VIEWPOINT

# Reproductive Autonomy Is Nonnegotiable, Even in the Time of COVID-19

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The COVID-19 pandemic has swept across the world, altering nearly every facet of contemporary life and causing behavioral and socioeconomic changes that seemed unthinkable a few months ago. The increased risks for human health include not just the dangers posed by the virus itself, but also the upheaval to the broader health care and societal landscapes, which has threatened access to critical sexual and reproductive health services.[1] In this viewpoint, we describe how the pandemic has already posed challenges to reproductive autonomy in both the United States and globally, and then offer insights on how it may do so in the future. We conclude with a call not only to resist a rollback of access to reproductive health care during this pandemic, but to center a broad conception of reproductive autonomy in sexual and reproductive health research, policies and programs moving forward.

We define reproductive autonomy as individuals' ability to be fully empowered agents in their reproductive needs and decisions and to access reproductive health services without interference or coercion. Threats to reproductive autonomy can arise from interpersonal relationships,[2] as well as from health systems and other structural sources,[3] including sexism and systemic racism.[4] As the COVID-19 pandemic both reveals and exacerbates preexisting social inequities,[5] reproductive autonomy offers a helpful lens through which to examine the crisis and protect against future COVID-related abuses.

## COVID-Related Threats to Reproductive Autonomy

• *Abortion access.* Several threats to reproductive autonomy have arisen since the start of the global pandemic. Among the most brazen has been the assault on abortion rights in some U.S. states under the guise of preserving personal protective equipment. Despite the time-sensitive nature of abortion care, as well as clear guidance from medical associations that abortion procedures should not be postponed because of COVID-19 concerns,[6] nearly a dozen states leveraged the pandemic to limit access to abortion services and shutter clinics.[7] Professional organizations, advocacy groups and abortion providers challenged these restrictions, pointing out that routine in-clinic abortion requires little protective equipment, while medication abortion can require none at all.[8] Indeed, researchers have pioneered protocols for no-test medication abortion,[9] and advocates have increased calls for establishing easier pathways to self-managed abortions.[10] Researchers and advocates have also argued for the relaxation of the Risk Evaluation and Mitigation Strategy (REMS) criteria for the drugs used in medication abortions. REMS is a drug safety program of the U.S. Food and Drug Administration that regulates the use of medications with serious safety concerns, yet medication abortion has been documented to be extremely safe.[11,12] Advocates have pushed back against certain REMS restrictions, particularly the limitations on who can prescribe medication abortion and how, as these have made medication abortion far more burdensome to access.[13] From a medical services standpoint, abortion could easily remain accessible throughout the pandemic without using precious hospital resources, yet some politicians have worked to make access more difficult.

Abortion access has also suffered internationally during the pandemic. Social distancing measures and lockdowns across the globe have closed numerous reproductive health clinics, which has led to the postponement or outright denial of time-sensitive abortion care for people who need it.[14] Abortion seekers who live in jurisdictions where abortion is legally restricted are often forced to travel to areas with more permissive laws to seek safe abortions.[15] Yet with many national borders closed and travel restricted, even these trips must be canceled.[16] Perhaps as a result of all of these clinic closures, calls to abortion hotlines and web-based abortion providers have skyrocketed.[14,17] While telemedicine providers have been able to meet some of this increased need,[17] restrictions to air traffic in India–where much of the global supply of drugs for medication abortion is produced–have caused drug shortages that have rippled around the world.[17] Fears of coronavirus infection have even disrupted the processing of international mail in some countries, thus blocking the shipment of medications by post.[16] In these ways, the COVID-19 response is posing threats not only to comprehensive abortion care in the traditional sense, but also to many of the effective workarounds that people have developed in response to legal restrictions and other access challenges.

• *Contraceptive services.* Threats to contraceptive autonomy have also emerged as a result of the COVID-19 pandemic. As hospitals, clinics and providers postpone elective medical procedures, sometimes indefinitely, many have restricted contraceptive services too. In the United States, the American College of Obstetricians and Gynecologists has advised its members to limit access to contraceptive discontinuation services during the pandemic, recommending that the "removal of IUDs and implants should be postponed when possible."[18] Emerging evidence also suggests that U.S. health insurance companies have used the pandemic to deny coverage for surgical sterilization,

claiming that the procedure is elective and therefore not covered during the pandemic, even when performed at the time of cesarean section.[19]

Internationally, some medical organizations and providers have emphasized the provision of long-acting reversible contraceptive (LARC) methods over other types, despite well-established critiques of a LARC-first approach that promotes long-acting methods at the expense of a broad contraceptive method mix.[20,21] According to the International Federation of Obstetricians and Gynecologists (FIGO), for example, "social distancing and limitations on mobility [speak] to an urgent need to expand postpartum family planning services, particularly long-acting reversible contraceptives."[22] Moreover, some obstetrician-gynecologists have called for LARC and permanent methods to be favored over shorter acting methods in light of quarantines and lockdown orders that can limit users' ability to visit pharmacies and clinics for refills or new prescriptions.[23] The controversial belief that LARCs should be promoted for their "set it and forget it"[24] ease appears to have renewed appeal during the COVID-19 pandemic.

At first blush, some of these changes to contraceptive provision seem sensible. FIGO's call to promote postpartum LARC provision can provide effective, long-lasting methods to people who are already visiting the facility for obstetric care, hence minimizing the need for follow-up care and multiple visits. Although treating routine contraceptive care as nonessential and postponing LARC removal may seem like acceptable ways to ensure that people stay home and to preserve critical medical resources, these practices are more dangerous than they may at first appear, as they could seriously restrict individuals' ability to control their own reproduction. For people who do not want a LARC method to begin with, for current LARC users who wish to get pregnant and for pregnant individuals who have already consented to surgical sterilization at their upcoming delivery, these policy changes may prevent them from having a pregnancy they want, avoiding an unwanted pregnancy or choosing the contraceptive method they desire. Especially because the COVID-19 crisis seems likely to be an extended affair that generates long-term disruptions in health care, people's ability to discontinue LARC use, as well as to choose shorter acting methods or sterilization from a broad contraceptive method mix, remains essential.

### Continuing Concerns After the Curve Flattens

As the pandemic presents challenges not only to people's health but to their economic well-being, we remain concerned about linking the use of modern contraceptives (LARCs in particular) with poverty reduction, both in the United States[25,26] and globally.[27–29] For years, some politicians, policymakers and researchers have argued that increased contraceptive use among individuals living in low-income communities can alleviate poverty. Implicit in these arguments is the notion that poverty and a range of other social ills are fueled by women having too many children, rather than by long-identified structural inequities that deprive many low-income individuals—in particular, people of color—of living wages, safe housing, high-quality education, and other forms of social and economic inclusion.[30] Arguments for the contraception-as-poverty-solution are built on the notion that unintended pregnancies are driven by lack of access to effective contraception, and not by poverty, lack of educational and employment opportunities, and legacies of racism—and that these pregnancies are a cause rather than a consequence of social inequality.[20]

In the Global South, arguments in favor of fertility control generally, and of use of modern methods specifically, have been expansive. Economists and demographers have expounded the case for linking population control to economic growth,[31] as well as for promoting the "demographic dividend" as a way to improve macroeconomic conditions through reduced fertility.[32,33] Rationales for maximizing contraceptive use and reducing fertility in the Global South extend beyond economic arguments to promoting increased contraceptive use and lowered fertility as solutions to problems ranging from food insecurity to declining marine resources to climate change.[29,34–36] In the effort to maximize uptake of the most effective modern methods, many family planning programs have adopted LARC-first strategies that can deemphasize the full range of contraceptive options,[37–39] and in turn pressure (if not coerce) people into using LARC methods.[40,41] Many of these LARC-first programs focus on the postpartum period, exemplified by the dedicated postpartum IUD programs that are increasingly common throughout Sub-Saharan Africa and South Asia.[39,42,43] By narrowly promoting LARC methods to the exclusion of shorter acting methods or none at all,[44] and by attempting to leverage LARC use to achieve a range of economic, ecological and social goals, such LARC-first programs can end up exploiting women's bodies. When family planning clients are denied informed, full and free choice about whether to use contraceptives and which method to use, their reproductive autonomy is directly jeopardized.

In the United States, where overall contraceptive prevalence is high and fertility rates are below replacement,[45] instrumentalist arguments for family planning have been more narrowly tailored than in the global context, focusing primarily on promoting LARC use among the poor.[25] In recent years, LARC-first programs have garnered considerable financial investments from donors and foundations with the hope that increased LARC use would reduce the frequency of unintended and adolescent pregnancy, and ultimately the intergenerational transmission of poverty.[26,46] The targeted nature of many LARC programs in the United States has fueled concerns that Brown and Black people are being disproportionately affected and receiving biased or coercive care.[47] In contrast to the global context where, puzzlingly, LARC-first and fertility-focused approaches to family planning have faced relatively little pushback from reproductive health researchers, in the United States, scholars and advocates have articulated strong critiques of LARC-first programs.[20,21,30] Research-

ers looking at reproductive autonomy have argued that facile attempts to portray increased LARC use as a simple solution to complex social problems are unproductive and harmful; instead, they suggest that what is needed is a comprehensive examination and understanding of the structural causes of poverty and social marginalization,[30] historical context[48] and the principles of reproductive justice to guide LARC service provision.[49]

As the world careens toward economic depression and increased social upheaval, we fear that these instrumentalist arguments and LARC-based policy efforts may gain steam and proliferate, and that widespread economic and employment uncertainty will likely add momentum to efforts to promote LARC use as a poverty solution. And with increased budget pressures on social and public health programs, politicians and policymakers may revive efforts to impose coercive measures, such as requiring LARC use as a condition for receiving government aid.[50] Such requirements would be especially likely to target the low-income Black and Brown bodies[51] who are already disproportionately affected by COVID-19 morbidity and mortality,[52] further exacerbating public health inequities.

### Call to Action

The sexual and reproductive health field must continue to push back against threats to reproductive autonomy and work to ensure that all people are able to create the families they want in safe and healthy environments. During this global pandemic, there is no justification for governments or health care organizations or institutions to impose restrictions on individuals' reproductive rights. Communities that are marginalized and discriminated against, especially racial and ethnic minorities, have already borne the brunt of the pandemic in many ways. Let's not continue to devalue these communities by pushing potentially coercive, biased LARC-first programs to control fertility or by making abortion more difficult to obtain.

All communities need access to high-quality, noncoercive services that offer the full range of contraceptive and reproductive options. We can harness the urgency of this time not only to resist rolling back pre-COVID reproductive rights, but to seize the opportunity to demand greater reproductive autonomy for all individuals worldwide. These efforts could include increasing access to clinic-based and self-managed abortion, as well as to a wide contraceptive method mix. Such endeavors should go hand in hand with broader demands to expand reproductive autonomy, such as affordable treatments for involuntary infertility, queer-inclusive reproductive health care, and care practices that acknowledge and seek to dismantle structural racism. In this uncertain time, we appreciate the need for short-term, emergency measures to prevent the spread of coronavirus infection. Yet we must remain vigilant and tireless advocates for a rights-based, person-centered approach to reproductive health around the world. The basic human right to control one's own reproductive destiny is nonnegotiable, regardless of COVID-19 or any crisis.

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