Improving Maternal Health Outcomes by Expanding Abortion Access

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Introduction and History

*Disclaimer this paper refers to 'women' as anyone who has a uterus and is capable of pregnancy. I want to acknowledge that there are people who do not identify as women including but not limited to intersex, transgender, or non-binary people who can also experience pregnancy and abortion.

Abortion is an integral part of comprehensive reproductive and medical health care. In 1973 the U.S. Supreme Court recognized the constitutional right to abortion in the *Roe v. Wade* case. Abortion is common in the United States with one in every four-women having an abortion by the age of 45 years old.[1] However, state laws have made it increasingly difficult to access and afford abortion services. The state level determines until what gestational age an abortion is permissible. At a certain gestational age, 43 states forbid women her right to an abortion. Oregon is only one of seven states that protects the women's right to abortion throughout the entire pregnancy.[2] Abortion access has direct implications on maternal health and wellbeing - including behavioral, physical, and financial - and therefore access should be expanded.[3,4,5] Access to abortion is often limited. Public health education about mailed and telehealth abortion options can overcome in-clinic access barriers and positively affect maternal health outcomes.

Healthy People 2030: Reduce the Proportion of People who can't get Medical care when they need it

In 2017 4.1% of people in the United States were not able to receive the health care services they needed. As part of Healthy People 2030, the target goal is to decrease that percentage to 3.3%.[6] Increasing access to comprehensive health care and reproductive health care includes access to abortion services.

Abortion Access and Maternal Health Outcomes

Abortion access has direct implications to maternal health outcomes including mental and behavioral health, physical health and financial well-being.

i. Mental and Behavioral Health

Being unable to receive a desired abortion can have negative outcomes on a woman's mental and behavioral well-being. Unwanted pregnancy increases the likelihood one will have anxiety, depression, and mental health complications.[3]

A prospective, longitudinal cohort study concluded that receiving an abortion does not negatively affect mental health in comparison to those that do not get an abortion. In fact, those that were denied an abortion initially had higher risk of negative physiological outcomes including, anxiety, lower self-esteem, and lower life satisfaction than those that received an abortion.[3] In another prospective study published in *Psychological Medicine,* similar results showed that those who were denied abortion had higher rates of anxiety than those who received an abortion.[7]

Additionally, those who are denied an abortion are less likely to have an aspirational one-year goal and less likely to achieve their goal if they had one than those who received an abortion.[4] Goal setting and reaching aspirational goals are critical in maintaining a positive future mindset and maintaining mental health.[4]

ii. Physical Health

Abortion restrictions are tied with higher rates of maternal morbidity and mortality. The World Health Organization (WHO) states that illegal abortion and abortion restrictions do not stop abortions but rather only make them more unsafe. In fact unsafe abortions are the third leading

cause of maternal death wordwide.[8] Legalizing abortion saves women's lives. Almost immediately after enacting *Roe v. Wade* the United States saw almost no hospitalized complications of unsafe abortions. In South Africa after liberalizing abortion, deaths from unsafe abortions dropped by over 50%.[9]

States with more restrictions on abortion have higher rates of maternal mortality. The Center for Reproductive Rights conducted a study comparing state abortion restrictions to maternal health outcomes. They found an inverse relationship of states with more abortion restrictions having worse maternal health outcomes and fewer policies in place to support maternal health.[10]

Giving birth has a higher rate of medical complications and death than receiving an induced abortion. In the United States it is estimated that mortality is 14% higher in pregnancy than induced abortion. Those denied an abortion are more likely to experience more serious and even life threatening pregnancy complications including eclampsia and postpartum hemorreage.[11] In a prospective cohort study those that were denied an abortion and gave birth had worse physical health outcomes than those that received an abortion. Five years later, women who gave birth reported poorer health including chronic pain, joint pain, headaches and migraines, and obesity than those that received an abortion.[12] Another study compared those being born after a denied abortion versus a desired pregnancy after an abortion, revealed being born after a denied abortion had higher incidence of poor maternal bonding and living below the poverty line without enough money to pay for basic living needs.[13]

iii. Financial Stability

There are economic and financial consequences to limiting abortion access. A study published in the American Journal of Public Health demonstrated that individuals who are unable to receive a

desired abortion report more economic insecurity and poverty than those who are able to receive an abortion. Out of those seeking abortion, 63% already had children, 76% reported not having enough money to cover housing, food and transportation and 51% were living below the federal poverty line. Those who were denied abortion were at a significantly greater likelihood of living in poverty and receiving public assistance for up to four years after giving birth. Denied abortion only worsens economic hardships even when adjusted for baseline financial stability.[14] The National Bureau of Economic Research published a study showing that if a woman is financially struggling, they are especially likely to fall into poverty after a denied abortion. Financial distress for women denied an abortion is sustained for 5 years. Denied abortion increases the amount of debt by 78 percent, increases bankruptcies and evictions by 81 percent, and decreases the likelihood of having a credit score in the ideal range (680-739).[5]

Given the interconnection between poverty and health and the connection between denied abortion and subsequent poverty, this study highlights the public health implications for accessible abortion options. Access to abortion services enables women to choose the right time in their life to have a child, when perhaps there exists more financial stability and resources to positively support their health and wellbeing.

Barriers to Abortion Access

Many barriers exist in accessing abortion care in the United States. These often include restrictive state abortion laws, cost and insurance, patient age, and distance needed to travel to a clinic that offers services. These barriers disproportionately affect people of color and those living in poverty.

i. Restrictive Abortion Laws

Since 2010 many states have increased the restrictions and hostile laws to abortion access and rights. These state specific restrictions include limitations on Medicaid coverage, publicly funded abortions, mandated counseling, mandatory guardian involvement, and waiting periods. In fact, as of September 1, 2021, the state of Texas passed a 6 week gestation abortion law. Additionally, this legislation allows anyone anywhere to sue somebody for $10,000 for aiding someone in Texas to receive an abortion in any capacity.[15] Currently, Oregon does not have restrictions on its abortion laws unlike many other states. To highlight the recent increase of restriction, between 2011 and 2019 there have been 483 new abortion restrictions enacted in the United States. This amount is 40% of all abortion restrictions enacted since *Roe v. Wade*.[2] The year of 2021 holds the greatest number of abortion restrictions enacted in any one year, 97, since *Roe v. Wade*.[15]

ii. Cost/Insurance

The cost of an abortion limits access to abortion. The average cost for an abortion in a clinic setting with anesthesia at 10 weeks' gestation is $508 and the average medication abortion (up to nine weeks gestations) is $535.[16] In 2014, 53% of patients receiving an abortion paid out of pocket while the next most common method of payment was Medicaid at 24%. The current Hyde amendment bans federal money like Medicaid from covering abortion services and only 15 states (including Oregon) require the state to provide funds for abortion for those with Medicaid.[2] Additionally, private insurance often does not cover abortion services. In the state of Texas, patients are banned from using any form of insurance, private or public, to cover abortion costs.[15]

Abortion is a fundamental right and not a reproductive service of privilege. Abortion restrictions disproportionately affect those in poverty and people of color and is a force that continues the cycle of poverty. For abortion to be accessible to people of all socioeconomic statuses, abortion

services must be covered by federal funds, Medicaid, and health insurance, and the Hyde amendment must be abolished.

iii. Distance Traveled

As of 2017, 89% of counties in the United States have no clinics providing abortion services. 38% of reproductive age women in the US live in those counties. 78% of counties in Oregon have no clinics that provide abortions and 23% of women in Oregon live in these counties. In 2014, one third of those who received an abortion had to travel more than 25 miles one way to reach a clinic with abortion services.[2]

A multi-state longitudinal analysis study published in 2020 researched abortion access (measured via distance someone lives from a clinic that provides services) and the prevalence of abortion. The further the distance to abortion access the less abortions occurred. The article concluded that distance to abortion services can be a barrier to receiving abortion and therefore farther distances to care have the potential for harm to pregnant people. In fact, each additional mile to a provider was associated with a decrease of 1.1% in the abortion rate. Living 30 or more miles from a provider was associated with 5.26 fewer abortions per 1,000 women.[17] Clearly, travel distance and the time, transportation access, and cost required to reach clinics in the United States, primarily in rural areas, can be an impossible barrier to reaching abortion services.

Furthermore, depending on the state where one is accessing abortion services, it may require several in person appointments. 33 states require counseling given prior to receiving an abortion and 13 states require counseling be given in person followed by a waiting period requiring a second trip to the clinic. Waiting times vary from 24-72 hours between the counseling and

receiving the actual abortion. According to planned parenthood, on average receiving an abortion requires 2-5 appointments.[18]

Published in the peer reviewed journal, *Contraception,* predicted changes in abortion access with the elimination or weakening of *Roe v. Wade* revealed abortion patients' average distance to the nearest facility would increase by 97 miles, from 25 to 122 miles. This increase in travel distances would likely prevent 93,500 to 143,500 individuals each year from accessing abortion care.[19] The most recent 6 week abortion ban in Texas increases the travel time for the average Texan receiving an abortion from 12 miles one way to 248 miles one way, a 20-fold increase.[15] Greater distances to abortion facilities are associated with increased burden on patients, including higher out-of-pocket costs for associated services such as food, lodging child care, and lost wages.[20]

iv. Age

Patient age is a barrier to abortion services depending on the state one lives in. In many states minors (18 or younger) must have guardian permission. In Oregon there is no requirement for parental consent.[2] Often parental consent is not provided, or an individual is reluctant to ask permission from their guardian and thus they do not receive services.[1]

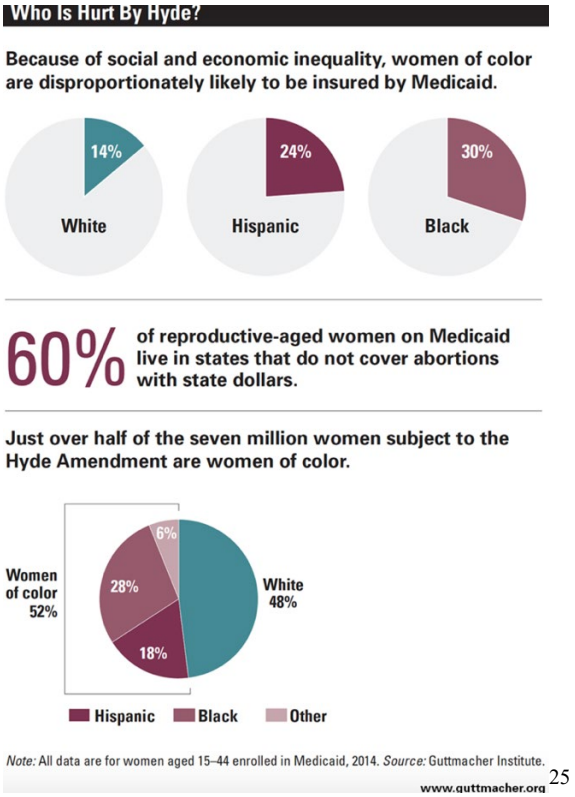
Abortion highlights the structural inequalities of the United States health care and reproductive health care system. The highest incidence of abortion patients are poor and low income women, black women, and young adults. Black and Hispanic women have higher abortion rates than white women—because they have higher rates of unintended pregnancy.[21] Thus abortion restrictions disproportionally affect these populations who are already more vulnerable.[22]

Prevalence

In 2017, approximately 862,320 abortions occurred in the United States. While 9,640 abortions occurring in Oregon state. There was an 8% decrease in abortion incidents in the United States from 2014 to 2017 and a 1% decline in Oregon state.[2]

Restrictions to abortion access highlight existing disparities for people in poverty, people of color, and youth. More than half of all abortions in the United States were for patients in their 20s and adolescents made up 12% of abortions. 59% of abortions were obtained by people who already had at least one birth. 75% of abortion patients in 2014 were poor (having an income below the federal poverty level of $15,730 for a family of two in 2014) or low-income (having an income of 100–199% of the federal poverty level).[1] The notable five year longitudinal study of 1,000 women in the United States known as the Turnaway study revealed that over half of those receiving an abortion paid more than one third of their monthly income for abortion related costs.[23] Because of social and economic inequalities due to racism, the Hyde Amendment disproportionally affects people of color as they are more likely to be covered by Medicaid. In fact, 30% of black women and 24% of Hispanic women are covered by Medicaid while only 14% of white women.[24,25]

There was a 5% decrease in facilities providing abortion in the United State from 2014 to 2017 where there were 1,587 facilities. 60% of abortions were provided at abortion clinics, 35% at nonspecialized clinics, 3% at hospitals and 1% at physician offices. While in Oregon there was a 7% increase in abortion providing clinics at 29 clinics.[2] In 2018, approximately three fourths (77.7%) of abortions were performed at ≤9 weeks' gestation, and nearly all (92.2%) were performed at ≤13 weeks' gestation.[26]



[25]

Figure 1: *Hyde Amendment inequalities based on race and ethnicity by the Guttmacher Institute.*

Expanding Abortion Access via Telemedicine and Mailed Medication

There are two types of FDA approved abortion methods in the United States. The first is the abortion pill consisting of two medications called mifepristone and misoprostol. The pills are prescribed and can be taken in clinic or at home with the supervision of a medical provider. In most states the abortion pills can only be taken up to 10 weeks' gestation. The second option is a surgical in-clinic abortion. Suction or vacuum aspiration is used to vacate the uterus and is utilized up to 14-16 week gestation. Dilation and evacuation uses both suction and medical tools to empty the uterus and is utilized most often at 16 weeks or greater gestation.[27]

In the face of dwindling abortion options that are accessible for all people regardless of income, distance to clinic, patient age, or state abortion laws, people are turning towards telehealth

mailed medication options. This option entails a telehealth visit with a licensed medical provider and subsequent mailed abortion medication, mifepristone and misoprostol, to the patient within several days to be self-administered at less than 10 weeks' gestation. This option can be particularly useful for those living in rural areas far from abortion services.

A study published in 2018 on motivations of people seeking medication abortion online included privacy, less travel, cheaper and more convenient.[28] People in both states with restrictive access to abortion and in nonrestrictive states are turning to telehealth abortion medication options. There is a public health justification to decrease barriers to clinic abortion services and to make telehealth abortion services as safe and efficacious as possible.[28]

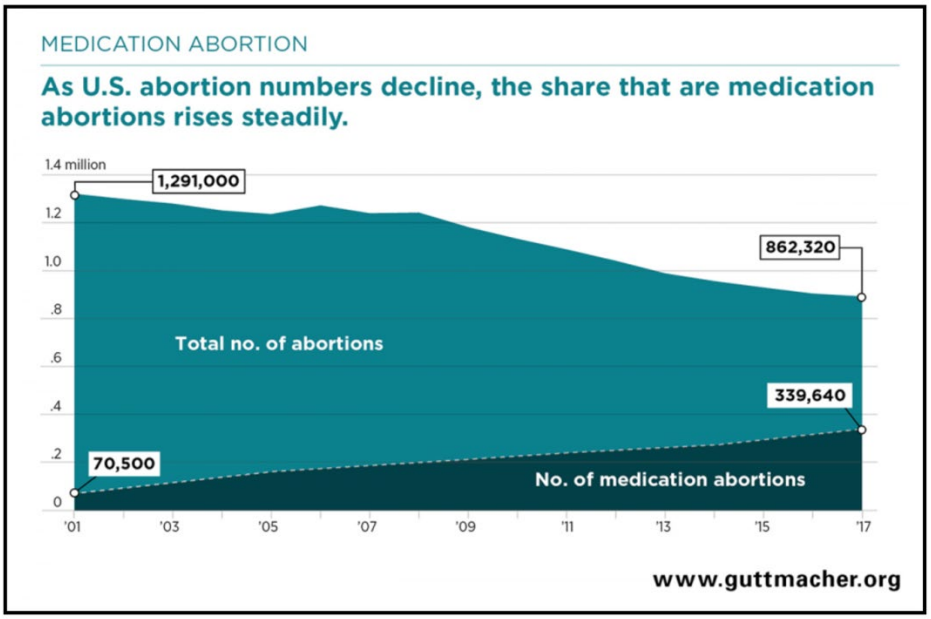
Telemedicine abortion services are safe, effective, efficient, and satisfactory in comparison to in person abortion services.[29,30] There is no significant difference in complication rates with telemedicine abortion as in-clinic abortion.[31] Women report satisfaction with telemedicine abortion and often state they would prefer telemedicine regardless of in-clinic access.[32,33] As abortion restrictions become more rampant in certain parts of the United States accessing in person abortion will become more difficult and travel distances to services will drastically increase only intensifying access spatial disparities. This will likely increase the desire for telemedicine and self-managed abortions moving forward.[19]

Several nonprofit organizations have recently developed that aim to offer online, accessible, safe and affordable abortion services regardless of the state one lives in. Two notable organizations are Plan C and Aid Access. Aid Access is a not-for-profit organization that provides low cost or free of charge mailed medication services to those who cannot access local abortion services in the United States. The services cost $110-150 however if one cannot afford the cost a solution is found. Aid Access consists of doctors and medical providers. Since the start in 2018 Aid Access

has received 40,000 requests from people in the United States for mailed medication abortion many of whom are young, raped, poor, or living in domestic violence situations.[34] This information and organization emphasize what a health crisis and human rights violation the lack of availability of accessible abortion care is to people in the United States. It is critical that we address barriers to abortion and sharing knowledge of organizations like these that provide telemedicine and mailed medication abortion options.

The telehealth model has the potential to increase abortion access by eliminating barriers including travel distance, time, and money. Additionally, it enhances the reach of providers who can offer abortion services and offers people a new option for obtaining care conveniently and privately that does not require an in person visit.

The percentage of medication abortions increased from 5% in 2001 to 39% in 2017, despite total number of abortions declining.[1] It is clear from the data that medication abortion and telehealth abortion services are a preferred choice by many people offering a viable option that eliminates most clinic abortion access barriers. Since poor women and women of color are most effected by existing clinic abortion barriers, medication abortion and telehealth abortion services could be most helpful to these population groups. Therefore, to support women's health, to help eliminate existing clinic abortion barriers and to provide abortion access equity education around medication and telehealth abortion should be expanded and included in comprehensive reproductive education.



[1]

Figure 2: *Medication abortion prevalence increases annually while total U.S abortion numbers decrease.*

Abortion Education

There is undoubtedly a lack of understanding of the interconnectedness between access to abortion services and maternal health outcomes. Furthermore, there exists a knowledge deficiency regarding abortion resources available to people in the United States and in particular telehealth and mailed medication abortion. I would argue expanding this knowledge is essential in providing comprehensive health care and human rights to women.

Educational programs about abortion resources and telemedicine efficacy and safety must be far reaching. This expansion could be directed to health care professionals, health professors and teachers, school counselors and nurses, and be included in comprehensive sexual education in schools. Practicing providers should be educated on the importance of asking their pregnant patients if they are interested in abortion information or services and then be knowledgeable on the services in their area including telehealth/mailed abortion services. The American College of

Gynecologists (ACOG) supports women's access to safe abortion and recognizes access to abortion is often limited by the availability of trained abortion providers. ACOG recommends that abortion training be included in all medical school curriculum and expand the trained pool of abortion providers beyond gynecologists to family practitioners and advanced practice providers. In a survey published by ACOG, 32% of medical students received one or more lectures on abortion, and only 42 of the 461 accredited family medicine residency programs offer abortion training.[35,36]

Schools are an excellent setting for health promotion and therefore health teachers in grade school and college play an important role in educating students on abortion options and access.[37] International Planned Parenthood Federation (IPPF) is a global nonprofit aiming to promote comprehensive sexual and reproductive health and strongly advocates for abortion to be a part of all sexual and reproductive health curriculum in schools. They provide an in-depth guide discussing how to best educate on the topic of abortion. The guide includes language to both use and avoid, group involvement, workshops and group activities, videos of personal abortion stories, and additional resources.[38]

IPPF focuses on breaking abortion stigma in pursuit of more easily accessing reliable abortion information. They suggest that the more abortion education and open abortion dialogue occurs, the less foreign or mythicized it will be. Many people have false preconceived notions about abortion that prevents them from considering all their pregnancy options. Examples of these false notions are that abortion may inhibit an individual's ability to have a future child or will cause breast cancer or severe mental illness. Accurate education on abortion will allow women to truthfully decide for themselves if they desire an abortion and allows for prompt medical treatment. Abortion education is also important as it allows people to consider the implications

of an unintended pregnancy and perhaps motivate people to practice safe sex and use contraception.[39]

IPPF argues that the language and way one communicates about abortion in education does matter. Focusing on nonjudgmental language and remaining respectful of different experiences and opinions are important. IPPF offers a handout on language and words to avoid and replacement words that are more appropriate. For example, instead of saying "late-term abortion" one could instead say "abortion in the second or third trimester" or instead of saying "baby" or "unborn child" one could say "embryo" (if up to 10 weeks' gestation) or "fetus" (after 10 weeks' gestation). Another important aspect of abortion education, when in a group setting, is creating safe space, involving the group members, and practicing inclusivity. They suggest evaluating your audience's initial knowledge of sexuality and abortion to address the gaps more accurately. Remembering that participants may be apprehensive about engaging or asking questions, so offering a confidential way to ask questions through a drop box is considerate. Be sure the materials and scenarios used are inclusive for all people and do not assume your audience is heterosexual or sexually active. In fact, those that identify as lesbian or bisexual are at higher risk for unplanned pregnancy than their heterosexual peers.[40] There is limited time in a workshop or training session, so it is critical to provide more resources for participants to refer to for future learning.

Many group activities are outlined in the guide including a group brainstorm of words participants associate with abortion. This exercise is excellent at highlighting the differences between facts about abortion and values and that values are what are different between different people. Role play scenarios are also provided including a pregnancy test role play that allows participants to explore the emotional impact of an unintentional pregnancy. This emphasizes the

rights of young people in decision making regarding their bodies and the short and long term implications of continuing with or ending a pregnancy.[38,39]

Similarly a nonprofit called Ipas, whose efforts focus on health access and rights worldwide, has an educational guide to abortion care for young women. This includes many lessons that focus on topics like gender and abortion, barriers to care including social, financial, stigma, and physical barriers, and ways to make abortion accessible.[41]

These curricula can be implemented into schools and universities to destigmatize abortion, empower women to make informed choices about their bodies, educate youth and young adults on abortion resources, and positively impact maternal health outcomes. I intend to present my abortion presentation to students in the medical field. I plan to address abortion stigma in our culture, access barriers, abortion access effects on maternal health outcomes and telemedicine abortion options. I am interested in presenting to nursing, PA, and or MD students. I am particularly passionate about presenting this information to students aiming to work in rural settings. I believe this information and highlighted resources are significant tools for all future health care workers, as it likely will benefit our future patients.

Conclusion

Access to reproductive health care including safe abortion access is essential for improving maternal health outcomes. Education on abortion resources and access including telemedicine and mailed medication abortion options must be offered in sexual education classes and from health care providers. Further, it is imperative to influence legislation to eradicate racist, misogynist, and classist barriers to safe abortion. Expanding funding for accessibility and education of telehealth mailed medication abortion option is critical in developing the

availability of safe abortion care for all people. Abortion access gives people control of their own bodies and futures which is a basic human right!

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