Reproductive Health Care

American College of Preventive Medicine Position Statement

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

KEY ISSUES:

1. In the United States, a high-income country, rates of unintended pregnancies remain high.
2. Limited access to reproductive health services has a negative impact on the health of women and infants, and has long-term economic and social consequences.
3. Expanding knowledge and limiting misinformation surrounding contraceptive methods and services increases utilization of contraception and decreases the incidence of unintended pregnancy.
4. Increasing access to affordable contraceptive services is cost-saving, reduces disparities, and prevents unintended pregnancy. Existing legislation restricts access to these services and threatens the positive health impacts of contraception.
5. Safe and legal abortion reduces maternal morbidity and mortality, and should be accessible to all women. Cost and legislative barriers to safe abortion disproportionately affect people from vulnerable populations.

Supporting Evidence:

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

According to the World Health Organization, an unintended pregnancy is an unwanted or mistimed pregnancy, occurring for one of three reasons: an unmet need for contraception, a contraceptive failure, or unwanted sex.[1] Worldwide, there are approximately 90 million unintended pregnancies annually.[2] In the United States in 2011, nearly 45% of the almost 6.1 million pregnancies were unintended, and 42% of these ended in abortion [3]. Despite a recent decrease in unintended pregnancies,[3] the United States continues to fall behind other developed countries in the Millennium and Sustainable Development Goals' reproductive health indicators, including maternal mortality rates, unmet need for contraceptives, adolescent birth rates, and unintended pregnancy rates.[2,4–8] One of the overall goals of the U.S. Office of Disease Prevention and Health Promotion's Healthy People 2020 is to "Improve pregnancy planning and spacing, and prevent unintended pregnancy," yet in 2018, the country continues to be below target for most specific metrics.[9] Multiple factors, including low health literacy (both men and women), sexual assault, abuse and reproductive coercion, user error, contraceptive failure, and lack of access to family planning contribute to high rates of unintended pregnancy in the United States.[10–18] The unavailability of family planning services, low provider knowledge, lack of insurance coverage and other financial challenges, and restrictive legislation all play crucial roles in constraining access to safe and effective contraception and abortion care.[19–22]

2. Limited access to reproductive health services has a negative impact on the health of women and infants, and has long-term economic and social consequences.

Prevention of unintended pregnancy has benefits at the individual, family, and societal levels. It is an important step in improving maternal and neonatal morbidity and mortality, and promoting positive child development. Mothers with unintended pregnancies take longer to recognize that

they are pregnant, are more likely to delay or forego prenatal care, and are less likely to make lifestyle changes, such as stopping smoking and discontinuing alcohol consumption.[23–28] When unintended pregnancies are continued, they are more likely to result in preterm birth and low birth weight.[23,29–31] Maternal behaviors also differ with unintended pregnancies, including lower rates of breastfeeding and lower quality maternal-child relationships, compared to intended pregnancies.[23,24,32,33] Children born of unintended pregnancy are more likely to have social-emotional and cognitive development issues resulting in poorer educational and behavioral outcomes.[34–36]

Unintended pregnancy also has an impact on society and development. Women who are not able to choose when to have children are less likely to complete higher levels of education, less active in the workforce, and contribute less to the economy.[37,38] Depriving women and couples of the tools to determine their family size allows household poverty to persist, as they are then not able to plan their resources to adequately educate, clothe, house, and feed existing family members.[39–41]

3. Expanding knowledge and limiting misinformation surrounding about contraceptive methods and services increases utilization of contraception and decreases the incidence of unintended pregnancy.

Many myths surround the use of contraceptives, both among providers[18,42,43] and patients.[44–50] This misinformation, usually about mechanisms of action and side effects, contributes to lower utilization.[51,52] Many factors are associated with knowledge gaps surrounding contraception, including lower educational achievement, adolescent age, nonwhite, single, and

nulliparity.[46,47,49,53] An increase in knowledge and awareness about a method is associated with an increased likelihood of initiation and continuation of that method.[43,44,46,54,55]

Providing patient-centered education at an appropriate literacy level is an important step that providers and public health professionals should take to increase family planning health literacy among patients. Comprehensive sex education programs in schools are another strategy that may decrease rates of unintended pregnancy, though evidence is inconclusive and effect sizes may be small.[56–59] Abstinence-only programs are associated with increased teenage pregnancy and birth rates.[58,60] Education programs should work to engage individuals of all genders and be offered at developmentally-appropriate levels.

Provider training on contraceptive competencies is also essential, as providers must have adequate training to provide counseling and education about the methods, as well as the skills needed to provide the methods themselves.[61,62] Efforts should focus on supporting programs that provide medically accurate and patient-centered information about effective contraception to all communities.

4. Increasing access to affordable contraceptive services is cost saving, reduces disparities, and prevents unintended pregnancy. Existing legislation restricts access to these services and threatens the positive health impacts of contraception.

The unmet need for contraceptives is estimated to cost taxpayers between $9 billion to $16 billion annually, coming from medical care for preventable sexually transmitted infections, cervical dysplasia, and unintended pregnancy (prenatal care, delivery, abortions, and medical care for preterm and low birth weight infants).[63–67] For every $1 spent on family planning

services, it is estimated that $4-8 is saved.[64,67,68] Even interventions as simple as the provision of a one-year supply of contraception have been shown to reduce the rate of unintended pregnancy.[69] Despite the benefits to patients as well as cost savings, 73% of insurers restrict patients to monthly prescriptions.[67]

The benefits of affordable family planning programs have been demonstrated in multiple communities in the last decade. The Colorado Family Planning Initiative (CFPI) was started in 2009[70] and provides no-cost contraception to patients, provider training, and clinic support at clinics which capture 95% of Colorado's population.[71] Funded by the state, the CFPI program's success is evident: it saw a dramatic increase in the number of women who chose long-acting reversible contraception (LARC), which includes implants and IUDs. It also contributed to a 40 percent drop in unintended pregnancies among teens, an increase in age at first birth, and an estimated $66-69 million cost savings.[70] The program primarily benefits women who are lower income, unmarried, and without a high school education.[70]

The Contraceptive Choice Project in St. Louis is a privately funded project that similarly provided women with contraceptive education and no-cost contraception for 2-3 years. The project resulted in high rates of LARC utilization and a significant decrease in pregnancy, birth, and abortion rates.[54] It also demonstrated a decrease in black-white disparities in unintended pregnancy rates.[72] Another government-funded program of this kind is California's Family Planning, Access, Care and Treatment (Family PACT) Program. Started in 1996, Family PACT provides comprehensive family planning services to low income men and women [73]. Studies showed that access to Family PACT decreased adolescent birth rates [74] and revealed a cost

savings of about 5:1.[75] And after passage of the Affordable Care Act (ACA), there was a significant increase in the number of women of reproductive age, especially minorities,[76] who had health insurance coverage and benefited from the contraceptive coverage mandate.

While these privately and publicly funded initiatives demonstrate the societal and individual benefits of reducing barriers to family planning, many obstacles prevent widespread implementation of similar programs. Many states refuse to promote family planning, prioritizing political leverage over public health. The ACA, for instance, is supported by many medical organizations, yet both the overall program and the specific contraceptive coverage mandate are under political attack.[77] Another program under threat is Title X; as the only federal grant program dedicated specifically to providing comprehensive family planning and related preventive health services, Title X clinics are critical in providing care to low-income and underinsured or uninsured individuals.[78] In California, family planning clinics that received Title X funding were more likely to improve the accessibility and quality of services for underserved populations, compared with other state-funded family planning clinics.[79] Yet current changes to the priorities of the Title X program threaten access to evidence-based health care, thereby undermining women's ability to make informed decisions and maintain their reproductive autonomy. These new priorities involve restructuring of Title X's provider network away from family planning clinics; promoting natural family planning over other contraceptive methods; promoting abstinence-only messaging to adolescents; and interfering with individuals' ability obtain confidential care.[80] There are also attempts to exclude Planned Parenthood from federal family planning funds and state Medicaid programs.[77,81,82] These politically motivated legislative restrictions disproportionately affect vulnerable populations, including adolescents, minorities,

and those with lower socioeconomic status and lower educational achievement. Those who are uninsured or underinsured rely on cost-effective programs such as the Title X or private organizations such as Planned Parenthood to provide affordable services.[66]

Though limiting these programs is more likely to impact those without other means to access care, people with private or employer-based insurance are not exempt from restriction: 20 states limit contraceptive access to minors, and many states allow insurers to limit contraceptive coverage.[67] Insurance billing regulations limit contraceptive options in the immediate postpartum period,[83] while other laws allow pharmacists to refuse to dispense contraception.[84] In another example that affects millions of people, many people seek care at religiously affiliated organizations that refuse to provide contraception, including sterilization.[85] Still others are employees at religiously affiliated organizations whose employer-based insurance will not cover these services.[86] Although individually each of these restrictions may seem small, in aggregate these legislative acts greatly impact people's ability to access contraceptives.

Logistic and financial barriers to contraceptive access also further potentiate racial and economic disparities that already exist. For example, black and Latina women and women living under the poverty line are more likely to overestimate the failure rate of condoms, contraceptive pills, and intra-uterine devices.[11] Although the rates of unintended pregnancies are decreasing for all groups, black non-Hispanic and Hispanic women have higher rates of unintended pregnancy compared to white non-Hispanics.[3] Black and Hispanic teenagers ages 15-19 have nearly double the pregnancy rate of their white and non-Hispanic peers.[87,88] And women with incomes below the federal poverty level (regardless of race or ethnicity) are more likely to have an unintended

pregnancy and an abortion than women with incomes above the poverty level.[3,22,89] Ensuring access to clinics that can provide education and low-cost contraceptives is key in bridging these gaps.

Affordable reproductive health services should be universally available – covered by insurance without restrictions or financial burden, as well as through alternative programs for people who are under- and uninsured. Efforts should be made to limit barriers to contraceptive access, including: systemic factors (universal insurance coverage, limitation of restrictive laws, keeping medications on-formulary at pharmacies and clinics, limiting restrictions at religiously-affiliated institutions, allowing over-the-counter access to hormonal contraception); clinic factors (encouraging open-access scheduling, avoiding unnecessary appointments); provider factors (increasing provider training, providing longer refills, avoiding unnecessary steps such a pelvic exam, providing prompt referrals when unable/unwilling to provide the woman's choice of contraception); and patient factors (providing financial assistance, providing evidence-based counseling, providing non-judgmental and patient centered services).[67] Development and distribution of novel contraceptive options for men and women should also be financially and logistically supported.

5. Safe and legal abortion reduces maternal morbidity and mortality, and should be accessible to all women. Cost and legislative barriers to safe abortion disproportionately affect people from vulnerable populations.

Although increased access and utilization of contraception decreases the number of abortions, it does not completely eliminate unintended pregnancies. There are many reasons why a woman

will seek out an abortion, including contraceptive failure, rape, incest, reproductive coercion/abuse, fetal anomalies, and pregnancy complications including maternal medical and psychological comorbidities.[21,90,91] 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."[92] Out of the one in five pregnancies that ends in abortion worldwide, about half of them are unsafe; this amounts to 25 million unsafe abortions per year.[93,94] Unsafe abortions are a leading cause of maternal mortality globally,[93,95,96] contributing to 8-13% of maternal deaths.[93,97,98] Millions more suffer from other complications resulting from unsafe abortion, such as incomplete abortion, post-abortion sepsis, hemorrhage, and genital trauma.[92,95] Nearly all abortion-related morbidity and mortality is preventable: rates of complications are drastically reduced in regions with safe and legal access to care,[92] and conversely, regions with restrictive laws have higher rates of unsafe abortion.[93]

Overwhelming evidence shows that abortion is a safe procedure when performed legally by licensed health care providers,[22,89,96] and is considered an essential health service for women.[92] In developed countries where abortion is safe and legal, the risk of death associated with abortion is far lower than the risk of death from continuing a pregnancy.[99–101] Regions that have decriminalized or legalized abortion have seen dramatic subsequent decreases in maternal morbidity and mortality, including but not limited to Uruguay,[102] South Africa,[103] Nepal,[103] and the United States.[104,105] Worldwide, there is a general trend to liberalize laws and expand access

to safe abortion services,[106,107] with support from human rights and global health organizations including the United Nations [108] and World Health Organization [92]

Despite the proven safety and benefits of having safe accessible abortion care, and despite the technical legality, there are many unnecessary barriers for women who seek abortion care in the United States.[22,109,110] These restrictions intend to limit access to abortion, not increase safety. [89,111] Since 2010, the number of regulatory laws has almost doubled, and affect multiple facets of abortion care, including: provider hospital admitting privileges, prescription limitations for medication abortion, telemedicine restrictions, requirement for clinics to be certified as ambulatory surgical centers, parental or spousal notification laws, waiting periods, and counseling requirements, among others.[19,89,112] These legislative acts, also called "Targeted Restrictions Against Providers" or TRAP laws, are medically unnecessary [89,92] and may even force providers to relay medically inaccurate information to patients.[113,114] Other laws (and attempted laws that were overturned) allow providers to decline to provide care,[84,115] allow providers to withhold information or lie to prevent a women from getting an abortion,[116] and force medically unnecessary procedures including ultrasounds or forced anesthesia.[117,118]

Recent executive actions will also limit women's access to information and referrals. The so-called 'domestic gag rule' would prohibit clinics who receive Title X funding from discussing abortion under almost all conditions. The rule would impact providers' ability to give options counseling and would keep many women from being referred to clinics that provide abortion, even for non-abortion care.[119] Attempts to force clinics to withhold information is not new; the 'global gag rule' (also called the Mexico City Policy) similarly prohibits U.S. funding to any

organization that discusses abortion, even if they do so with non-US funding.[120] Although its intent was targeted at abortion, the effect has been to drastically affect all family planning activities, and has instead increased the rate of both unintended pregnancy and abortion.[94,121]

Laws restricting access to abortion not only pose logistical barriers, but also financial barriers to receiving timely care.[19] Therefore, only women with the financial means to afford an abortion are freely able to exercise their right to it. The Hyde Amendment, first passed in 1976 and amended in 1993, bans the use of federal funds for abortion services, except in cases of pregnancies resulting from rape or incest or those that threaten the mother's life.[122] Most low-income women who rely on Medicaid face this imposed restriction on their insurance coverage, as most states follow the restrictive federal standard rather than use their own funds to provide this coverage. This restriction additionally impacts members of the military, public employees, Native Americans, federal prisoners, and until recently, Peace Corps volunteers, whose lack of coverage had no exceptions.[123–125] These restrictions force women to either find other funding sources for the abortion, thereby delaying a desired abortion and threatening their economic security, or to continue an undesired pregnancy.[21,126–129]

Women who have private insurance or who live in states where Medicaid funding is available to cover costs of abortion are more likely to have an abortion at a lower gestational age, belong to a higher income bracket, and are less likely to report cost as a reason for delaying abortion.[130] Waiting periods and restrictions that limit geographic access to abortion services can result in barriers such as taking more time off work (with loss of associated wages), finding childcare, finding and paying for transportation or lodging near the clinic, and other financial

limitations.[19,21,131] And geographic access is limited: 90% of U.S. counties do not have an abortion provider.[132] These and other restrictions disproportionately impact low-income women, who may not be able to make accommodations, with lifelong consequences. To investigate these consequences, the University of California, San Francisco (UCSF) conducted The Turnaway Study, which assessed the impact of receiving versus being denied abortion services. The study enrolled and interviewed over 400 women who were able to access an abortion, and compared them to over 200 women who were denied abortions from the same facilities.[133] Upon follow-up, they found that women who were refused abortions were less likely to be employed full-time, more likely to rely on social services, more likely to be below the federal poverty level (nearly 4 times as often), and more likely to stay with physically abusive partners.[130,134]

While social, political and economic inequalities contribute to the barriers in accessing reproductive health care services for many different populations, laws and policies like the Hyde Amendment, the domestic and global gag rules, and TRAP laws harm women by restricting their reproductive autonomy, and further perpetuate health disparities.[135] Efforts should be made to limit barriers to access and protect women's legal and human right to an abortion. These efforts may include eliminating unnecessary regulation, providing insurance coverage equal to other related services, public outreach to counter abortion myths, ensuring that women have reasonable geographic and financial access to abortion services, reducing unnecessary delays, supporting new methods to provide services such as telemedicine, training of providers in abortion care, and training of providers in providing non-judgmental and bias-free options counseling.

Conclusion

The ACPM strongly urges state, federal, and non-governmental organizations to make access to reproductive health care a top priority, and welcomes partnerships with other organizations that work to ensure access to reproductive health care. Providing comprehensive, unrestricted access to sexuality education, contraceptives, and safe abortion maintains reproductive autonomy, improves health, reduces disparities, is cost saving, and benefits society overall. All people should have access to accurate information and high-quality contraception and abortion care. Steps needed to improve reproductive health access include, but are not limited to: reducing financial barriers, including the provision of insurance coverage; repealing and preventing legislation that creates unnecessary barriers or interferes with the patient-provider relationship; providing audience-appropriate comprehensive sexuality education programs; creating models of culturally-competent care in collaboration with communities; expanding training programs for physician and non-physician providers; ensuring that all hospitals and clinics provide essential reproductive health services; and advocating for increased services to under-served communities. The ACPM affirms that access to reproductive health is necessary to uphold public health and opposes any restrictions to this access.

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