Abortion Disparities: A Public Health Approach

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Health Disparities

• In the US, there are pervasive disparities in health by race/ethnicity and socioeconomic status

• Examples include:
  – Life expectancy
  – Infant mortality
  – Cancer incidence
Abortion by Income and Race/Ethnicity, 2008

Rate (per 1,000 women)

- <100% FPL
- 100-199% FPL
- >200% FPL

Black, Hispanic, White

Jones et al, Perspect Sex Repro Health 2011
Disparities are Increasing

- In 2000, 27% of the abortion patients in the U.S. were poor women.
- In 2008, 42% of the abortion patients in the U.S. were poor women.
- Rates of abortion are declining more rapidly among white women than among black and Hispanic women.

Abortions by Race, 1973-2004

Guttmacher Institute
Abortions by Ethnicity, 1991-2004

Guttmacher Institute
One Interpretation of these Disparities

“The Black community has not benefited either socially or economically from an atrocity that is enthusiastically promoted by those who make millions of dollars from our dead babies; and by those who seek to entice the Black community to self-genocide through abortion.”

- Abortionfacts.com
Problems with this Approach

• Treats abortion as the problem, rather than one means to achieving a women’s reproductive goals
  – Motivates limiting abortion → disparities in unplanned childbirth

• Asserts women who have abortions are victims
What is a public health approach to addressing these disparities?
Unintended Pregnancy Rates by Income and Race/Ethnicity, 2008

Finer and Zolna, AJPH, 2014
Problems with this Approach

• Tendency to focus on the individual, rather than structural causes, of disparities in unintended pregnancy
• Treats abortion as a problem, rather than one means to achieving a women’s reproductive goals
Let’s Think About Diabetes....

• Primary prevention: Helping patients to not become diabetic
• Secondary prevention: Ensuring patients with diabetes do not have complications
Timing of Abortion: Differences by Race/Ethnicity, 2008

Jones and Finer, Contraception, 2012
Timing of Abortion: Differences by Education, 2008

- <12th grade
- HS graduate
- Some college
- College graduate

Jones and Finer, Contraception, 2012
Abortion Safety by Gestational Age

Deaths per 100,000 abortions

Gestational Age

- <9
- 9–10
- 11–12
- 13–15
- 16–20
- 21+
- All abs.

Grimes, AJOG, 2006, Bartlett et al., Ob Gyn, 2004
Disparities in women’s ability to have an abortion at all

• Lack of public funding for abortion limits access
  – 25% of Medicaid-eligible women who would have an abortion give birth when funding is unavailable
  – Study of variation in funding in North Carolina found this effect most pronounced among Black women

Henshaw, Guttmacher Institute, 2009; Cook, J Health Economics, 1999.
Public Health Approach to Abortion Disparities

• Address disparities in both need for and access to abortions
• Ensure access to prompt, safe abortion care when needed
Decreasing Disparities: Primary Prevention

- Work to expand contraceptive use
- Acknowledge and work to address underlying causes of disparities in unintended pregnancy, including:
  - Disparities in opportunities and resources
  - Racism and class discrimination
  - Effect on health care quality
  - Contraceptive safety concerns rooted in history of coercion and mistrust
Decreasing Disparities: Secondary Prevention

- Address barriers to access that disproportionately affect disadvantaged women include:
  - Lack of insurance coverage
  - Lack of public funding (only 17 states provide)
  - Lack of providers (87% of counties have no abortion provider)
  - Logistical barriers including mandated waiting periods, gestational age limits

- Work to ensure women who wish to continue pregnancy are able to do so
Conclusion

• Consider abortion disparities in context of disparities in other aspects of reproductive health
  – Contraception
  – Abortion care
  – Pregnancy services
  – Economic supports

• Prioritize optimizing women’s health, not the goal of reducing abortion