Proposed APHA policy:

Recognizing Attacks on Abortion Care as a Public Health Emergency, Strengthening and Uniting Public Health Voices for Reproductive Justice Feb. 17, 2015

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Sponsorships and Endorsements

Sponsors: Medical Care Section, Women's Caucus

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Summary APHA policy has long held that access to the full range of reproductive health services, including safe, legal abortion, is a fundamental right. International covenants recognize individuals' human rights to decide whether and when to have children and how many children to have, and to have the information and means to do so, free of coercion, discrimination and violence. However, measures that obstruct access to abortions have accelerated in number and severity in the U.S. since 2010. They now constitute a public health emergency, requiring concerted mobilization by the public health community. Through local, state and national laws and regulations, and court decisions, these measures: 1) Restrict funding and coverage for abortions, building on the Helms Amendment, which restricts federal funds for abortions internationally; and the Hyde Amendment, which prohibits federal funding for abortions in the U.S., primarily through Medicaid. 2) Obstruct patients' access to services. 3) Obstruct providers' ability to practice. These cascading restrictions drive out safe and legal services, placing women at greatly elevated risk of injury or death from unsafe abortions; or they violate women's personal bodily autonomy by coercing them to carry unintended pregnancies to term. They systematically ignore or distort scientific evidence; stigmatize abortion; communicate loaded, destructive messages regarding women's worth, sexuality and competence; and discriminate against women. State anti-abortion measures are associated with worse population health, and exacerbate health disparities and economic, social and political inequalities by gender, race/ethnicity, and income. The public health community must call attention to the negative public health consequences of these policies, and should affirmatively assert the conscientious provision of abortions, within the context of a multi-sectoral agenda to achieve optimum population health in all arenas of policy, to advance economic equality and social justice; and as a bedrock of individual freedom.

Rationale for consideration

The public health community must develop an emergency response to the public health threats resulting from initiatives to stigmatize and eliminate access to abortion care, and must increase public health awareness and support for campaigns to improve such access, including eliminating the Hyde and Helms amendment restrictions on funding. Recent analysis identifies sharp inequality in unintended pregnancies and births in the U.S. by race/ethnicity, income, and location; lower funding for women's and children's health services in states where anti-abortion campaigns have prevailed, resulting in worse health outcomes; and economic costs associated with exacerbated inequality. An emergency public health response must include affirmative advocacy for the benefits of access to abortions for the health of women and populations; for economic equality and social justice; and as a bedrock of individual freedom.

Problem statement

Introduction

APHA policy has long held that access to the full range of reproductive health services, including abortion, is a fundamental right. International human rights covenants recognize individuals' rights to decide whether and when to have children and how many children to have, and to have the information and means to do so, free of coercion, discrimination and violence. However, measures in the U.S. that obstruct access to abortions have accelerated in number and severity since 2010. They now constitute a public health emergency, requiring concerted mobilization by the public health community. Through local, state and national laws and regulations, and court decisions, these measures: 1) Restrict funding and coverage for abortions, building on the Helms Amendment, which restricts federal funds for abortions internationally; and the Hyde Amendment, which prohibits federal funding for abortions in the U.S., primarily through Medicaid; 2) Obstruct patients' access to services; and 3) Obstruct providers' ability to practice. These cascading restrictions drive out safe and legal services, abandoning women to seek unsafe abortions that result too often in death; or they violate women's personal bodily autonomy by coercing them to carry unintended pregnancies to term. These measures systematically ignore or distort scientific evidence; stigmatize abortion; communicate loaded, destructive messages regarding women's worth, sexuality and competence; and discriminate against women. State anti-abortion measures are associated with worse population health, and exacerbate health disparities and economic, social and political inequalities by gender, race/ethnicity, and income. The public health community must call attention to the negative public health consequences of these policies, and assert the importance of access to safe, legal abortions, within the context of a multi-sectoral agenda to achieve optimum population health in all arenas of policy, to advance economic equality and social justice; and as a bedrock of individual freedom

I. APHA has long recognized that access to the full range of reproductive and sexual health care, including legal, safe abortions, is essential for women's lives and therefore for population health, and to advance income equality, women's rights, and women's individual freedom. [1 2 3 4 5 6 7]

Access to safe, legal, affordable family planning services, including sex education, contraception, and abortion, as well as health care before, during and after a pregnancy, are vital basic and preventive health care services. A public health framework for clinical reproductive health care considers access to a full range of contraceptive services as primary

prevention of unintended pregnancy and unintended birth. Secondary prevention, in the event that contraception fails, includes screening for pregnancy, pregnancy options counseling and availability of safe, legal early abortion care. Tertiary prevention includes later abortion services. [8] [9] [10]

Abortion is one of the most common and safest surgical gynecological procedures. In the United States, about 1.2 million abortions are performed per year, about 18% of all pregnancies.[11] By age 45, approximately one third of U.S. women will have had an abortion.[2] The risk of death from carrying a pregnancy to term is 14 times that of abortion in the U.S. [12] Access to safe abortion is a key factor in preventing deaths and disability among women due to pregnancy-related causes.[7] While the legal status of abortion has no effect on a woman's need for abortion, it affects her access to safe abortion.[13] exponentially. According to the World Health Organization (WHO), legal restrictions, in addition to other barriers, contribute to the likelihood of women seeking unsafe abortion care.[13] The economic and social costs of unsafe, delayed, clandestine, or illegal abortions include maternal mortality, as well as long-term complications from damage to reproductive organs, pelvic inflammatory disease, and secondary infertility, as well as the potential harm to a woman's existing children. [2]

The U.S. Supreme Court recognized the right to obtain contraception in 1965 (Griswold v. Connecticut), and the right to an abortion in 1973 (Roe v. Wade).

II. However, local, state, and national laws and regulations, court challenges, and media campaigns to obstruct patients' access to abortions and coerce women to carry unintended pregnancies to term have accelerated in number and severity since 2010. [14]

Anti-abortion campaigns depend on continuing to stigmatize abortion. They aim to treat abortion differently from other medical procedures by: restricting funding for abortions through both public and private sources in the U.S. and internationally; segregating the kinds of medical locations and providers who can and do provide abortions; restrictions on coverage of abortion, including through implementation of the Affordable Care Act at the state level; burdensome limits on patients' access to care such as parental notification requirements and fetal personhood legislation; and Targeted Regulation of Abortion Providers (TRAP) laws. These are being fought by women's health and rights proponents.

Restrictions on funding through the Helms and Hyde amendments are the bedrock on which these initiatives build.

A. The Helms Amendment, adopted by the U.S. Congress as part of the Foreign Assistance Act in 1973, prohibits the use of foreign assistance funds for "the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortion." [15] This provision has been applied as a complete ban on all abortion-related services and information, regardless of legality at the country level, and without exceptions for rape or incest, or when a woman's life is endangered due to the pregnancy.

It applies to recipient country governments, U.S. and non-U.S. NGOs, and multilateral organizations, such as the United Nations Population Fund (UNFPA). Although it amends the Foreign Assistance Act of 1961 and is permanent statute, the provision is referenced annually in appropriations legislation.

Each year, an estimated 22 million women and girls have an unsafe abortion, almost all in the developing world. As a result, 47,000 lose their lives and millions more suffer serious injury.[16] The health systems of the countries in which they live spend inordinate amounts of funding to manage these preventable injuries, and economies suffer from diminished economic participation. The WHO asserts that safe abortion services should be available and accessible to the fullest extent of the law for all women—regardless of geography, ability to pay, age, gender, race, and ethnicity.[13]

Several developing countries have liberalized their abortion laws in the last decade to address the problem of unsafe abortion and to promote women's human rights. But the U.S. is the largest supporter of family planning and reproductive health programs overseas. Even in countries where abortion is legal, women and girls are denied access to information and safe abortion care in U.S.-funded clinics and facilities, contributing to preventable deaths and injuries. By limiting the availability of safe abortion services, restrictions due to the Helms Amendment impose barriers on access to basic reproductive health care and violate women's fundamental human rights. [17]

The Mexico City Policy, also known as the Global Gag Rule, has also had a negative impact on women's ability to control their fertility.[18] First instituted by U.S. President Reagan in 1984, this Rule prohibits foreign organizations receiving international family planning assistance from using private, non-U.S. funds for any abortion-related activity including service provision, referral and counseling, and discussion or advocacy related to abortion. Countries with proportionately higher levels of foreign assistance from the U.S. for family planning/reproductive health experienced an increased abortion rate following introduction of the Mexico City Policy,[19] likely due to lost funding for their family planning programs. The Mexico City Policy was rescinded by President Clinton on January 22, 1993, restored by President G. W. Bush on January 22, 2001 and rescinded again by President Obama on January 23, 2009.

B. The Hyde amendment, first enacted in 1976, prohibits spending federal funds for abortions in domestic U.S. programs. The rule is not a permanent law; rather it has been attached annually to Congressional appropriations bills, and has been approved every year by the Congress since 1976.

Medicaid has been the primary target of the Hyde restrictions.[2] Medicaid is a federally authorized health care program that covers low-income people. It is jointly administered by the state and federal governments. States can determine many of the rules for eligibility, including the maximum income allowed for eligibility.

States can use "their own" funds to provide abortion coverage to Medicaid beneficiaries. Only 4 four do so voluntarily, at the states' initiative (Hawaii, Maryland, New York, and Washington); 13 others do so under a court order. Thirty-three states and the District of Columbia do not cover abortions through Medicaid. About 13% of all abortions in the United States are paid for with public funds (virtually all from state governments). [20]

The ban has been extended via other legislation to cover the Federal Employees Health Benefit Program, active duty and veteran women in the military, federal prison inmates, Peace Corps volunteers, and American Indian and Alaska Native women who use Indian Health Service health care.

The Hyde amendment identifies exceptions: circumstances in which federal funds can be used to fund an abortion. These are pregnancies resulting from rape or incest, or that pose a threat to the mother's life. Appropriations legislation has recently extended these exceptions to Peace Corps volunteers and military women.

C. Other state/federal coverage/funding restrictions

The Patient Protection and Affordable Care Act (ACA) creates new state insurance marketplace exchanges that intend to offer "private" affordable commercial health insurance, with federal subsidies to help pay the premiums. The ACA restricts women's ability to obtain coverage that includes abortion services. [21]

25 states restrict abortion coverage to limited circumstances in insurance plans created through the ACA.

10 states restrict the circumstances under which **any private insurance** will cover abortions.

In states that allow abortion coverage to be offered in their state insurance exchanges, the ACA requires consumers to make two premium payments—one for abortion coverage and one for every other covered benefit. Insurers are required to process those two payments from the individual and a third payment from the federal government for any subsidies to which the enrollee is entitled, in order to segregate the federal subsidy money from the insurer's private abortion premium payment.

Increasingly onerous obstruction of women's access to services.

Since 2010, state legislatures have enacted 205 restrictions on funding and access to care in thirty-six states. Five states require informing women that abortion causes breast cancer. It doesn't.[27]

A variety of measures delay women from obtaining an abortion, although abortion is simplest at the earliest stages. [23] These include:

- Bans on private insurance coverage of abortion
- Restrictions on provision of medication abortion
- Gestational age limit for abortion set by law at between 6 weeks and 20 weeks from fertilization
- Parental consent before a minor obtains an abortion
- Mandatory counseling prior to abortion
- Mandatory waiting periods between time of first appointment and abortion
- Requirement to have an ultrasound prior to an abortion

Targeted Regulation of Abortion Providers (TRAP) laws obstruct providers' ability to practice by imposing requirements beyond what is necessary to ensure patients' safety, and that may be impossible for providers to meet. Some regulations apply to physicians' offices where abortions are performed or even to sites where only medication abortion is administered. TRAP laws have already forced numerous clinics to shut down, including most abortion providers in Texas. The regional clustering of restrictions in the South and Midwest makes it extremely difficult for women to obtain needed abortion care in neighboring or nearby states.

TRAP laws include:

- Only licensed physicians may perform abortions, excluding qualified clinicians such as nurse practitioners.

  However: Other qualified clinicians safely perform abortions.[24] This provision denies access to women in rural areas where physicians do not provide abortions.

- Ambulatory surgical center standards are imposed on facilities providing abortion, even though surgical centers tend to provide more invasive and risky procedures and use higher levels of sedation.

- Hospital privileges or alternative arrangement required for abortion providers, provisions that add nothing to existing patient protections or safety, while granting hospitals effective veto power over whether an abortion provider can exist.

  However: Abortions are safely performed outside of hospitals. In the rare event of post-abortion complications, existing Emergency Department staff provide necessary care. [25]

- Refusal to provide abortion services allowed.

D. "Exceptions" present additional complications.

Technically, the Hyde amendment permits federal funding for abortions in the case of "exceptions," when a pregnancy is caused by rape or incest, or poses a threat to a woman's life. Some state policies limit the availability of coverage for abortion services in private or Medicaid plans to these same exceptions, or are even more limited, such as only in the case of life endangerment.[26]

These restrictions and the associated exceptions communicate loaded, destructive messages regarding women's worth, sexuality, autonomy and competence. These include that women are entitled to terminate a pregnancy only if they can establish that it occurred in circumstances beyond their control (rape), and/or more morally reprehensible than their own normal behavior (incest).

In addition, states change income eligibility and other rules for coverage periodically.

The combination of these fragmented rules and systems can make it difficult for women, health care providers and payors to know whether or not their state, or their particular health plan, covers abortions. [27]

As a result, **the "exceptions" are in fact rarely the basis for funding an abortion**. In 2010, the 34 states (plus the District of Columbia) that adhere to the Hyde restrictions contributed to the cost of 7 procedures; the federal government contributed to the cost of 331 procedures. The 17 states that use their own funds to pay for most or all medically necessary abortions provided to Medicaid recipients covered about 181,000. [20]

Further, these restrictions unfairly target and discriminate against disenfranchised groups, particularly women of color, young women, and women in poverty, who are more likely to access vital reproductive health services through the public health system and lack funds to cover out-of-pocket expenses for safe abortion care outside of the recognized exceptions.

While recognizing exceptions in the limited cases of rape, life, and incest has become a focus for incremental reforms, restrictions on access to safe abortion must be fully repealed in order for women and girls to fully realize their reproductive health and rights.

E. In sum, the Helms and Hyde Amendments undermine sound health policy, and present significant blows to women's health and rights, by:

1. Codifying the government's right to provide a lower standard of health care coverage based on gender and income, by treating funding for abortions for low-income women differently, even though it is a legal service. In the United States, most commercial insurance plans have routinely covered abortions;

2. Treating abortion differently from other health care services, and stigmatizing abortion as shameful;

3. Fracturing potential political alliances for reform by separating women's interests in and experiences of access to abortion by income, and further dividing them by characteristics associated with income, including **race/ethnicity, level of education, and geographic location**; and

4. Establishing a **questionable standard regarding the nature of "public" and "private" sources of payment for health care services, and use of payment source as a basis for determining health policy**.

Domestically, these explicit and implicit assumptions and messages have contributed to destabilizing the basis for group insurance coverage, an important aspect of health policy. Group insurance is built in part on the principles that the risk of financial loss for unforeseeable events, such as a health condition, can be reduced by combining a "sufficient number of exposure units to make their individual losses collectively predictable. The predictable loss is shared proportionately among all participants. The risk is reduced or eliminated for the insured, and all the individuals who paid into the fund share the resulting loss." [28]

Assertions that individual employers and individuals should have the right to withhold paying for insurance coverage for selected benefits which they don't want, or of which they don't approve, for virtually any reason, undermine this system. This view was most recently and fully articulated in the Supreme Court's decision in the *Hobby Lobby* case on contraception coverage in private health insurance plans. It asserts that religious beliefs about a medical procedure or benefit, if sincerely held, are a higher standard for determining the responsibility to contribute to group insurance coverage for that procedure or benefit than scientific and medical evidence, or the preferences or experience of the covered group as a whole. While the immediate procedure at issue was a contraceptive erroneously believed to be an abortifacient, the decision undermines the basis for group funding for any health insurance purpose, and arguably for any government purpose, while undermining the validity of scientific evidence as a basis for public health policy.

III. Attacks on abortion care deepen discrimination by income, race and gender

The social determinants of health begin with pregnancy, according to Marmot et al. "The interaction between gender inequities and other social determinants increases women's vulnerability and exposure to risk of negative sexual and reproductive health outcomes. Poor maternal health, inadequate access to contraception, and gender-based violence are indicators of these inequities." [29]

The overall rate of abortions is declining in the U.S., as the provision of contraception is increasingly widespread and effective. However, while 40% of pregnancies are unintended worldwide, the U.S. rate is higher, at 51%.[30]

Unintended pregnancies are increasing dramatically among low-income women and women of color, while declining for women with incomes over 200% of the federal poverty rate and white women. [31]

Poor women are five times as likely as higher income women to have an unintended pregnancy, five times as likely to have an abortion, and six times as likely to have an unplanned birth. [32]

Medicaid coverage of abortion has an important effect on the ability of poor women to end unintended pregnancies. [33] About one in four women who would have had Medicaid-funded abortions instead give birth when this funding is unavailable. [34]

Rates of unintended pregnancy and unintended birth among women of color are more than twice the rates for White women. Black women have the highest unintended pregnancy rate. Hispanics have the highest unintended births. [35] [36]

Low-income women who are able to raise the money for an abortion have reported that they often do so at a great sacrifice to themselves and their families, diverting money that would otherwise be used to pay for rent, utility bills, food and clothing for themselves and their children. Additionally, the cost of the procedure and the risk of complications increase with gestational age.[37]

Abortion restrictions depress women's incomes and increase income inequality

Discrimination based on gender, race, and other social characteristics undermines economic opportunity and growth. Eliminating the costs of perpetuating discrimination, such as maintaining inferior educational systems, and freeing the productive talents of the population, benefit economic growth, particularly in economies dependent on consumer purchases.[38] Abortion restrictions weaken women's personal economic status, and their potential contributions to the economy.

Policies that deny women abortions they seek deepen and entrench poverty for women and children. The Turnaway study found that women denied abortion were three times as likely to end up below the federal poverty line two years later, compared with similar women who sought and obtained an abortion.[39]

Income inequality persists and is widening, drawing concern from U.S. President Barack Obama, and Pope Francis.[40]

IV. Anti-abortion measures are associated with worse population health, and constitute a public health emergency

States with the most antiabortion policies have significantly lower indicators of infant/child well-being.[41] Women in states that prohibit Medicaid funding of abortions have significantly higher rates of postpartum depression than in those states that fund Medicaid abortions. [42]

In Sept., 2014, the Center for Reproductive Rights (CRR) and researchers at Ibis Reproductive Health published a major report [43] evaluating the association between the enactment of anti-abortion policies, and the passage of state policies known to improve the health and well-being of women and children, or to improved state-level health outcomes for them. They also examined women's and children's health policies and outcomes in states with relatively few abortion restrictions.

The report evaluated the prevalence of 14 state abortion restrictions against indicators of population health in four topic areas: women's health outcomes (15), children's health outcomes (15), social determinants of health (10), and policies supportive of women's and children's health (22). (See the list in "APPENDIX: Variables in CRR-Ibis Study")

They found an inverse relationship between a state's number of abortion restrictions and a state's number of evidence-based policies that support women's and children's well-being. States with more abortion restrictions tend to have fewer supportive policies in place that are crucial to ensuring women and families are able to live healthy and safe lives.

They also found that the more abortion restrictions that were present, the worse a state performed overall on indicators of women's and children's well-being. Among the 23 states with 0-6 abortion restrictions, 18 (78%) were above the median overall score for well-being. In contrast, only eight of the 28 states with 7-14 abortion restrictions (29%) were above the median.

V. Political ramifications: **Consolidation of political opposition.**

Debate on abortion has polarized many state legislatures and Congress, and has undermined the ability of these bodies to address other pressing policy concerns.

A conservative political coalition has built a base and political momentum by focusing on stigmatizing abortion and blocking access to and funding for abortions. Abortion stigma is a wedge issue that has undermined many public health goals.

Opponents comprise a coalition of conservative concerns: social, moral and religious groups, such as Christian evangelicals and the U.S. Conference of Catholic Bishops, as well as economic and political organizations driven by corporate and financial concerns. While each interest may not share all the views of their allies on opposition to abortion, it has proven to be a powerful, durable and effective convening point.

Abortion restrictions constitute the leading edge of regressive policies to curtail political and economic rights, including living wages, equal pay, expanding Medicaid eligibility, voter rights, immigrant rights, environmental sustainability, affordable child care and quality education, affordable housing, and protection from violence.

A key example is the American Legislative Exchange Council. ALEC generates model legislation, and cultivates and convenes state legislators who carry it forward, in the interests of extractive energy companies and others seeking to roll back environmental protections that address climate change, health care reform, workers' rights, corporate accountability, and taxes on the wealthy, as well as opposing abortion.

VII. Conscientious provision: Opportunities and imperatives for public health

"Conscientious provision" of abortion care calls on health care clinicians to affirmatively and publicly assert the value of abortion care, and to mainstream and to frame such care as an extension of their requirement to place patients' needs as the highest priority in providing treatment. [44] Public health agencies, health plans, and other health care providers and institutions, serve the public's health and interests when they affirmatively state and publicize the range of reproductive health care services they perform, provide, pay for and otherwise make available.

Public health has an important responsibility to step up to de-stigmatize abortion care and legitimate the important public health benefits of abortion care and rights, within the context of a multi-sectoral agenda to achieve optimum population health in all arenas of policy.

A coalition of women's health and reproductive justice organizations has been working for years to lift restrictions on federal funding for abortion, including the Hyde and Helms Amendments, asserting that they effectively deprive the world's most vulnerable women of access to a safe, legal health service.

X. Evidence-based strategies

Eliminating discrimination based on gender and race improves prospects for economic and social equality, and prospects for economic growth.[38]

XI. Opposing arguments presented and refuted

A. Conservative religious groups disagree that preventing unintended pregnancies is a public health goal. Christian evangelicals, and some sectors of the Catholic Church such as the U.S. Conference of Catholic Bishops, assert that conception is a divine occurrence, with which individual women cannot interfere. It is women's responsibility to accept that heterosexual activity may result in a pregnancy. Once pregnant, a woman's own health, economic prospects, and self-determination are secondary to her responsibility to see the delivery to term. Concerned Women for America (http://www.cwfa.org/), for example, rallies grassroots women to oppose what they term "the abortion industry."

These groups oppose efforts to modify the traditional, biologically and religiously based roles of men and women. [45] They denigrate efforts to achieve equal pay for women as anti-capitalist. Material success is evidence of virtue. ''Deceitful sloganeering such as 'comparable worth' and 'glass ceiling' "… are merely examples of ''feminists' devious devices to achieve power in the workplace.''[46]

In a five-part response to preliminary findings of the Turnaway study described above, the National Right to Life asserted that abortion is associated with conditions including breast cancer, future miscarriage, infertility, and mental illness, though these may become apparent only later. Reputable research does not support such claims.[47] [48] The Turnaway study has found "no correlation between having an abortion and increased symptoms of depression and anxiety." [39]

These are radical views, not shared by most Americans. Given the extreme and discriminatory nature of these beliefs, intended to govern the behavior of the 50% of the world's population who are women and girls, opponents of abortion rights have couched their beliefs in appeals to more mainstream American values, such as the right to free speech, and the right to direct the expenditure of certain public and private funds.

As documented here, these incursions into women's rights have devastating effects on their lives and on democracy.

The Montana Supreme Court applied strict scrutiny in its analysis of a physician-only abortion restriction. The state had to demonstrate a compelling state interest for infringing on a woman's right in "making personal health care decisions and in exercising personal autonomy." The court found that the state's only possible compelling interest that might override the right to personal autonomy in making health decisions was that of "regulat[ing] or preserv[ing] the safety, health and welfare of . . . patients or the general public from a medically-acknowledged *bona fide* health risk." Legislating "under the guise of protecting the patient's health," but in reality for political ideology, personal beliefs, or values, the court deemed was "not only constitutionally impermissible . . . [but] intellectually and morally indefensible." [49]

B. Some proponents and providers of abortion services assert that public challenges to opposition views and events will result primarily in giving opponents greater visibility and "unearned" media. However, as documented in this statement, opponents are disseminating their views and translating them into policy with increasing success and frequency. Failure to respond undermines the potential to inform and mobilize supporters. Others assert that opponents' rights to free speech cannot be successfully countered. But public challenges to misinformation are always appropriate, and demonstrably false statements that pose a threat to the public's health can be constrained.

XIII. Action steps

- APHA calls on members, components, and elected officials to show support for lifting or repealing abortion-related restrictions, including the Helms and Hyde Amendments
- Call on health care clinicians, institutions and health plans to practice "conscientious provision" of abortion: to affirmatively and publicly assert the value of abortion care, and to mainstream and frame such care as an extension of the commitment to place the needs of patients as the highest priority in providing services.
- Public health as a community – individuals, workers, professionals, academics, organizations, officials – must identify and overcome the impact of stigma on suppressing public discussion, debate and action on abortion; recognize the disproportionate impact of abortion stigma on relatively less powerful populations, particularly low-income women, young women, and women of color, and on population health; and engage peers, community, and policy makers to support universal access to safe, legal and affordable sexual and reproductive health services, using the well-established public health framework of primary, secondary and tertiary prevention to address unintended pregnancy with abortion included as secondary and tertiary prevention.
- Advocate that states both expand income eligibility for their Medicaid programs, and cover abortions through Medicaid.
- Advocate universal access to accurate, evidence-based information about reproduction, and education of young people, in the U.S. and abroad.
- Educate Pope Francis and Pres. Obama regarding effects of stigmatizing abortion on economic inequality, and call on them to forge a 21st century policy on women's rights and abortion as a key reproductive health care service.
- The public health profession as a whole, as represented by its professional organizations, needs to become actively involved.

APPENDIX: Variables in CRR-Ibis Study (Sec. IV)

Abortion Restrictions

Below average number of abortion providers
Ambulatory surgical center standards imposed on facilities providing abortion
Gestational age limit for abortion set by law
Hospital privileges or alternative arrangement required for abortion providers
Mandatory counseling prior to abortion
Parental involvement required before a minor obtains an abortion
Only licensed physicians may perform abortions
Medication abortion restrictions
Refusal to provide abortion services allowed
Restrictions on abortion coverage in Medicaid
Restrictions on abortion coverage in private health insurance plans
Restrictions on abortion coverage in public employee health insurance plans
Requirement to have or be offered an ultrasound
Waiting periods required between time of first appointment and abortion

Women's Health Outcomes

Asthma prevalence
Cervical cancer screening
Chlamydia incidence
HIV incidence
Lifetime prevalence of sexual violence
Low birth weight
Maternal mortality ratio
Overweight/obesity prevalence
Poor mental health status
Preterm birth
Proportion of pregnancies unintended
Smoking prevalence
Suicide deaths
Women without health insurance
Women with no personal health care provider

Children's Health Outcomes

Child mortality rate
Children receiving medical and dental preventive care
Children receiving needed mental health care
Complete vaccination (children 19-35 months)
Confirmed child maltreatment
Exclusive breastfeeding for 6 months
Infant mortality rate
Percentage of children aged 10-17 who are overweight or obese
Percentage of children living in a home with someone who smokes
Percentage of children with health insurance
Percentage of children with a medical home
Percentage of children with asthma problems
Teen alcohol or drug abuse
Teen birth rate
Teen mortality rate

Social Determinants of Health

Children aged 3-5 not enrolled in nursery school, preschool, or kindergarten
Gender wage gap
Homelessness
On-time high school graduation rates
Percentage of children living in poverty
Percentage of women aged 15-44 living in poverty, 2011-2012 rates
Prevalence of household food insecurity
Unemployment
Violent crime rate
Women's participation in the labor force

Policies Supportive of Women and Children

Improving Access to Care

Moving forward with the Affordable Care Act's Medicaid expansion
Allows telephone, online, and/or administrative renewal of Medicaid/CHIP
Requires domestic violence protocols, training, or screening for health care providers

Supporting Pregnant Women

Medicaid income limit for pregnant women is at least 200% of the federal poverty line
Has expanded family/medical leave beyond the FMLA
Provides temporary disability insurance
Maternal mortality review board in place
Requires reasonable accommodations for pregnant workers
Prohibits or restricts shackling pregnant prisoners

Promoting Children's and Adolescents' Health, Education and Safety

Allows children to enroll in CHIP with no waiting period
Requires physical education for elementary, middle, and high school

Mandates sex education
Mandates HIV education
Has broad eligibility criteria for Early Intervention services for children at risk of developmental delay

Initiative(s) to expand Early Head Start in place
Requires districts to provide full-day kindergarten without tuition·
Has firearm safety law(s) designed to protect children

Supporting Families' Financial Health

Allows families receiving TANF to keep child support collected on their behalf
State minimum wage is above the federal minimum
Income limit for child care assistance is greater than 55% of state median income
Does not have a family cap policy or flat cash assistance grant

Promoting a Healthy Environment:

Requires worksites, restaurants, and bars to be smoke free

XIV. References

[1] Preserving Access to Reproductive Health Care in Medicaid Managed Care. APHA Policy #200313. While federal Medicaid funding covers all medically approved methods of birth control, condoms for control of AIDS, and voluntary sterilization, states have the discretion to determine the specific services and supplies that will be covered as family planning, so long as the services "are in sufficient amount, duration, and scope to reasonably achieve their purpose." Federal law also guarantees Medicaid beneficiaries "freedom-of-choice," the right to obtain family planning from any Medicaid provider including those outside of their Plans;
Despite Medicaid's coverage of comprehensive reproductive health services, the Balanced Budget Act allows Plans to refuse "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds;" and the implementing regulations allow Plans to refuse to provide information or referrals for these services;
There are Plans that do not cover or pay for a full range of reproductive health services due to corporate practices based on religious beliefs, and there are Plans in which some member providers do not deliver these services, despite the Plan's own policies to cover these services.
Access to reproductive health services can be severely undermined for members of Plans that do not provide access to comprehensive reproductive health services, resulting in increases in unintended pregnancies, births, abortions, and sexually transmitted infections;
Medicaid beneficiaries enrolled in these Plans may be denied "freedom-of-choice" without information or referral to other providers and without appropriate payment mechanisms for out-of-plan providers;
It is the long standing position of APHA that access to the full range of reproductive health services is a fundamental right;
It is the position of APHA that state Medicaid agencies and agencies regulating private insurance should allow contracts only with providers who provide comprehensive information and the full range of reproductive services.

[2] Protecting Abortion Coverage in Health Reform. APHA Policy #20103. APHA considers the availability of safe, legal, and affordable abortion care to be essential for safeguarding maternal health, reducing maternal mortality and morbidity, and enabling healthy spacing of pregnancies.

[3] Preserving Consumer Choice in an Era of Religious/Secular Health Industry Mergers (Position Paper) APHA Policy #20003. It has been the longstanding position of the American Public Health Association that access to the full range of reproductive health services, including abortion, is a fundamental right. The great majority of women want their hospital to offer medically indicated abortions.

[4] Support for Sexual and Reproductive Health and Rights in the US and Abroad (11/18/2003, APHA Policy #200314) Supporting access to emergency contraception.

[5] Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference. (10/28/08, APHA Policy #2003). APHA urges education of state legislatures and elected and appointed officials to repeal or oppose existing state laws, including those that antedate Roe vs. Wade, that restrict or remove access to abortion services, and support state laws that improve access to safe abortion services, including several specified. APHA calls on the public health community to become active at the local and state level to ensure access to safe and legal abortion.

[6] Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants (11/1/2011, APHA Policy #20112). APHA supports.

[7] Call to Action to Reduce Global Maternal Neonatal and Child Morbidity and Mortality (11/01/2011, APHA Policy #201113) Access to safe abortion is a key factor in preventing deaths and disability among women due to pregnancy-related causes, which are in turn related to child mortality rates. But the actual decline of 1% per year in maternal mortality falls far short of the annual reduction rate of 5.5% needed to meet Millennium Development Goal 5 by 2015.

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The World Population Plan of Action states that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so, and that, in exercising this right, they should take into account the needs of their living and future children and their responsibilities to the community.
A substantial number of women throughout the world already desire no more children as now documented by the World Fertility Survey, but lack easy and convenient access to a full range of voluntary family planning services, including surgical and reversible methods.
Large-scale adoption of family planning practices and ensuing declines in birthrates have taken place in a number of countries both with and without rapid economic development.
APHA: 2. Urges Congress to include in development assistance legislation specific recognition of the basic human right to decide freely and responsibly the number and spacing of their children and in implementing this right to assist in providing a full range of services including reversible methods delivered where appropriate by paramedical and community personnel, voluntary sterilization based upon informed consent, and medically safe abortion techniques for those countries which request such help. To this effect, the Helms amendment prohibiting use of U.S. funds for abortion should be repealed.

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[26] Idaho has exceptions for cases of rape, incest, or to save the woman's life for plans sold on the Marketplace, but limits abortion coverage to cases of life endangerment to the woman for all other private plans issued in the state. Utah has exceptions to save the life of the mother or avert serious risk of loss of a major bodily function, if the fetus has a defect as documented by a physician that is uniformly diagnosable and lethal, and in cases of rape or incest. However, six states (Kansas, Kentucky, Missouri, Nebraska, North Dakota, and Oklahoma) have an exception only to save the woman's life for all private plans. Michigan allows abortion coverage in cases of life endangerment to a woman and when the abortion increases the probability of a live birth or preserves the life or health of the child after live birth, such as in cases involving a reduction, or multi-fetal pregnancy. Five states had these laws on the books prior to the ACA, and five more states have passed new laws banning private plan coverage post-ACA. While nine of these states allow insurers to sell riders for abortion coverage on the private market, there is little evidence about their availability and no documentation of their cost or impact on access. Utah does not allow riders to be sold for abortion coverage.

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