HEALTH COMMISSION
CITY AND COUNTY OF SAN FRANCISCO
Resolution No. 22-19

ACCESS TO REPRODUCTIVE CARE IS A PUBLIC HEALTH ISSUE

WHEREAS, the American Public Health Association formally recognized abortion access as a public health concern in 1970, before abortion was legal at the federal level in all states; and

WHEREAS, Access to the full spectrum of sexual and reproductive health care, including abortion, is fundamental to the health of individuals, families, and communities; and

WHEREAS, 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 gynecological care; and

WHEREAS, Abortion can be conducted through a surgical procedure or by taking medication; and

WHEREAS, The latest available U.S. data from the Centers for Disease Control and Prevention and the National Center for Health Statistics are that maternal mortality due to legal induced abortion is 0.41 per 100,000 procedures, as compared with the overall maternal mortality rate of 23.8 per 100,000 live births; and

WHEREAS, In the United States, the opportunity to obtain a full range of reproductive health 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; and

WHEREAS, Laws prohibiting or restricting access to surgical or medication abortions threaten all childbearing individuals and their families, but disproportionately impact People of Color, younger people, those with lower incomes, as well as queer, and transgender people; and

WHEREAS, 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:

- Women who were turned away from having an abortion and went on to give birth experienced an increase in household poverty lasting at least four years relative to those who received an abortion.
- Among women with existing children at the time they sought abortion, four years later the existing children of those who were more likely to live in poverty compared to the children than women who received an abortion.
- Years after an abortion denial, women were more likely not to have enough money to cover basic living expenses like food, housing and transportation.
- 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.

- Women turned away from getting an abortion were more likely to stay in contact with a violent partner.
- The financial wellbeing and development of children was negatively impacted when their mothers were denied abortion; and

WHEREAS, On June 24, 2022, the United States Supreme Court struck down Jane Roe v. Henry Wade decision, removing federal protection for abortion in all states; and

WHEREAS, Many states passed highly restrictive abortion laws in preparation for the removal of federal protection. The result is that abortion is now completely illegal in some states and highly restricted in other states. Some of these state laws make it a felony for a person to leave the state to get an abortion, for a provider to perform surgical or medical abortion, or to aid a person in getting an abortion. Additional laws allow for individuals to be able to sue anyone who assists a person getting an abortion; and

WHEREAS, When abortion was illegal in the United States, women with 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. 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 instruments like coat hangers; and

WHEREAS, From 1972-74, the illegal abortion mortality rate for Women of Color was 12 times that for White women; and

WHEREAS Restrictions on the use of federal funds to provide abortions have limited the access to abortion services at American Indian Service Facilities for Native American women, who experience disproportionately high rates of sexual assault and unintended pregnancies; and

WHEREAS, 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; and

WHEREAS, 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, including abortion; and

WHEREAS, on July 8, 2022, President Biden signed an Executive Order to protect access to FDA-approved abortion medication, strengthen enforcement of the Affordable Care Act's contraceptive protections and defend the legal rights of both patients and providers; and

WHEREAS, on July 15, 2022, Speaker Nancy Pelosi and Democrats in the U.S. House of Representatives advanced two bills preserving access to reproductive health care: the Women's Health Protection Act which will enshrine the protections of Roe v. Wade into federal law and restore the right to an abortion nationwide; and the Ensuring Women's Right to Reproductive Freedom Act which will reaffirm the right to freely travel across state lines to obtain an abortion; and

WHEREAS, Abortion is legal in California. The Governor and state legislature are attempting to pass legislation and policy to make the state a sanctuary for people seeking abortions in California from states which have outlawed abortion.

BE IT RESOLVED, The San Francisco Health Commission supports the right for every pregnant person to have a full range of sexual and reproductive health services, including abortion, available to them by trained licensed professionals; and

FURTHER RESOLVED, The San Francisco Health Commission lauds Mayor London Breed for her efforts to work with the San Francisco Department of the Status of Women to prepare for a possible influx of pregnant people visiting San Francisco for abortion services; and

FURTHER RESOLVED, the San Francisco Health Commission commends the San Francisco Department of Public Health for its full range of inclusive reproductive health services designed to meet the needs of diverse individuals.

I hereby certify that the San Francisco Health Commission adopted the foregoing resolution at its August 2, 2022 meeting.

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Mark Morewitz, M.S.W.
Health Commission Secretary

Data Sources:

"Abortion Is a Public Health Issue: Achieving Access and Equity," County of Los Angeles Public Health Report; February 2022
http://publichealth.lacounty.gov/owh/SexualReproHealth/OWHAbortionReport.pdf

2019 Center for Disease Control Abortion Statistics;
https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm

Guttmacher Institute. Induced Abortion in the United States. Published September 2019.
https://www.guttmacher.org/fact-sheet/induced-abortion-united-states"
"Reproductive Rights Denied: The Hyde Amendment and Access to Abortion for Native American

"Women Using Indian Health Service Facilities." Shaye Beverly Arnold. American Journal of Public Health: 2014

History

Abortion did not become politically controversial in the United States until the 1800's, when states began regulating who could provide pregnancy-related care, including abortion.

United States Laws regulating abortion and maternity care at the time served to empower White, male physicians, while disenfranchising female midwives, notably including Black African American midwives, who throughout two centuries of slavery had continued the traditional African practices of serving their communities as healers and spiritual leaders.

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; and (National Abortion Federation. History of Abortion. Available from https://prochoice.org/education-andadvocacy/about-abortion/history-of-abortion/)

Data collected from New York City in the early 1960's demonstrated the stark disparities, with abortion-related deaths among non-white and Puerto Rican women twice as common as White women.

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.

As states began to legalize abortion and allow people to legally terminate their pregnancies, maternal and infant mortality declined dramatically. After New York State legalized abortion up to 24 weeks gestational age in April 1970, health department officials noted a 37% decline in the maternal mortality rate by the end of 1971.

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. 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 doctors; it often overlooked the needs of poor women and Women and Color.

Public Health Data

By age 45, nearly 1 in 4 American women will have intentionally terminated a pregnancy.

The latest available U.S. data from the Centers for Disease Control and Prevention and the National Center for Health Statistics are that maternal mortality due to legal induced abortion is 0.41 per 100,000 procedures, as compared with the overall maternal mortality rate of 23.8 per 100,000 live births.

In 2017, approximately 18% of all pregnancies in the United States ended in abortion, with 66% occurring by eight weeks of gestation and 88% by 12 weeks.

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, may pose risks of significant harm.

Data show abortion is safer than many common medical procedures including wisdom teeth removal and colonoscopy.

For People of Color, low-income people, young people, and immigrants, barriers to accessing abortions may include experiences of racism, discrimination, stigma, and marginalization in interactions with the health care system; cultural and/or linguistic issues; uncertainty about what the steps are for obtaining and paying for abortion services; lack of reproductive health knowledge; religious concerns; and strict federal immigration enforcement.

Black African American women experience pregnancy-related death at 3 times the rate of White women in the United States, and over twice the risk of experiencing an infant's death during the first year of life.

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-approved prescription drugs, mifepristone and misoprostol.

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.

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. These restrictions prohibit 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.
These restrictions, in place for 20 years, were lifted during the COVID-19 pandemic and permanently removed in December 2021. These changes allow people in some states to access abortion services through telehealth and safely end their pregnancies without traveling to a clinic, although this information has not been widely disseminated to providers or the public.

Roughly half of states already have restrictions in place limiting access to mifepristone and/or telehealth abortion services.