



About this document: challenges facing pregnant and birthing people during COVID-19

In the midst of the COVID-19 pandemic, pregnant and birthing people are particularly vulnerable to rapidly changing public health conditions that are likely to disrupt their access to care, as well as compromise best practices or controvert the medical or midwifery standard of care. Access to quality information and elimination of misinformation are critical: solid, evidence-based information can counter panic and provide a sense of control even during a pandemic.¹ This document offers individuals and advocates a guide to informing themselves and preparing to take action.

Legal and institutional background

In the U.S. perinatal system as elsewhere, a crisis tends to amplify or expose existing problems: the [health care system as a whole is inequitable](#), structural racism causes a segment of the pregnant population to face even graver [outcomes](#), pregnant people regularly [lack access to best practices](#) and experience [increasing maternal mortality](#) in hospitals, and most pregnant people lack access to the midwifery model of perinatal care due to the [lack of integration of midwives](#) into mainstream health care.² If deepening inequality in access to care and quality of care were not enough, our country is generally afflicted by a piecemeal and disconnected health care non-system that itself [exacerbates the problems](#) listed above.³

During declared emergencies, the State is permitted to curtail personal liberties; the legal basis for individual rights in childbirth, already limited, becomes even more tenuous as the power of governors and the president increase.⁴ The Executive Branch at both State and Federal levels possesses broader power to waive, adjust, and change laws and regulations in the interest of public welfare and crisis mitigation. This power is the source of executive orders now being issued across the country that require schools to close and residents to shelter in place. If we expect [civil and political rights](#) to be protected in this setting, emergency orders must be clearly communicated, transparent, necessary, proportionate, grounded in law and a legitimate purpose, limited in duration, and subject to oversight.

¹ Reliance on digital information may exaggerate disparities during this time of social distancing. Human Rights Watch, Closing the 'Digital Divide' Critical in COVID-19 Response. Available at: <https://www.hrw.org/news/2020/03/25/closing-digital-divide-critical-covid-19-response#>.

² We explored these issues in depth in our [Report to U.N. Special Rapporteur on Violence Against Women: Mistreatment and Violence Against Women During Reproductive Health Care With a Focus on Childbirth in the USA](#).

³ J.D. Kleinke, Oxymorons: The Myth of a U.S. Health Care System (2001).

⁴ For more about rights during birth in general, we recommend our [Know Your Rights](#) document.

Because of the extreme virulence of COVID-19, health systems and providers will be forced to make crisis-mode decisions to mitigate virus transmission at the expense of other priorities and/or risks.⁵ Advocates for pregnant people can help to prevent a scenario in which the rights of pregnant people and their newborns are spontaneously “risked out” of existence.

Specific violations of the rights of birthing and pregnant people

Infringements on birth rights and justice are increasing during the current public health emergency. We identify and describe such occurrences below, and will continue to update them, so that advocates for birthing and pregnant people are empowered to press for emergency responses to local manifestations of these violations.

Hospital policies

- Restrictions on number of support persons present, such as partners or doulas, during labor and delivery.
- Separation of babies from parents at birth.
- Hospital prohibitions on videotaping or streaming used to limit patient access to virtual doula support.
- Constraints on informed consent processes due to overwhelmed health care systems, pressure to consent to interventions (induction, cesarean surgery), lack of access to requested/needed interventions (including epidural anesthesia), lack of information about alternatives, pressure to accept the risk priorities of providers over those of families.
- Lack of continuity of care, sudden shifts in plans and policies, changes of care providers without notice, relocations (to temporary or converted structures outside the hospital) without notice.
- Breakdown in process/notice; increased lack of accountability, including executive orders that offer hospitals and providers greater protection than usual from legal liability for harm to patients.

Access to care alternatives

- Families hoping to switch care from hospital to home or birth center birth may find no available midwife or birth center due to pre-existing laws/regulations that either exclude home birth midwives, complicate or forbid the establishment of birth centers, or fail to invest in the midwifery workforce.

⁵ For example, policies that separate babies from their mothers at birth in order to shield babies from *possible* infection do so at the cost of inflicting other *certain* harms: disruption in bonding and the breastfeeding relationship, prevention of newborn receipt of maternal antibodies through breast milk, and a weakening of newborns’ ability to regulate their temperature through maternal proximity.

- Midwives wishing to contribute their expertise to an overburdened health care workforce during a pandemic may be limited by the existing state regulatory scheme that restricts the scope of midwifery practice or excludes some credentials altogether.
- Likewise, midwives may be limited by government failure to include or consider their profession in emergency health care workforce planning.⁶
 - Executive orders to modify or waive licensing requirements and scope of practice limitations omit or inadequately incorporate midwives, student midwives and birth centers.
 - Provisions for essential workers, including ability to travel, may omit or inadequately address the needs of midwives and birth centers.
 - Provisions for emergency equipment, including but not limited to personal protective equipment, may exclude midwives and birth centers, putting at risk not only midwives but also the families they serve.
- Midwives, birth centers, and families may struggle to interpret and track fast-changing executive orders; states of emergency similarly hinder the already limited capacity of advocacy organizations to disseminate analyses and updates in an organized, consistent manner.

Insurance

- Health insurance carriers may cite the emergency as justification for their denial of necessary changes to their plans and/or networks of providers and facilities. Alternatively, carriers may attempt to proceed under a “business as usual” model, using habitual policies to deny changes. Either type of refusal would harm people who require out-of-network care because they are away from home or sheltering-in-place and thus unable to access their usual providers.
- Insurance carriers’ refusal to cover out-of-network care will add unpaid and contested medical bills to the economic consequences of the pandemic.
- Even those families that receive adequate and affordable coverage during the pandemic may fear the likelihood of future increases in insurance premiums to compensate carriers for the increase in service utilization.
- Varying Medicaid coverage of midwives by state renders home birth accessible to some while inaccessible to others based on nothing more than geography, leading to predictable geographic outcome disparities.
- Varying Medicaid coverage of doulas by state renders access to professional doulas and improved outcomes inequitable.
- Because insurance generally bills for pregnancy as a bundled service, access to care may be complicated by billing codes lagging behind changing circumstances

⁶ As of April 1, 2020, only New Jersey and New York have explicitly included midwives in their emergency executive orders.

(telemedicine versus an office visit) or by care being denied based on unavailability of billing codes.

- Malpractice liability insurance modifications and protections from malpractice liability may not be extended to all maternity care providers, including CNMs, CMs, and CPMs.

Other risks to pregnant people

- Pregnant people, like others, are faced with the risks of [contracting COVID-19](#).
- Birthing people are also at risk of harms caused not by the virus itself, but by its secondary effects: a flood of sick patients that overwhelms hospitals, a slow and inadequate response to the emergency by policymakers, and the dire shortage of needed equipment and personnel that results from the fusion of these two conditions.
 - In normal times 23% of all patients [discharged from U.S. hospitals](#) are childbearing people and newborns.
 - Even when populations with special needs are factored into system-responses to emergencies, the unique needs of pregnant and laboring people are often left out.
 - Health outcomes during birth, already variable by facility and geography, are likely to be exacerbated by disparate state responses to emergencies.
- [Health outcome disparities](#) based on bias may worsen during a crisis; implicit biases may become explicit (e.g. existing provider distaste for high-BMI pregnant people may evolve into an institutional policy to deny such patients ventilator access, based on a biased understanding of risk), institutional processes established to mitigate implicit bias may be considered non-essential and subsequently abandoned, and stress placed on providers by the emergency can amplify any existing bias in their treatment of patients.
- Child protective service agencies often judge families for their risk-benefit calculations. Risk analysis becomes all the more intense and morally charged during a pandemic. [The involvement](#) of CPS in a pregnant person's care, particularly with use of a punitive approach to patients' non-hospital birth, refusal of medical recommendations, choice to bedshare, or substance use during pregnancy, may affect outcomes for pregnant people, who are already vulnerable to judgment, and their newborns.
- Pregnancies may be affected by other stressors, including a lack of accommodations for pregnant workers (especially health care workers), xenophobia based on misperception of immigrants as primary viral carriers, loss of employment/income, and lack of access to shelter, food or other essentials.
- Pregnant people who receive medication-assisted treatment (typically methadone or buprenorphine) often require in-person, daily access to clinics, a [challenge during a pandemic](#). The federal Substance Abuse and Mental Health Services Administration allows states to apply for exceptions to the usual limit of take-home doses, but states

and providers must first be aware of this opportunity and then take action to implement these new exceptions.

- Access to abortion care, either self-managed or clinic-based, may become even more limited as politicians take advantage of [the pandemic to introduce restrictive changes](#) to abortion laws. Abortion care is an essential and time-limited health service; access restrictions during a pandemic have no basis in medical evidence or the rights of pregnant people.
- [Incarcerated](#) pregnant people already experience limited access to information, options, essential supplies and care; these shortcomings are likely to be intensified during a pandemic both in correctional facilities and in any clinic- or hospital-based care for prisoners. Crowded conditions inside prisons and jails also put incarcerated pregnant people at heightened risk for contracting COVID-19.
- Undocumented pregnant people already experience both structural and individual exclusions from safety net programs and health system responses. [A pandemic may magnify this exclusion, causing](#) even more extreme consequences, especially for people detained in immigration facilities where exposure to the virus and other secondary harms are higher.
- Pregnant people in general are at heightened risk of [domestic violence](#); the isolation that accompanies social distancing and sheltering in place may increase the risk of harm from domestic violence even more.
- [LGBTQ people](#) in general face increased economic risks and lack of access to health care; pregnant people who are LGBTQ may be uniquely impacted because LGBTQ-specific responses may not include or consider pregnant people.

Legal challenges to hospital policies

In the normal course of business, hospitals enjoy wide latitude in establishing policies. During a public health crisis, this latitude increases both as a legal matter, since executive orders often expand the role of medical personnel and hospitals, and as a political matter, as hospitals are better positioned than individual patients to advocate for accommodations in their interest.

Legal mechanisms that might empower patients to push back against unjust hospital policies are underdeveloped. For example, in the 1970s the presence of fathers in the delivery room was generally prohibited by hospital policies. Legal challenges to these policies failed (*Fitzgerald v. Porter Mmm. Hosp.*, 523 F.2d 716 (7th Cir. 1975)), but advocacy efforts, public pressure, and changing norms succeeded.

Particularly when legal grounds strongly protect hospital policies, legal challenges are the least effective approach to protect the rights of pregnant people and their newborns. This is the case in separation of families by hospitals and/or states whose legal basis arises from the state's role in protecting the health and welfare of children, despite the [well-documented adverse effects of family separation](#), especially on infants. Strong advocacy by both advocates and affected families directed at both health care providers and administrators is necessary to prevent undue separations.

Recommended responses to violations

In recognition of these issues of concern to birthing people, their families, and their care providers, BRBA suggests that advocates prepare to be vocal and persistent. We cannot count on emergency response teams, public health officials, hospitals, or courts to protect or even perceive the numerous needs of pregnant people during this time, including respect for their human rights. We recommend that the following principles guide advocacy actions:

- Pregnant and birthing people, and others with expertise in pregnancy and birth, should be involved in planning and decision-making;
- Established priorities will dictate the inevitable hard choices to be made; therefore, honoring the humanity of pregnant people, their families and newborns should constitute a top priority;
- Even when dire situations require both patients and providers to make hard choices, informed consent cannot be disregarded. Pregnant patients must be provided with information and opportunity to decide how that information affects them, including information about the risks, benefits and alternatives for any procedure, test, or hospital policy;
- The safety of health care workers need not be at odds with the wellbeing of pregnant people. [Laboring people should not be separated from their chosen support people while in labor](#). Hospitals should be mandated to prioritize accommodation of this need even during crisis situations;
- Parents and newborns should not be separated; risk of infection should be minimized in ways that support bonding and attachment;
- In general, providers and policymakers must be encouraged to think outside the box in order to change their procedures in ways that continue to defend against transmission of disease without sacrificing human rights;
- State and/or federal [executive orders must increase access](#) to midwives and birth centers as described in the linked document.

Conclusion

Advocacy is not easy and neither is coping with a pandemic. We nevertheless urge advocates to refrain from assuming that the problems we have identified in this document are foregone conclusions. We believe that energetic, sustained, and well-supported actions by advocates at the local level can resolve or even forestall human rights violations.

We will continue to update this document. We welcome your suggestions on how to improve it or expand it. You can reach us at info@birthrightsbar.org.

While we're here ... Birth Rights Bar Association promotes the rights of birthing people: physical liberty, bodily integrity, autonomy, privacy, due process, equal protection, religious liberty, and informed consent. In order to support birthing people, we also protect the right of midwives to practice their profession. We carry out this work by building skills and networks among legal professionals, providing public education, and collaborating on institutional legal advocacy efforts. You can support us by encouraging any attorneys you know to consider a BRBA membership. Please see www.birthrightsbar.org/membership.

