ACPM Policy Statement on Women's Reproductive Rights

Emilie Prot, DO MPH, Preventive Medicine Resident, Texas State Department of Health Services, Austin, Texas

Brandy A. Liu, DO, Preventive Medicine Resident, Loma Linda University

Sara Baird, MD, Family Physician

Linda Hill, MD, MPH, Preventive Medicine Residency Director, University of California, San Diego

Policy recommendation: The American College of Preventive Medicine (ACPM) recommends that state and federal governments ensure women's access to comprehensive, coordinated, and high quality reproductive health services to include education; emergency, short, and long-term contraception; sterilization; and abortion. ACPM stands with other organizations in opposing legislative restrictions that decrease access to safe abortions for all women.

KEY ISSUES:

1. In the United States, a high-income country, rates of unintended pregnancies remain high.
2. Women from minority communities and lower SES are over-represented in unintended pregnancies.
3. Comprehensive sex education programs, and access to affordable contraceptive services reduce the incidence of unintended pregnancy.
4. Making family planning services widely available is cost-saving and reduces disparities.
5. Limited access to contraceptive services has a negative impact on the health of women and infants, and has long-term economic and social consequences due to increased unintended pregnancies.
6. Abortion is a safe procedure. Legislative restrictions decrease access to safe legal abortion, especially for low income and vulnerable women, while increasing morbidity and mortality risk.

Supporting Evidence:

1. In the United States, a high-income country, rates of unintended pregnancies remain high.

The World Health Organization defines an unintended pregnancy as unwanted or mistimed pregnancy owing to the unmet need for contraception, to contraceptive failure or to unwanted sex.[1] Worldwide, there are more than 80 million unintended pregnancies annually, and in the United States in 2008, 51% of the almost 6.6 million births were unintended.[1,2] Despite advancements toward the maternal health and family planning Millennium Development Goals for 2030, the United States falls behind other developed countries.[4] Low health literacy (both men and women), sexual abuse and assault, user error, and lack of access to family planning

services has contributed to high rates of unintended pregnancy in the United States. Availability of family planning clinics, provider knowledge, insurance issues, and restrictive legislation all play a role in restricting women's access to safe effective contraception in the United States.

2. Women from minority communities and lower SES are over-represented in unintended pregnancies.

The burden of unintended pregnancies falls disproportionately upon vulnerable populations. Women with incomes below the federal poverty level are 5 times more likely to have an unintended pregnancy than women with incomes above the poverty level.[5,6] Studies also show that rates of unintended pregnancies are highest among Black and Hispanic populations compared to White populations[6,7] with rates highest in Hispanic teenagers[8]. Studies also show that contraceptive type varies by age and races/ethnicities. Black and Hispanic teenagers are likely to use no contraceptive rather than a highly (intrauterine devices, implants, male/female sterilization) or moderately (injectable, oral) effective methods .[6,7] It is crucial to provide access to comprehensive sexual education and effective contraception options to all communities.

3. Comprehensive sex education programs, and access to affordable contraceptive services reduce the incidence of unintended pregnancy.

The rate of unintended pregnancies is decreased in communities that provide access to accurate information about safe sex and contraceptive services. Pregnancy rates are lowest with the use of LARC (long acting reversible contraceptives), reducing the failures associated with user error. Condom use is infrequent in youth[6], also increasing the risk of sexually transmitted diseases. Unintended pregnancies in these high-risk populations are associated with high rates of STIs.[9,10,11] Additional research has shown that state funded abstinence-only programs are correlated with increased teenage pregnancy and birth rates[12]. Other studies point to underlying social and economic problems[13]. By increasing health literacy, access to contraception, and family planning service, unintended pregnancies and STIs can be prevented.

4. Making family planning services widely available is cost-saving, reduces disparities, and reduces the rates of abortions.

What are the costs to taxpayers that are associated with no family planning? These costs, estimated to run from about $9 billion to $16 billion annually, come from medical care for preventable sexually transmitted infections, cervical cancer, and unintended pregnancy (prenatal care, delivery, abortions, and medical care for preterm and low birth weight infants). For every $1 spent on family planning services, it is estimated that $7.09 is saved in taxpayer money.[14,15,16,17]

The benefits of family planning programs for low-income communities have been demonstrated recently in Colorado through the Colorado Family Planning Initiative (CFPI).[18] This program, funded through an anonymous foundation, was initiated in 2009. Funding allowed for the no-cost provision of effective long-acting, reversible contraceptive (LARC) methods (intrauterine devices and implants) to 28 Title X agencies in 37 counties, which contained 95% of the state's total population, including 95% of the low-income population, those at highest risk for unintended pregnancy.[18] The funding also supported LARC training for providers and staff, counseling, along with technical assistance with coding and billing and contraceptive rings, along with training on non-reversible long-term contraception, such as vasectomies and tubal ligations. Two years later in 2011, the results have been positive. LARC use among 15-24 year-olds had grown from 5% to 19%.[18] Compared with the expected 2011 fertility rates, observed rates were 29% lower among low-income 15-19 year-olds and 14% lower among low income 20-24-year-olds.[18] The proportion of births that were high-risk declined by 24% and abortion rates fell 34% and 18%, among women aged 15-19 and 20-24, respectively; there was also a 12% decline in preterm births.[19] Statewide, infant enrollment in WIC declined 23% between 2010 and 2013.[18]

5. Limited access to contraceptive services has a negative impact on the health of women and infants, and has long-term economic and social consequences due to increased unintended pregnancies.

Prevention of unintended pregnancy is an important step in improving maternal and neonatal morbidity and mortality. Mothers with unintended pregnancies take longer to recognize that they

are pregnant, are more likely to delay or forego prenatal care, and less likely to make lifestyle changes, such as stopping smoking and discontinuing alcohol consumption.[20,21,22,23,24,25,26] When unintended pregnancies are continued, they are more likely to result in preterm birth and low birth weight.[19,21,27,28,29] Maternal behaviors have also been shown to differ with unintended pregnancies, including delayed prenatal care, lower rates of breastfeeding, and lower quality maternal-child relationships.[21,22,30,31,32] These unplanned children are more likely to have social-emotional and cognitive development issues resulting in poorer educational and behavioral outcomes.[32,33,34,35,36,37]

6. Abortion is a safe procedure. Legislative restrictions decrease access to safe legal abortion, especially for low income and vulnerable women, while increasing morbidity and mortality risk.

Increased contraceptive care decreases the number of abortions, though does not completely eliminate the need. There are many reasons why a woman will seek out an abortion: failure of contraception, lack of access to contraception, rape, incest, subject to an abusive partnership, major fetal anomalies, and pregnancy complications.[38,40,41] Where heavy restrictions exist that prevent safe and timely access to medically provided abortions, women are left with few options, which may include unsafe abortions. An unsafe abortion is defined by the World Health Organization as a "procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both"[39].

Women who seek to have abortion, but who are unable to access abortion care, continuing pregnancies to term, are more likely to be living in poverty, and to stay with abusive spouses.[40,41] For the one in five pregnancies that end in abortion worldwide, about half of them are unsafe, a leading cause of maternal mortality.[42,43] Millions more women suffer with complications resulting from unsafe abortions like incomplete abortion, post-abortion sepsis, hemorrhage, genital trauma, and death.[42]

The laws restricting access to abortion not only pose logistical barriers, but also financial barriers, to receiving timely care. A study done on abortion funding both through private insurance and Medicaid revealed that many women delayed abortion due to cost.[44] Women who

lived in states where Medicaid funding was available to cover costs of abortion or had private insurance were more likely to have an abortion at a lower gestational age, belong to a higher income bracket, and were less likely to report cost as a reason for delaying abortion.[38]

Evidence shows that abortion services, an essential health service for women, are being safely provided in the United States by licensed health care providers.[43] However, many states have enacted laws to restrict women's access to abortion and contraceptive services. Since 2010, the number of regulatory laws has increased and affect multiple facets of abortion care, including: provider hospital admitting privileges, medication prescription limitations for medication abortion, requirement for clinics to be certified as ambulatory surgical centers, parental or spousal notification laws, waiting periods, and counseling requirements, among others.[45] These legislative acts have been shown to be medically inaccurate and medically unnecessary.[39] To reduce maternal mortality and morbidity, information on and unrestricted access to safe, effective and legal abortion should be provided to all women.[4]

References

1. World Health Organization. The world health report: 2005: Make every mother and child count: Overview. 2005.
2. Sedgh G, Singh S, Hussain R. Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends. *Studies in family planning*. 2014;45(3):301-314. doi:10.1111/j.1728-4465.2014.00393.x.
3. Finer LB, Zolna MR. Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008. *American Journal of Public Health*. 2014;104(Suppl 1):S43-S48. doi:10.2105/AJPH.2013.301416.
4. Bernstein S, Hansen CJ. Public choices, private decisions: Sexual and reproductive health and the millennium development goals. *Public choices, private decisions: sexual and reproductive health and the Millennium Development Goals*. 2006.
5. Christensen AL, Perry DF, Le H, Ahmed S. Correlates of unintended birth among low-income hispanic immigrants at high risk for depression. *Journal of Immigrant and Minority Health*. 2011;13(3):478-486.
6. Dehlendorf C, Park SY, Emeremni CA, Comer D, Vincett K, Borrero S. Racial/ethnic disparities in contraceptive use: Variation by age and women's reproductive experiences. *Obstet Gynecol*. 2014;210(6):526. e1-526. E9.
7. Masinter LM, Feinglass J, Simon MA. Pregnancy intention and use of contraception among hispanic women in the united states: Data from the national survey of family growth, 2006–2010. *Journal of Women's Health*. 2013;22(10):862-870.
8. Miller E, Levenson R, Herrera L, Kurek L, Stofflet M, Marin L. Exposure to partner, family, and community violence: Gang-affiliated latina women and risk of unintended pregnancy. *Journal of Urban Health*. 2012;89(1):74-86.
9. Moss NJ, Harper CC, Ahrens K, et al. Predictors of incident herpes simplex virus type 2 infections in young women at risk for unintended pregnancy in san francisco. *BMC infectious diseases*. 2007;7(1):1.
10. Carter MW, Hock-Long L, Kraft JM, Henry-Moss D, Hatfield-Timajchy K, Singer M. Strategies for managing the dual risk of sexually transmitted infections and unintended pregnancy among puerto rican and african american young adults. *Am J Public Health*. 2012;102(3):449-456.
11. Branch M, Harvey SM, Zukoski AP, Warren J. Prevention of unintended pregnancy and HIV/STIs among latinos in rural communities: Perspectives of health care providers *Health Care Women Int*. 2010;31(8):718-736.

12. Stanger-Hall KF, Hall DW. Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S. Vitzthum VJ, ed. *PLoS ONE*. 2011;6(10):e24658. doi:10.1371/journal.pone.0024658.
13. Kearney MS, Levine PB. Why is the teen birth rate in the united states so high and why does it matter? *The Journal of Economic Perspectives*. 2012;26(2):141-166.
14. Frost JJ, Sonfield A, Zolna MR, Finer LB. Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program. *The Milbank Quarterly*. 2014;92(4):667-720. doi:10.1111/1468-0009.12080.
15. Frost JJ, Finer LB, Tapales A. The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. J Health Care Poor Underserved. 2008 Aug;19(3):778-96. doi: 10.1353/hpu.0.0060.
16. Monea E, Thomas A. Unintended pregnancy and taxpayer spending. Perspect Sex Reprod Health. 2011 Jun;43(2):88-93. doi: 10.1363/4308811. Epub 2011 May 19.
17. Sonfield A, Kost K, Gold RB, Finer LB.The public costs of births resulting from unintended pregnancies: national and state-level estimates. Perspect Sex Reprod Health. 2011 Jun;43(2):94-102. doi: 10.1363/4309411. Epub 2011 May 19.
18. Ricketts S, Klingler G, Schwalberg R. Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women. Perspect Sex Reprod Health. 2014 Sep;46(3):125-32. doi: 10.1363/46e1714. Epub 2014 Jun 24.
19. Goldthwaite LM, Duca L, Johnson RK, Ostendorf D, Sheeder J. Adverse Birth Outcomes in Colorado: Assessing the Impact of a Statewide Initiative to Prevent Unintended Pregnancy. *American Journal of Public Health*. 2015;105(9):e60-e66. doi:10.2105/AJPH.2015.302711.
20. Ayoola AB. Late Recognition of Unintended Pregnancies. Public Health Nurs. 2015 Sep-Oct;32(5):462-70. doi: 10.1111/phn.12182. Epub 2015 Feb 6.
21. Kost K, Lindberg L. Pregnancy Intentions, Maternal Behaviors, and Infant Health: Investigating Relationships With New Measures and Propensity Score Analysis. *Demography*. 2015;52(1):83-111. doi:10.1007/s13524-014-0359-9.
22. Lindberg L, Maddow-Zimet I, Kost K, Lincoln A. Pregnancy intentions and maternal and child health: an analysis of longitudinal data in Oklahoma. Matern Child Health J. 2015 May;19(5):1087-96. doi: 10.1007/s10995-014-1609-6.
23. Dibaba Y, Fantahun M, Hindin MJ. The effects of pregnancy intention on the use of antenatal care services: systematic review and meta-analysis. *Reproductive Health*. 2013;10:50. doi:10.1186/1742-4755-10-50.
24. Williams L, Zapata LB, D'Angelo DV, Harrison L, Morrow B. Associations between preconception counseling and maternal behaviors before and during pregnancy. Matern Child Health J. 2012 Dec;16(9):1854-61. doi: 10.1007/s10995-011-0932-4.
25. Naimi TS, Lipscomb LE, Brewer RD, Gilbert BC. Binge drinking in the preconception period and the risk of unintended pregnancy: implications for women and their children. Pediatrics. 2003 May;111(5 Pt 2):1136-41.
26. Sable MR, Spencer JC, Stockbauer JW, Schramm WF, Howell V, Herman AA.Pregnancy wantedness and adverse pregnancy outcomes: differences by race and Medicaid status. Fam Plann Perspect. 1997 Mar-Apr;29(2):76-81.
27. Shah PS, Balkhair T, Ohlsson A, Beyene J, Scott F, Frick C. Intention to become pregnant and low birth weight and preterm birth: a systematic review. Matern Child Health J. 2011;15(2):205–216.
28. Mohllajee AP, Curtis KM, Morrow B, Marchbanks PA. Pregnancy intention and its relationship to birth and maternal outcomes. Obstet Gynecol. 2007;109(3):678–686.
29. Orr ST, Miller CA, James SA, Babones S. Unintended pregnancy and preterm birth. Paediatr Perinat Epidemiol. 2000 Oct;14(4):309-13.
30. Kost K, Landry DJ, Darroch JE. The effects of pregnancy planning status on birth outcomes and infant care. Fam Plann Perspect. 1998 Sep-Oct;30(5):223-30.
31. Taylor JS, Cabral HJ. Are women with an unintended pregnancy less likely to breastfeed?J Fam Pract. 2002 May;51(5):431-6.
32. Logan Cassandra, Holcombe Emily, Manlove Jennifer, Ryan Suzanne. The consequences of unintended childbearing: A white paper. Washington, DC: Child Trends; 2007.
33. Mack JM, Chavez JM. Cumulative effects of maternal age and unintended pregnancy on offspring aggression. J Interpers Violence. 2014 Nov;29(16):2931-50. doi: 10.1177/0886260514527169. Epub 2014 Mar 24.
34. David HP. Born unwanted, 35 years later: the Prague study. Reprod Health Matters. 2006 May;14(27):181-90.
35. David HP, Dytrych Z, Matejcek Z. Born unwanted. Observations from the Prague Study. Am Psychol. 2003 Mar;58(3):224-9.
36. Baydar N. Consequences for children of their birth planning status. Fam Plann Perspect. 1995 Nov-Dec;27(6):228-34, 245.

37. Barber JS, Axinn WG, Thornton A. Unwanted childbearing, health, and mother-child relationships. J Health Soc Behav. 1999 Sep;40(3):231-57.
38. Roberts SC, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. BMC Med 2014; 12:144.
39. Cook RJ, Dickens BM, Horga M. Safe abortion: WHO technical and policy guidance. *International Journal of Gynecology & Obstetrics*. 2004;86(1):79-84.
40. American College of Obstetricians and Gynecologists (ACOG). Increasing access to abortion. Committee Opinion No. 613. Obstet Gynecol 2014;124:1060–5.
41. World Health Organization and Guttmacher Institute. Facts on Induced Abortion Worldwide. November 2014. http://www.guttmacher.org/pubs/fb_IAW.html.
42. Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, Shah IH. Unsafe abortion: the preventable pandemic.Lancet. 2006 Nov 25;368(9550):1908-19.
43. Berer M. National laws and unsafe abortion: The parameters of change. *Reprod Health Matters*. 2004;12(24):1-8.
44. Roberts SC, Gould H, Kimport K, Weitz TA, Foster DG. Out-of-pocket costs and insurance coverage for abortion in the united states. *Womens Health Issues*. 2014;24(2):e211-e218.
45. News in Context. Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2015. https://www.guttmacher.org/article/2015/07/laws-affecting-reproductive-health-and-rights-state-trends-midyear-2015. July, 2015. Accessed April 2016.