Beyond Silos: How Embryo Personhood Rhetoric Reshapes Reproductive Healthcare Access Across the Continuum of Care

Arianna D. Injeian, MPH, MSc

PhD Candidate, Biocultural Medical Anthropology, University of Alabama

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EXECUTIVE SUMMARY

Reproductive healthcare policy has long operated in silos, treating IVF, contraception, abortion, and maternal care as separate regulatory problems requiring separate solutions. Alabama's 2024 embryo personhood crisis made the cost of that approach visible. When the state Supreme Court ruled that frozen embryos qualify as "extrauterine children" under the Wrongful Death of a Minor Act, IVF access collapsed within days, but the damage did not stop there. Clinical professionals faced legal uncertainty about miscarriage management. Legislators warned that contraceptive access was next. SB 159, the Alabama IVF Protection Act (Act No. 2024-28), was signed within five days as an immunity measure to protect patients, providers, and transporters of biogenetic materials. The same legislature that moved in five days to protect IVF had not addressed the state's nation-leading Black maternal mortality rate. Governing reproductive healthcare as a set of unrelated domains did not contain the harm. It guaranteed the cascade.

In June 2026, HHS issued Notice of Funding Opportunity PA-EAA-26-001, an active $1.9 million grant program that uses language throughout its program description treating frozen embryos as children with legal rights, frames standard IVF practices as subjecting children to risk, and designates faith-based organizations as primary recipients. Critically, the grant's responsiveness criteria — which applicants must affirm to be eligible — bar the use of grant

funds to create or discard human embryos, practices that standard IVF requires as a clinical matter of course. The ASRM Ethics Committee warned in 2023 that precisely this kind of language would "restrict established and protective IVF practices." The federal government has now built it into a funding mechanism that operates without any new act of Congress.

This paper draws on original ethnographic fieldwork with intended parents and fertility professionals in Alabama (February 2024 through December 2025) to document what personhood-based governance produces at the level of lived experience, and on close analysis of the NOFO and related federal actions to show how the mechanism now operating federally is the same one that closed clinics in Alabama.

Policy Recommendations

ASRM: Monitor and engage on federal personhood language in reproductive health funding, drawing on the Ethics Committee's existing 2023 position.

Congress: Pass the Right to IVF Act and extend its protections to administrative as well as judicial personhood threats; Repeal or limit the Comstock Act's application to reproductive healthcare and codify the FDA telehealth mifepristone prescribing rule; Enact statutory clarification that contraception cannot be regulated under personhood frameworks, modeled on the bipartisan approach of Alabama's HB 642.

SECTION 1: INTRODUCTION — THE SILO PROBLEM

In February 2024, the Alabama Supreme Court ruled in *LePage v. Center for Reproductive Medicine* (SC-2022-0515, Ala. 2024) that frozen embryos qualify as "extrauterine children" under the state's Wrongful Death of a Minor Act of 1872 — not a general constitutional determination of embryo personhood, but an application of that specific statute to frozen embryos stored outside the womb. The case arose after three families alleged the

accidental destruction of their frozen embryos at a Mobile, Alabama fertility clinic. Within days of Chief Justice Tom Parker's opinion, every IVF clinic in Alabama had suspended services. Patients mid-cycle received calls with no timeline for resumption. Providers faced potential wrongful death liability for decisions regarding how to store, transfer, or discontinue care for embryos — all components that IVF requires as a clinical matter of course. Days later, patients and physicians filled the State House wearing orange, the color associated with infertility awareness, to testify about what had been taken from them.

The months that followed exposed what the ruling's framing had concealed: these domains were never actually separate. One patient connected her IVF struggle to the dearth of maternal health resources across the state. State Representative Chris England of Tuscaloosa called SB 159's immunity-only response "morally ambiguous and intellectually dishonest," arguing it left the underlying constitutional question untouched (Rocha and Stephenson 2024). House Minority Leader Anthony Daniels identified the downstream risk directly, warning that contraceptive access could be next (Rocha and Stephenson 2024). A participant in this study drew a line from the embryo personhood ruling to Alabama's nation-leading Black maternal mortality rate. In exasperation, she noted that the same legislature that passed IVF protection in five days had passed nothing to address the women dying in its hospitals.

Reproductive healthcare is governed as if IVF, contraception, abortion, and maternal care occupy distinct regulatory domains with distinct political constituencies. What the Alabama crisis revealed is that personhood rhetoric does not honor those distinctions. When it enters one domain, it generates legal pressure across all adjacent ones, reshaping provider behavior, patient access, and institutional risk calculation in ways that no single-domain policy framework can contain or anticipate. This paper traces that mechanism from Alabama's courts to federal grant

criteria, documents its consequences through original ethnographic fieldwork, and argues that governing these domains as separate is not just analytically incomplete, but that it is a governance failure in real time.

SECTION 2: EMBRYO PERSONHOOD AS A GOVERNANCE MECHANISM

Questions about when human life begins have a long history across philosophy, theology, and law, with Hippocrates and Aristotle debating the ethics of abortion and the beginnings of human life in Ancient Greece (Patsioti 1998). What is distinctive about the contemporary United States is not the question but the legal operationalization of the answer, and its consequences for clinical reproductive care. Embryo personhood as a governance strategy predates Alabama. In the years following *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe* and *Casey* without resolving whether fetuses or embryos hold Fourteenth Amendment rights that would affirmatively restrict reproductive healthcare, several states accelerated efforts to define life as beginning at fertilization. Alabama's *LePage* ruling was the first to disrupt fertility care specifically, reaching a domain that had long maintained bipartisan support by being understood, incorrectly, as separate from abortion politics.

Personhood rhetoric does not require judicial victory to reshape governance. The mechanism operates through uncertainty, which is itself a form of enforcement. Several Alabama fertility clinics did not reopen after SB 159 passed, not because the law required their closure, but because providers and administrators looked at the unresolved constitutional question and concluded that the liability exposure was too great. The loss of providers was not a legal outcome; it was a risk calculus. That is how personhood rhetoric works: it destabilizes enough that institutions reorganize before any ruling compels them to, and the costs of that reorganization fall on patients.

The ASRM Ethics Committee recognized this pattern in its 2023 opinion on embryo donation, warning that importing adoption language into embryo legislation "would serve to inappropriately elevate the legal status of embryos" and would, if enacted, "restrict established and protective IVF practices, including cryopreservation and preimplantation genetic testing" ("Defining Embryo Donation" 2023). By June 2026, that analysis had materialized in federal grant infrastructure. HHS NOFO PA-EAA-26-001 uses language throughout its program description treating frozen embryos as children with legal rights — referring to "children who already exist," centering program activities on "the child's right" to origins information and screened placement, and framing existing practices as inadequate to protect children's interests. Chief Justice Parker's concurrence grounded Alabama's embryo personhood ruling in explicitly theological language; the NOFO institutionalizes the same reasoning in federal funding criteria, through a grant program issued under existing appropriations authority with no new act of Congress required. Alabama was the state-level proof of concept. The NOFO is its federal replication.

SECTION 3: ALABAMA AS PROOF OF CONCEPT

What the Ruling Did

On February 16, 2024, the Alabama Supreme Court's 8-1 ruling in *LePage v. Center for Reproductive Medicine* (SC-2022-0515, Ala. 2024) held that frozen embryos qualify as "minor children" under the Wrongful Death of a Minor Act of 1872. The ruling concerned the application of that specific statute to embryos stored outside the womb — it was not a general constitutional determination that embryos hold personhood rights. All IVF services in the state halted immediately. Patients scheduled for egg retrievals or embryo transfers received notice with no timeline for resumption. SB 159, the Alabama IVF Protection Act (Act No. 2024-28),

provided civil and criminal immunity for IVF providers, patients, and transporters of biogenetic materials and was signed into law within five days. While a significant legislative response, it resolved liability without resolving the constitutional question the ruling had opened. The Supreme Court's holding was not overturned; it was insulated. The same legal logic remains embedded in Alabama law, and the constitutional conflict remains unresolved.

Patients who had the means transferred embryos out of Alabama or began receiving care across state lines, a variation on what researchers have called reproductive exile (Inhorn and Patrizio 2009). With an ongoing constitutional conflict, this immunity is recognized as only temporary, and what's more is the proliferation of embryo personhood rhetoric on a national level.

The Labor of Mattering

Throughout the fieldwork period, it became clear that this crisis was not only a policy disruption but a reorganization of daily life. Throughout interviews with intended parents and parents through fertility care in Alabama, a pattern I describe as the labor of mattering became evident: the compounded financial, bodily, emotional, and political work that patients perform just to access care they have been promised and deserve. Patients describe depleting savings, retirement funds, and emergency reserves to complete cycles before another disruption could intervene. They describe the fear of beginning a new treatment only for the legal ground to shift again. They describe managing the logistics of reproductive exile while simultaneously managing the grief, hope, and physical demands that fertility care requires under any circumstances. As Margot, a mom of one pregnant with her second child through IVF told me, ″Fertility treatments are amazing. But they will also take everything from you, both financially and emotionally and physically."

The political dimension of this labor was its most distinctive feature. In the months following *LePage*, accessing IVF increasingly required patients to become public advocates by attending legislative hearings, testifying before committees, and contacting elected officials. Oftentimes this was done in ways that felt, to many of them, like a precondition of care rather than a choice. The labor of political visibility became inseparable from the labor of family formation. Rachel recounted her immediate panic after the decision: "I didn't sleep for two solid weeks. I was up at night googling, can I get a cryogenic freezer on a U-Haul?"

This compounded burden is what the labor of mattering names, and it is not distributed equally. Patients with financial resources, employment flexibility, transportation access, and proximity to out-of-state providers could absorb portions of it. Patients without those resources could not. The labor of mattering maps onto existing inequalities of race, class, geography, and insurance status, and it intensifies at every point of policy disruption.

The Spectrum of Reproductive Freedom

Across interviews, intended parents in Alabama drew connections between their fertility care struggles and the broader reproductive landscape without being prompted to do so. They named contraception, abortion care, miscarriage management, and maternal mortality — not as adjacent issues but as points on what one participant called "a spectrum of reproductive freedom." Lynn, another mom of one and pregnant with her second through IVF told me, "You cannot separate abortion. You cannot separate contraception because it's needed during fertility care, and you cannot separate even the abortion pill, because that's involved in managing pregnancy loss." Beyond that, Julia, who faced her first loss after IVF in the days after *Dobbs* and her second loss in the wake of *Lepage* commented on the embryo personhood language: "It

was hideous that you're able to use theology and scripture to get a bill passed that can affect so many people. You're not pro-life. You're anti-family."

What patients described from inside the Alabama crisis, including the structural connection between IVF access, contraceptive access, medication abortion, and maternal care, is precisely what federal policy in 2026 has proceeded to enact. The following section documents how.

SECTION 4: FEDERAL ESCALATION

The Mechanism Deployed Nationally

n June 2026, HHS Office of Population Affairs issued NOFO PA-EAA-26-001: Embryo Adoption Awareness and Services. The program dates to 2002, but its 2026 reissuance represents a significant departure. Throughout the program description, guidance, and eligibility criteria, language treating frozen embryos as children with legal rights appears systematically: the program "recognizes embryo adoption first and foremost as a response to the needs of children who already exist and are in need of a family," centers activities on "the child's right to know their biological origins" and "the child's right to be placed with adoptive parents who have undergone rigorous screening," and frames current embryo adoption practices as inadequate to protect children's interests.

The embryo adoption framing is not new as agencies promoting it have operated since the Bush administration. But as one research participant put it explained it to me, in a way that resonated across my participant sample, "people who have been through IVF know better than anybody that an embryo is not a person. It's only the potential to become one."

What is new is that this personhood framing is now embedded in federal grant criteria determining which programs receive public funding and which do not. ASRM's 2023 Ethics

Committee opinion warned that importing adoption language into embryo legislation "would serve to inappropriately elevate the legal status of embryos" and would "restrict established and protective IVF practices, including cryopreservation and preimplantation genetic testing." The NOFO is the realization of that warning, operating not through legislation or litigation but through administrative action — issued under existing appropriations authority with no new Congressional authorization required.

The Direct IVF Threat

The NOFO's threat to IVF practice is explicit in its own grant conditions. The responsiveness criteria, which all applicants must affirm to be eligible, state that no grant funds will be used to "pay for, subsidize, promote, or otherwise support discarding or destroying human embryos," and that no grant funds will be used to "create new human embryos." These restrictions apply to the use of grant funds, not to IVF practice generally — but they establish, within a federally funded program, the premise that creating and discarding embryos are impermissible. Standard IVF requires both: creating multiple embryos to maximize the probability of a successful transfer and making clinical decisions about embryos that are not transferred. A federal program that funds infrastructure premised on the impossibility of these practices uses the same personhood logic that suspended IVF in Alabama, now embedded in the criteria governing federal reproductive health funding.

The Contraception Cascade

Personhood logic does not stop at IVF, and the threat to contraceptive access operates through political and legal reasoning rather than through medical science. Under personhood frameworks that define life as beginning at fertilization, anti-abortion advocates have historically characterized certain contraceptives as abortifacients — claiming they act after fertilization to

prevent implantation — regardless of what the clinical evidence shows. Current medical evidence indicates that IUDs work primarily by preventing fertilization rather than by preventing implantation. Copper IUDs create a spermicidal environment that impairs sperm viability before fertilization can occur; hormonal IUDs thicken cervical mucus and inhibit sperm penetration. The threat to contraceptive access under personhood frameworks is thus a political and legal claim that overrides clinical evidence with theological assertions about when life begins — the same pattern that produced the *LePage* ruling and the NOFO.

In Alabama, legislators recognized this risk immediately. Representative Chris England characterized SB 159 as an incomplete fix that left the constitutional question unresolved (Rocha and Stephenson 2024). House Minority Leader Anthony Daniels warned publicly that leaving personhood language intact in state law created downstream risk for contraceptive access, and Alabama House Democrats introduced legislation specifically protecting contraceptives within weeks of the *LePage* ruling (Rocha 2024). Representative Marilyn Lands formalized this connection in the 2026 session with HB 642, the Alabama Family Planning Act, modeled on a Tennessee law that had passed with Republican support in 2025. The bill treated IVF access and contraceptive rights as a single, unified legislative ask. It did not receive a committee hearing in Alabama's Republican-controlled legislature, but the significance of its introduction reflects the understanding, developed in real time by legislators closest to the crisis, that the IVF and contraception threats are the same problem requiring a unified response.

Mifepristone, the Comstock Act, and a Federal Pattern

In May 2026, a unanimous three-judge panel of the Fifth Circuit reinstated the in-person dispensing requirement for mifepristone — one of two medications used in medication abortion and in the clinical management of miscarriage and pregnancy loss — effectively blocking the

FDA's 2023 rule permitting telehealth prescription and mail dispensing. The Supreme Court stayed that ruling, preserving telehealth access while litigation continues. The stay resolves nothing on the merits, and the dissents from Justices Thomas and Alito signal where the deeper threat lies. Thomas argued that mailing mifepristone constitutes a federal crime under the Comstock Act — an 1873 postal statute banning the mailing of materials related to abortion, contraception, and sexual health that has never been formally repealed — calling the manufacturers' application an attempt to profit from a "criminal enterprise." Alito framed the majority's stay as "a scheme to undermine" the Court's decision in *Dobbs*, making clear his objection was not procedural but ideological.

At his Senate Judiciary Committee confirmation hearing on July 15, 2026, Attorney General Todd Blanche committed to reviewing DOJ's interpretation of the Comstock Act and signaled the administration's intent to restrict mifepristone access by mail, indicating executive-branch alignment with the judicial pressure to deploy this 150-year-old statute against reproductive healthcare access. Taken together — the NOFO, the Fifth Circuit ruling, the Comstock threat, and the *LePage* decision — these are not coincidental developments in the same policy space. They are deployments of the same mechanism across different levels of governance and different access channels. Treating them as separate problems is not just an analytical error; it is the condition that allows each individual action to appear limited in scope while the cumulative effect dismantles access across the continuum.

SECTION 5: THE DANGERS OF SILO GOVERNANCE

Silo-based reproductive governance cannot respond adequately to personhood-based legal mechanisms because those mechanisms do not respect the silos. A ruling about the status of a frozen embryo reaches into the clinical management of miscarriage. A grant program built

around embryo adoption creates the regulatory preconditions for restricting IVF. An 1873 postal statute becomes a potential vehicle for eliminating telehealth medication abortion. Each action appears targeted and bounded; the cumulative effect is a restructuring of reproductive access across domains that governance frameworks are not designed to see as related.

Alabama compressed this dynamic into a documented, observable period. The *LePage* ruling destabilized IVF access, chilled contraception prescribing, raised fears about medication abortion and miscarriage management, and intersected with preexisting maternal mortality disparities — all occurring throughout the span of fieldwork. The legislature that moved to protect IVF in five days simultaneously refuses Medicaid expansion, leaving hundreds of thousands of Alabamians uninsured, maintains maternal mortality rates of approximately 100 per 100,000 for Black women (Hoyert 2024), and restricts abortion access even in cases of rape and incest. The swift protection of IVF reflected not a consistent pro-life or pro-family commitment but a determination about which patients the state was willing to protect.

That selectivity is the structure of reproductive governance, not an exception to it. Researchers have described this as stratified and uneven reproduction: the differential valuation of reproductive futures based on race, class, and social position (Colen 1995; Davis 2023). The labor of mattering is its experiential form — the compounded work extracted from patients who must prove, across financial, bodily, emotional, and political dimensions simultaneously, that their reproduction is worth protecting. The disruptions that intensify this labor are not evenly distributed, and the policy frameworks that govern them in silos are not equipped to see the pattern.

The federal NOFO introduces a further dimension: administrative action moves faster and faces fewer accountability structures than litigation. NOFO PA-EAA-26-001 was issued

under existing appropriations authority; Congress did not authorize the personhood framing now embedded in reproductive health grant criteria. At the federal administrative level, where no judicial process is required and no legislative vote triggers review, the timeline from action to consequence compresses further. Patients and providers navigating these changes in real time are working with less warning and fewer institutional resources than even the Alabama crisis allowed.

The patients who filled the Alabama State House in orange in February 2024 understood what silo governance was failing to track. They named it themselves, drawing connections across IVF, contraception, medication abortion, and maternal care from the vantage point of people who actually live in reproductive bodies under these conditions. Policy frameworks that treat those connections as incidental are not just analytically behind. They are governing in ways that guarantee the harms they claim not to intend.

SECTION 6: POLICY RECOMMENDATIONS

The following recommendations address two overlapping audiences: ASRM as an organizational actor with established ethics and advocacy infrastructure, and federal legislators with authority over the legal mechanisms this paper has documented.

For ASRM:

Monitor and engage on federal personhood language in reproductive health funding.

The ASRM Ethics Committee's 2023 opinion explicitly anticipated the harms that NOFO PA-EAA-26-001's language produces. ASRM has a clear, published institutional position that speaks directly to this moment. As federal administrative actions continue to embed personhood framing in reproductive health infrastructure, ASRM's ongoing engagement — through its ethics opinion process, member guidance, and advocacy channels — will be essential. Future grant

cycles and administrative actions deploying personhood frameworks in reproductive health funding warrant ASRM's attention.

Build formal coalitions connecting fertility medicine advocacy to reproductive justice and contraceptive access organizations.

Alabama patients described the structural connections across these domains before policymakers had language for them. ASRM's clinical credibility and organizational reach, combined with the reproductive justice community's political infrastructure, would produce more durable advocacy outcomes than either can achieve in separate silos. HB 642's legislative framing — treating IVF access and contraceptive rights as a unified ask — offers a practical model.

Extend IVF protection legislation to cover executive-branch administrative action.

Bipartisan legislation — including the Right to IVF Act (S.5108/H.R.9941) and the Protect IVF Act (S. 2035) — addresses state-level bans and provider liability, but not executive-branch administrative action. HHS NOFO PA-EAA-26-001, issued without a Congressional vote, demonstrates this gap: existing proposals would not have prevented a federal agency from embedding personhood framing in reproductive health grant criteria or conditioning grant eligibility on personhood-based restrictions on embryo creation and disposal. Federal IVF protection must be extended through statutory language explicitly prohibiting executive agencies from conditioning reproductive health funding on personhood frameworks.

Enact federal statutory clarification that contraception cannot be regulated under personhood frameworks.

Alabama legislators identified this risk in real time and acted on it. Representative Lands' HB 642, which connected IVF and contraceptive rights in a single legislative ask and was modeled on a Tennessee law that passed with Republican support in 2025, offers a federal template. Federal statutory clarification should preempt personhood frameworks from reaching FDA-approved contraception before politically motivated mischaracterizations of how contraceptives work are tested in court.

Repeal or limit the Comstock Act's application to reproductive healthcare and codify the FDA telehealth mifepristone prescribing rule.

The Comstock Act represents the same governance pattern traced throughout this paper: old legal infrastructure newly applied to constrain reproductive care without new Congressional action. The Stop Comstock Act, introduced in the Senate, would address the most acute threat. Statutory codification of the FDA telehealth mifepristone rule would protect access from both litigation vulnerability and future administrative reversal.

Require Congressional review of HHS grant programs embedding personhood language in reproductive health criteria.

NOFO PA-EAA-26-001 was issued under existing appropriations authority. No Congressional vote authorized the personhood framing now embedded in federal reproductive health grant criteria. Closing this accountability gap — through requiring legislative review of future programs that deploy personhood frameworks in reproductive health funding — is the necessary procedural response to an administrative action that has already outpaced Congressional oversight.

CONCLUSION

In February 2024, hundreds of Alabamians filled the State House in orange, waiting for hours to testify about what a court ruling had taken from them. They testified about embryos in storage, cycles interrupted, money spent, bodies strained, and futures suspended. They testified about what it felt like to need five days of legislative action to recover access to care that had existed the week before, and about what it meant that those five days were possible — that the political will materialized when the right patients were affected. Brenna, a fertility patient who had been on the frontlines of advocacy while managing her own treatments and losses, described SB 159 as "a band-aid on a bullet hole." She and many others continue to push for a constitutional amendment.

The constitutional conflict that produced Alabama's IVF crisis was never resolved. The NOFO does not resolve it either; it extends the same logic into federal grant infrastructure, moving faster and with less accountability than litigation allows. What Alabama patients described from inside the crisis — the structural connection between IVF, contraception, medication abortion, and maternal care — has since been confirmed by every federal action this paper has documented. The people living in reproductive bodies under these conditions understood the pattern before the policy frameworks designed to protect them did.

The question for policymakers, for ASRM, and for the advocates and clinicians working in this space is whether governance will be designed to see what patients already see, or whether it will continue governing the continuum of reproductive care as if the silos it has drawn actually exist.

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