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March 9, 2022

To: Supervisor Holly J. Mitchell, Chair
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From: Fesia A. Davenport
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REPORT ON PRESERVING REPRODUCTIVE HEALTH ACCESS ON THE ANNIVERSARY OF ROE V. WADE (ITEM NO. 22, AGENDA OF JANUARY 25, 2022)

On January 25, 2022, the Board of Supervisors (Board) unanimously passed a motion by Supervisors Holly J. Mitchell and Sheila Kuehl to ensure women's access to quality reproductive health care services. The Board instructed the Chief Executive Officer, the Directors of the Departments of Health Services (DHS), Public Health (DPH), and County Counsel (CC), in coordination with Planned Parenthood and other reproductive health advocates, to meet and develop written recommendations on how the County of Los Angeles (County) could respond should *Roe v. Wade (Roe)* be overturned.

On February 1, 2022, the Chief Executive Office's (CEO), Women and Girls Initiative (WGI), convened a workgroup of representatives from CC; DPH; DHS; CEO Legislative Affairs and Intergovernmental Relations; Planned Parenthood-Los Angeles; Black Women for Wellness; the University of California, Los Angeles, Law Center for Reproductive Health, Law, and Policy; and Planned Parenthood Affiliates of California (Workgroup) to discuss the best approach to address the five directives in the Board motion. The Workgroup met once more on February 10, 2022, to finalize and confirm the information to be included within this report.

Upon meeting, the Workgroup discussed the complexity and nuance for developing written recommendations on how the County could respond should *Roe* be overturned. There are barriers that are not fully understood, including varying charters and policies

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related to reproductive and sexual health from hospital to hospital, clinic to clinic; challenges in navigating people to proper points of care; and delays due to a lack of providers and services, among other issues. Moreover, new challenges are anticipated as more states tighten abortion laws, and criminalize abortion and those seeking abortion. As a result of these complexities, this Workgroup has settled on a two-phased approach. This 30-day report back is phase one of a two-phased reporting back process.

In phase one, this report includes information regarding monitoring the legislative timeline related to reproductive health care and contains recommendations for each of the Board directives in the areas of budget, enhanced medical training, expansion of the reproductive healthcare workforce, creating a uniform referral system, and opportunities to reduce and address health disparities. The Workgroup identified a strategy for each directive that includes a justification and steps to get closer to the intended outcome. For phase two, the Workgroup is proposing to convene focused workgroups in each directive area to further understand the barriers and opportunities, and to develop strategies and plans to ensure everyone has a right to access a full spectrum of reproductive and sexual health services.

Attached for your review is the phase one report back (Attachment I) prepared by the WGI with input from the full Workgroup for the Board's consideration and action. You will also find the February 2022 publication of the DPH Office of Women's Health, *Abortion as a Public Health Issue: Achieving Access and Equity* (Attachment II). The DPH report is useful to help explain the connection between abortion access and how that access is tied to sexual and reproductive health access, infant and maternal health, and health outcomes more broadly.

Should you have any questions concerning this matter, please contact me or Abbe Land, WGI Executive Director, at (213) 332-4942 or aland@ceo.lacounty.gov.

FAD:JMN:JO
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Attachments

c: Executive Office, Board of Supervisors
County Counsel

REPORT BACK ON PRESERVING REPRODUCTIVE HEALTH ACCESS ON THE ANNIVERSARY OF ROE V. WADE (ITEM NO. 22, AGENDA OF JANUARY 25, 2022)**BACKGROUND**

On January 25, 2022, the Board of Supervisors (Board) unanimously passed a motion by Supervisors Holly J. Mitchell and Sheila Kuehl to ensure women's access to quality reproductive health care services. Specifically, the Board instructed the Chief Executive Officer, the Directors of the Department of Health Services (DHS), Public Health (DPH), and County Counsel (CC), in coordination with Planned Parenthood and other reproductive health advocates, to meet and develop written recommendations on how the County of Los Angeles (County) could respond should *Roe v. Wade* (*Roe*) be overturned. This 30-day report back provides information on the directives from the Board in the areas of budget, enhanced medical training, expansion of the reproductive health care workforce, creating a uniform referral system, and opportunities to reduce and address health disparities.

On February 1, 2022, the Chief Executive Office's (CEO), Women and Girls Initiative (WGI), convened a workgroup of representatives from CC; DPH; DHS; CEO Legislative Affairs and Intergovernmental Relations (CEO-LAIR); Planned Parenthood-Los Angeles (PPLA); Black Women for Wellness; University of California, Los Angeles (UCLA), Law Center for Reproductive Health, Law and Policy; and Planned Parenthood Affiliates of California (Workgroup). The Workgroup met once more on February 10, 2022, to discuss the best approach to address the five directives raised in the motion:

- a. Analysis of any potential County budget impact of State proposals to relax residency requirements to ensure everyone has access to reproductive health care, including abortion services and related social services;
- b. Analyze opportunities to enhance medical training, especially training on how to respond to emergent medical complications related to septic non-hospital abortions;
- c. Analyze opportunities to expand the reproductive health care workforce, including efforts to ensure providers are working at the top of their license;
- d. Analyze opportunities to create uniform referral systems to optimize access to reproductive health services; and
- e. Analyze opportunities to reduce and address health disparities by expanding reproductive and sexual health services, supplies and education, for marginalized communities and those who might be harder to reach, including women who are:
 - i) Unhoused
 - ii) Incarcerated
 - iii) Have substance use disorders
 - iv) Have serious mental health concerns

The County has a long history of supporting access to reproductive health care. By providing services at County-owned clinics and funding community clinics and organizations involved in providing services and education to women and girls, the

County has continually allocated resources and adopted policies that support people's rights to access full reproductive services, including abortion. In the next few months, the Supreme Court will decide a case, *Dobbs v. Jackson Women's Health Clinic*, which seeks to overturn *Roe*. Experts are predicting this Supreme Court will overturn *Roe* or take other action that will eliminate or weaken the constitutional right to abortion and allow states to make it difficult or impossible to access abortion care. It is important to note, even without the Supreme Court deciding the case mentioned above, people currently have limited access to abortion services in 29 states. LA County providers have shared stories of providing services to women from states as far away as Maine.

In September 2021, Governor Newsom and legislators declared their intent for California to be open to out-of-state women seeking access to abortion and issued a proclamation declaring California a Reproductive Freedom State. In so doing, California aims to be a safe haven for people who have determined they need abortion services.

On January 5, 2022, the County's Health and Mental Health Services cluster held a meeting where a panel including representatives for CC, DPH, DHS, and reproductive health advocates discussed the current and potential impact of pending Supreme Court decisions and the State's response. Participants discussed how people coming from other states to the County could lead to increased demand for contraceptives and abortion services at public and private hospitals and clinics, possible delays to care, and increased medical complications and morbidity.

OVERVIEW: LA COUNTY'S ROLE AS A REPRODUCTIVE RIGHTS SAFE-HAVEN

The Workgroup discussed the challenges and opportunities for expanding and improving the system of sexual and reproductive health care for women in the County. The idea of the County serving as an abortion safe-haven and a model for other regions, counties, and cities that seek to improve health outcomes and advance health equity through the development of a pilot program was suggested by the Workgroup. The intention for this proposed pilot program is to use the directives in the motion as focal areas to cohesively integrate the work and serve as a basis to share best practices with other jurisdictions.

This Workgroup would like to highlight the connection between abortion access and how that access is tied to sexual and reproductive health care access, infant and maternal health, and health outcomes more broadly, including physical and mental health and social and economic stability and well-being, more fully explained in the February 2022 publication of the DPH Office of Women's Health, *Abortion as a Public Health Issue: Achieving Access and Equity* (Attachment II). Sexual and reproductive health access for marginalized and harder to reach communities, such as those who are unhoused, incarcerated, have substance use disorders and/or serious mental health concerns, require a dedicated focus. Concerted efforts are needed to address barriers to adequate sexual and reproductive health care among marginalized populations, including legal impediments, lack of enabling services (e.g., transportation, case management, navigation), and access to information about benefits and services. To ensure that the targeted communities are benefiting from services and yield the desired outcomes,

ongoing evaluation, measurement, and data capture, both qualitative and quantitative, must be built in at the onset of these efforts.

Lastly, this Workgroup anticipates increased hostility, physical safety issues, privacy and confidentiality concerns, and criminalization in various regions, which could impact persons traveling to LA County to seek services. These are complex issues alone; combined, they require great minds and multiple disciplines to work together to solve these long-standing issues, tackle the emerging problems, and help increase access.

RECOMMENDATIONS

Strategies to resolve these issues will not realistically be fully developed within this 30-day report back period. Rather, they will require the convening of all the right stakeholders to conduct a thorough analysis of the barriers, opportunities, landscape, and a holistic look at the system of care. To complete this task, this Workgroup is recommending using the next 90 days to divide into sub-workgroups by the directives contained within this report, and report back to the Board with a more detailed analysis and recommendations for next steps.

This report back includes the recommendations for phase one of a two-phased approach. In this report back, the Workgroup has begun the work to flesh out what next steps to take, which sub-workgroups to form and the member composition in many instances, items to be discussed, and the legislative timeline. Phase two will be a comprehensive report back to the Board and will contain the budget impacts, a plan to enhance medical training and expand the health care workforce, the initial steps to implement a more integrated internal uniform referral system, recommendations on how to reduce and address health disparities for marginalized communities, and an analysis of barriers and strategies to address any obstacles identified by the analysis.

The recommendations below, provided by the Workgroup, outline actions that should be taken to enable the County and its partners to provide the full array of sexual and reproductive health services, including abortion, to all County residents who need them, and that the County continues to lead in its commitment of protecting reproductive rights for all who come to the County for these services:

Budget

Recommendation: The CEO-LAIR Branch will support proposals that ensure continued and expanded access to reproductive health care. CEO-LAIR will also coordinate with WGI and CEO Budget, to review, analyze, and recommend advocacy positions on State funding requests to relax residency requirements to ensure everyone has access to reproductive health care, including abortion and related social services.

Strategy: CEO-LAIR, in collaboration with WGI, CEO Budget, and other relevant impacted Departments, will monitor proposals and provide updated information on the

impact to the County as proposals are identified. CEO-LAIR will support the relevant proposals throughout the State legislative process, consistent with existing Board approved policies, to: 1) expand access to and provide funding for a full range of prevention and treatment services for all women, including removing barriers to access; and 2) expand or protect an individual's right to access a full spectrum of sexual and reproductive health care, including advocating for dedicated State funding for a local pilot project.

Justification: To operationalize a pilot project and to support innovative approaches and patient-centered collaborations to safeguard patient access to abortions, regardless of residency, dedicated State funding could be used to:

- Prioritize County efforts to advance and improve health outcomes, including through access to comprehensive sexual and reproductive health services;
- Streamline and secure infrastructure (including, but not limited to, equipment, i.e., ultrasounds, security apparatuses and personnel, etc.);
- Coordinate care and other patient support services, such as behavioral health services;
- Provide access to tools to empower patients to overcome barriers to care;
- Provide medically accurate education and training tools specific to community needs within the County;
- Provide training to providers and health care workers; and
- Counter mis/disinformation campaigns and provide medically accurate information to health care providers and patients.

Training

Recommendation: *Convene a workgroup led by PPLA, with support from DPH, DHS, Department of Mental Health (DMH), and other reproductive and sexual health organizational advocates, to address current and urgent needs related to medical training, countering misinformation and disinformation campaigns, developing comprehensive sex and reproductive health education for targeted/relevant health care workers, and strategies to support an overburdened workforce.*

Strategy: We recommend the training workgroup develop a plan to address opportunities to enhance medical training, especially training on how to respond to abortion side effects and emergent complications. The plan would also include comprehensive sex and reproductive health education for targeted/relevant health care workers and recommending services and programs to support an overburdened health care workforce that is still grappling with the COVID-19 pandemic.

Additionally, the plan will include strategies to destigmatize abortion, identifying it as a common pregnancy outcome, and counter intentional mis/disinformation campaigns led by anti-abortion entities. Education of the workforce will aim to elevate health care workers' basic literacy on sexual and reproductive health and its intersection with other health issues like infant and maternal mortality, intimate partner violence, and/or

reproductive coercion. Health care workers in specific roles will learn how to comfortably talk to patients about their pregnancy options.

Notably, while in a post-*Roe* situation, some patients may use instrumentation or other potentially harmful ways to end their pregnancies, the “septic abortions” that were common in the decades before *Roe* are less likely to be prevalent in the 21st Century United States. Rather, training for frontline health care workers will expand their familiarity with medication abortion, which is typically used under clinical guidance but may be used by an increasing number of people to “self-manage” their abortion following a weakening or overturning of *Roe*.

Justification: Identifying and bringing the right voices to the table is of paramount importance to ensure a comprehensive plan that incorporates the needs of the whole reproductive health care community, including first responders, licensed providers, mental health professionals, doulas, promotoras, hospital partners, and transportation providers (if needed). This plan will identify partners, prioritize goals and outcomes, and identify training modalities and/or courses for health care, health educators, and ancillary staff.

Workforce

Recommendation: Convene a workgroup co-led by DHS and DPH and includes PPLA, to explore avenues and recommend ways to expand the reproductive health care workforce and ensure providers are working at the top of their license.

Strategy: The workforce workgroup should look for ways to support and broaden an overburdened workforce by making recommendations for establishing pathways to train out-of-state providers, and partnerships with academic medical programs and institutions. The workgroup should seek partnerships and develop strategies to expand the overall health care provider network pool, retain the current workforce, and ensure providers are working at the top of their license. In addition, the workgroup should suggest ways to improve the education pipeline for physicians, nurse practitioners, certified nurse-midwives, physician assistants, and others in health care professions with diverse and/or rural backgrounds dedicated to providing abortion care in underserved areas in California. This workgroup should articulate barriers and potential strategies to optimize loan repayment to increase retention and recruitment of clinicians and identify sources of financial support for programs that support abortion training. This workgroup should develop an overall strategy for how to apply these recommendations.

Justification: To provide timely care to California patients and absorb a significant portion of the anticipated increase in out-of-state patients should *Roe* be overturned, California must take steps now to ensure the growth and retention of a network of clinicians trained in abortion and sexual and reproductive health care. These clinicians must reflect California’s diverse racial, ethnic, and linguistic communities and patients and be equipped to meet the reproductive health needs of all people in California. By working with top grade academic medical programs in Los Angeles, the County has a unique

opportunity to create visiting programs and residencies that will quickly increase the number of providers in LA County, while addressing the long-term impacts of closures of such training in states across the country.

Uniform Referral System

Recommendation: DHS to convene a workgroup of public and private health care providers to describe the current state of service availability; articulate a shared vision of what is possible for care optimization; and propose mechanisms to streamline the navigation of patients to the proper points of care given existing resources and priorities.

Strategy: The current system of care is varied and nuanced, with providers and hospitals having individualized charters and policies. First, understanding the landscape and the current state of the health care referral system will allow the workgroup to identify barriers to services and reveal opportunities for network mapping and for patients to present to any “door” for a clinical service on the spectrum of sexual and reproductive health care and have seamless navigation to timely access for the desired service. The plan should also explore mechanisms to allow patients to understand, in advance of seeking services at a “wrong door,” that some health care systems (particularly faith-based systems) do not provide access to, or even referrals for, the full spectrum of sexual and reproductive health care, including abortion and some forms of contraception.

The accomplishment of this objective would include the engagement of: 1) Ambulatory care providers, community clinics, Health Services and Public Health providers, and private providers of sexual and reproductive health services, abortion and post-abortion care; 2) Inpatient providers, public and private hospitals and surgical centers with multidisciplinary care teams who can provide care for medically complex clients; and 3) Emergency providers, Emergency Response System and their network of Emergency Department partners.

The plan should also include steps for developing a guide for accessing benefits and insurance to cover care and services. This guide should be fully integrated with services and referrals from multiple entry points, list resources, and contain strategies for in-state and out-of-state patients to access services confidentially and safely.

We recommend this workgroup articulate a phased approach in consideration of a uniform referral system, or other mechanisms for streamlining care delivery. This workgroup should provide a detailed plan that outlines the intention for each phase of the plan, anticipated outcomes, and next steps. This plan should identify the barriers, the current state, and the action plan to address findings.

Justification: Patients should not be unduly burdened with the nuances of understanding the networks of care. The proposed *no wrong door* approach¹ would require broad engagement of the private and public sector; organization of resources to optimize capacity; and finally, the potential for implementation of both provider-facing and client-facing navigation tools. This is a complex endeavor which would require a phased approach. The County is well poised to integrate the efforts of these diverse partners to meet the growing needs of our community and those who travel here for services, but overcoming the current fragmentation will take great intention and focus. With broad engagement, a phased implementation, and a strategic approach, these efforts can realize significant improvements in access, quality, and timeliness of care.

Addressing Health Disparities

Recommendation: *DPH to convene a workgroup comprised of DHS; DMH; the Women’s Health Equity Coalition; the LA County Gender Responsive Advisory Committee; UCLA Law Center for Reproductive Health, Law, and Policy; and the CEO Homeless Initiative, to review and analyze reproductive and sexual health disparities in marginalized communities and for those who might be harder to reach, including women who are unhoused, incarcerated, and those with substance use disorders, or serious mental health concerns.*

Strategy: This workgroup should develop a plan to determine ways to increase access and information to marginalized communities, specifically focused on women who are unhoused, incarcerated, have serious mental health concerns, and/or have substance use disorders. The plan should contain strategies for increasing awareness of accessible benefits and insurance and include ways to quantify the increase in access to culturally competent reproductive health services. This workgroup should establish various sets of metrics to measure progress in increases in care, provider services, access to benefits and insurance, and qualitative experiences. The workgroup should partner with legal entities that provide low cost and pro bono legal services to assist low-income patients in navigating the hostile legal landscape that includes criminalization, privacy concerns, and confidentiality. The plan should include marketing strategies and the use of trusted messengers to reach and educate these populations, and an action plan to roll out each area of the plan.

Justification: Abortion access and outcomes are inherently tied to sexual and reproductive health access, including infant and maternal health, and health outcomes more broadly, including physical health, mental health, and social and economic stability and well-being. Sexual and reproductive health information, education, and care access are tied to maternal and infant mortality outcomes and Sexually Transmitted Infection rates, treatment, and prevention. By addressing issues related to access to services, information, benefits, insurance, and free legal assistance, this workgroup can find ways to address and reduce health disparities for people who have traditionally been hard to

¹ <https://papers.governing.com/No-Wrong-Door-A-Holistic-Approach-to-Human-Services-73108.html> (Accessed Feb 5, 2022)

reach, and in places and settings that have not traditionally focused on or funded reproductive health services for these populations.

LEGISLATIVE TIMELINE

CEO-LAIR, in collaboration with the WGI, CEO Budget, and other relevant impacted departments, will continually monitor legislation and the budget process to ensure the County's priorities are being met. Several bills have been introduced to advance the Governor's proclamation of California as a Reproductive Freedom State. The legislature will not consider Governor Gavin Newsom's Proposed Budget until the June deadlines and must approve the Budget bill by June 15, 2022. The bill will become law as soon as it is signed by the Governor between June 15 and July 1, 2022.

Monitoring these developments over the next few months will be a key function of CEO-LAIR, in collaboration with the WGI, CEO Budget, and other relevant impacted departments. The last day for the State legislators to introduce new legislation was February 18, 2022. The last day for any bill to be passed through the legislature is August 31, 2022. Governor Newsom will have until September 30, 2022, to sign or veto bills.

The Supreme Court of the United States can issue a decision on cases they are reviewing at any time, but they are traditionally announced in early summer. Over the next 90 days, as findings and directives emerge from the workgroups recommended in this report, a more refined legislative timeline will be developed that addresses federal and State opportunities.

CONCLUSION

The Workgroup will continue efforts to monitor developments related to sexual and reproductive health care in the coming months and will collaborate on the following:

- CC will monitor developments to *Roe*;
- CEO-LAIR will monitor policy proposals; and
- CEO-LAIR will monitor and coordinate with the WGI and CEO Budget to review, analyze, and recommend advocacy positions on State funding requests. The WGI, DHS, DPH, in partnership with reproductive rights activists, will advocate for funding to assure that LA County is able to provide premier reproductive health care to all within the County and to those around the County seeking our assistance.

In the next 90 days, the Workgroup will divide into the directive areas listed above and begin phase two of the work. These focused workgroups will convene and develop the strategies and plans necessary to ensure greater access for marginalized and harder to reach communities, find ways to keep providers and patients safe, and ensure that everyone who needs it has a right to access a full spectrum of reproductive and sexual health services. However, to accomplish these complex goals requires funding at the

State level. As new details on the State budget emerge in the coming months, this Workgroup will look for ways to link the directives in this report to the overall funding for this initiative.



Abortion is a Public Health Issue: Achieving Access and Equity

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Introduction

Access to the full spectrum of sexual and reproductive health care, including abortion, is fundamental to the health of individuals, families, and communities. People’s ability to reliably control if and when to bear children was one of the most significant public health achievements of the 20th century.¹ However, these gains are now threatened in the United States, with state laws dismantling more than a half century of protections that have provided pregnant people significant autonomy over their reproductive decisions. In recent weeks, the Supreme Court has twice let stand a Texas law that essentially bans all abortion after 6 weeks of pregnancy, denying Texas residents a right that has been constitutionally protected for nearly 50 years. This law and similar regressive policy changes threaten all childbearing individuals and their families, but disproportionately impact people of color, younger people, those with lower incomes, as well as two-spirit, lesbian, bisexual, queer, transgender, gender non-conforming, and intersex people (2SLGBQ-TGI).²³

In the U.S., unsafe, illegal abortion accounted for 17% of maternal deaths as recently as 1965.⁴ Poor women, women of color, and their families were disproportionately impacted by illness and death related to illegal abortion, because White, middle class and upper-class women were able to access safer abortion options. As states began to liberalize their abortion laws and allow people to legally terminate their pregnancies, maternal and infant mortality declined dramatically.^{5,6,7}

Currently in the U.S., giving birth is connected to more serious health problems than having an abortion and is approximately 14 times more likely to result in death.⁸ The greatest threat related to abortion and maternal and child health in the U.S. is *declining access to abortion care*. When access to abortion is denied through state or federal law or court decisions, the consequences are enduring and harmful. Unfortunately, despite decades of evidence supporting the role of legal, safe, accessible abortion in protecting health, we now face a future in which abortion may again be illegal in most U.S. states.

In this report, the Los Angeles County Department of Public Health explores why abortion is a critical public health issue. Through the lenses of history, equity, health outcomes, and policy change, we review the importance of access to abortion services in achieving health, well-being, and equity.

History

Women have developed and used abortifacients, agents that cause abortion, since ancient times.⁹ Throughout human history, across diverse cultures, and regardless of whether abortion is illegal or legal, people have attempted to decide for themselves if and when to bring children into the world. The cyclic human experiences of war and peace, famine and feast, and strife and joy invariably create personal and societal conditions that lead some people to decide that carrying their pregnancies to term would cause difficulty or harm to them or their family, including their existing children.

There is evidence that as early as the 1600s, Indigenous and colonial women in America ingested abortifacient teas and pastes and conducted abortion using manual instruments.^{10,11} Abortion did not become controversial in the U.S. until the 1800's, when states began regulating who could provide pregnancy-related care, including abortion, particularly after "quickening," the onset of fetal movement. Laws regulating abortion and maternity care served to empower White, male physicians, while disenfranchising female midwives, notably including Black midwives, who throughout two centuries of slavery had continued the traditional African practices of serving their communities as healers and spiritual leaders.¹² The American Medical Association, founded in 1847, increasingly sought to control maternity care practice by criminalizing others who provided abortion and arguing that abortion was immoral and dangerous. States laws that criminalized abortion were also motivated by racism, fearing that newly arriving immigrants, whose birth rates were higher than those of the resident White Anglo-Saxon population, would become dominant if White Americans could choose to abort.^{10, 13} For example, Leslie Reagan reports in her history of criminalized abortion in the U.S that Dr. Horatio Storer,

a founder of the specialty of gynecology and leader of the medical campaign against abortion:

*"...envisioned the spread of 'civilization' west and south by native-born white Americans, not Mexicans, Chinese, Blacks, Indians, or Catholics. 'Shall' these regions, he asked, 'be filled by our own children or by those of aliens? This is a question our women must answer; upon their loins depends the future destiny of the nation.' Hostility to immigrants, Catholics, and people of color fueled this campaign to criminalize abortion. White male patriotism demanded that maternity be enforced among white Protestant women."*¹⁴

The resulting patchwork of state laws resulted in abortion becoming more difficult, dangerous, and expensive to obtain for a century. **A striking indicator of the prevalence of illegal abortion was the death toll.** Abortion was listed as the official cause of death for almost 2,700 women in 1930, comprising approximately 18% of maternal deaths recorded in that year.⁴ While the number of deaths due to illegal abortion had fallen to under 200 by 1965, illegal abortion still accounted for 17% of all deaths associated with pregnancy and childbirth that year.⁴ These numbers represent abortion deaths that were officially reported; the illegal status of abortion at the time means that actual numbers were most likely much higher.⁴ Estimates of the number of illegal abortions performed in the U.S. during the 1950s and 1960s range from 200,000 to 1.2 million each year.¹⁵ Abortion remained a major cause of maternal death until states started liberalizing their laws in the late 1960's.¹⁶

Poor women, women of color, and their families were disproportionately dependent on and harmed by illegal abortions. Laws making abortion illegal did not prevent people from ending their pregnancies, or trying to, but rather forced them to turn to the remedies and practitioners available to them, which were often unsafe or unscrupulous. Data collected from New York City in the early 1960's demonstrated the stark disparities, with one in four childbirth-related deaths among White women linked to abortion compared to one in two childbirth-related deaths among "non-White and Puerto Rican" women.¹⁷ Even when abortion became legal in some states in the early 1970s, women of color were disproportionately affected, with the Centers for Disease Control and Prevention (CDC) estimating that "130,000 women

obtained illegal or self-induced procedures, 39 of whom died” in 1972 alone. In fact, from 1972-74, the illegal abortion mortality rate for non-White women was 12 times that for White women.⁴

When abortion was illegal in the U.S., women of financial means generally were able to obtain abortion by finding private doctors they could pay to perform the procedure or by traveling to other countries.¹⁴ Poor women and women of color experienced a disproportionate burden of suffering and death due to unsanitary abortions provided illegally, often by unscrupulous and unqualified practitioners, and by attempts to abort themselves with the use of poisons and coarse instruments like coat hangers.¹⁸

The widespread harm to women’s health, and the growing women’s movement that called attention to it, led to the liberalization of abortion law in 11 states, including California, by 1969. The California Therapeutic Abortion Act, passed in 1967, allowed for abortion when pregnancy posed a substantial risk to the physical or mental health of the mother or when pregnancy resulted from rape or incest.¹⁹ The law, however, required those seeking abortion to receive approval from hospital therapeutic abortion committees that required at least two physicians to approve pregnancy termination. This requirement favored White women with financial means who were most able to find sympathetic doctor gatekeepers; it often overlooked the needs of poor women and women of color.

In 1970, the right to abortion was formally recognized as a public health concern by the American Public Health Association. In 1973, the U.S. Supreme Court handed down the *Jane Roe v. Henry Wade* decision, which legalized abortion at the federal level and invalidated all state abortion bans (many of which remain on the books and will go into effect if *Roe v. Wade* is overturned). The majority argument in the *Roe v. Wade* decision established that a woman’s right to terminate a pregnancy by abortion falls under the right to personal privacy implicit in the Bill of Rights and the Fourteenth Amendment of the Constitution. The *Roe v. Wade* decision rejected the argument made by Henry Wade, the Texas Attorney General, that a fetus is a person.

Half a century later, the political stakes around abortion remain high.²⁰ As recently as 2020, 11 states tried unsuccessfully to restrict access by classifying abortions as “non-essential” care and therefore off limits to pregnant people while health care providers confronted the COVID-19 surge.²¹ (In California, abortion services remained available.²²) Nonetheless, abortion continues to be one of the most common, most effective, and safest medical procedures performed in the U.S.



In 1974, within 18 months of the Roe v. Wade Decision, Ruth Roemer, JD from the UCLA School of Public Health wrote in the American Journal of Public Health:

The right to choose abortion is in serious jeopardy.

In the short time since abortion has been legalized, impressive gains have been achieved by shifting abortion from the illegal sector to legitimate medical service. Significant reductions in maternal mortality, improvements in maternal health, lowered perinatal mortality rates, and decreases in high risk...births...have already been demonstrated. One might have thought, therefore, that the matter of abortion and the law was settled for all time. Unfortunately, however, a small but vocal minority, with strong financial backing, has once again set itself to attempt to deprive women of the right to choose abortion....

If we want to protect the lives and health of generations of women now and in the future, then we must say to our Senators and Congressmen in the most effective way we know: Preserve the Right to Choose Abortion Established by the Highest Court in the Land.

Roemer R. The right to choose abortion. Am J Pub Health. 1974; 64(8):821-823.

Abortion Today

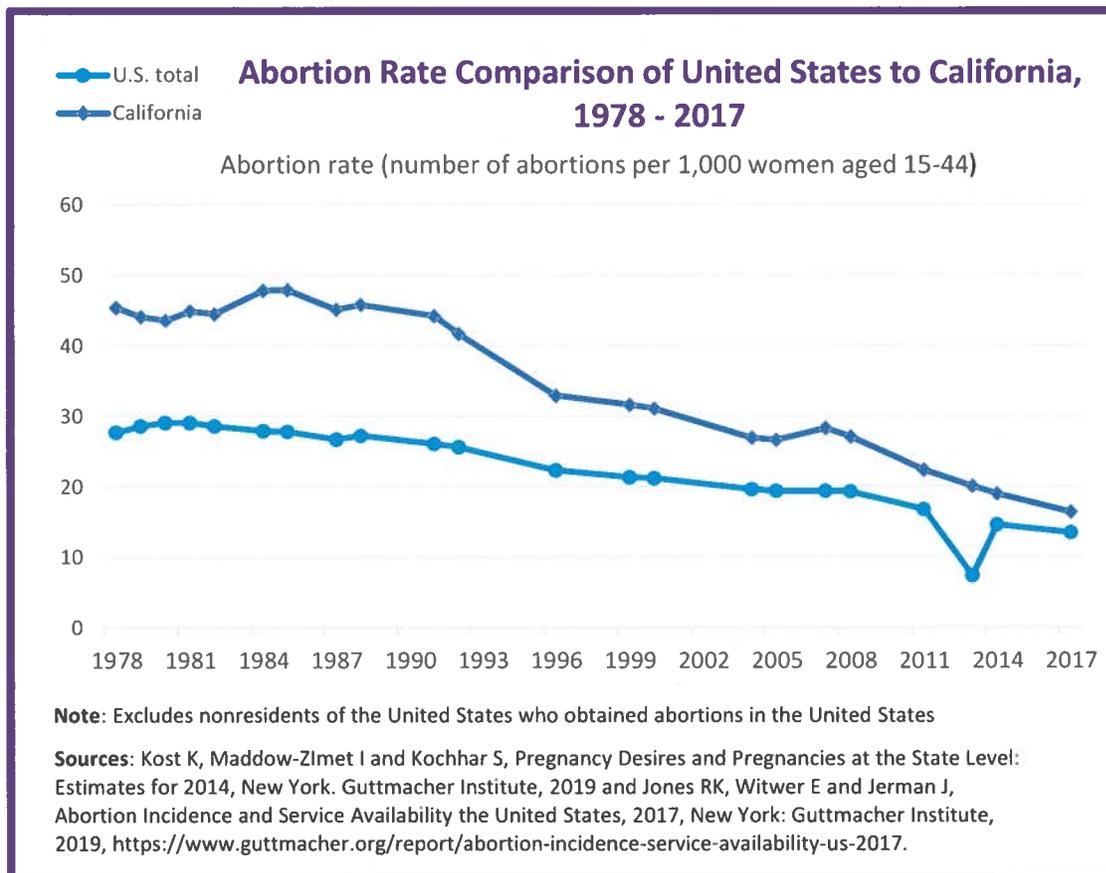
Several methods— medication, aspiration, dilation and evacuation (D&E), and induction—are used to perform abortion depending on the length of the pregnancy, patient preference, provider skill, need and desire for sedation, costs, clinical setting, and state policies and regulations.²³ Abortion is common among Americans. **By age 45, nearly 1 in 4 women will have terminated a pregnancy.²⁴ In 2017, approximately 18% of all pregnancies ended in abortion,** with 66% occurring by eight weeks of gestation and 88% by 12 weeks.²⁴ Overall, around 2-3% of patients experience any complication, confirming that abortion is one of the safest medical procedures performed in the U.S.^{25,26,27} A person's risk of complications from removal of wisdom teeth, for example, is twice as high, and the risk for complications from childbirth is 14 times greater.^{28,29} The death rate for women from abortion in the U.S. is 0.6 per 100,000 women, compared to 8.8 deaths per 100,000 women who deliver live infants.²⁹ Most Americans vastly underestimate the safety of abortion.³⁰

Despite its demonstrated safety record, abortion is extensively regulated in many states, with restrictions on patients and providers that do not exist in any other area of medicine. These restrictions, described later in the report, pose risk of significant harm.

Abortion Rates, U.S. and California

Abortion rates have been declining since 1992, both throughout the U.S. and in California (Figure 1).

Figure 1: Trends in Abortion Rates: California and United States



Research suggests that these declines in abortion reflect improved contraceptive use and/or use of more efficient methods.^{24,31,32,33} Other potential causes of declining U.S. abortion rates include reduced fertility, reduced sexual intercourse, and changes in fertility preferences.³⁴ However, increased restrictions on access are likely also impacting rates of abortion in parts of the U.S.^{35,36,37}

Abortions in California comprise 17% of all abortions in the U.S.,²⁴ while the state comprises 12% of the U.S. population.³⁸ In 2014, Los Angeles County accounted for 36% of all induced abortions in California and 28% of the state's population.^{39,40,41} The disproportionate prevalence of abortion in California and in Los Angeles County, in particular, likely reflects **better access to abortion in California** than in other states and other parts of this state, and that nonresidents come to these locations for abortions they cannot access in their home state or county.

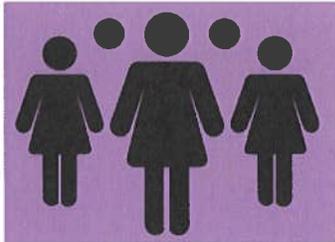
Abortion and Health Equity

Abortion services are part of the spectrum of sexual and reproductive health services that people may need throughout their life span. Sexual and reproductive health is defined by the World Health Organization as:

“A state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so...Every individual has the right to make their own choices about their sexual and reproductive health.”⁴²

To achieve and maintain sexual and reproductive health, people need freedom from sexual coercion as well as access to accurate information and comprehensive, quality health services for contraception, abortion, gender affirmation, and sexually transmitted disease prevention, testing and treatment. Full sexual and reproductive health also entails access to pregnancy-related support and care ranging from preconception, prenatal, and miscarriage services to labor and delivery, postpartum, and interconception care. **In the U.S., the opportunity to obtain these services, including abortion, often varies by race/ethnicity, income, educational attainment, health insurance coverage, immigration status, disability status, age, geographic location, sexual orientation, and gender identity, creating persistent inequities.**^{43,44,45,46,47,48,49} The overlap among these and other markers of difference strongly influence people’s sexual and reproductive health experiences and outcomes.⁵⁰

Of people having abortions in the US in 2014:⁵¹



- 61% were between the ages of 20 and 29.
- 39% identified as White, 28% as Black and 25% as Hispanic.
- 75% were considered poor or low-income.
- 62% percent claimed a religious affiliation, while 38% claimed no religious affiliation.
 - Of those religiously affiliated, 30% identified as Protestant (13% Evangelical Protestant), 24% as Catholic, and 8% as another religion.

These statistics highlight the importance of abortion across demographic groups. Nonetheless, low-income women disproportionately utilize abortion services compared to higher income women. Low income women are far more vulnerable to crises, such as the loss of a job or home, the breakup of a marriage under financial pressure, or the onset of injury or illness in the family that may drive them to abort an otherwise wanted pregnancy.

Black and Latinx women also disproportionately use abortion. In 2014, the U.S. abortion rate for non-Hispanic Black women was 27 per 1000 women of reproductive age, compared to 18 per 1000 for Latinx women and 10 per 1000 for non-Hispanic White women.¹³ These data reflect social and economic inequities, as described

above, because women of color in general have fewer resources than their White counterparts. Importantly, abortion data also reflect rates of unintended (mistimed or unwanted) pregnancies in these populations.

In Los Angeles County in 2016, despite reductions in the rate of unintended pregnancy during the last decade, 52% of Latinx and 56% of Black women reported that their pregnancies were unintended, compared to 30% of Asian women and 24% of White women.⁵² These data reflect **complex health and social factors, including racial discrimination, geography, increased levels of stress, poor living and working conditions, transportation access, decreased access to health care, and public disinvestment in health facilities.**⁵³ Additionally, health, social and financial factors may influence a person's answer to question about intendedness. A pregnancy, even when not explicitly planned, may be characterized as intended by people who have the time and money required for child-rearing.

The social conditions that place some people at elevated risk of unintended pregnancy can also make it difficult for those people to access abortion, even in places like Los Angeles where clinical services are widely available. **For women of color, low income women, young women, and immigrants, barriers may include experiences of racism, discrimination, stigma, and marginalization in interactions with the health care system; limited English proficiency; uncertainty about what the steps are for obtaining and paying for abortion services; lack of reproductive health knowledge; and strict federal immigration enforcement.**^{53,54,55,56} **Transgender and non-binary individuals who seek abortion services may also face barriers to care** including economic hardship, discrimination, and stigma; the gender exclusivity of sexual and reproductive health care language and environments; and lack of provider understanding about the reproductive health care needs of transgender and non-binary people.^{57,58} Finally, people facing physical or psychological restrictions of their freedom of movement, including those experiencing **intimate partner/domestic violence or human trafficking**, may struggle to access needed sexual and reproductive health services.^{59,60,61}

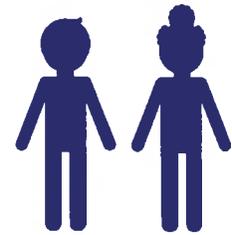
Impact of Abortion Restrictions on Social Determinants of Health

An innovative recent study demonstrated how inequities in abortion access can perpetuate social and economic inequities. **The Turnaway Study** followed nearly 1000 women across the U.S. who sought abortion, including some who presented for care just under the state-defined gestational limits in effect at the clinic at which they sought care, and some who were up to 3 weeks past the clinics' gestational age limits and were immediately turned away. The study found that restricting people's ability to obtain abortions is associated with worsening of already precarious living conditions for vulnerable women.⁶²

- Women who were turned away and went on to give birth experienced an increase in household poverty lasting at least four years relative to those who received an abortion.⁶³
- Among women with existing children at the time they sought abortion, four years later the existing children of those who were turned away were 3.7x

more likely to live in poverty compared to the children than women who received an abortion.⁶⁴

- Years after an abortion denial, women were more likely not to have enough money to cover basic living expenses like food, housing and transportation.⁴⁸
- Being denied an abortion was associated with lowered credit scores, increased debt, and increased number of negative public financial records, such as bankruptcies and evictions.⁶⁵
- Women turned away from getting an abortion were more likely to stay in contact with a violent partner.⁶⁶
- The financial wellbeing and development of children was negatively impacted when their mothers were denied abortion.^{67,68}



Depriving women of the chance to determine if and when pregnancy is feasible for them results in significant economic and social consequences, perpetuating poverty for many women and their families. Poverty in turn is a key predictor of disease, disorder, injury, and mortality, all key indicators of overall public health.⁶⁹

At the societal level, evidence also shows that **states that have passed multiple abortion restrictions have fewer social supports for women's and children's well-being**, compared to states with fewer restrictions on abortion, and that **states with more abortion restrictions have worse women's and children's health outcomes**.⁷⁰ Thus, restrictions on abortion often interact with restriction on social investment, contributing jointly to health inequities in the U.S.

Impact of Abortion Restrictions on Health Outcomes

Data demonstrate that **restrictive abortion laws are harmful to women's health**. Current policies in the U.S. that restrict access often result in women having abortions later in gestation, when the procedure may be more complicated to perform, though still safer than childbirth. In some instances, restrictions force women to carry an undesired pregnancy to childbirth. Historically, in countries where abortion is illegal or inaccessible, the abortion rate has been equal to the rate in countries where abortion is legal— but **where abortion is illegal, women resort to unsafe abortion, which leads to a range of health complications and death**.^{71,72} Worldwide, over **7 million women are admitted to hospitals** every year due to complications that arise from having unsafe and illegal abortions and **up to 31,000 women die**.^{73,74}

In the U.S., research has shown that **women who are denied an abortion** because of state gestational age restrictions experience significantly **more life-threatening conditions in the short term** than those who terminate their pregnancy as requested. These conditions include preeclampsia and other serious pregnancy-related complications.⁷⁵ Women denied abortions are more likely to experience **violence** from the

man involved in the pregnancy during the subsequent 2.5 years than are women who obtain abortions.⁶⁶ Longer term, data suggest that women turned away from abortion care who give birth experience higher rates of **chronic headaches/migraine and joint pain**, and are more likely to report their own **health status as “fair or poor”** 5 years later compared to those who receive a requested first or second trimester abortion.⁷⁶

Abortion **does not increase women’s risk of experiencing symptoms of stress, depression, suicidal ideation, post-traumatic stress, or anxiety.**⁷⁷ A 2015 national study that tracked 667 women for three years after their abortions found that at all time points, 95% of women felt that terminating their pregnancy was the right decision for them.⁷⁸ Another recent study tracked women for five years after their abortions and found no evidence of mental harm from receiving an abortion.⁷⁹ Furthermore, this study showed that women who want and have access to abortion are better able to maintain a positive future outlook and achieve their life plans than those who seek but are denied the procedure due to state restrictions.⁸⁰ Meanwhile, a comparison of outcomes of children born following abortion denial found **worse maternal bonding among children born following abortion denial** compared to children later born to women who received an abortion.⁸¹

Abortion and Maternal and Child Health

The importance of abortion to maternal and child health was profoundly demonstrated **after New York State legalized abortion** up to 24 weeks gestational age in April 1970. Health department officials observed a **37% decline in the maternal mortality rate** by the end of 1971.⁸² Other research published after *Roe vs. Wade* demonstrated that **legalized abortion reduced infant mortality.**^{83,84} One study found that the primary mechanism for declines in infant mortality among White women was a reduction of births to “young and old” women. Among Black women, the ages of women giving birth remained the same, but abortion reduced the number of pre-term deliveries.⁸⁵ * **The importance of abortion continues to be especially pronounced in relation to the health of Black women and children in the U.S.**



Black women contend every day with multiple, layered health inequities driven by systemic and structural racism, and generations of discrimination and reproductive control by the medical community.^{86,87,88,89,90} The same stressors that contribute to Black women’s need for abortion services also make it more difficult for them to access abortion. As noted by the National Partnership for Women and Families, National Partnership for Women and Families, Black women disproportionately face geographic, transportation, infrastructure, and economic barriers to obtaining abortion care, and are more likely to be harmed by federal and state abortion bans.⁹¹

The creation of medically inappropriate barriers to abortion care, especially in the context of systemic barriers to quality of care overall for Black women, deepen inequities in maternal and child health. Black women experience pregnancy-related death at 3 times the rate of White women in the U.S., and over twice the risk of experiencing an infant’s death during the first year of life.^{92,93,94} Disparities in Los Angeles County

*This study also presciently noted in 1987 that, “...if the United States is to sustain the rate of decline in early infant deaths that it has enjoyed over the past 20 years, greater emphasis must be placed on lowering the incidence of prematurity.”

mirror national patterns. In 2019, Black women in Los Angeles County were about two times more likely to die as a result of pregnancy and delivery or postpartum complications than people of other races, while that same year, infants of Black mothers faced over four times the risk of death during their first year of life compared to babies in the County overall.⁹⁵ These disparities reflect not personal characteristics or behaviors, but rather differential exposures to chronic, intergenerational stress and health trajectories during pregnancy and across the life span.^{96,97,98} To eliminate these inequities and optimize women’s health, intervention is needed at multiple levels of society, including an improvement in access to high quality sexual and reproductive health care throughout the life span. Equitable access to abortion services is an important part of this equation.

Data from public opinion polls among women of color reflect the importance of abortion care to these populations. Surveys conducted in 2018 and 2019 by *In Our Own Voice: National Black Women’s Reproductive Justice Agenda* found that the **overwhelming majority of women of color (90%) recognize the threats posed by women’s loss of control over if and when to have children.**⁹⁹ Survey responses identified improvement in children’s quality of life, reduced number of unplanned pregnancies, reduced number of children in foster care, healthier families, and increased economic and educational opportunities for women as personal and societal benefits of women’s reproductive autonomy.

Abortion Policy

Legal and Legislative Challenges to Abortion

The first major legal challenges to the Supreme Court’s *Roe v. Wade* decision came in 1989 and 1992, with the *Webster v. Reproductive Health Services* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* decisions, respectively. While both technically upheld *Roe v. Wade*, they **allowed states to implement expanded restrictions on abortion and on people seeking abortion.** State legislatures have since become a battleground for abortion regulation, resulting in a multitude of abortion laws, regulations and licensing requirements across the U.S. **A surge of abortion restrictions in the last decade, in particular, have made abortion less accessible and are endangering women’s health across the nation.**¹⁰⁰ The varying laws across states create confusion, force people to navigate financial burdens, complex health systems, and travel logistics, and result in delays in care and consideration of self-induced abortion.¹⁰¹



As of December 30, 2020, 29 state governments were considered hostile toward abortion rights.¹⁰² The assessment of whether states are hostile or supportive of abortion rights is based on their implementation of six types of policies that restrict abortion and six types of policies that support abortion access. In 2019, 58% of U.S. women of reproductive age (nearly 40 million women) lived in these states.¹⁰² State legal and regulatory restrictions on abortion services have made it increasingly difficult for people in the U.S. to terminate a pregnancy. **The COVID-19 pandemic was used as an excuse to further block access to pregnancy**

termination services; eight states attempted to restrict access to abortion care by claiming that it is not an essential service.¹⁰³ While physicians urged the nation to recognize abortion as an essential health service and in some cases restrictions were withdrawn or struck down by courts, other states seized the opportunity of the pandemic to further restrict access to time-sensitive abortion care.

The year 2021 was most far-reaching anti-abortion state legislative session since *Roe v. Wade*.¹⁰⁴ States across the country have rapidly enacted an unprecedented number of abortion restrictions and bans designed to directly challenge both *Roe v. Wade* and the constitutional right to abortion. With 90% of the 90 restrictions enacted in 2021 coming out of states already considered to be hostile or very hostile toward abortion rights, new abortion restrictions exacerbate the logistical, financial, and legal barriers to care people face.¹⁰⁵ This creates major challenges for access, especially where clusters of neighboring states restrict abortion services. **Despite the premise that these laws are passed to protect women's health, they harm people who already face barriers to safe abortion access.**

Abortion Coverage Restrictions

Among the most impactful of restrictive abortion policies are **bans on funding for abortion** enacted over last 45 years. **These bans have been imposed on private and public health insurance programs and inserted into federal block grants that support state family planning services.**¹⁰⁶ These funding restrictions have made abortion an **out-of-pocket expense** for most people.^{107,108} A 2013 study found that out of pocket costs ranged from \$397 for a first trimester abortion to \$854 for a second trimester abortion, prices that are out of reach for the average American.^{109,110} Given that 42% of women seeking abortion in the U.S. have incomes below poverty, **high out of pocket costs result in inequitable access to abortion services and an exacerbation of existing reproductive health disparities.**¹¹⁰

The Hyde Amendment

A few years after *Roe v. Wade* was decided, Congress enacted the **Hyde Amendment**, an **amendment to appropriations (budget) laws that blocks federal funds from being used to pay for abortion except in cases of rape or incest, or to save the life of the woman.** The passage of the Hyde Amendment immediately impacted poor women covered by Medicaid,[†] who are disproportionately women of color.¹¹¹ The Hyde Amendment later was expanded to apply to other populations of women, including women served by the Indian Health Service, which is the principal health care provider for American Indians and Alaska Natives.¹¹² Table 1 highlights how the Hyde Amendment restricts abortion for many groups through the federal government's role as public insurer, employer, and provider of health care services. Hyde



[†] Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Amendment provisions have been included in Congressional appropriations every year since the initial adoption.

Table 1: Programs affected by Hyde Amendment Ban on Abortion Funding	
Public Insurance Programs	Medicaid (*CA and 15 other states use their own funds to cover abortion) Medicare Children’s Health Insurance Program
Federal Coverage for Military Personnel	Federal Employees Health Benefits Program TRICARE Veterans Affairs
Federal Health Service Programs	Indian Health Service Peace Corps (volunteers) Bureau of Prisons Immigration and Customs Enforcement (ICE) Federally Qualified Health Centers (FQHC’s)

Adapted from Guttmacher Institute, Guttmacher.org

The Hyde Amendment causes severe hardship for affected populations. Further, it demeans them by removing decisions about their most intimate life choices, and their health, from their control.¹¹³ As early as 1978, researchers observed that in states that did not publicly fund abortion, Medicaid-eligible women had abortions on average 2.4 weeks later in pregnancy than women in states that provided state funding for abortion. For each week of delay, the risk of complications from legally induced abortion increased sharply.¹¹⁴ While the risk of complications and death from abortion now are extremely low, with only a fraction of one percent resulting in a major complication, risk still increases as gestational age advances.²³

Lack of Medicaid funding is a particularly significant barrier to abortion care. Medicaid coverage is crucial for many women in the U.S.; approximately 20% of women of reproductive age are enrolled in Medicaid, including 49% of women with incomes under the federal poverty level.¹¹⁵ About one in four low-income pregnant women who would have had an abortion if Medicaid had paid for it instead give birth, meaning that many poor women become mothers or have additional children when that is not their choice about what is best for them and their families.^{116,117}

By law, states must cover abortions – including medication abortions – that qualify for exception under the Hyde Amendment exceptions.¹¹⁸ Nonetheless, people who are pregnant and meet state-specified income requirements for Medicaid **face difficulties getting Medicaid to pay for eligible abortions. Facilities providing abortion care also face difficulties obtaining reimbursement for women whose pregnancies threaten their lives or result from rape or incest.**^{107, 119, 120, 121} States do not always comply with federal requirements; a recent Government Accountability Office study reported that one state (South Dakota) did not cover abortions in cases of rape or incest, and 14 states were not covering the drug used in medication abortions under any circumstances.¹²² **In a 2002 study of abortion access for Native Americans, personnel in 62% of IHS units surveyed stated that they did not provide either abortion services or funding for abortion,**

even in cases where the woman's life was endangered by the pregnancy.¹²³ The study found that only 25 abortions had been performed in the IHS system since 1976, when the Hyde Amendment was first passed.¹²³

Constraints on Private Insurance Coverage for Abortion

Until the last decade, abortion was widely covered by most private health insurance plans. A 2002 Guttmacher Institute study found that 87% of typical employer-based insurance policies covered abortions deemed medically necessary or appropriate by health care providers.¹²⁴ In 2003, the Kaiser Family Foundation's Annual Employer Health Benefits Survey found that 46% of covered workers had coverage for abortion; by 2010, only 3 in 10 employers said they covered "elective" abortion and a higher proportion of employers did not respond to questions about abortion coverage (71% in 2010 vs. 26% in 2003).¹²⁵ Studies conducted throughout this period indicated that most women with private insurance paid out of pocket for abortion.^{109,126}

State laws banning insurance coverage for abortion in private insurance plans have proliferated since passage of the Affordable Care Act (ACA). Twenty-six states now restrict abortion coverage in plans offered through their insurance exchanges, which enable income-eligible consumers to qualify for tax subsidies that help pay for the cost of health insurance premiums.¹²⁷

As a combined result of state laws and insurance company choices, women in 34 states currently do not have access to insurance coverage for abortions through an insurance exchange plan.¹²⁷ Eleven states ban abortion coverage in all private insurance plans regulated by the state, and 22 states have bans on plans that cover public employees.¹²⁸ Only six states (California, Illinois, Maine, New York, Oregon, and Washington) require abortion coverage in most private insurance plans; some of these also prohibit cost-sharing, eliminating or greatly reducing out of pocket expenses.¹²⁸



Private Efforts to Fill the Gap: Abortion Funds:

With public and private health insurance coverage for abortion increasingly limited, abortion care can be out of reach for people without the money to pay out-of-pocket expenses. Private entities, including many known as “abortion funds,” have partially alleviated this financial need.

Abortion funds are organizations that mitigate financial and logistical barriers to abortion access, thereby making abortion functionally accessible. One study found that up to 20% of women seeking abortion utilize these funds to obtain the care they need. Many of these organizations are linked through the National Network of Abortion Funds (NNAF).

Helpful though they are for increasing access, the dollars available through the funds remain insufficient to meet the need for financial assistance, particularly among low-income women. As access to abortion has been tightened, so has the financial burden on women trying to access abortion. As people must increasingly travel further, find lodging farther away from home, arrange for child care, and comply with mandatory waiting periods, the amount they need from abortion funds has increased. The amount of money NNAF organizations spent in 2018 covered barely one-fifth of the 150,000 requests for aid they received during that fiscal year. Even with dramatic increases in fundraising as a response to the onslaught of restrictive policies, organizations find themselves falling short. Current inflationary trends may worsen this crisis.

*Sources: National Network of Abortion Funds. Mission. Available from <https://abortionfunds.org/>; Jones, RK, Upadhyay UD, Weitz TA. At what cost? Payment for abortion care by US women. *Women's Health Issues*. 2013. 23(3): 173-178; Littlefield, A. How Abortion Funds Showed America that 'Roe' is Not Enough. *The Nation, Special Issue*. December 16/23, 2019. Available from: <https://www.thenation.com/article/archive/abortion-funds-access-medicaid-hyde-amendment/>*

Limitations on Medication Abortion

Medication abortion allows people to **terminate a pregnancy or treat early miscarriage without surgery**, using the safe and effective Food and Drug Administration (FDA)-approved prescription drugs, mifepristone and misoprostol.^{129,130,131,132,133,134} More than 3 million women had used this combination of drugs by 2017, 16 years after mifepristone’s approval by the FDA, **and about a fourth of abortions taking place in the U.S. are medication abortions.**^{135,136} However, **knowledge of this option remains low**, with only 21% of U.S. adults and 36% of women between the ages of 18 and 49 reporting they have ever heard of the drug mifepristone or a medication abortion.¹³⁷

Medication abortion is an approved, **safe and effective means of ending a pregnancy of less than 10 weeks gestation**; evidence also suggests safety and efficacy of medication abortion to **11 weeks** and through the

entire first trimester when used under clinical guidance.^{138,139} Other research demonstrates that medication abortion can be performed safely **without an ultrasound** to measure gestational age or to confirm completion of abortion, **removing key requirements for the need to visit an abortion provider in person.**

Despite its demonstrated safety and efficacy, mifepristone access in the U.S. has been limited because the medication has been subject to **unique and burdensome FDA-imposed restrictions** known as a Risk Evaluation and Mitigation Strategy (REMS).¹⁴⁰ These restrictions **prohibited mifepristone sales by retail or mail-order pharmacies.** Consequently, **mifepristone, which is crucial in areas with severe abortion provider shortages and/or with repressive abortion policies, has been underutilized.**¹⁴¹ These restrictions, in place for 20 years, were temporarily lifted during the COVID-19 pandemic and permanently removed in December 2021, following a lawsuit. These changes allow **people in some states to access abortion services through telehealth** and safely end their pregnancies without traveling to a clinic. Unfortunately, **roughly half of states already have their own restrictions in place limiting access** to mifepristone and/or telehealth abortion services.¹⁴²



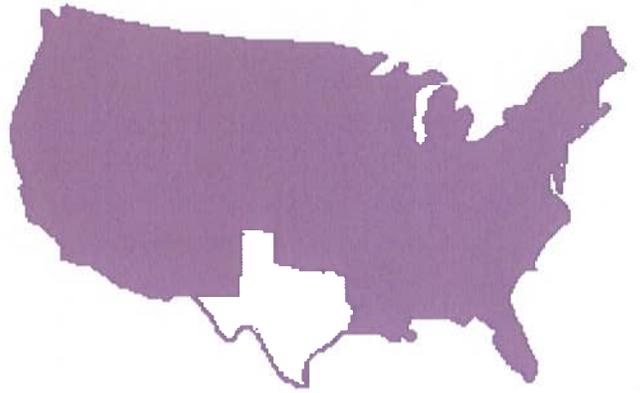
“TRAP” Laws and Restrictions Targeting Patients

Targeted Restrictions on Abortion Providers (TRAP laws) specifically and uniquely regulate abortion providers and clinics that provide abortions, focusing on facility licensing, accreditation, physical plant, and operations.^{143,144,145} These constraints are uniquely placed on abortion and not on other medical procedures of equal or greater risk. Although proponents typically justify TRAP laws as medically necessary, in fact, these laws are designed to **make operating abortion clinics so expensive and complicated that they are forced to close.**^{143,146} These restrictions include:^{23,147,148,149}

- Requiring **admitting privileges** to a local hospital for abortion providers, though abortion is extremely safe, routinely performed in outpatient settings, and no evidence indicates that admitting privileges improve safety;
- Requirements that abortion facilities meet the **standards of ambulatory surgery centers,** despite evidence indicating no differences in patient safety between abortions in ambulatory surgery centers and office-based settings; and
- **Physician-only laws** that limit abortion provision to physicians, prohibiting advance practice clinicians with appropriate clinical and technical skills from providing care, even though evidence demonstrates the safety of their services.

A 2013 Texas law demonstrates the profound impact restrictive TRAP laws can have on access to abortion care. **TRAP law HB2 forced clinics to close and resulted in a 14% decline in the number of abortions in the state within one year and a 54% decline in the number of abortion clinics in the state in 3 years.**¹⁵⁰ Women experienced longer wait times and higher costs at facilities that remained open.¹⁵⁰ The long distance to a clinic post implementation of HB2 not only impacts rural women; even before SB8 passed this year, Texas had 10 cities with populations over 50,000 where women must travel 100 miles or more to access abortion care.

These Texas data illustrate that **despite the unequivocally demonstrated safety of abortion, the U.S. abortion landscape has grown increasingly restrictive as more states become hostile to abortion rights.**¹⁵¹ Though in 2016, the U.S. Supreme Court ruled in *Whole Woman's Health v. Hellerstedt* that key provisions of HB2 were unconstitutional, **other states continue to use the law as a model.**



Examples of other abortion-specific regulations impacting pregnant people in states across the country include:

- **Mandatory waiting periods** between consultation and pregnancy termination as well as **requirements to return twice to providers for care when care can be provided safely in one visit (“two visit requirements”)**¹⁵²
- **Mandatory counseling laws** in 22 states that force abortion providers to give patients **misleading or scientifically false information** enforcing the state’s aim of dissuading patients from having abortions.²³
- **Parental consent or parental notification** of abortion laws exist in 37 states, requiring consent or notification of one or both parents of a minor’s decision to have an abortion.¹⁵³ despite professional consensus that these laws neither protect adolescent health nor promote family communication^{154, 155, 156}

Abortion Bans

Between 2019 and June 2021, **nine states passed bills that would effectively outlaw or severely restrict abortion.** Descriptions of these state laws are available in this appendix. Some bills create penalties for physicians who perform abortions such as fines or up to 99 years in prison. Other provisions include “fetal heartbeat” laws, which are bans on abortion as soon as embryonic cardiac electrical activity can be detected. This happens as early as six weeks estimated gestational age, or four weeks after conception. This electrical activity does not have the functionality of a fully developed “heart;” the term “heartbeat” is anatomically and physiologically misleading. These laws are especially punitive because at this stage of pregnancy, many people do not even know they are pregnant.

In May 2021, Texas Governor Greg Abbott signed into law legislation, **Senate Bill 8 (SB8)**, that **prohibits abortion once fetal cardiac activity can be detected, with no exceptions for pregnancies that threaten the health or life of the pregnant person or that were caused by rape or incest.** Furthermore, in a novel approach to abortion regulation, **enforcement of SB8 is tasked to private citizens**, who can file **lawsuits against anyone who performs an abortion after the six-week mark, or who “engages in conduct that aids and abets” an abortion**, or who even **“intends”** to do such a thing.¹⁵⁷ In return, they are entitled to at least \$10,000 in damages if successful.



The U.S. Department of Justice (DOJ) filed a lawsuit to prevent the State of Texas from enforcing SB8. While a federal district court temporarily blocked the law, the 5th Circuit Court of Appeals stuck down the lower court’s ruling. The case was appealed to the **Supreme Court, which declined to block the law** and has left doctors and abortion clinics with few legal options for challenging it.¹⁵⁸

Texas providers have shut down all abortion services or are only providing abortions to the few patients who meet SB8 criteria, **turning away hundreds of patients** since September 1st.^{159,160} Providers in neighboring states describe growing backlogs of patients. For example, at a Planned Parenthood clinic in Oklahoma City, within one month of the law’s implementation more than 60% of scheduled visits were from Texas.¹⁶⁰ **Wait times for abortion in states near Texas**, including Oklahoma, Louisiana, New Mexico, and Arkansas had increased two weeks by mid-September and were **up to six weeks** in some places by late October.¹⁶¹ **Delays can result in more complex procedures and make abortion more expensive.** By early November, clinics in eleven other states not bordering Texas, as well as the District of Columbia, were also reporting increased numbers of patients from Texas.¹⁶² Some providers noted that the influx of patients from Texas has decreased the availability of appointments for in-state residents, pushing some residents to travel out of state for care themselves.¹⁶²

Texas SB8, and the courts’ decisions to allow it to stand, represents a new **crisis in women’s health and for the health of all pregnant people.** Research estimates that with the new law in effect, **next year the state could see increases in maternal mortality of up to 15% overall, and up to 33% for Black women.**¹⁶³ The estimate is based on previous research that has established a clear link between abortion restrictions and maternal mortality. Other populations of vulnerable pregnant women are also being disproportionately impacted by the law, including **minors**; women with **major mental disorders and cognitive disabilities**; and those with **decreased freedom of movement**, including women in the **armed forces**, those experiencing **intimate partner violence or labor or sex trafficking**, **homeless women**, **medically dependent women** (e.g. bedridden or dialysis dependent), **impoverished women**, single women who are **primary care providers for dependents or young children** with no one else available to care for their dependents, and **incarcerated or detained women.**⁶¹

Meanwhile, on December 1st, 2021, the Supreme Court heard a case on **Mississippi’s ban on nearly all abortions starting at 15 weeks of pregnancy**, which is currently blocked by lower courts.¹⁶⁴ **The case, *Dobbs v. Jackson Women’s Health Organization***, directly challenges *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, **which guarantee the right to abortion and prohibit states from barring**

it before the point of viability. Although for almost 50 years, the Supreme Court held that abortion rights are constitutionally protected, the Court's recent actions signal that these rights are subject to dispute.¹⁶⁴ Based on the Justices' questions at the hearing, **experts and journalists throughout the U.S. expect that the Court's decision will result in the gutting of Roe vs. Wade or will overturn it completely.**

Protecting Reproductive Health & Rights in a Post-Roe Nation

Assuring Access to Self-Managed Abortion

As parts of the US severely restrict abortion provision and legal barriers continue to mount, **self-managed or self-induced abortion offers a harm reduction approach that can ameliorate these barriers.**¹⁶⁵ In the 21st century, **self-managed abortion is increasingly recognized as a means to improve abortion access.** Self-managed abortion means that **people initiate and undergo the abortion process on their own, without medical supervision.** **Self-managed abortion now usually consists of the use of medical abortion pills,** including misoprostol alone or in combination with mifepristone—the same drugs that clinicians use for medication abortion.

Given the safety of medication abortion, **the main risks for people self-managing abortion are now not medical, but legal risks.**^{166,167} Laws in **many states criminalize behaviors during pregnancy** that are viewed as causing harm or potential harm to fetuses. Since 2000, at least 21 people in the U.S., including two in California, have been arrested for ending a pregnancy or helping a loved one do so, resulting in incarceration for some.¹⁶⁶ The American College of Obstetrics and Gynecology opposes criminalization of self-managed abortion because the threat of prosecution may deter women from seeking medical care, including care related to complications after abortion, potentially resulting in negative health outcomes.¹⁶⁸



Furthermore, criminalization of abortion— including self-managed abortion— results in suspicion of people who present to health care providers with signs of pregnancy loss. Before Roe v. Wade, women who experienced miscarriage commonly were interrogated in their hospital beds to determine the cause of their pregnancy loss. This scenario will likely happen again in states that make abortion illegal. Currently, approximately 31% of pregnancies result in early loss.¹⁶⁹ **Laws criminalizing self-managed abortion therefore pose a threat to the privacy and safety of all pregnant people.**

Given the dearth of abortion access throughout the U.S., access to self-managed abortion with modern methods has become increasingly important. Key steps going forward include improving access to information; most Americans lack awareness about abortion medication.¹⁷⁰ Those who must end a pregnancy on their own in the absence of legal, accessible services need accurate information to guide them through their process safely. For those who experience side effects or complications, health care providers, especially

those in urgent care settings and emergency departments, must be better trained in modern miscarriage management; incomplete medication abortions present the same way miscarriages do.¹⁷¹

Self-Managed Abortion

People have “self-managed” their abortions, or ended their pregnancies outside of clinical settings, since ancient times. Indigenous practices, herbal remedies, and other methods to regulate menstrual flow and control reproduction are still practiced by many communities in the U.S. and around the world.

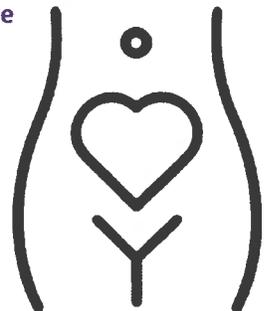


Protecting Access in California

In January 2022, California Attorney General Rob Bonta issued a [legal alert](#) to all California district attorneys, police chiefs, and sheriffs stating that the section of the California Penal Code that holds accountable those who inflict harm on pregnant individuals, resulting in miscarriage or stillbirth, is not intended to and should not be used to criminalize people who lose their pregnancy.

California law also offers pregnant people other significant protections. Abortion statutes in California:

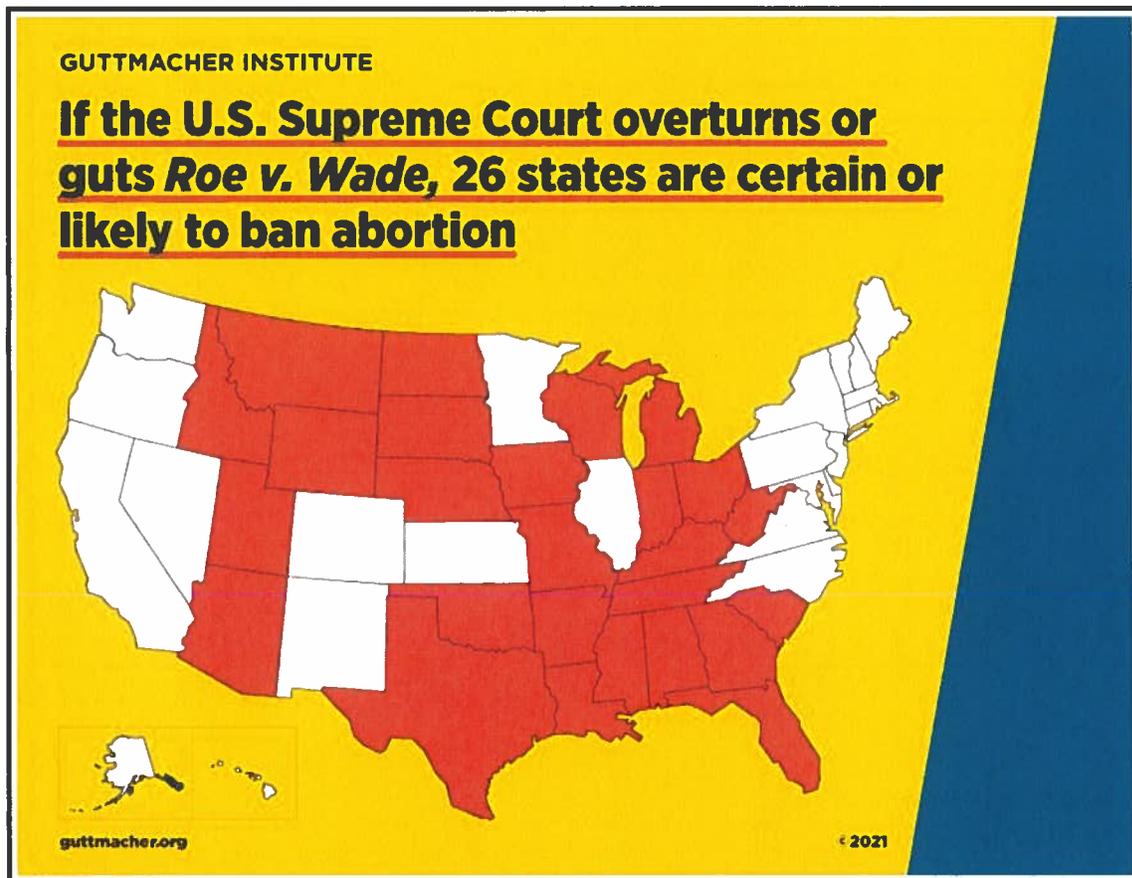
- Allow for certified **physicians, nurse practitioners, nurse-midwives, and physicians' assistants who complete specified training to perform abortions.**¹⁷²
- Require 34 **University of California and California State University campuses** to stock abortion medication by 2023.
- Require that **Medi-Cal (California's version of Medicaid) insurance plans provide comprehensive abortion coverage** paid for by the state.
- Allow **pregnant, low-income individuals to qualify for immediate, temporary pregnancy-related coverage** pending completion of a Medi-Cal application, after which they may use Medi-Cal **for abortion services** and 12 months of follow up care.¹⁷³
- **Require most private health plans to cover abortion services.**



California law allows access to abortion up to fetal viability (typically estimated as around 24 weeks estimated gestational age, or 26 weeks after fertilization). After that point, **abortion may be performed in this state only to protect the life or health of the pregnant person. Otherwise, California has no abortion restrictions.**

In 2019, the Governor’s office declared California a **“Reproductive Freedom”** state, and in June 2021, the California legislature passed a resolution urging the federal government to support reproductive rights including access to abortion.¹⁷⁴ In December 2021, with support from the Governor and the state legislature, **the California Future of Abortion Council** outlined **45 strategies to reduce barriers and strengthen equitable and affordable access to abortion care for Californians and all who seek care here.**¹⁷⁵ When *Roe v. Wade* is weakened or overturned, abortion is likely to be outlawed in 26 states, and the **number of people who drive to California each year to obtain abortion access could increase almost 3,000%, up to 1.4 million people.** (Figure 2).^{176, 177} In Los Angeles County, the Board of Supervisors notes that “Preserving women’s access to quality reproductive health care services is critical” and aims to prepare the County to meet the needs of our own residents, as well as people who travel here from other parts of the state and country to access sexual and reproductive health services.

Figure 2. States Certain or Likely to Ban Abortion in a Post-Roe v. Wade Nation, Guttmacher Institute

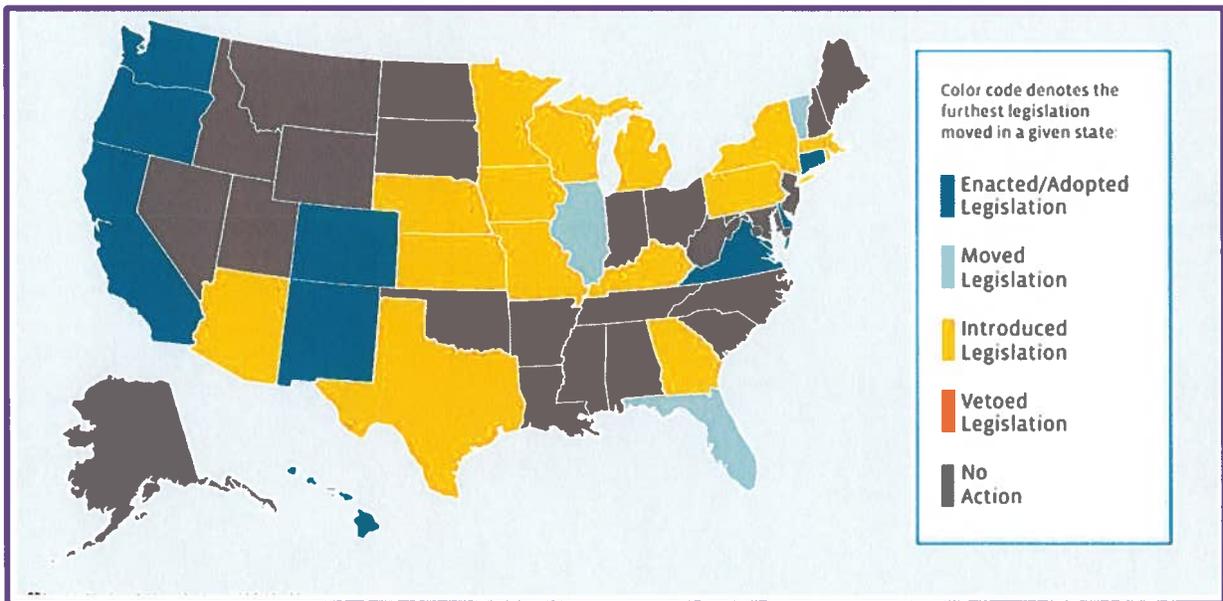


Orange-colored states certain or likely to ban abortion

Proactive Legislation

Though the national landscape for abortion access appears bleak, California is not alone in advancing reproductive freedom. In 2021, a record number of states passed bills to secure abortion access and advance equity in reproductive health care.¹⁷⁸ Thirty-six states and the District of Columbia enacted at least one proactive law addressing a range of sexual health issues including abortion access.¹⁷⁸ Figure 3 shows the movement of proactive abortion legislation across the U. S.¹⁷⁸

Figure 3. Status of Proactive Abortion Access Legislation, U.S. States, 2021, National Institute of Reproductive Health



Conclusion

Access to abortion is essential for reproductive health. **Evidence from even the most repressive countries suggests that when abortion is illegal, it does not stop, but becomes less safe.**^{179,180,181} Before *Roe v. Wade*, well-off women could have abortions arranged or performed by private physicians, and those who could amass the funds to do so could travel to other territories or nations to safely terminate unintended or mistimed pregnancies. Most abortions in the U.S., however, were performed in unsafe and illegal circumstances, resulting in high rates of morbidity and mortality. Eventually, policymakers, both long-term

supporters and those who responded to pressure from their constituents, acceded to public and professional demand by passing increasingly liberal abortion laws in several states.

The landmark *Roe v. Wade* Supreme Court decision transformed abortion throughout the country, allowing women to obtain the procedure under safe and medically appropriate conditions. American women experienced a dramatic reduction in abortion-related complications. Maternal and infant deaths decreased as safer options became available to those choosing to terminate an unwanted, unsafe, or unviable pregnancy, and continued pregnancies became healthier.¹⁵ **Decades of evidence demonstrate that full-spectrum reproductive health care, including abortion, empowers people to make reproductive choices that are best for them, their families, and their futures; supports social and economic well-being; and prevents morbidity and mortality of those that are most vulnerable.**⁷¹

Poor people and people of color experience social, economic, and reproductive health inequities that manifest both in more frequent need for abortion and more limited access to abortion care. State-level abortion regulations also affect people differently based on their **geographic location**, disadvantaging those in certain states and in rural areas of most states. **When abortion is technically legal but functionally inaccessible, or when it is outlawed, all who face barriers to education, employment, housing, and health care are further marginalized.** The implementation and enforcement of anti-abortion laws and policies that have no basis in scientific evidence endanger health, compromise medical ethics, and violate the principles of public health, including equity, justice, respect for individuals, transparency, and the obligation to prevent harm and protect health.^{182,183}



Access to abortion remains a public health priority, as laws and policy changes roll back reproductive rights, putting pregnant people's health and lives, and the lives of their families, at risk.¹⁸⁴ Abortion also is a key **reproductive justice issue— a component of the complex, intersecting rights and conditions that allow all women, but most strikingly women of color, to achieve and maintain autonomy over their own bodies and pregnancies, their power to have or not have children, and to raise the children they have in safe and sustainable communities.**¹⁸⁵

Recommendations

Abortion is a public health issue and must be addressed as such, rather than as a political issue. Abortion exists along the spectrum of sexual and reproductive health care, intersecting with maternal health, infant health, mental health, general physical health, and sexually transmitted infections, including HIV. Inequities in these realms are grounded in, and perpetuate, historic and modern-day injustices and discrimination. **It is crucial for public health to confront the roots of these inequities and to advance change by employing science and evidence-based solutions and community-led innovations.** As a discipline, as we address

racism, barriers to health care, and disproportionate burdens of disease and death among low income people and people of color, we must advocate for universal access to safe, legal, and accessible abortion in the U.S.

Researchers at UCSF have proposed a 21st-century framework that can shape efforts of public health departments around abortion and reproductive health equity, based on the Centers for Disease Control and Prevention’s 10 Essential Public Health Services.¹⁸⁶ Here, we adapt this framework to outline a public health approach to ensuring equitable access to abortion and advancing reproductive health equity in Los Angeles County.

The Centers for Disease Control & Prevention 10 Essential Public Health Services APPLIED TO ABORTION & REPRODUCTIVE HEALTH EQUITY FOR LOS ANGELES COUNTY	
Essential Public Health Service	Abortion and Reproductive Equity: Specific Examples
1. Monitor health status to identify community health problems.	<ul style="list-style-type: none"> • Use existing public health surveys to: <ul style="list-style-type: none"> ○ Document the experiences of individuals seeking abortion among Los Angeles County residents. ○ Assess women’s physical and mental health, and social circumstances before, during, and after pregnancy, including among people who miscarried or had an abortion. ○ Identify populations that face barriers to reproductive health care ○ understand contraceptive use among those with the potential to become pregnant • Analyze and share data by age, race/ethnicity, geography, income, educational attainment, health insurance coverage, immigration status, disability status, sexual orientation, and gender identity, as possible.
2. Diagnose and investigate health problems and health hazards in the community.	<ul style="list-style-type: none"> • Investigate utilization of self-managed abortion among Los Angeles County residents. • Examine how systemic racism affects black women and infants’ health outcomes and implement solutions to improve quality of care and community support with the African American Infant and Maternal Mortality (AAIMM) initiative. (https://www.blackinfantsandfamilies.org/). • Examine factors contributing to high rates of unintended (mistimed or unwanted) pregnancies in Los Angeles County • Prioritize investigations of HIV and other sexually transmitted infections among people with the capacity for pregnancy and ensure they receive treatment.
3. Inform, educate, and empower people about health issues.	<ul style="list-style-type: none"> • Educate the public, providers, and policymakers on the safety and public health importance of access to reproductive health services, including abortion. • Expand outreach about availability of free and low-cost contraceptive and sexual health services among marginalized communities of women.

	<ul style="list-style-type: none"> • Destigmatize abortion: clarify that it is a frequent pregnancy outcome. • Disseminate information about lack of access to abortion services due to financial barriers and ways these financial barriers can be overcome to help people avoid delays in accessing care. • Address racism and implicit bias in medicine as threats to public health, acknowledging histories of reproductive coercion. • Train direct service professionals to use client-centered reproductive health goals and counseling methods to screen people for pregnancy desire and allow timely access to preconception and prenatal care, family planning services, and reproductive life counseling. • Educate people traveling to LA County for abortion services about available resources for support and about “crisis pregnancy centers,” which advertise assistance for pregnant people but discourage abortion and do not provide medically accurate options counseling or abortion services.
<p>4. Mobilize community partnerships to identify and solve health problems.</p>	<ul style="list-style-type: none"> • Elevate community dialogue on the importance of the full range of reproductive health services including abortion services to women’s health with LA County stakeholders. • Promote or provide sexual health education and services in LA area schools. • Engage community-based organizations that serve immigrants, people of color, and disabled people to address reproductive health and abortion-related equity issues. • Continue to engage abortion providers in efforts to improve women’s health in LA County.
<p>5. Develop policies and plans that support individual and community health efforts.</p>	<ul style="list-style-type: none"> • Support policies that uphold the right to abortion, as recognized by Roe v. Wade and Casey v. Planned Parenthood of Southeastern Pennsylvania. • Identify policy solutions that ensure financial barriers are removed for abortion services, including policies that support government-financed abortion services. • Advocate and model the use of science to inform abortion policy. • Update Medi-Cal reimbursement of abortion services to reflect evidence-based clinical practices. • Advocate for robust implementation of legislation that expands the roles of midwives and doulas, including abortion doulas. • Support strengthened state legal protections for abortion patients, providers, and supporting organizations and individuals. • Maintain current California policies and programs that protect access to reproductive health services, including abortion, and ensure they are sufficiently funded. • Reduce institutional barriers to abortion care in California. (See California Future of Abortion Report)
<p>6. Enforce laws and regulations that protect health and assure safety.</p>	<ul style="list-style-type: none"> • Ensure that the best available scientific evidence is considered in the process of developing regulations, standards, recommendations, and guidelines that apply to abortion provision. • Within violence prevention efforts, promote the safety of abortion providers and facilities.

	<ul style="list-style-type: none"> • Enforce California’s Dignity in Pregnancy and Childbirth Act, which requires implicit bias training for all health care professionals working in perinatal services.
<p>7. Link people to needed personal health services and ensure provision of health care when otherwise unavailable.</p>	<ul style="list-style-type: none"> • Engage partners regarding formation of a Los Angeles County Abortion Fund. • Ensure newly pregnant patients/clients are informed of their pregnancy options, including abortion. • Facilitate referrals to abortion care, including second trimester and late abortion services, indicating which organizations provide accurate abortion education and abortion services. • Promote inclusion of information about abortion in teen health education and services. • Clarify referrals for abortion patients considered “high risk” to avoid multiple provider visits and facilitate prompt, appropriate care. • Assure availability of the full range of post-abortion contraception. • Partner with County and City Departments to provide transportation and other enabling services to help people get to and from their abortion appointments.
<p>8. Assure a competent public health and personal health care workforce.</p>	<ul style="list-style-type: none"> • Plan and implement trainings for County staff, including home visitors and community health workers, to reduce abortion stigma and broaden professional knowledge of abortion through topics such as: <ul style="list-style-type: none"> ○ Access to abortion as a public health issue ○ Abortion care as an essential part of reproductive health and maternal health care ○ Inequities in access to abortion care. • Provide such trainings for other local service providers who serve people with the capacity for pregnancy. • Train physicians and advanced practice clinicians about self-managed medication abortion and how to treat patients who present in emergency and urgent care settings with incomplete abortion. • Expand the reproductive health and abortion workforce, recruiting and developing individuals from communities most impacted by reproductive health disparities.
<p>9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.</p>	<ul style="list-style-type: none"> • Using quantitative and qualitative methods, evaluate barriers to abortion care at various stages of pregnancy, especially among disadvantaged communities. • Evaluate challenges faced by abortion providers in Los Angeles County, including stigma, safety, and public and private insurance reimbursement. • Collaborate with community partners to evaluate abortion care quality and access in Los Angeles County.
<p>10. Conduct research to attain new insights and</p>	<ul style="list-style-type: none"> • Conduct research to understand any inequities in abortion care among women in LA County.

Innovative solutions to health problems

- Use mixed methods research to understand pregnancy desire, intention, and choices among people of reproductive age in LA County.
- Work with community and academic partners to measure the impact on abortion services in LA County after the weakening or overturning of Roe v. Wade brings more people to California for abortion care.

Adapted from A 21st-Century Public Health Approach to Abortion and the UCSF ANSIRH Envisioning a 21st Century Public Health Approach to Abortion: A Convening for MCH Professionals in Health Departments, May 2020

The Los Angeles County Department of Public Health recommends policy approaches at the local, state, and national level to advance sexual and reproductive health and protect the right to bodily autonomy, including the right to terminate a pregnancy through abortion. It is imperative to affirm every person’s ability to make their own reproductive choices, without coercion or state-sponsored barriers, and to create the social, economic, and structural conditions that allow all to achieve health equity and reproductive health and justice.



**Thank You to Our Partners:
The Los Angeles County Women’s Health Equity Coalition**



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Appendix: State Laws Attempting to Ban Abortion, 2018-2021

Most of the provisions in these laws have been blocked by U.S. District Courts but will largely go into effect if *Roe v Wade* is weakened or overturned.

State policies around people’s reproductive choices have become increasingly draconian, threatening decades of social and medical progress. Over the last decade and especially in the past few legislative sessions, nearly half of U.S. states have passed bills that restrict access to abortion, and many states have attempted to ban abortion at certain stages of pregnancy. These laws are designed to challenge the *Roe v. Wade* and *Casey v. Planned Parenthood of Southeastern Pennsylvania* Supreme Court decisions and allow states to again criminalize people obtaining abortions and the practitioners who provide them. Most of these laws have been blocked by the Courts, but would go into place if the current *Dobbs v. Jackson Women’s Health Organization* Supreme Court case results in the weakening or overturning of the right to abortion.

Alabama

In May 2019, Alabama Governor Kay Ivey signed HB314 into law— the most restrictive and severe abortion ban in the country.¹ The “Human Life Protection Act” makes abortion a Class A felony, which carries up to 99 years in prison for the performing physician. HB314 includes a clause granting personhood to unborn fetuses. The law does not include an exception for rape or incest.²

Arizona

In March 2021, Arizona Governor Doug Ducey signed SB1457, which bans abortions due to genetic abnormalities.³ This bill also bans mail and delivery of abortion-inducing medications, leaving no options for people who face barriers to seeking abortion in person. This bill also restricts public facilities or institutions from performing or providing an abortion, counseling on abortion, or referring patients for an abortion. Public institutions include community colleges, universities, school districts, charter schools, and the Arizona state schools for the deaf and the blind.

Arkansas

In March 2019, Governor Asa Hutchinson signed HB1439 into law, banning abortions after 18 weeks of pregnancy with exceptions for medical emergencies, rape and incest.⁴ In the 2021 legislative session, Governor Hutchinson signed SB6, an act attempting to protect ‘unborn’ children and abolish all abortions in the state of Arkansas, except when a woman’s life is endangered.⁵

Georgia

In May 2019, Georgia Governor Brian Kemp signed HB481 into law, banning abortion as early as six weeks into a pregnancy.⁶ This measure bans abortion once a fetal heartbeat* (electrical cardiac activity)

* At approximately 6 weeks, cardiac electrical activity begins. This electrical activity does not have the functionality of a fully developed “heart”; the term “heartbeat” is anatomically and physiologically misleading.

has been detected, except in the case of a medical emergency.⁷ HB481 also contains a fetal “personhood” provision that defines a person to mean “any human being including an unborn child.” The law includes an exception for pregnancies that are the result of rape or incest—but only if the pregnancy is less than 20 weeks and the pregnant woman has reported it to law enforcement.

Idaho

In April 2021, Governor Brad Little signed HB366, “The Fetal Heartbeat Preborn Child Protection Act,” which mandates that physicians must check for a fetal heartbeat (electrical cardiac activity), and if a heartbeat is detected, performing an abortion is illegal, except in the case of a medical emergency, rape or incest. In the case of rape or incest, the woman must provide documentation to the physician that she has reported the assault to law enforcement before proceeding with the procedure.⁸

Indiana

In April 2019, Governor Eric Holcomb signed HEA 1211 into law, eliminating access to abortions requiring a dilation and evacuation (D&E) procedure, which tend to be performed during the second trimester of pregnancy. This bill includes exceptions for medical emergencies but does not include exceptions for rape or incest.⁹

Iowa

In May 2018, Governor Kim Reynolds signed SF 359, requiring providers to perform an ultrasound to identify a heartbeat (electrical cardiac activity) prior to performing an abortion; if electrical cardiac activity is detected, the provider is prohibited from performing the abortion. The bill includes exceptions only for medical emergencies, such as mortality or severe morbidity for the pregnant woman.¹⁰

Kansas

In January 2021, the state legislature voted to refer an amendment to the state’s constitution in an August 2022 special election. The measure would amend the state’s constitution to give women no constitutional right to an abortion or to receive funds for an abortion.¹¹ In special cases, the legislature may pass laws when there is a case of an abortion resulting from incest or rape.

Kentucky

In March 2019, Governor Matt Bevin signed SB9 into law, banning abortion after approximately six weeks, or once a fetal heartbeat (electrical cardiac activity) is detected. The bill requires providers to offer to show the pregnant person the “heartbeat” on ultrasound, if detected. The law offers exemptions for medical emergencies such as mortality or severe morbidity to the pregnant person.¹²

Louisiana

In May 2019, Governor John Bel Edwards signed SB184 into law, banning abortion after approximately six weeks, or once a fetal heartbeat (electrical cardiac activity) is detected, with exceptions for medical emergencies, such as mortality or severe morbidity for the pregnant woman, with no exceptions for rape or incest.¹³

Montana

In April 2021, Gov. Greg Gianforte signed three bills restricting abortion into law; one of those, HB136 bans abortion starting at 20 weeks.¹⁴

Mississippi

In March 2018, Governor Phil Bryant signed the “Gestational Age Act,” which bans abortions at or after the estimated gestational age of 15 weeks. The ban offers no exceptions for cases of rape or incest, but allows narrow exceptions for “a medical emergency, or in the case of a severe fetal abnormality.” This law is currently under review by the Supreme Court of the United States in the case, *Dobbs v. Jackson Women’s Health Organization*.¹⁵

In March 2019, Governor Phil Bryant signed SB 2116, banning abortion after approximately six weeks, or once a fetal “heartbeat” (electrical cardiac activity) is detected, with exceptions for medical emergencies, such as risk of mortality or severe morbidity of the pregnant woman. No exceptions for cases of rape or incest exist in this law.¹⁶

Missouri

In May 2019, Governor Mike Parson signed HB126 into law, making it a felony punishable by up to 15 years in prison to perform an abortion after eight weeks’ gestation.¹⁷ It also includes provisions banning abortion at 14, 18 and 20 weeks, in case the ban at eight weeks does not pass judicial evaluation. This law includes exceptions for medical emergencies—such as risk of mortality or severe morbidity for the pregnant woman—but not for cases of rape or incest.

Ohio

In April 2019, Governor Mike DeWine signed SB23 into law, banning abortion as early as six weeks, or once a fetal heartbeat (electrical cardiac activity) has been detected.¹⁸ The “Human Rights and Protection Act” includes exceptions for medical emergencies, such as mortality or severe morbidity for the pregnant woman, excluding pregnancy due to rape or incest.

South Dakota

In March 2021, Governor Kristi Noem signed HB1110 to make abortions illegal based on genetic abnormalities such as Down Syndrome, except when a mother’s life may be at risk.¹⁹

Texas

In May 2021, Governor Greg Abbot signed SB8, a fetal heartbeat (electrical cardiac activity) bill that bans abortions as early as six weeks.²⁰ He also signed a bill in June 2021, known as a trigger bill, that would outlaw abortions almost immediately if the Supreme Court overturned *Roe vs. Wade*.²¹

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