible historically. In either context, the potential need for medical intervention would result in increased contact with clinicians who would require more personal protective equipment than would have been otherwise necessary. Restricting access to abortion services during a global pandemic multiplies risk to both the patient and medical staff astronomically (Bayefsky et al., 2020). Thus, no underlying public health objective can be named because abortion procedures require the use of fewer resources, including personal protective equipment, and involve fewer interactions with health care professionals than prenatal care and delivery comparably – which are services that are being retained during the ongoing pandemic (Donley et al., 2020).

The restriction of abortion services under the guise of a public health emergency is not rooted in any medical necessitation wherein the preservation of personal protective equipment is of concern. Instead, this move in the latest in a succession of political debates concerning the question of whether abortion services are a legitimate health care service. Elective abortion procedures have been isolated in a way so as to physically separate the procedure from other

common and routine health care services. For example, although it would be more medically feasible and less costly to perform abortion procedures in private obstetrics and gynecology practices, these procedures take place almost exclusively at independent clinics. Further, the national discourse in the United States has painted abortion providers as clinicians who fall outside the realm of conventional health care services, thus misrepresenting them as a distinctive group of clinicians who possess questionable medical motivations and thus must be managed via a set of laws applying exclusively to these procedures (Watson, 2018). This idea of abortion exceptionalism is cultivated and spread by those people and groups driven by a desire to make procuring abortion services nearly impossible and/or completely illegal. Legislators and policymakers who hold this abortion exceptionalism mentality have used their positions of power to impose hundreds of novel restrictions on abortion services since the Supreme Court's landmark ruling in *Roe v. Wade* in 1973 (Bayefsky et al., 2020).

The historical misclassification of abortion services as elective health care plays a crucial role in the fragility and vulnerability of abortion care. The enduring classification of the majority of abortion procedures as elective creates a situation in which a woman's right to bodily autonomy is viewed as disposable and their equality is not secure nor necessary. The classification of abortion procedures as elective treatment is not medical consensus, but a moral and political judgment that allows those who continue to utilize this misleading language to assess a pregnant woman's level of worthiness in seeking out abortion services. In the medical community, a surgical procedure labeled as elective does not govern whether the procedure will be done; it simply indicates that the nature of the procedure allows for planning and scheduling compared to those procedures that must be performed urgently so as to not cause further harm to the patient. As a result of the COVID-19 pandemic, a large number of medical organizations

appropriately suspended those procedures for which the patient will not be harmed by a delay. However, due to the complexity of abortion procedures coupled with the increasing risks of procuring the procedure over the passage time – especially considering the fact that many states impose strict limits on the gestational age at which abortion procedures can be performed – indefinitely suspending abortion procedures under the guise of public health will result in a situation where pregnant women seeking the termination of a pregnancy will be unable to obtain an abortion and will be forced to carry the pregnancy to term in the midst of a global health emergency (Bayeskfy et al., 2020).

Though suspending elective and non-essential medical procedures is germane in a time of a global health crisis, including abortion services in this category is legally and medically problematic. Chiefly, abortion services are essential health care and thus should be considered with high priority. Labeling abortion services as elective or non-essential is medically false and will result in adverse health effects if access to these procedures is restricted or forbidden. Statements by the world's top-tier medical and public health organizations including the American College of Obstetricians and Gynecologists, the American Medical Association, the World Health Organization, and the United Nations Population Fund declare abortion to be a time-sensitive procedure that requires urgent action. That said, these organizations uphold the assertion that these time-sensitive procedures should not be blocked in the midst of this pandemic. Any halt to abortion services will result in negative health outcomes and increase harm borne by the patient. Further, the overwhelming majority of these orders use language that encompasses only surgical procedures, and thus should only apply to surgical abortions. In instances of medication abortion, no surgical procedure is required; yet states are still using their emergency orders to prohibit this category of abortion services, which is medically inaccurate

(Donley et al., 2020). All things considered, from a purely medical perspective, abortion is a time sensitive, urgent, and essential medical procedure, and thus should be excluded in all forms from these emergency orders.

Moreover, the legality of these orders restricting access to abortion services under the guise of public health should be considered as well. Suspending abortion services through the end of COVID-19 pandemic – for which the timeline remains unclear – will make it impossible for pregnant women to utilize their constitutional right to obtain a pre-viability abortion if that is what they have decided they must do. Thus, abortion is not only medically essential and time sensitive, but also legally essential and time sensitive; therefore, none of these orders published by state entities should be interpreted to prohibit abortion services in any form. The Supreme Court of the United States has explicitly acknowledged a woman's right to procure a pre-viability abortion for nearly 50 years and has not faltered in holding that a state cannot constitutionally preclude a pregnant woman from obtaining an abortion prior to fetal viability. Those women who are seeking abortion services, but who are close to their state's abortion deadline will be denied their constitutional right to procure this service as a result of the indefinite closure of clinics that provide abortion procedures. Though it is true that some orders are set to expire in the following weeks or months, experts on the issue hold that the COVID-19 pandemic may not be subdued until a point of complete vaccination. This could very well take years. Thus, even those women who are currently in the early stages of pregnancy may potentially be hindered in their attempt to access their constitutionally protected pre-viability abortion procedure (Donley et al., 2020).

In those states where COVID-era abortion bans are in place, the options for women who wish to terminate a pregnancy are to travel out of state in an attempt to obtain an abortion

procedure, to proceed with pregnancy with the hope that the ban will expire and they will be able to access abortion services some time prior to their state's gestational cut off, to revert to the dangerous method of self-managed abortion outside of a medical setting, for example, by procuring abortion drugs on the Internet to take unsupervised, or to carry the pregnancy to term. Traveling out of state in search of abortion services is not a realistic option for many women who wish to terminate a pregnancy as the COVID-19 pandemic made travel increasingly inaccessible for most as a result of mandated quarantine, lockdowns, and travel bans. Further, costs associated with this necessity of travel present an additional barrier to accessing this care. As a result of the current state of affairs caused by the COVID-19 pandemic, economic barriers are further exacerbated by record highs in the U.S. unemployment rate coupled with vast reductions in work hours and the subsequent loss of health insurance. Many women seeking abortion services may have young children who are now forced to be at home as a result of online schooling in response to the pandemic. Thus, securing additional funds to pay for the cost of traveling out of state and lodging as well as childcare present insurmountable obstacles in the attempt to secure abortion services. These short-term impediments in the attempt to access abortion services during the COVID-19 pandemic will likely have long-term effects. Longitudinal research consisting of American women who wanted to terminate a pregnancy but were unable to obtain an abortion found these women to suffer more debt, have lower credit scores, and have poverty-level incomes comparatively. They were also faced with more chronic pain, had worse health, and were more likely to experience sustained physical violence from the man involved in the pregnancy (Jones, 2020). Further, 59% of abortions are obtained by women who already have a child and are primarily concerned that they would not be able to financially care for another. 49% of women seeking abortion live below the poverty level as is; this is an important

consideration given the economic downturn component of the COVID-19 pandemic (Guttmacher Institute, 2021).

Even in the event that women looking to terminate a pregnancy have the ability to travel out of state in search of securing the procedure, abortion clinics in neighboring states will not be fit to meet this increase in demand. Before the COVID-19 pandemic even took root, accommodating standard patient flow presented a challenge for many clinics because of the multitude of superfluous standards abortion clinics are held to, like waiting periods and counseling requirements. which multiply the cost of providing health care services. Abortion clinics were struggling to function fully pre-COVID, and simply do not have the ability to provide for the increased demand of patients traveling from out of state in an attempt to secure the procedure. Moreover, in a COVID-context, these clinics have limited their facility's capacity and are further short-staffed as those they employ may become sick with virus, may be required to quarantine, or must stay home with children. These clinics have appropriately implemented new protocols in order to ensure staff and patient safety, but decreasing caseloads to adapt to social distancing standards nfor staff and patients means that these clinics cannot accommodate an increased influx of out of state patients (Jones, 2020). For example, if a pregnant woman in Arkansas was seeking out abortion services at this time, they would be forced to travel to the boarding state of Missouri in order to secure abortion services as Missouri is the only neighboring state that did not attempt to restrict access to abortion services under the guise of COVID-19 (Kaiser Family Foundation, 2020). Missouri is another state considered to be very hostile toward abortion rights (Nash, 2020). The state has only one abortion clinic, and nearly became the first U.S. state with no abortion-providing clinics. Missouri's only abortion clinic is barely operational for women located in Missouri as a result of result of years worth of anti-

abortion legislation and court cases and, as such, would not be able to meet increased demand from out of state patients.

Despite the medical viewpoint that abortion services are an essential component of comprehensive health care as well as a constitutional right upheld by the Supreme Court, an observable effort by anti-abortion advocates at a coordinated and systematic attempt to bar access to abortion services and otherwise compromise reproductive health care and rights in the midst of a global pandemic has taken root. These efforts, which have undermined abortion access, may exist as facet of broader agenda as many anti-choice advocates work with the goal of reverting reproductive rights and freedoms in the United States in a stoutly retrogressive manner. These attacks on reproductive health care are particularly dangerous during this pandemic, as they result in a situation in which our nation is less prepared to counteract the COVID-19 crisis. Moreover, public health crises like the COVID-19 pandemic only heighten the already existing inequities in the health care system embraced by the United States, leaving women, immigrants, people of color, LBGTQ+ people, people with disabilities, and people with low incomes most detrimentally affected (Guttmacher Institute, 2020).

Anti-abortion advocates are effectively causing COVID-19 to be an even greater threat to public health. In the United States, this pandemic has generated an entirely new category of restricting abortion access, which has posed novel yet pressing challenges that may be attributed to both the virus itself, but also to the anti-abortion movement, which has made clear its intent to use this global crisis in a way so as to further promote an anti-choice agenda. The combination of the extremity, uncertainty, and longevity of this global public health crisis has been used as a deceptive front for the expansion of anti-reproductive rights.

As a result of this, prejudice, discrimination, and inequality seep into the American health care system as women are not able to access the care that they need. Because of the existing legal precent and united stance of the medical community, it seems as though anti-reproductive rights measures have no true no objective of assisting Americans in their time of need amidst a global pandemic. Instead, it seems as though the purpose of these provisions was to further restrict abortion procedures at a time when hundreds of thousands were dying at the hands of an unprecedented global pandemic (Guttmacher Institute, 2020).

## Conclusion

This paper examined the use of the COVID-19 global pandemic to limit accesses to abortion services under the guise of public health in the United States in the year 2020. I reported on various state orders that sought to restrict abortion access, which were undertaken by predominately southern and almost exclusively Republican-led states. I examined in depth those actions taken by the states of Arkansas, Alabama, and Alaska who used the COVID-19 pandemic in a way so as to restrict abortion access. None of these orders are currently in effect as a result of litigation efforts. I conclude that no COVID-19 orders should be enforced against abortion services for the reason that abortion procedures are essential healthcare and a time-sensitive constitutional right. Access to abortion services is a fundamental right and an essential component of comprehensive reproductive healthcare; thus abortion services should not be prohibited nor suspended at the time of a public health emergency.

Though COVID-19 public health guidelines apply to all regardless of sex or gender, there has been little thought paid to how many restrictions put in place disproportionately afflict women. These short-term impediments in the attempt to access abortion services during the

COVID-19 pandemic will have long-term effects. Longitudinal research consisting of American women who wanted to terminate a pregnancy but were unable to obtain an abortion found these women to suffer more debt, have lower credit scores, and have poverty-level incomes comparatively. They were also faced with more chronic pain, had worse health, and were more likely to experience sustained physical violence from the man involved in the pregnancy (Jones, 2020). Further, 59% of abortions are obtained by women who already have a child and are primarily concerned that they would not be able to financially care for another one. 49% of women seeking abortion live below the poverty level as is; this is an important consideration given the economic downturn component of the COVID-19 pandemic (Guttmacher Institute, 2021). Those policies hindering access to abortion services under the guise of public health undermine reproductive health care and rights via the denial of access to tools and resources necessary to utilize this right.

It is estimated that 71,000 women will seek abortion services in the United States for each month that the pandemic persists (Jones, 2020). Research indicates that self-directed abortion in the United States has increased substantially during the pandemic, to a large extent in those Republican-led states that have placed heavy restrictions on abortion procedures during the public health emergency (Baker, 2020). The United States' health care system has the means and expertise necessary to provide this care safely. Thus, what is required now is an evidence-based knowledge and the political will necessary by those leading the country to label abortion services as the time-sensitive and essential health care service that they are in order to keep these procedures accessible during the pandemic. (Jones, 2020). The pace of some states in suspending abortion care during the COVID-19 pandemic underscores the vulnerability of access to abortion services in the United States. This public health crisis requires a unified voice – medically,

politically, and legally – in support of access to abortion services. If these professions come together to defend and advocate for abortion services to be considered timely and essential health care during the COVID-19 pandemic, this consensus has the potential to lay a strong enough foundation to strengthen abortion infrastructure for years to come. Further, expanding access to telemedicine for purposes of providing accessible, socially distant, and safe abortion services is an essential aspect moving forward. An increase in the use of medication abortion coupled with the expansion of telehealth during the COVID-19 pandemic will allow pregnant women wishing to terminate a pregnancy a means by which to access abortion in a way that is both safe and private.

**Table 1**

*State Actions Restricting Access to Abortion Services During the COVID-19 Pandemic, 2020*

| State | Abortion Landscape Pre-COVID | Governor Party | State Legislature Control | Date of initial action | Action taken |
|---|---|---|---|---|---|
| Louisiana | Very hostile | Democrat | Republican | 03/21 | Louisiana Department of Health issued a directive postponing medical and surgical procedures for 30 days. Attorney General Landry threatened to shut down abortion clinics claiming they have violated the state directive. |
| Texas | Hostile | Republican | Republican | 03/23 | Gov. Abbott issues an executive order requiring the postponement of all surgeries and procedures that are not immediately medically necessary including abortion. |
| Ohio | Hostile | Republican | Republican | 03/26 | Ohio Department of Health clarifies that their March 17 non-essential surgery ban prohibits all abortions. |
| Oklahoma | Hostile | Republican | Republican | 03/26 | Gov. Sitt issues a clarification of the state's March 24 non-essential surgery ban explicitly prohibiting all abortion care. |
| Alabama* | Hostile | Republican | Republican | 03/27 | Alabama Department of Public Health imposes an abortion ban in its non-essential care policy. |
| Iowa | Leans hostile | Republican | Republican | 03/27 | Iowa governor's office states that abortions are included in the non-essential surgeries prohibited by the state's March 26 ban. |
| West Virginia | Hostile | Republican | Republican | 03/31 | Gov. Justice issues an executive order prohibiting all elective medical procedures not immediately medically necessary to preserve the patient's life or long-term health. Attorney |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | General Morrisey stated that abortion services are impermissible under this executive order. |
| Alaska* | Leans supportive | Republican | Republican | 04/07 | Gov. Dunleavy, the Alaska Department of Health and Social Services, and the chief medical officer for the state of Alaska updated their health mandate to specify abortion services should be deferred. |
| Tennessee | Hostile | Republican | Republican | 04/08 | Gov. Lee issues an executive order barring people from accessing abortion services by labeling the procedure as non-emergency health care. |
| Arkansas* | Very hostile | Republican | Republican | 04/10 | Arkansas Health Department inspectors deliver a cease-and-desist order to the state's only abortion clinic, asserting that it was in violation of the Department's April 03 prohibition on elective surgeries. |
| Mississippi | Very hostile | Republican | Republican | 04/10 | Gov. Reeves issued an executive order requiring the delay of all non-essential elective surgeries and medical procedures including abortion. |

*In depth analysis above

**Figure 1**

*Timeline of Arkansas's Actions Restricting Access to Abortion Services During the COVID-19 Pandemic, 2020*

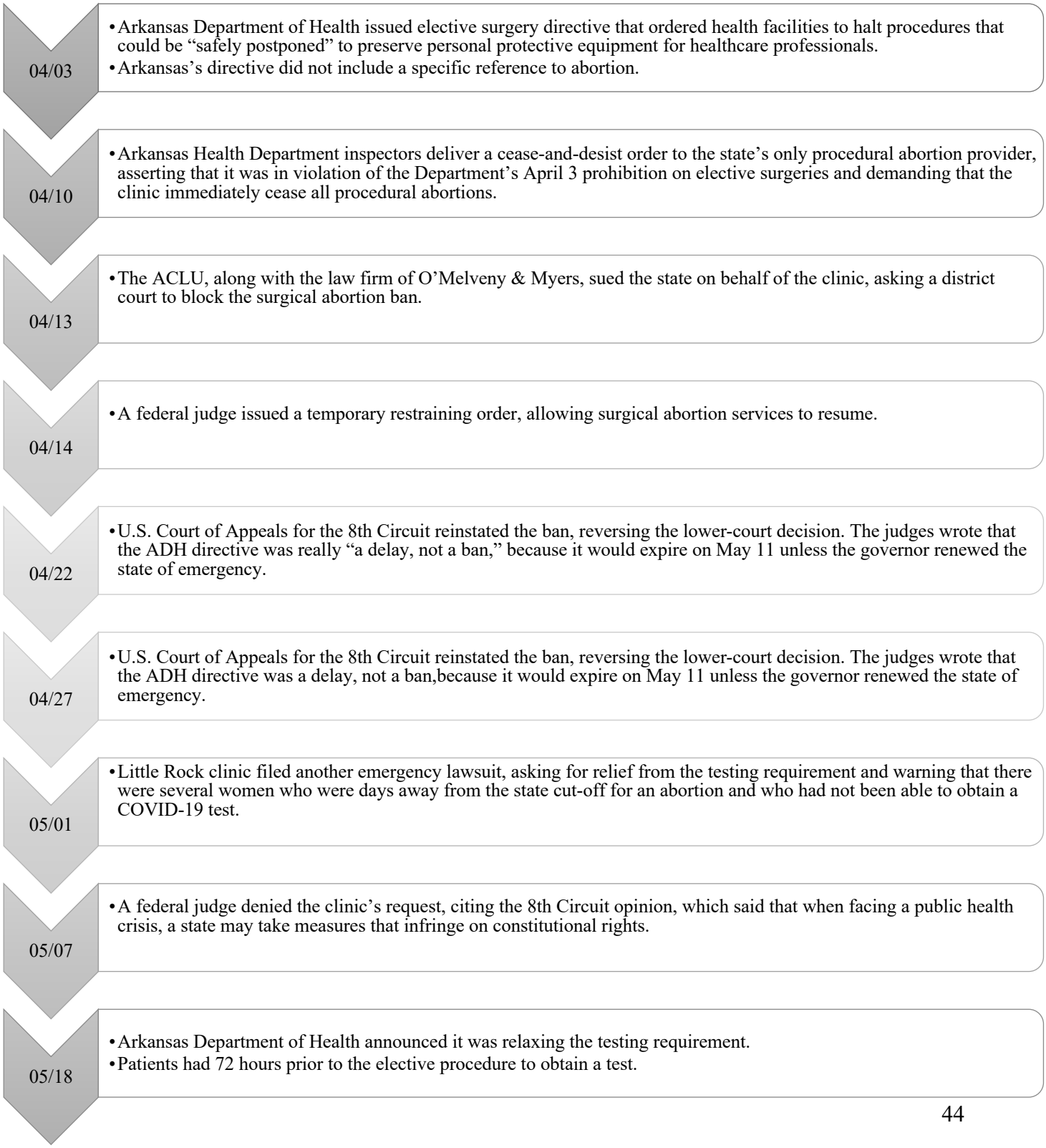


**Figure 2**

*Timeline of Alabama's Actions Restricting Access to Abortion Services During the COVID-19 Pandemic, 2020*

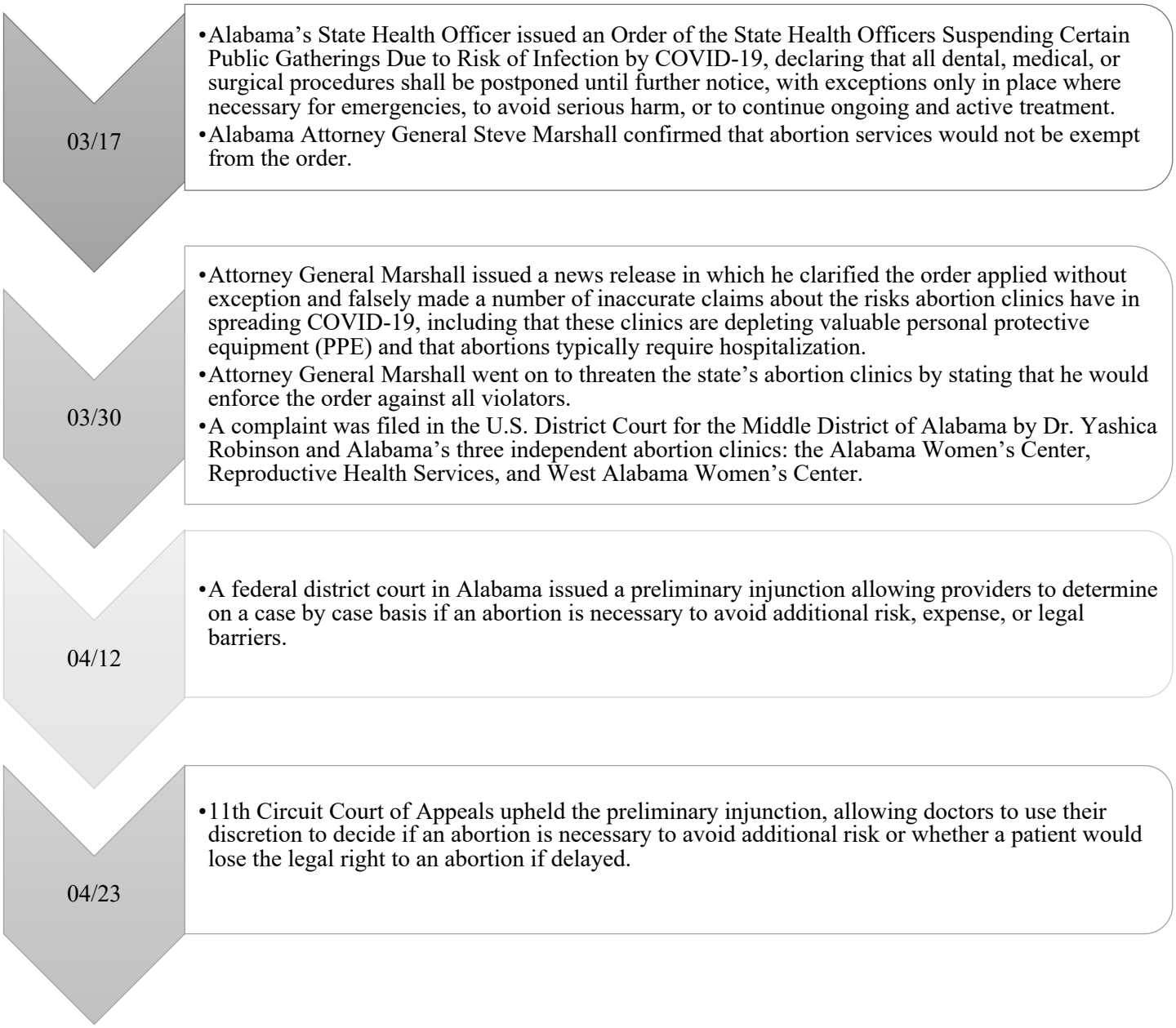
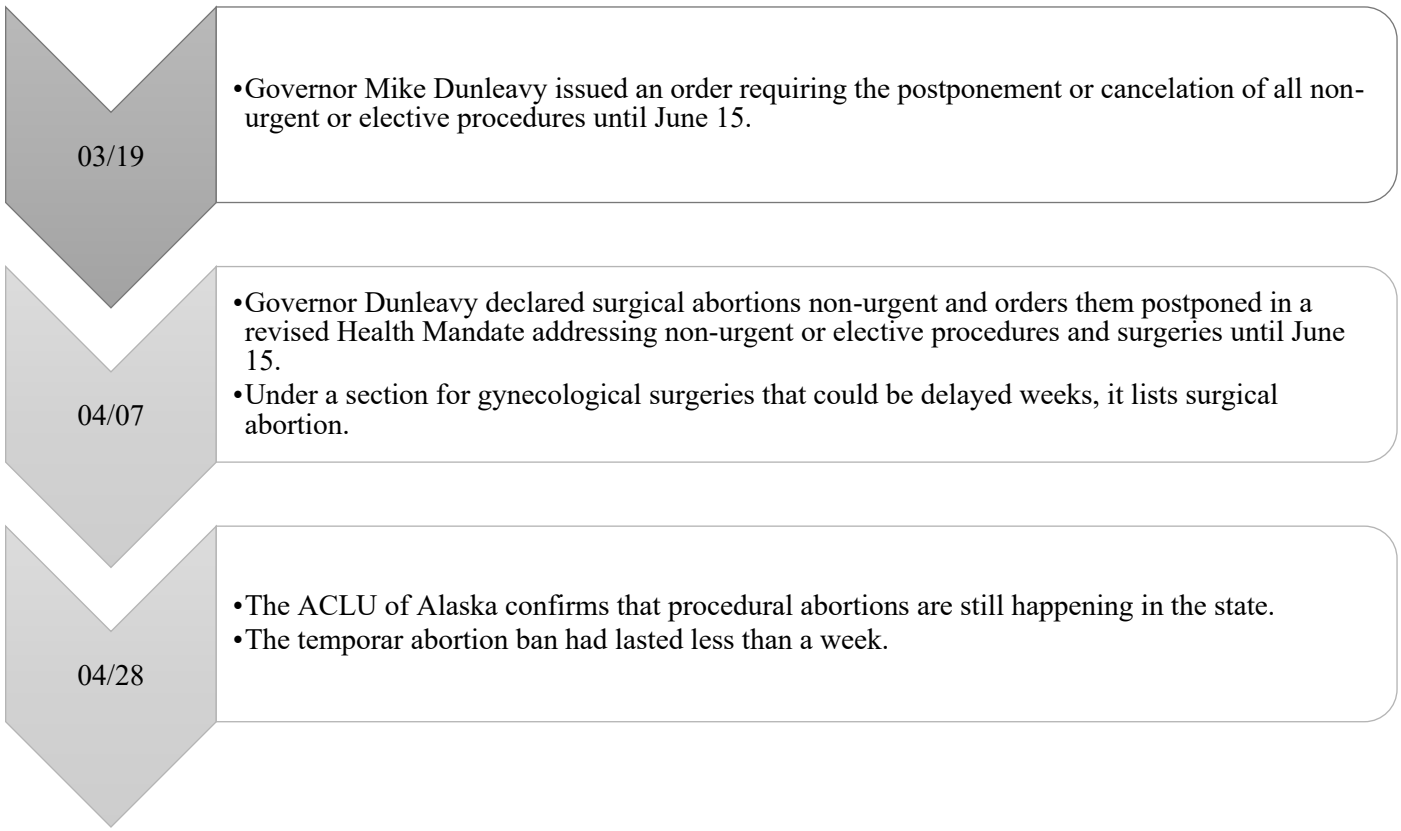


**Figure 2**

*Timeline of Alaska's Actions Restricting Access to Abortion Services During the COVID-19 Pandemic, 2020*



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