Evaluating the Impact of Policies, Disasters, and Racism on Abortion Access: A Call for Mandated and Standardized Public Health Abortion Surveillance

Kate Coleman-Minahan, RN, PhD

ABOUT THE AUTHOR

Kate Coleman-Minahan is with the College of Nursing, University of Colorado Anschutz Medical Campus, Aurora.

See also Roberts et al., p. 1504.

This January, the Supreme Court of the United States granted a stay in the case of *Food and Drug Administration* [FDA] *et al. v. American College of Obstetricians and Gynecologists et al.*, reinstating the FDA requirement that mifepristone, a medication used to induce abortion, be obtained by patients in person.[1] In the case, the federal government claimed that the FDA regulation was not unnecessarily burdensome during the pandemic. But this claim is unfounded. First, even without a pandemic, the entire purpose of this medically unnecessary requirement is to be burdensome and restrict access to abortion care. Second, although abortion is a common pregnancy outcome, robust state-level data were not available to assess abortion access during the pandemic.

The federal government used the total number of abortions in just two states, Nebraska and Indiana, from two years, 2019 and 2020, to defend reinstating a medically unjustified barrier to abortion during a pandemic. They did not compare medication and procedural abortions, account for trends in abortions, or compare to states that removed the in-person requirement. In this issue of *AJPH*, Roberts et al. (p. 1504) provide crucial research on abortion access during the pandemic. However, standardized and depoliticized abortion surveillance is needed so the highest court in the country does not continue to rely on "cherry-picked data" that are, according to Justice Sotomayor, "no more informative than reading tea leaves."[1]

ABORTION ACCESS DURING COVID-19

Roberts et al. conducted a rigorous statistical analysis accounting for gestational age, abortion type, and trends in abortion care, over 29 months and across multiple states, to examine changes in abortions in Louisiana before and after the onset of the pandemic. They found that abortions decreased by almost one third and that the odds of having a second-trimester abortion nearly doubled.

State policymakers exploited the COVID-19 pandemic by classifying abortion as "nonessential" and eliminating legal access in several states. A recent study found that fewer abortions were provided in Texas, whereas more abortions were obtained by Texas residents outside of Texas during the executive order, which prohibited abortion care.[2] Although Louisiana did not eliminate abortion access, Roberts et al. argue that the categorization of essential health care was "ambiguously worded" and may have contributed to the disruption in available services and the reduction in abortions.

The reduction in abortions and an increase in the proportion of second-trimester abortions are harmful to the health of individuals, families, and communities. First, it is likely that at least some people were forced to carry a pregnancy to term against their will, which, when compared with obtaining a wanted abortion, is associated with more life-threatening conditions, poorer physical health,[3] and a greater risk of poverty.[4] Second, although abortion is safer than giving birth, it is safest earlier in pregnancy. Policymakers who demonize abortions later in pregnancy enact policies that delay access to care,

pushing abortion care to later in pregnancy. Finally, as the authors argue, restricted access to abortion may result in people self-managing abortion, which carries a risk of criminal prosecution. Despite these clear harms to maternal health, data limitations constrain researchers' ability to evaluate the impact of policies, disasters like the pandemic, and racism on abortion access.

STIGMATIZATION AND POLITICIZATION

Abortion, like birth, is a common pregnancy outcome and part of maternal health. Decades of policies, regulations, and stigma among policymakers and clinicians have separated abortion philosophically and physically from other forms of pregnancy care. For example, federal Medicaid covers births and miscarriages but does not cover abortion. Most primary care clinicians provide prenatal and miscarriage care, but not abortion. And we have standardized public health surveillance for birth, but not abortion.

FACILITATE PUBLIC HEALTH SURVEILLANCE

The US public health abortion surveillance system needs to be mandated, standardized, and depoliticized. Birth data are considered a vital statistic. Federal and state laws mandate the standardized collection of birth certificate data, and the Centers for Disease Control and Prevention (CDC) provide additional surveillance through the Pregnancy Risk Assessment Monitoring System. By contrast, state reporting of induced termination of pregnancy, the CDC's abortion surveillance program, is voluntary, and data collection forms and procedures vary widely.[5] Abortion surveillance is also politicized. Some states require unnecessary and invasive information that jeopardizes abortion client and provider confidentiality. Not all states release disaggregated data, and others purposely delay data access, for example, Texas delayed releasing data until after *Whole Woman's Health v. Hellerstedt* (579 US; July 27, 2016), a Supreme Court case on abortion restrictions, was decided.

To supplement incomplete CDC abortion surveillance data, the Guttmacher Institute conducts an important national survey of abortion providers. However, data are collected every two to three years and are limited in scope at the state level. To address abortion surveillance limitations, Roberts et al. used induced termination of pregnancy data as well as data from abortion clinics. Data were not available from seven Texas clinics, thankfully representing only 7% of abortions in the state. Using clinic data, instead of or in addition to induced termination of pregnancy data, is common practice largely because of incomplete or unavailable induced termination of pregnancy data. However, relying on clinic data can further burden abortion providers and is not always standardized, feasible, or timely.

In addition to abortion surveillance, we need public health indicators of abortion access. The CDC asserts that the importance of abortion surveillance is to "evaluate programs aimed at preventing unintended pregnancies" and ultimately "reduce the number of abortions."[5(p9)] Deeming abortion a "bad" outcome further stigmatizes and marginalizes abortion. We need public health indicators that value access to a wanted abortion as a positive maternal health outcome.[6] For example, in Sweden, abortion is included in the national public health surveillance system, and the proportion of abortions before 10 weeks gestation is a quality indicator.[7] In the United States, abortion quality indicators could be added to the proposed improvements to maternal health surveillance in the 2021–2022 MOMMA's Act (117th Congress) or the Black Maternal Health Momnibus Act (2021–2022; 117th Congress, Simple Resolution 153).

Abortion surveillance and quality indicators can also be used to evaluate and improve health equity. Birth surveillance data have been used to identify how Black women experience poorer maternal health and birth outcomes and how policies or disasters negatively affect birth outcomes for women of color.[8] Yet, 21 states do not report race or ethnicity in abortion surveillance.[5] So it is unsurprising that like most studies evaluating abortion access, Roberts et al. did not examine whether changes in abortions in Louisiana differed across racial/ethnic groups. Indeed, there is extremely limited research on how abortion restrictions disproportionately affect people of color. We must build on momentum to study racism in maternal health to evaluate "how racism is working"[9] in abortion care. However, without abortion surveillance data that accurately capture race/ethnicity, it is difficult to apply novel frameworks on structural determinants of maternal health[10] or measures of structural racism[11] to abortion research.

Equitable access to abortion is a public health priority.[12] If we want more rigorous research like that of Roberts et al. and research that evaluates racism in abortion care, then we need public health indicators for abortion and a public health abortion surveillance system that respects the confidentiality of abortion clients and providers. To improve maternal health equity, our public health systems must treat abortion as the essential

and common health care and pregnancy outcome that it is. AJPH

CORRESPONDENCE

Correspondence should be sent to Kate Coleman-Minahan, Mail Stop C288, 13120 East 19th Ave, Aurora, CO 80045 (e-mail: kate.coleman-minahan@cuanschutz.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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CONFLICTS OF INTEREST

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