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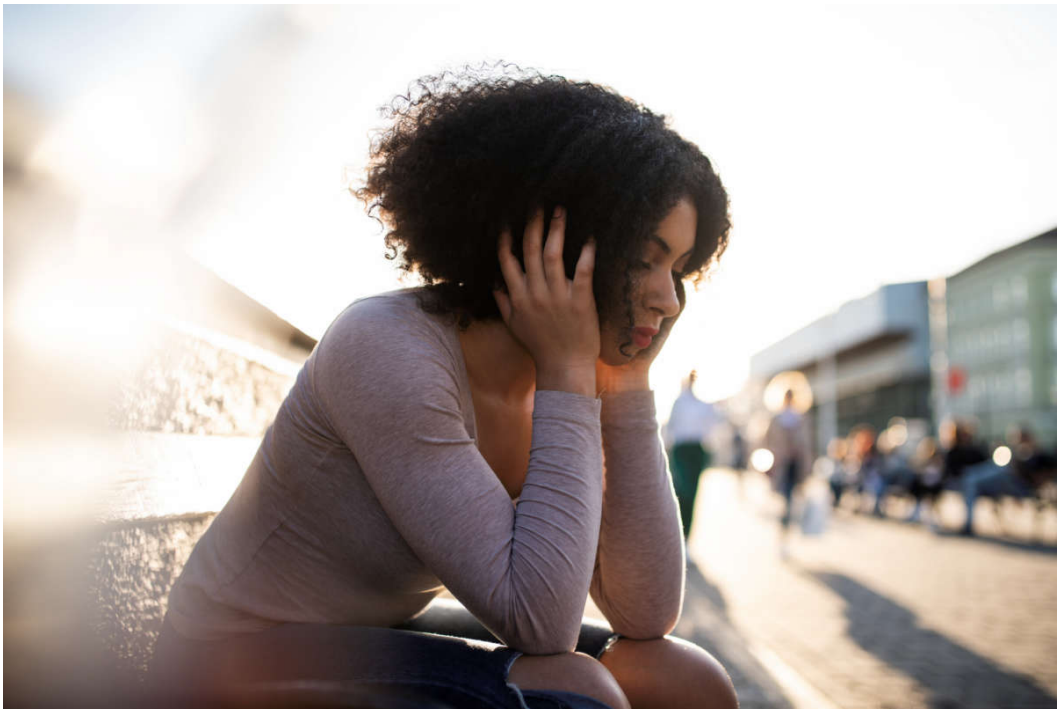
The War on Reproductive Care Is Preventing Patients From Seeking Help



2019's relentless attacks on abortion were intended to create chaos and confusion in reproductive health care.

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Looking back at 2019, it's now clear that the relentless attacks on the 61 million U.S. residents (https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states) at risk of pregnancy were intended not only to restrict access, but to also successfully create as much chaos and confusion in the reproductive health care landscape as possible. This is particularly true in the South and Midwest, disproportionately affecting those in rural areas, people of color, youth and low-income communities.

Ensuring that the populace doesn't understand what's legal, available and/or covered by their insurance creates a barrier to care that advocates say can be as effective in some communities as clinic closures — another epidemic on its way to a breaking point as 2020 kicks off.

Overall Picture: A Land of Confusion

A record number of states and municipalities ***did*** (https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back) pass proactive, access-expanding

legislation in 2019. However, the implementation of 483 separate restrictions (https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back) on abortion and historic new hurdles to contraception through federal policy changes since 2010 have forced a record 39 independent clinics (https://www.abortioncarenetwork.org/wp-content/uploads/2019/12/CommunitiesNeedClinics2019.pdf) to close. As seen in Texas through the ultimately successful challenge of a provision that closed half the state's clinics (https://www.texastribune.org/2016/06/28/texas-abortion-clinics-have-closed-hb2-passed-2013/), even a Supreme Court victory does not magically reopen those shuttered community health centers.

Declaring the Texas law unconstitutional may have been more like hitting the pause button than forcing anti-abortion legislators and advocates to redirect their efforts. "The damage has already been done [once a clinic closes]," Aimee Arrambide, executive director of NARAL Pro-Choice Texas, told *Truthout*. "[These laws are] a solution in search of a problem that isn't an actual problem; all it did was prevent more abortion providers from being able to provide abortion."

Quita Tinsley, co-director of ARC-Southeast, an abortion fund based out of Atlanta, Georgia, told *Truthout* the Southeast U.S. is in the fastest-growing abortion desert with nearby states Kentucky, Mississippi, Missouri, North Carolina and West Virginia struggling to keep their last clinic open.

"You don't put a 'closed temporarily!' sign on a clinic and think that you can just open up shop in three months or six months," said Tinsley, who says that *any* clinic closure in their region for *any* length of time would mean an immediate massive rerouting of patients.

Tinsley and their volunteers — along with sister funds in neighboring states — plan for and respond to these eventualities. There hasn't been a time over the past decade when abortion restrictions haven't been clogging up circuit courts, resulting in laws going in

and out and back into effect until one side (typically the state attorney general) or the other (typically one or more of the clinics whose patients are affected by the law) drops their suit.

> Policies and laws that shutter clinics over abortion regulation don't just cut off access to abortion.

"In the meantime, people are still going to be pregnant or wanting to end pregnancies," Tinsley told *Truthout*. "We can't say, 'Oh, I know that you're pregnant now, but could you wait till the fight is over to access health care?'"

And the fight isn't set to wane anytime soon.

Also on the horizon, **as *Truthout* has reported previously (https://truthout.org/articles/louisiana-becomes-latest-front-in-national-battle-over-abortion-rights/)**, the Louisiana legislature has created the follow up to 2016's ***Whole Woman's Health v. Hellerstedt* (https://reproductiverights.org/case/whole-womans-health-v-hellerstedt)** decision affirming that any law purporting to restrict access to abortion for patient safety *must* show that the law is founded in science and data. Restrictions for the sake of restrictions, explained Justice Stephen Breyer in **his unequivocal decision (https://www.scotusblog.com/case-files/cases/whole-womans-health-v-cole/)**, are wholly unconstitutional.

Strikingly, while *Whole Woman's Health* was still winding its way to the highest court in the land, **the state of Louisiana (https://www.guttmacher.org/article/2019/10/admitting-privileges-are-back-us-supreme-court-serious-implications-abortion-access)** embarked on a nearly identical journey as its neighbor Texas. Hospital **admitting privileges (https://www.guttmacher.org/article/2019/10/admitting-privileges-are-back-us-supreme-court-serious-implications-abortion-access)** allow a physician to personally admit a patient *and* personally provide specific medical services at that facility. While it may sound standard to anyone who has followed their personal physician to a particular hospital for a procedure, it's completely unnecessary in regards to abortion.

"People don't really understand what these laws actually do and the opposition has done a great job in guising them in medical rhetoric," Arrambide said. "So, it sounds like they're created to help provide health care, but that's actually not the case. The opposite, in fact: Admitting privileges don't do anything to make sure that people are safer."

According to Arrambide, because abortion is such a safe procedure, not very many people are in need of emergency care. For those who are in need, existing laws such as the **federal Emergency Medical Treatment (https://www.guttmacher.org/article/2019/10/admitting-privileges-are-back-us-supreme-court-serious-implications-abortion-access)** and Labor Act of 1986 (EMTALA) require hospitals to take care of them.

According to the **National Institutes of Health's National Library of Medicine (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6000974/)**, a mere 0.11 percent — one-tenth of 1 percent — of abortions in the U.S. resulted in follow-up emergency care. Of those, only half required observation and 22 percent were likely due to attempts to self-induce in an era where information on self-administered abortion was less available.

Arrambide outlined two very specific concerns that have developed over 2019: an escalating confusion about what is/is not legal and the potential repercussions of pushing the exact same, very specific restriction — admitting privileges requirements — in front of the Supreme Court just four years after precedent was set.

"It's worrisome because precedent was already set in *Whole Woman's Health v. Hellerstedt* on this *exact same* issue," she said. "I think that's concerning because if [the Supreme Court] were to rule in a different way on this case — I mean, of course it's going to be devastating for abortion access, but it also creates this legal situation where precedent [apparently] doesn't matter."

Arrambide said that the legal tug of war was really just the backdrop for patients. Fluctuating federal policies and insurance coverage changes combined with hyper-local "trigger bans" designed to criminalize abortion should ***Roe v. Wade* (https://truthout.org/articles/can-the-trump-pence-administration-overturn-roe-v-wade/) be nullified (https://truthout.org/articles/can-the-trump-pence-administration-overturn-roe-v-wade/)** are further threats.

Arrambide said these trigger bans spring up on tiny towns' city council agendas, even if the communities do not actually want them. These towns currently do not have existing abortion clinics or plans to open any.

> The more pervasive conscience clauses and false "information" requirements become, the harder it will get to build trust in any health care scenario.

As if to punctuate that the land of confusion solidified in 2019, the day after Arrambide spoke with *Truthout*, the Department of Health and Human Services released the **final version of a rule change to the Affordable Care Act (https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-27713.pdf)** (ACA) that affects abortion coverage for privately purchased health insurance.

Even for those who are up to date on their local laws, federal changes and health insurance specifics, knowledge doesn't guarantee anyone an accessible provider — or the income to afford an appointment. The immediate outlook for the tens of millions lacking the sizable resources required to weather unexpected medical treatment and its increasingly related travel needs is bleak and — with rare exception — getting bleaker.

As these trusted clinics which provide the full spectrum of reproductive health care are shuttered, those living in adjacent communities often have nowhere to go not just for abortion care, but also for wellness exams, STI testing and treatment, pregnancy tests and counseling, cancer screenings and more.

It is all of these basic necessities that are in jeopardy going forward. Fewer clinics means less availability at the clinics that remain — even in states with protections in place. Policies and laws that shutter clinics over abortion regulation don't just cut off access to abortion, even if that is the claim of state legislators as well as policy-makers in the Trump administration.

But it's within their relentless attack on abortion — a medical need **as old as pregnancy (https://truthout.org/articles/abortion-is-as-old-as-pregnancy-4-000-years-of-reproductive-rights-history/)** — that those who would deny marginalized communities cancer screenings, STI care, prenatal exams and assistance, contraception, gender-affirming treatments like hormone therapy (in many regions, only found at reproductive health clinics) and more hide their true intentions.

Tinsley told *Truthout* these relentless attacks feel personal.

"Our organization is led by people of color and folx who are from the South [and] we know these abortion bans largely impact people of color, queer and trans people, low-income folx, those in rural areas," Tinsley said. "We know that a lot of people who are anti-abortion are anti-A LOT of things. They know that the [reality] of the things they stand [for is] the death of a lot of people and they don't care."

Positive Pushback

Like so many advocates in 2019, Tinsley feels communities are rebounding in the knowledge that they will just have to keep taking care of and looking out for each other. **Analysis from reproductive health research nonprofit, the Guttmacher Institute (https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back)**, of the positive actions from 2019 affirms the power of this approach.

State legislatures and city councils — primarily in the Northeast and West along with Illinois — enacted a record 36 measures that protect abortion access, and five governors vetoed restrictions that had passed the legislature. Also sprinkled across the country are 17 policy improvements to sexual health education, 46 measures intended to decrease maternal mortality and 13 expansions to contraceptive coverage.

With the Trump administration further separating both abortion and contraception out of the basic health care category — just as the ACA had begun reintegrating them — all reassurances from state and local legislators that these services are available and accessible will be necessary for the foreseeable future. Thanks to the 2019 additions, 29 states have a **contraceptive coverage guarantee (https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives)**, meaning that insurance companies in those states must include birth control in their prescription plans.

The ultimate future of contraception is a true 2019 bright spot, according to Kate Grindlay Kelly, project director for the Free the Pill campaign at Ibis Reproductive Health.

"Over the last couple of years, [we've] seen a lot of advances on the state level in contraceptive access and a lot of new opportunities to effect change there," Kelly told *Truthout*. "For example, there are a **growing number of states (https://truthout.org/articles/pharmacist-prescribed-birth-control-could-broaden-access-lower-costs/)** that now allow pharmacists to prescribe hormonal methods of contraception and those states range in the political spectrum."

Making well-vetted contraception methods available over the counter would catch the U.S. up to **over 100 other countries (http://ocsotc.org/wp-content/uploads/worldmap/worldmap.html)** that have removed the cost barrier of a doctor's visit, cited by **one in five women (https://www.contraceptionjournal.org/article/S0010-7824(06)00311-8/abstract)**as a reason it's difficult to consistently access and take the pill.

Kelly explained that it isn't just those low-income patients facing monetary hurdles that would benefit from increased contraception availability. "We know that barriers that limit access to the pill disproportionately impact young people, low-income people, people of color and immigrants — but anyone who wants to use birth control could benefit from easier access to getting it," she said. "[The] beneficiaries are really everybody who wants to use a birth control pill as their contraceptive method."

One of the other barriers to consistent (and therefore effective) use of an oral contraceptive is the quantity patients can purchase at a time. A 28-day pill pack in a system where most insurance companies disallow refill orders submitted more than a week ahead of the 30-day mark since the previous pack pickup creates a very short window for a trip to the pharmacy. Depending on the number of days in any given month, that window can be as short as four days to order *and* pickup or risk an unplanned pregnancy. While a few companies in some areas allow mail orders of up to three months at a time, expansion of multiple-month quantities is sorely needed.

As attacks from the Trump administration have escalated, a number of states have tackled this quantity issue — an extremely important step in a time when the options for patients with unplanned pregnancies are constantly shifting.

"There are 18 states now that have a year supply covered at a time," said Kelly. "Research shows that when you have more pill packs that are given at a time, the greater the likelihood that someone's going to be able to stay on it and use it consistently."

Medicaid, Maternal Mortality, Conscience Clauses and the Domestic "Gag Rule"

Consistency is a keyword in all preventative medicine — as is trust. Both were hard to come by in vast regions of the country before 2019; both are being pushed farther out of reach as states legislate clinics out of existence.

"States that have some of the least access to abortion care also have the highest rates of maternal mortality," said Tinsley, "because people not only are having to travel farther and wider to access abortion care, they have to travel farther and wider to access an OB/Gyn, period."

People who found, run and volunteer for abortion funds like ARC-Southeast hear patient stories one-on-one while also navigating in the broader reproductive health care climate.

"In Georgia, Black women in this region have a maternal mortality that's two to three to four times higher than white folks," said Tinsley, who explained that a desire to expand one's family is not the only factor that weighs on the minds of those in their community.

"We know that something is very wrong and we know that Black people are being faced with this decision of being healthy or continue wanting to have the families that they choose for themselves," Tinsley told *Truthout*. "And that's not something anyone should ever have to face when they're trying to decide what they want their families to look like. People should be able to do that with dignity and autonomy and without fear."

As ***Truthout*** **(https://truthout.org/articles/georgia-joins-national-anti-abortion-onslaught-with-heartbeat-ban/) reported in April (https://truthout.org/articles/georgia-joins-national-anti-abortion-onslaught-with-heartbeat-ban/)**, Georgia has been singled out by Amnesty International as the U.S. state with the worst maternal mortality rate despite declines around the world, even in the "least developed" countries. The overall number is an inexcusable 40.8 deaths per 100,000 births; the racial disparity is even more frightening at 27.1 deaths per 100,000 live births for white women and 62.1 for Black women. As expected, trust in the medical establishment overall is low in communities of color.

An important and often missed factor, according to Tinsley, is the **lack of Medicaid expansion in the South (https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/)**. Of the 14 states that have passed on expanding this crucial access to preventative services, 11 are in the South — including all six of the states served by ARC-Southeast. There's a direct line between making it as easy as possible to access consistent and safe care and the ability to build trust between patients and medical practitioners.

"People are avoiding getting care because they can't afford it," Tinsley said of those who fall into the sizable coverage gap. "So what does that do to our communities when people aren't even screening for cervical cancer or breast cancer, or other reproductive health care issues?"

The answer to that question is increasingly hard to answer with **Planned Parenthood pulling out of the Title X program (https://www.plannedparenthood.org/about-us/newsroom/press-releases/trump-administration-gag-rule-forces-planned-parenthood-out-of-title-x-national-program-for-birth-control-2)** this year after

refusing to comply with Trump's "gag rule" prohibiting patient referrals for abortion or any discussion of abortion at all as an option. It's unclear just how widespread the repercussions are, but experts at Guttmacher have been **predicting near disaster (https://www.guttmacher.org/gpr/2017/01/why-we-cannot-afford-undercut-title-x-national-family-planning-program)** should there be any reduction in Title X's crucial funding for contraception and other preventative care since January 2017.

Title X has been relied on by millions of people every year since its signing by President Nixon in 1969 **with the words (https://www.guttmacher.org/sites/default/files/article_files/gr040105.pdf)**: "no American woman should be denied access to family planning assistance because of her economic condition."

Rolling back on decades-old, popular, bipartisan programs like Title X hardly inspires confidence that necessary services will be available and offered without stigma.

That confidence has been further eroded in recent years by **state requirements for abortion providers to lie to patients (https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion)**, telling them falsely that they are at risk of infertility, breast cancer and more should they choose to terminate a pregnancy. At present, the sole North Dakota abortion provider and the American Medical Association are fighting **one of that state's 2019 restrictions (https://khn.org/news/ama-abortion-lawsuit-puts-doctors-in-the-thick-of-debate/)**, a requirement that doctors incorrectly "inform" patients that medication abortion can be "reversed."

These laws unequivocally require doctors to commit ethical violations and degrade trust with patients or risk losing their license — a trust the abortion providers who spoke with *Truthout* say is about to be impacted again by the implementation not just of the Trump administration's domestic "gag rule," but also of the expanded "**conscience clauses (https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services)**."

"A religious refusal allows professionals — usually those in the medical profession — to not fulfill their duties based on their religious beliefs," said Indiana-based pediatrician Tracey Wilkinson, who serves as a board member for Physicians for Reproductive Health.

Wilkinson told *Truthout* that these "**refusal clauses (https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services)**," as they're more broadly known, necessarily impact access, particularly to

emergency contraception and abortion. Beyond that, "it also interferes with the *patient's* own conscience and faith."

These concerns were echoed by her colleague, Missouri-based Leilah Zahedi-Spung, an OB/Gyn and fellow with Physicians for Reproductive Health, who couldn't condemn these policies strongly enough. For her, there simply aren't ethical reasons to deny a patient what they need.

"Truly all aspects of health care are negatively impacted by these clauses — they are about refusing care," Zahedi-Spung told *Truthout*. "I provide abortion care *because* of my conscience and because I believe everyone should have access to health care. When there are providers in a community who refuse to offer or provide these services, the burden falls on [those] who are willing. The system can get very overwhelmed and patients feel abandoned — which can lead to lack of follow-up and poor outcomes."

Spung cited her oath as a physician to "first do no harm" as well as the emotionally complicated situations where medical providers often find themselves. "I care for a high-risk patient population as an obstetrician. I practice in a state with an exceptionally high maternal mortality rate [**the seventh-highest in the U.S. (https://www.kansascity.com/news/business/health-care/article231126448.html)**]. Most of the women I care for only have medical care when they are pregnant because that is the only time they qualify for insurance," Zahedi-Spung said, explaining that a lack of insurance often means an inability to identify and tackle pre-existing disorders and conditions that can complicate carrying a pregnancy.

"These 'disclaimers' [with inaccurate "information"] that politicians force us to provide to our patients do nothing to benefit them but simply make them feel judged and unsafe in their health care system," Zahedi-Spung added. "Those who will suffer the most are already the people who have the most barriers to care: people of color, people with low incomes, queer and trans folks, immigrants, people with disabilities and people who live in rural areas."

Rough Days Ahead

The one guarantee for 2020 is that mainstream media will continue to portray the legal battles and policy changes as the status quo in the "abortion wars" as Trump runs on his anti-choice record. Writers who routinely cover abortion as part of their work **report frustration with editors (https://www.contraceptionjournal.org/article/S0010-**

7824(17)30401-8/pdf) invested in the polarization trope — an indication that increased context and the incorporation of other, equally important aspects of reproductive health isn't likely to be on the horizon.

And even if reporting shifts, 2019 and the preceding decade are still on the books. Clinics are closed. Supreme Court precedent is at risk with arguments for ***June Medical Services v. Gee*** **(https://www.guttmacher.org/article/2019/10/admitting-privileges-are-back-us-supreme-court-serious-implications-abortion-access)** in March and a decision likely a few months later in June. Meanwhile, the "gag rule" goes into effect and ongoing updates dismantling the ACA and Title X reduce preventative care.

Access to care that prevents unplanned pregnancies necessarily **curbs the need to end unplanned pregnancies (https://www.theguardian.com/world/2017/jan/17/us-abortion-rate-lowest-roe-wade-contraception-access)**. Legislators in hostile states and members of the Trump administration can continue to pretend that these medical necessities and procedures are unconnected, but the data from decades of evidence and best medical practices (as well as common sense) say otherwise.

And as if all of that weren't enough to create widespread confusion about what's legal, what's available and what's affordable, the more pervasive conscience clauses and false "information" requirements become, the harder it will get to build trust in any health care scenario.

Wilkinson is already seeing evidence of this issue.

"Having a positive experience during any interaction with the medical system is crucial to build trust in the relationship moving forward," she told *Truthout.* "If [patients] don't feel they can trust health care providers, they may avoid interacting with the health care system altogether unless they are *really* sick and have no choice."

For the sake of our overall public health, it's a trend we cannot afford, but will likely see continue into 2020.

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