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NATIONAL URBAN REPRODUCTIVE HEALTH AGENDA

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INTRODUCTION: A CALL TO ACTION

The Urban Initiative for Reproductive Health (Urban Initiative) is pleased to present you with the National Urban Reproductive Health Agenda (Agenda), a roadmap for local leaders to take action and create change in their communities. The goal of the Agenda is to inform and motivate local elected leaders, public health officials, and advocates by offering a common vision and concrete strategies for improving the reproductive, sexual, and maternal health of urban communities.

BACKGROUND ON THE URBAN INITIATIVE FOR REPRODUCTIVE HEALTH

Launched at a groundbreaking summit in 2008, the Urban Initiative is a multi-year national initiative to create and promote real policy solutions to address reproductive health problems currently facing cities across the nation. The Urban Initiative was developed as a strategy for addressing the unmet reproductive health challenges of urban residents while seizing on the untapped opportunities among local leaders to effect positive change. Through regional summits, grantmaking, and online coordination, the Urban Initiative is creating partnerships between mayors and city councilmembers, county executives, public health officials, and advocates to advance policies and programs that address disparities, increase access to comprehensive reproductive, sexual and maternal health information and services, reduce unintended pregnancies, and lead to healthier birth outcomes.

In 2009, the Urban Initiative established the National Urban Reproductive Health Agenda Advisory Committee (Advisory Committee), comprised of national, state, and local experts on a broad range of reproductive health and justice issues, to collectively synthesize and articulate the critical values, issues, and recommendations for advancing reproductive health and justice on a local level. The Advisory Committee provided invaluable guidance and feedback on the creation of the Agenda.

WHAT IS THE AGENDA?

- **A VISION.** In order to craft solutions that are guided by our values, leaders need a collective vision for change. The Agenda begins with a statement of Values and Principles that provide the framework for advancing policies and programs at the local level.
- **A RESOURCE.** In order to create and advance solutions, leaders need specific information about the problems that exist and why. The Advisory Committee identified twelve interrelated Focus Areas covering a range of issues that are specific to urban areas or disproportionately prevalent in urban communities. Each Focus Area includes a short brief that provides an overview of the issue along with supporting research and analysis. Together these briefs define the most pressing reproductive health challenges and why they must be addressed in urban communities specifically.
- **A CALL TO ACTION.** In order to strategically address urban challenges, leaders need specific recommendations to support and act upon. The Agenda offers concrete local recommendations that can and should be implemented to address the issues identified in the Focus Area briefs. The recommendations have been culled from urban areas across the country and represent a synthesis of best practices and promising strategies. To demonstrate their real-life applicability, the Agenda includes examples of how these models are working in real cities, big and small. By sharing what we know has worked and what we believe is possible, we can effect real change.

Recognizing that policy and budgetary decisions made at the state and federal level have an immense impact on the lives of urban residents and often shape the potential of advocacy work at the local level, the Agenda concludes with a set of recommendations for state and federal governments that help address urban reproductive, sexual, and maternal health issues.

www.UrbanInitiative.org

The Agenda is available on the Urban Initiative website at www.UrbanInitiative.org. This website serves as an on-line Clearinghouse, containing additional detailed information about model policies and programs from cities around the country. All of the models highlighted in this Agenda are included in the Clearinghouse. In addition, each Focus Area can be linked to promising models online in order to facilitate implementation of Agenda recommendations in your community. The website also offers the opportunity to share resources and network with others working in urban areas. Please visit us today!

WE BELIEVE...

Every woman, man, and young person, regardless of race and ethnicity, nationality, gender identity and expression, sexual orientation, marital status, age, immigration status, disability, or socio-economic status, has the fundamental human right to make personal decisions regarding her or his reproductive and sexual health.

The reproductive and sexual health of an individual and his or her community is inextricably linked to overall well-being.

The adverse reproductive, sexual, and maternal health outcomes facing many urban residents, especially the racial and ethnic disparities in these outcomes, contribute to the poor health of urban communities and our entire nation.

Therefore, it is imperative that we commit to ensuring the reproductive health, rights, and justice of urban residents.



WE WILL ACCOMPLISH THIS BY...

Protecting and ensuring the right to terminate a pregnancy and the right to parent.

Employing a reproductive justice frameworkⁱ in our advocacy to improve the social and economic conditions that can affect the reproductive, sexual, and maternal health of urban residents.

Using research, evidence, and evaluation to inform the programs and policies for which we advocate.

Building strong and sustainable community environments that support healthy relationships, lifestyles, and decision-making, especially among young people.

Increasing access and eliminating discriminatory barriers to reproductive, sexual, and maternal health information and services that are comprehensive and affordable for both women and men, of high quality, confidential, free of judgment, culturally competent, and linguistically and age-appropriate.

Investing public dollars in reproductive, sexual, and maternal health services in urban areas, which will reduce health care costs associated with cervical and breast cancer, sexually transmitted infections, unintended pregnancies, poor birth outcomes, and other preventable adverse reproductive, sexual, and maternal health outcomes.

Advocating for change that will address the social determinants of health—including poverty, poor education, inadequate housing, racism, and limited neighborhood opportunities—that are the primary causes of unacceptable disparities, particularly by race and ethnicity, in reproductive, sexual, and maternal health.

ⁱ Reproductive Justice is when we all have the power to protect and advance our human rights, determine the number and spacing of our children, protect our bodily integrity, improve the quality of the environment in which to parent our children, and obtain the necessary social supports to live healthy lives within healthy families, and in safe and sustainable communities.
—Definition provided by SisterSong Women of Color Reproductive Health Collective.

FOCUS AREAS AND LOCAL RECOMMENDATIONS

The following twelve Focus Area briefs cover a range of reproductive, sexual, and maternal health issues that are either specific to urban areas or disproportionately prevalent in urban communities:

- Reduce Reproductive, Sexual, and Maternal Health Disparities
- Increase Access to Family Planning and Abortion Information and Services
- Empower Young People to Make Healthy Decisions
- Support and Implement Comprehensive Sexuality Education Programs in Local Schools
- Ensure Health through the Continuum of Pregnancy, Birth, and the Postpartum Period
- Advance HIV/AIDS and Sexually Transmitted Infection Prevention and Treatment
- Preserve Safety Net Reproductive, Sexual, and Maternal Health Care Services
- Promote Healthy, Consensual, and Safe Relationships
- Integrate Strategies to Improve Environmental and Reproductive Justice
- Safeguard and Expand the Rights of Immigrants to Reproductive Health Care
- Improve Reproductive Health Services for Homeless Women
- Protect the Rights of Incarcerated Women to Reproductive Health Care

Together these briefs define the most pressing challenges and why they must be addressed in urban communities specifically. Each Focus Area provides an overview of the issue along with supporting research and analysis, as well as concrete local recommendations to address the challenges that have been identified. In addition to the research, analysis, and recommendations, we have provided examples of local successes from across the country to help guide local action.

REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL, HEALTH DISPARITIES





REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES

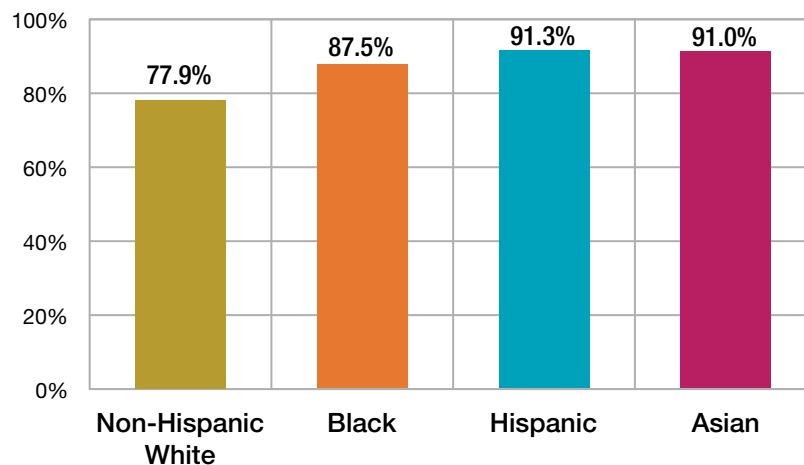
For many reproductive, sexual, and maternal health indicators, wide disparities exist based on socioeconomic status, race, and ethnicity. Although national rates have decreased for some of these indicators, racial, ethnic, and socioeconomic disparities continue to grow.¹ While these disparities are often attributed to personal behavior and individual decision-making, reproductive, sexual, and maternal health disparities highlight the failure of a broken health care system and underscore stark inequities in economic, environmental, and social conditions in the United States.¹ Many factors related to socioeconomic status, including income level and educational and employment opportunities, as well as the effects of racism, impact health choices and outcomes.² The social determinants of health, an emerging analysis used by public health leaders, elucidates the complex systems and social factors that perpetuate inequity and are impacting the health of urban communities. Acknowledging and addressing the social determinants of health are critical to closing persisting health disparities and achieving reproductive justice.

URBAN DEMOGRAPHICS

There are many reproductive, sexual, and maternal health disparities that must be eliminated, especially the increased rates of unintended pregnancy, abortion, teen pregnancy, infant mortality, and sexually transmitted infections (STIs) among poor women and women of color. Urban areas, which are more diverse and poor than other parts of the United States, are home to many women and families who are experiencing these health disparities. According to the U.S. Census Bureau, 87.5% of the U.S. Black population lives in a metropolitan area, with 51.5% living inside a central city;³ 91.3% of the Hispanic population lives in a metropolitan

area, with 45.6% living inside a central city;⁴ and more than 91% of Asian Americans live in metropolitan centers.⁵ In comparison, 77.9% of the non-Hispanic White population in the United States lives in a metropolitan area, with 21.1% living inside a central city.⁶ In 2007, the poverty rate in metropolitan areas reached 11.9%. Central city residents are almost twice as likely to be poor than those residing in the suburbs. Further, the poor in central cities are more likely to be foreign-born.⁷

PERCENT DISTRIBUTION OF U.S. RACIAL AND ETHNIC POPULATIONS LIVING IN METROPOLITAN AREAS



Source: U.S. Census Bureau

i Throughout the Agenda, we use the same racial and ethnic categorization as the data source.

EXAMINING THE CAUSES OF REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES

Race is a social construct without a biological basis, as scientific consensus and research have determined.⁸ Therefore, the underlying factors for persistent health disparities based on race and ethnicity cannot be explained solely by genetic predispositions. Racial and ethnic reproductive, sexual, and maternal health disparities are the result of a complex interplay between the social determinants of health, structural racism, and individual behavior.

The World Health Organization has defined the social determinants of health as “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.”⁹ For low-income and poor people of color in the United States, the social determinants of health reflect a history of racist policies and practices that have led to the perpetuation of disparate health access and outcomes. In other words, health disparities are related to and caused by the overall impacts of racism. Racism is in turn connected to a wide range of interrelated factors that affect health disparities, such as disadvantaged socioeconomic status,¹⁰ lack of health insurance and other barriers to access, unhealthy living environments, residential segregation, and stress.¹¹

The frame of structural racism can further our understanding of how all of these economic, social, and environmental factors intersect to produce health disparities. The Aspen Institute states that structural racism “refers to a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.”¹²

Structural racism has created the conditions for people of color to be systemically disadvantaged socioeconomically. Socioeconomic determinants impact health by limiting the social and economic resources available to an individual and his or her community. Educational opportunities are connected to health, not only as a gauge for a person’s current and potential occupational and economic choices, but also because education helps to shape health behaviors.¹³ Occupational opportunities, which are related to education, can be linked to expected income earnings and the workplace’s effect on health, in both psychosocial and toxic exposures. Socioeconomic status also limits access to health

insurance and preventive care, which profoundly affect health outcomes.

However, socioeconomic status alone is insufficient in fully explaining racial and ethnic health disparities and outcomes. For example, recent analyses of birth outcome data, including low birthweight, preterm birth, and infant mortality, show racial disparities spanning socioeconomic status.¹⁴ African American infants are twice as likely to die before their first birthday as non-Hispanic White infants.¹⁵ These data correspond to an approximately twofold increase in low birthweight and preterm deliveries among African Americans in comparison to non-Hispanic Whites.¹⁶ Furthermore, even when controlling for socioeconomic status, African Americans continue to have higher infant mortality rates. This disparity is seen even when African American women of high socioeconomic status are compared with non-Hispanic White women with low socioeconomic status.¹⁷ If socioeconomic status cannot account for these disparities, then limited access to reproductive health care due to poverty cannot be the sole causal factor for disparate birth outcomes along racial lines.¹⁸ Here the life-course context becomes crucial in addressing maternal health development in relationship to race—there are factors adversely affecting the reproductive health of African American women that are not affecting the birth outcomes among non-Hispanic White women.¹⁹ These disparities must be interpreted inside the context of the accumulation of stressors related to the social determinants of health, including racism and discrimination.

Racism within the health care system specifically has direct impact on the reproductive, sexual, and maternal health of women of color. The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* has stated that “(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care.”²⁰ A recent study of African American women found that 67% of the women who had received family planning and contraceptive services experienced race-based discrimination.²¹ The relatively small numbers of people of color in the health profession can reduce access for people of color and shape their health care experiences. As the United States has become more diverse, there has not been a proportional growth in the

diversity represented in jobs held by health professionals.²²

Provider bias, as well as lack of diversity among health care professionals, is a particular concern given the historical medical mistreatment of people of color in reproductive and sexual health care—a history that has sowed distrust of the health care system within many communities of color. One example of such mistreatment in reproductive and sexual health care is the Tuskegee Syphilis Study run by the U.S. Public Health Service from 1932 to 1972 during which the Service experimented on African American men by testing them for syphilis but withheld the diagnosis and treatment.²³ Another source of distrust is the historically coercive use of sterilization and long-term contraceptives in women of color, a practice that has been government-sponsored.²⁴

In sum, while much attention has been paid to individual behavior in regard to sexual health outcomes, recent studies show that individual behavior does not significantly correlate with many racial sexual health disparities.²⁵ For example, African American women who do not engage in high-risk behavior are still more likely to suffer high-risk outcomes than their White female counterparts. In a 2007 study in

which 37.6% of the African American participants fell into a low-risk category of sexual behavior and drug use, in contrast to only 12.7% of White participants, the African American participants were still 7.8 times more likely to contract human immunodeficiency virus (HIV).²⁶ Similarly, the 2002 National Vital Statistics Report from the Centers for Disease Control and Prevention (CDC) reported that African Americans who abstained from smoking during pregnancy were still more likely to experience infant mortality than non-Hispanic White women who smoked while pregnant.²⁷ Thus, on an epidemiological level, an individual can be considered only within the larger social network and community in which he or she lives—communities that are shaped by the social determinants of health.

In the following briefs, we lay out data on the most pressing reproductive, sexual, and maternal health issues facing urban areas today. For all of the issues highlighted in this Agenda, the social determinants of health must shape not only our understanding but also our plans for how to close disparities and increase equity.



RECOMMENDATIONS TO REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES

Continued inequality and lack of access to information and services perpetuate health disparities that harm communities. There are a variety of socioeconomic, social, and environmental inequities that affect reproductive, sexual, and maternal health disparities. To address reproductive, sexual, and maternal health disparities, urban areas should not only increase and ensure equitable access to health care but also work to dismantle the structures that perpetuate the inequities that adversely impact health.

WE CALL ON LOCAL LEADERS TO REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES BY:

Coordinating all local public agencies to implement efforts that will address disparities. Given the intersectionality of a myriad of determinants affecting health disparities, any efforts to redress these disparities must be across agencies and advocacy groups. Local government or administrative departments that may not often focus on reproductive, sexual, and maternal health care, such as public transportation, education, and housing, play an important role in reducing health disparities by facilitating access to services and supporting healthy neighborhoods.

- We urge local leaders to streamline and integrate service delivery of public assistance and health care to underserved communities.

Acknowledging and addressing the impact of structural racism in their communities through public commitment to reducing disparities. Learning about and understanding the frame of structural racism can help communities begin the work required to dismantle structures that benefit some groups at the expense of others.

- We urge local elected and public health officials to commit to reducing disparities through an exploration of the role that structural racism plays in their communities and health care systems.

Implementing data collection plans that will further support targeted education and health care interventions. Local policymakers are positioned to address health disparities. Collecting local data is essential to effectively prioritizing resources and developing programs aimed at eliminating disparities.

- We urge local leaders to create or support plans for local data collection on disparities in reproductive, sexual, and maternal health outcomes.

LOCAL EXAMPLES:

■ In 2007, the **Los Angeles County Department of Public Health** spearheaded collaborative local efforts to identify current gaps, trends, and future steps to improve the health status of women and to develop short-term priority policy recommendations that will reduce health disparities and improve health outcomes for Los Angeles County women, especially low-income women of color.

■ In order to further the analysis of health disparities, **The Boston Public Health Commission's Center for Health Equity and Social Justice** has standardized the collection and reporting of data related to health care access and utilization by race, ethnicity, education, and language.

■ In **Atlanta, Fulton County** has created a local health initiative, **Common Ground**, to transform local health services to better address the social determinants of health and eliminate health disparities.

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INCREASE ACCESS TO FAMILY PLANNING AND ABORTION INFORMATION AND SERVICES





INCREASE ACCESS TO FAMILY PLANNING AND ABORTION INFORMATION AND SERVICES

Family planning information and services provide individuals with the tools necessary to time and plan pregnancies and prevent unintended pregnancies. In addition, these services are critical to ensuring women, men, and young people are able to access safe abortion services; protect against human immunodeficiency virus (HIV) and sexually transmitted infections (STIs); access confidential testing and treatment for HIV and STIs; and access screening for cervical and breast cancer. Accessible family planning education and services are critical to guaranteeing the human right to self-determination.

THE IMPORTANCE OF FAMILY PLANNING

Family planning has numerous benefits for the health and well-being of women, young people, families, and communities. Beyond the benefits of enabling women to determine when and whether to become pregnant, family planning services also facilitate the delivery of screenings and treatment for HIV and STIs and other conditions such as cervical and breast cancer.¹

A typical woman in the United States spends three decades of her life trying to avoid an unintended pregnancy.² For U.S. women of reproductive age (15–44 years of age), use of contraceptive services and supplies is extremely common; 98% of women who have had intercourse have used contraception.³ Nationally, the most popular method is the oral contraceptive pill, followed by female sterilization and the condom.⁴ However, depending on age, there are differences in the contraceptive methods women choose. Among U.S. women 15–19 years of age currently using contraception, the oral contraceptive pill is used by 16.9% and the condom is used by 14.1%. Among women 20–24 years of age currently using contraception, 31.9% are using the oral contraceptive pill and 21.8% report using condoms.⁵

Despite widespread experience with contraceptives among U.S. women, nearly half of all pregnancies in the United States are unintended, meaning women report that their pregnancies were either mistimed or unwanted. Of these unintended pregnancies, 44% are carried to term and 42% end in abortion.⁶ Ninety-five percent of unintended pregnancies occur among women who are not using contraceptives at all or are using them inconsistently.⁷ The proportion of unintended pregnancies remains highest among women under 20 years of age, which reflects teens' relatively inconsistent use of contraception.⁸ Among sexually active teens ages 15–19, approximately 59% report using a form of contraception consistently.⁹ Unintended pregnancies that are carried to term are associated with delayed initiation of prenatal care and increased likelihood of smoking and alcohol use during pregnancy. Unwanted pregnancies, which are not just mistimed but unwanted, are more likely to result in low birthweight and even infant mortality.¹⁰ Women carrying these pregnancies are also more likely to smoke and consume alcohol during pregnancy, and following delivery are less likely to breastfeed and more likely to report postpartum depression.¹¹

THE CRITICAL ROLE OF FEDERAL FAMILY PLANNING PROGRAMS

It is estimated that around 17.5 million U.S. women are in need of publicly funded contraceptive services.¹² In 2002, the direct medical costs of unintended pregnancy in the United States reached \$5 billion, while savings from avoiding unintended pregnancies through contraceptive use were estimated to be \$19 billion.¹³ For every dollar spent on family planning services, \$4.02 is saved by averting an unintended pregnancy.¹⁴ In 2002, 42% of women of reproductive age had received family planning services within the last year; 30% of these women went to private doctors while 14% went to a publicly funded clinic.¹⁵

Medicaid and the Department of Health and Human Services' Title X Family Planning program are the two main sources of public funding for family planning services. Medicaid accounts for 70% of the public dollars spent on family planning.¹⁶ Many states have opted to expand the number of women eligible for family planning services through Medicaid family planning waivers.¹⁷

Established in 1970, Title X is the only federal program devoted solely to family planning services, supplies, and infrastructure.¹⁸ No Title X funds can be used for abortion

services. In 2006, the Title X program supported family planning services received by 4.7 million U.S. women, of whom 67% had incomes at or below the federal poverty level and 61% were uninsured.¹⁹ In addition, women under 25 and women of color are more likely to rely on Title X for family planning services.²⁰ Despite the critical role Title X plays in ensuring access to family planning services—especially among those who do not meet the eligibility requirements

for coverage under Medicaid—funding for Title X has been stagnant, and the program faces a number of critical challenges that increased funding could help address. One key challenge is providing services to all women needing publicly subsidized contraceptive services, including hard-to-reach clients and clients with special needs, such as homeless or disabled women, women with substance-abuse issues, and immigrants who are ineligible for Medicaid.

THE NEED FOR SAFE AND ACCESSIBLE ABORTION SERVICES

In addition to access to contraceptive services and supplies, a woman's self-determination is also supported by her legal right to abortion. In the United States, abortion is a common medical procedure and experience for women; about one-third of women will have an abortion at some point during their reproductive years.²¹ In the United States, 88% of abortions occur at twelve weeks or earlier in pregnancy.²² Most abortions occur among women in their twenties (56.5%).²³

Women cite many reasons for choosing to terminate their pregnancies. Seventy-four percent of women who have had an abortion state that having a child would have directly interfered with their education, work/employment, or ability to care for other children; 73% say they could not afford a

child. Furthermore, four in ten women state they feel they have completed childbearing; about one-third were not ready to have a child.²⁴ Many women also terminate their pregnancies because it is medically indicated; that is, the pregnancy or birth endangers a woman's health and life, as well as that of the fetus.

While abortion is a critical experience in women's lives, the procedure is stigmatized and marginalized. To truly exercise their right to abortion, women must have access to abortion counseling that is medically accurate and unbiased as well as services that are affordable and free from judgment and harassment. In addition, contraceptive services should be available at the time of abortion to help women prevent subsequent unintended pregnancies.

UNINTENDED PREGNANCY AND ABORTION DISPARITIES

Unintended pregnancy is an area of reproductive health where disparities based on income, race, and ethnicity are particularly wide. Recent analysis has shown that while the unintended pregnancy rates nationwide have stabilized, unintended pregnancy rates for poor women increased by 29% between 1994 and 2001.²⁵ Poor women are almost four times more likely to have an unintended pregnancy, about three times more likely to have an abortion, and five times more likely to have an unintended birth than higher-income women.²⁶

However, while low-income women are more likely to experience an unintended pregnancy, their ability to exercise their right to abortion is greatly limited. The Hyde Amendment, which prohibits the use of federal Medicaid funds for abortion services except in the cases of rape, incest, and life endangerment, drastically reduces low-income women's ability to afford abortion procedures. Seventeen states use state funds to cover some abortion services for women on Medicaid.²⁷ Low-income women are almost twice as likely as more affluent women to face difficulties in arranging for abortion services, mostly due to the time needed to secure payment for the services.²⁸ Further, recent research shows that restrictions on Medicaid funding for abortions force a quarter of the women who would have used Medicaid

funding for an abortion procedure to carry that pregnancy to term.²⁹

Further, the unintended pregnancy rates vary drastically by race and ethnicity; Black women experience an unintended pregnancy rate almost three times the rate of White women, while Hispanic women's unintended pregnancy rate is double the rate of White women.³⁰ The disparities among women experiencing unintended pregnancy are then reflected in abortion and unintended birth rates.

Reasons for increased rates of unintended pregnancy among low-income women and women of color are complex and continue to be explored; however, lack of access to contraceptive education and services and, for women of color, a distrust of and dissatisfaction with contraception and family planning services are factors leading to the continued unintended pregnancy rate disparities among populations.³¹ Women of color who are at risk for unintended pregnancy are more likely to report using no method of contraception or to experience gaps in use of contraception.³² Low-income women, women of color, and women on Medicaid are more likely to either use no contraception or experience gaps in usage.³³ Furthermore, lack of insurance coverage has been found to be a strong indicator for whether women at risk of unintended pregnancy are not using contraception.³⁴

THE NEED FOR FAMILY PLANNING AND ABORTION INFORMATION AND SERVICES IN URBAN AREAS

Urban areas are home to greater proportions of women of reproductive age and have higher fertility rates than national averages, resulting in a large demand for family planning services.³⁵ Unintended pregnancy rates among urban low-income women have been found to be higher than national averages.³⁶

For women facing unintended pregnancy, abortion information and services are critical to ensuring their health and right to determine their lives. Abortion services are most often accessed in urban areas due to increased availability. Many areas across the United States do not have doctors or clinics that are equipped or willing to provide safe abortion services—87% of counties do not have an abortion provider, and 35% of women ages 15–44 live in these counties.³⁷ There

are regional variations in women’s access to abortion; in the South, 91% of counties do not have an abortion provider, and in the Midwest, the number is as high as 94%.³⁸ The lack of providers outside major metropolitan areas means that women disproportionately seek abortion services in urban areas. Nearly one in four women obtaining an abortion travels more than fifty miles to reach a provider, and 8% travel more than one hundred miles.³⁹ Although there are a variety of health care facilities in urban areas that have the potential to meet this need for safe abortion services, research indicates the number of abortion providers in metropolitan areas is decreasing. In addition to the women from non-metropolitan areas relying on urban abortion services, 24% of women living in metropolitan areas are without local abortion services.⁴⁰



RECOMMENDATIONS TO INCREASE ACCESS TO FAMILY PLANNING AND ABORTION INFORMATION AND SERVICES

Family planning and abortion services that are of high quality, safe, and accessible ensure women have the ability to determine the timing and size of their families. Given the continually high rates of unintended pregnancy in the United States, access to these services is increasingly imperative to the health of urban communities. In addition to providing reproductive health services, family planning clinics also serve as many women's primary source of medical care and provide screenings for breast and cervical cancer. Family planning services have fiscal benefits in addition to widespread improvements in the health of women, men, and youth. When unintended pregnancies do occur, it is critical that women have the right to choose and access abortion services. Communities rely on family planning services and need local advocates and policymakers to support and protect access.

WE CALL ON LOCAL LEADERS TO INCREASE ACCESS TO FAMILY PLANNING AND ABORTION INFORMATION AND SERVICES BY:

Ensuring that the family planning services provided by cities and counties are available and continue to offer quality care. Quality family planning services need to be provided in a safe and accessible manner to ensure utilization. Further, in order to increase successful contraceptive use by women, access to a broad range of contraceptive services and supplies needs to be fully integrated into the health care system.

- We urge local governments to support the family planning providers and clinics in their communities.
- We urge local public health officials to provide continuing education to providers on cultural competency and current best contraceptive provision practices.
- We urge local health departments to provide routine reproductive health screenings as part of primary care and provision of or referral to other providers for contraceptive supplies and services.

Supporting and creating public education awareness campaigns and outreach efforts for local family planning services. Increasing access to family planning includes supporting both clinical services and education. Public education campaigns can inform and alert women about the importance of family planning as well as how to easily access services in their community.

- We urge local health departments to collaborate with local advocacy groups to implement public education campaigns that can educate the community about contraception, help change

social norms about sexuality to increase acceptance of contraceptive use, particularly among young people, and produce resource guides to direct women to the services they need.

- We urge local leaders to include information about family planning services in city or county websites and helplines.

Securing and protecting women's rights to family planning and abortion services. In order to exercise their fundamental right to abortion, women need access to safe and affordable services. Ensuring that family planning and abortion clinics and their patients are protected is key to guaranteeing the fundamental human right to self-determination and privacy.⁴¹

- We urge local elected leaders to enact buffer zone legislation to protect the rights and preserve the safety of providers and their patients who need to access clinic services.
- We urge local leaders to affirm that the full range of reproductive health care services, including abortion, is a human right.
- We urge local elected leaders to ensure that low-income women can realize their right to choose by allocating city or county funding to cover abortion counseling and services.

Advocating for the federal government to increase funding and eliminate restrictions on coverage for reproductive health care. Increasing access to critical family planning and abortion services will require funding and the elimination of coverage bans. More federal funding is needed to support Title X clinics, including their basic infrastructure needs such as paying utility bills and purchasing equipment, providing newer and more effective, long-lasting methods of contraception, and offering state-of-the-art diagnostic tests that promise improved detection rates for STIs and cervical cancer.

- We urge local leaders to call on the federal government to increase funding for the Title X program.
- We urge local leaders to call on the federal government to repeal the discriminatory Hyde Amendment.

LOCAL EXAMPLES:

- In **New York City**, public funds were allocated for public education campaigns to increase awareness about contraception, and the city's 311 free helpline now provides resources on available local family planning services.
- In **Madison, WI**, the City Council passed an ordinance ensuring pharmacies that do not stock emergency contraception post a sign giving information about emergency contraception and where to obtain it.
- In **Austin, TX**, the City Council passed an ordinance to ensure that any pharmacy contracting with the city would be required to fill clients' birth control prescriptions at the time the prescription was presented at the pharmacy.
- In **Pittsburgh**, the City Council passed a buffer zone ordinance to protect women from undue harassment when accessing services at reproductive health clinics.

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EMPOWER YOUNG PEOPLE TO MAKE HEALTHY DECISIONS





EMPOWER YOUNG PEOPLE TO MAKE HEALTHY DECISIONS

Reproductive and sexual health for young peopleⁱ is critical to the healthy development of the next generation. Despite the importance of accessible, high-quality health care, many young people in the United States are without the services and support necessary to ensure their health and prosperity during adolescence and adulthood. Young people are often isolated from education and service provision due to social and familial discomfort surrounding sexuality, policies limiting adolescent access to information and services, structuralized and institutional racism, gender stereotypes, and lack of cultural competency among health providers, school faculty, and other adults who interact with adolescents. The combination of these factors leaves young people ill-informed and isolated from reproductive health services.¹ These barriers put young people at higher risk for sexually transmitted infections (STIs), unintended pregnancy and birth, non-consensual sexual interactions, early sexual debut, and multiple sexual partners at a young age, with widespread ramifications for adolescents, their families, and their communities. Given these challenges, local advocacy groups and elected and public health officials in urban areas must expand efforts to improve the health of young people in their communities.

URBAN YOUNG PEOPLE

Urban young people bear a disproportionate reproductive and sexual health burden. In comparison to national averages, urban teens are more likely to have ever had sex, to have had sex before age 13, to have had four or more sexual partners, to have experienced dating violence, and to have experienced forced sex.² Furthermore, a closer look at city demographics reveals widespread adolescent reproductive health disparities

between urban neighborhoods in the same metropolitan area.³ Low-income communities of color are the hardest hit by the aforementioned burdens and often have the fewest resources to address adolescent health due to many barriers such as poverty, isolation, unstable housing, lack of health insurance and underinsurance, and exposure to violence.⁴

SEXUAL ONSET

Nationwide, approximately 46% of adolescents ages 15–19 and 20% of adolescents ages 12–14 have had sex.⁵ Sexual onset before 14 years of age correlates to an increased likelihood of high-risk behaviors, including having multiple sexual partners, having low levels of condom use, having or having caused a pregnancy, contracting an STI, and drug and alcohol abuse.⁶ African American, Latino, and Native American youth are more likely to have sexual debut at a younger age than White youth. This is particularly true among non-Hispanic Black teenage boys, nearly one-third of whom report having had sex before the age of 13 versus 11% of Hispanic and 5% of White youth. Additionally,

non-Hispanic Black young people are more than twice as likely to have had multiple sexual partners.⁷ These racial disparities in age of sexual onset can be attributed to systemic factors such as racial profiling in school, health care, and other settings; lack of opportunity; discrimination; lack of cultural competence among health practitioners; limited access to reproductive and sexual health services; and persistent levels of racial segregation among both schools and cities, which create urban areas with high levels of neighborhood-concentrated poverty and lower levels of collective efficacy for African American young people.⁸

ⁱ *Young people* refers to those between the ages of 12 and 24. Adolescent studies tend to focus primarily on teens ages 15–19, neglecting the equally important early adolescent (ages 12–14) and young adult (ages 19–24) years. In order to accurately represent the state of adolescent reproductive health and ensure young people have a healthy future, the Agenda will focus on the full spectrum of adolescence through young adulthood.

CONTRACEPTIVE USE AND STI PREVALENCE

While many young people do use contraceptives to protect against unintended pregnancy and STIs, there is significant room for improvement. Among heterosexually active young people, condoms are the most popular form of contraception, with 61.5% nationwide reporting condom use at last intercourse. However, markedly fewer young people use condoms consistently. Only 50% of sexually active males ages 15–19 report using condoms consistently and, overall, teenage girls are less likely to report using condoms than teenage boys.⁹ Given that male condoms require partner negotiation, adolescent girls are put in a particularly vulnerable position. Many young women lack the agency required to ensure safe sexual practices through partner negotiation and are thus less likely to protect

themselves against pregnancy and STIs, including human immunodeficiency virus (HIV). Over nine million new STI cases are diagnosed in young people each year, accounting for almost half of all new STIs, yet young people account for only one-quarter of the overall population.¹⁰ Teenage girls ages 14–19 bear a large share of this burden. One in four (26%) has an STI, and teenage girls in urban environments are faring even worse.¹¹ For instance, the New York City Department of Health and Mental Hygiene reports one in three (34.1%) teenage girls ages 15–19 has an STI; rates are even higher in low-income neighborhoods such as the Bronx borough.¹² Additionally, there has been a notable decline in the use of hormonal contraceptives among teens, particularly non-Hispanic Black and Hispanic teens.¹³

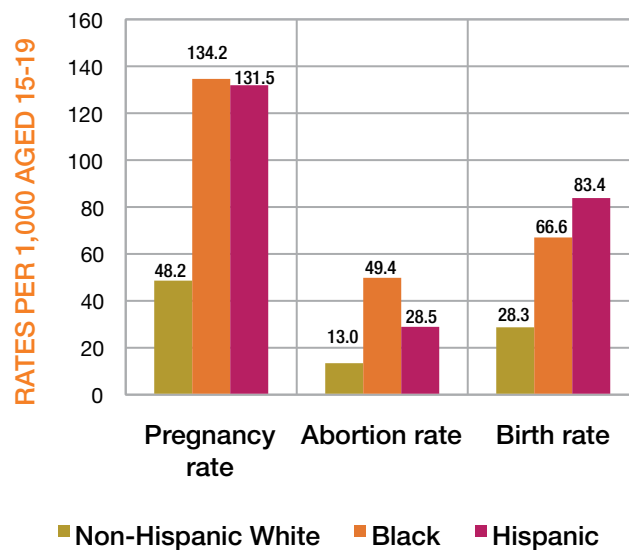
TEEN PREGNANCY

The United States has the highest teen pregnancy rate in the industrialized world.¹⁴ One out of every three girls becomes pregnant at least once before the age of 20.¹⁵ Teens and young adults have unplanned pregnancy rates much higher than other age groups (67 and 104 per 1000 women, respectively) and, in 2006, the national U.S. teen birth rate increased for the first time in fifteen years by 3%.¹⁶ These high rates of pregnancy and birth can be attributed to a combination of factors, including inadequate sexuality education, societal discomfort with sexuality, limited economic mobility and educational opportunity, and difficulty obtaining contraception. These barriers are particularly problematic in urban environments and among communities of color, where pregnancy and birth rates for young people can be significantly higher than national averages.¹⁷

Hispanic and non-Hispanic Black young people ages 15–19 have teen pregnancy rates nearly three times higher than non-Hispanic White young people in the same age group (134.2 and 131.5 per 1,000 versus 48.2 per 1,000, respectively).¹⁸ Low-income urban neighborhoods with large communities of color, such as the South Bronx in New York City, have even higher rates of teen pregnancy (153 pregnancies per 1,000).¹⁹ Birth rates for non-Hispanic Black and Hispanic teens are two to three times higher than for their non-Hispanic White teen counterparts, yet despite similar overall pregnancy rates, Hispanic teens have a 25% higher birth rate than non-Hispanic Black teens.²⁰ Studies show the children of teen parents are more likely to become teen parents themselves, engage in risky behaviors, and be incarcerated.²¹ These outcomes for some teen parents

demonstrate that pregnant and parenting teens need more support in order to succeed. Oftentimes, teen pregnancy is the result of limited access to educational and occupational opportunities as well as reduced access to health information and services. Efforts to prevent unintended teen pregnancy must not stigmatize teens who are pregnant or parenting.

TEENAGE RATES OF PREGNANCY, ABORTION AND BIRTH BY RACE AND ETHNICITY



Source: *The Guttmacher Institute*

ROLE OF SOCIAL AND PARENTAL INFLUENCES

Adolescent reproductive health is deeply affected by social influences, ranging from a young person's school environment to the activities and behaviors of his or her peer group. Recent studies show that peer influence can either motivate or inhibit healthy sexual behavior. The majority of teens (58.9% of those ages 12–17) report that peer influence plays a positive role in making healthy decisions about sex.²² Regardless of whether peer influence results in positive or negative outcomes, it is clear that the sexual activity and habits of a peer group remain a primary indicator for individual teen sexual behavior. Teens with sexually active friends are more likely to have had intercourse themselves, and teens with peers who practice safer sex, such as the consistent use of condoms, are more likely to practice safe sex themselves.²³

ACCESS TO INFORMATION AND SERVICES

Many young people lack health insurance, limiting their access to reproductive and sexual health care. More than one-quarter (27.5%) of young adults ages 18–24 in the United States currently are uninsured.²⁶ On top of this, many young people are underinsured, with overwhelming out-of-pocket liabilities and coverage gaps and limitations. Even when young people have insurance, obtaining services can jeopardize confidentiality if insurance providers mail communications such as Explanations of Benefits to the home.

In addition to insurance coverage barriers, many young people find it difficult to access culturally competent practitioners with whom they feel comfortable discussing their sexuality and health. A 2004 study of urban African

While the key role of social influence cannot be undervalued, teens rank parents as the most influential factor in their decisions about sex. For teenage girls, an open mother-daughter relationship is especially important due to the gatekeeper role many mothers play for female adolescents initiating reproductive health care services.²⁴ Sexual debut is the recommended time to initiate gynecological care, but many mothers are not aware when sexual debut takes place. Delays between sexual onset and first pelvic exam are substantial, particularly for low-income, urban teenage girls. One New York City study, consisting of primarily low-income adolescent girls from the Bronx, found the mean interval between sexual onset and initial pelvic exam was 13.3 months. Often, gynecological care was initiated due to symptoms of STI or pregnancy.²⁵

American teens found that their experiences with the health care system were among the most demoralizing and upsetting experiences they encountered within the human services system.²⁷ Additionally, much concern exists among teens regarding the confidentiality of reproductive and sexual health care. Teens report having more positive experiences with the health system in clinics that are targeted toward teens, such as school-based health clinics, highlighting the importance of culturally competent and easily accessible care.²⁸ Overall, young people are more vulnerable to poor reproductive and sexual health outcomes than other populations, yet they often face significant barriers to accessing the education and health care services necessary to overcome these disparities.

YOUNG PEOPLE EXPERIENCING THE HIGHEST RISK

Given the importance of a stable home life and close parent-child relationships, young people from lower socioeconomic, urban neighborhoods with higher prevalence of crime and residential turnover often face reproductive and sexual health deficits.²⁹ This is particularly true for marginalized adolescents, such as LGBTQ (lesbian, gay, bisexual, transgender, queer and questioning) young people and teens in foster care, who often suffer from social isolation and familial castigation and bear a disproportionate reproductive health burden. Teens in the foster care system, as well as former participants who have aged out, have fewer health care resources, tend to be less familiar with the health care system than other youth, and have decreased or no

familial support.³⁰ Young people who have ever lived in foster care are more likely to be female, more likely to have had sex, and report higher rates of adverse reproductive and sexual health outcomes, including STIs, unintended births, and forced sex.³¹ LGBTQ young people are more likely to have ever had sex, have multiple partners, experience unplanned pregnancy, contract an STI, and experience non-consensual intercourse.³² Yet, despite these increased risks, LGBTQ young people are less likely to access care due to barriers such as lack of familial support, lack of safe and culturally competent health care environments, and negative past experiences with health care providers.³³



RECOMMENDATIONS TO EMPOWER YOUNG PEOPLE TO MAKE HEALTHY DECISIONS:

Young people need strong, unwavering support from local policy and public health leaders to ensure access to critical reproductive, sexual, and maternal health information and services. Communities must collectively address the primary reproductive, sexual, and maternal health issues facing young people in urban areas. Many local public health departments and policymakers are working to address these issues. These efforts must be expanded and strengthened with renewed support.

WE CALL ON LOCAL LEADERS TO EMPOWER YOUNG PEOPLE TO MAKE HEALTHY DECISIONS BY:

Creating local programs where young people can support and educate each other about reproductive and sexual health. As this brief highlights, in addition to the role played by parents, young people's sexual behavior can be strongly influenced by their peers. Furthermore, culturally competent reproductive and sexual health care is lacking, creating significant barriers for young people when accessing information and services. Peer-to-peer education opportunities can positively impact young people's use of condoms and engagement in safe sex and improve the reproductive and sexual health decision-making among youth participating as educators.³⁴ In addition, these programs can also foster positive youth development and self-esteem, which are essential to healthy decision-making.

- We urge local leaders to support peer-to-peer education programs to reduce stigma, communicate reproductive and sexual health information in a safe and comfortable environment, and create vital leadership opportunities for urban youth.

Utilizing education and service provision strategies that can be easily accessed by young people in urban areas. While many urban public health departments have education campaigns aimed at youth, innovative strategies, such as utilizing new technology, should be explored. In addition, outreach should be targeted at youth with the least access or at the highest risk, who often experience increased barriers and greater disparities.

- We urge local health departments to adopt or expand education strategies that employ social marketing and social media technologies currently popular among young people to disseminate reproductive and sexual health information and advertisements.
- We urge local advocates and public health officials to implement new strategies targeting their communities' underserved youth, including youth of color, young males, youth in the foster care system, LGBTQ youth, and parenting teens.

Expanding students' access to comprehensive reproductive and sexual health services in school-based settings and community-based health centers. Health care services provided in schools, or in coordination with school clinics, can be an effective way to provide culturally competent reproductive and sexual health counseling and, in some cases, services to young people in a safe and youth-oriented environment.³⁵ School-based clinics tackle many obstacles that otherwise force adolescents to delay or forego necessary care, such as cost, lack of transportation, inflexible clinic hours, and fears about privacy and confidentiality.³⁶

- We urge local public health officials to work with school board administrators to ensure that school-based or school-linked health centers are either providing counseling and reproductive and sexual health services or offering timely referrals for such services.

Enhancing young people's access to, and utilization of, contraceptives and condoms to prevent pregnancy and STIs. In order for young people to successfully protect themselves against unintended pregnancy and STIs, services and supplies must be easily accessible, including offering the full range of contraceptive methods.

- We urge local public health officials to facilitate the use of clinic protocols that make the range of effective contraceptives available on site to young people, including long-acting, reversible contraceptives and contraceptive initiation at any time without requiring a pelvic exam.

Supporting young mothers by fostering environments where mothers and their children are healthy and encouraged to reach their potential. For pregnant and parenting young people living in urban areas, education and services must be provided to address the challenges associated with young parenthood. This vital support—not only for the children of young mothers but for the mothers themselves—will help to ensure stronger and healthier communities.

- We urge local leaders to develop and continue to support programs targeting young mothers and their children.
- We urge local leaders to support parenting teens' right to access education by ensuring they are accommodated in schools with water and space to breastfeed or pump.

Protecting young people's right to confidential reproductive health services and information and educating young people and health care providers about rights to this care. As this brief highlights, concerns about the confidentiality of reproductive and sexual health care services are common among young people. Educating providers and young people about minors' rights to reproductive and sexual health care is a critical part of breaking down this education and service access barrier.

- We urge local elected leaders to introduce local legislation that affirms and protects minors' right to confidential reproductive and sexual health care.
- We urge local advocates and city and county health clinics to protect confidentiality and educate teens and their health care providers about minors' rights to access reproductive health services.

LOCAL EXAMPLES:

- In **New York City**, as part of the Healthy Teens Initiative, the Department of Health and Mental Hygiene supports access to teen-friendly sexual and reproductive health services.
- The School-Based Health Center Reproductive Health Project is a joint project of two **New York City** government offices that provides contraception in the city's school-based health centers.

- **San Francisco's Department of Public Health** uses text messaging technology to provide information on reproductive and sexual health to local young people.
- In **Philadelphia, the Department of Public Health**, with the support of the School District of Philadelphia, has implemented a voluntary, school-based screening program to educate, screen, and treat city high school students for Chlamydia and gonorrhea.

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SUPPORT AND IMPLEMENT COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS IN LOCAL SCHOOLS





SUPPORT AND IMPLEMENT COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS IN LOCAL SCHOOLS

Comprehensive sexuality education is a lifelong learning process that addresses issues related to sexual development, reproductive health, interpersonal relationships, affection, intimacy, and gender roles. The goal of comprehensive, school-based sexuality education is to help young people gain a healthy view of sexuality, provide them with sexual health information, and empower them to make sound decisions now and in the future.¹ Providing young people with information about sexual and reproductive health is important because most young people engage in sexual activity for the first time during adolescence.² Evaluations of comprehensive sexuality education, HIV-prevention, and adolescent pregnancy-prevention programs have shown that these programs delay the onset of intercourse, reduce the frequency of intercourse, decrease the number of sexual partners, and increase condom and contraceptive use.³ Comprehensive sexuality education programs provide an important strategy for creating healthy communities for young people in urban areas.

THE NEED FOR COMPREHENSIVE SEXUALITY EDUCATION

Adolescents are in need of comprehensive reproductive and sexual health information and services to help prevent unintended pregnancies and sexually transmitted infections (STIs). In 2001, more than 811,000 U.S. women under the age of 20 became pregnant and 82% of those pregnancies were unintended.⁴ Each year, over nine million teens and young adults are diagnosed with STIs.⁵ A recent nationally representative study from the Centers for Disease Control and Prevention (CDC) found that one in four teenage girls has a sexually transmitted infection.⁶ Comprehensive sexuality education is an important component of preventing unintended teen pregnancies, the spread of HIV and other STIs.

In addition to educating young people about reproductive and sexual health, comprehensive sexuality education

programs teach students about sexual identity and sexual orientation. These lessons can provide valuable support and information for teens who may be exploring and questioning their own sexuality, as well as create an environment that dispels the perpetuation of homophobia by removing stigma and building knowledge. Traditional abstinence-only programs inherently alienate LGBTQ (lesbian, gay, bisexual, transgender, queer and questioning) teens by promoting heterosexual marriage as the only acceptable family structure. This message also ostracizes students from divorced and single-parent families. Comprehensive sexuality education provides students with critical information about healthy relationships and healthy sexuality, which is much needed in light of the high rates of dating violence present in teen relationships.

PUBLIC SUPPORT FOR COMPREHENSIVE SEXUALITY EDUCATION

Recognizing the need for reproductive health information, an overwhelming majority of American adults (89%) support sex education that includes information about contraceptives and STI prevention.⁷ In addition, major medical associations across the country have expressed their support for comprehensive sexuality education, including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Medical Association, American Public Health Association, and Society for Adolescent Medicine.⁸

Unfortunately, despite vast public support and research showing their effectiveness, comprehensive sexuality education programs are not employed in many of our cities'

schools. Instead, abstinence-only programs that either do not teach about contraception or provide misinformation have proliferated over the past decade. Under the George W. Bush administration, over 1.5 billion state and federal dollars were spent on abstinence-only programs.⁹ Despite their prevalence, numerous research studies, including a federally funded study authorized by Congress, have proven abstinence-only programs to be ineffective by demonstrating that they do not prevent young people from engaging in sexual intercourse.¹⁰ As of August 2008, twenty-five states had refused federal abstinence-only funding.¹¹ Fortunately, it is widely expected that federal funding for comprehensive sexuality education and teen pregnancy prevention programs will be available in 2010.



RECOMMENDATIONS TO SUPPORT AND IMPLEMENT COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS IN LOCAL SCHOOLS

Political support at the local level for comprehensive sexual health information and services is essential to the health and well-being of young people and the community as a whole. Each state and county has a unique set of laws, regulations, and funding sources regarding sexuality education. Some states mandate comprehensive sexuality education, some require that abstinence be stressed or that curricula be medically accurate and comprehensive if taught at all, and some are silent on the issue. Beyond the point of what curriculum is mandated or recommended, individual principals and teachers vary greatly in the content they teach. The variations between state, county, and school board policies, and their complicated relationship to each other, make it necessary for advocates to be well informed and to strategically target appropriate decision-makers. Ultimately, local activists and local policymakers are well positioned to respond to the unique and complex set of policies determining and regulating sexuality education and funding in their school districts.

WE CALL ON LOCAL LEADERS TO SUPPORT AND IMPLEMENT COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS IN LOCAL SCHOOLS BY:

Creating, implementing, and enforcing local policies that require comprehensive sexuality education within local school districts. School-based sexuality education is a lifelong lesson that develops a broad range of knowledge and skills. In addition to providing necessary information to combat rising teen pregnancy rates, comprehensive programs also target critical issues in the lives of young people. Comprehensive programs include not only information on preventing pregnancy and STIs, but also on how to communicate more effectively, develop healthy relationships, and boost self-esteem. This information extends beyond the confines of a school day and truly prepares students with the knowledge they need to make informed and healthy choices throughout their lives.

- We urge local elected officials to enact legislation mandating and supporting medically accurate comprehensive sexuality education.
- We urge local officials to collaborate with advocacy groups to implement a comprehensive sexuality education model for students of all ages that targets issues facing younger adolescents, such as peer pressure, healthy body image, and media messaging.
- We urge local officials to ensure implementation by adopting guidelines that schools can use to measure the quality of and evaluate their sexuality education programs.

Supporting local efforts that encourage parents to provide sexuality education and coordinating these efforts with school-based curricula. The most effective comprehensive sexuality education involves not only a school-based program but parents as well. Research has proven the success of parental involvement—when parents tell their teenager to wait, their son or daughter is more likely to delay sexual activity.¹²

- We urge local officials to support school boards and parents in implementing programs focused on improving parent-child communication and educating parents with the latest health information.

LOCAL EXAMPLES:

- **Chicago** has created local guidelines to ensure that students receive comprehensive sexuality education that is medically accurate and age-appropriate despite a state policy that requires an emphasis on abstinence.
- When the mayor of Cleveland called for comprehensive sex education in **Cleveland public schools** to combat the rising number of HIV cases, the Collaborative for Comprehensive School Age Health, a diverse coalition of stakeholders, worked with the Metropolitan School District to develop and institute a comprehensive sex education plan that relied on the CDC's Healthy People 2010 goals for the city's entire student body.

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ENSURE HEALTH THROUGH THE CONTINUUM OF PREGNANCY, BIRTH, AND THE POSTPARTUM PERIOD





ENSURE HEALTH THROUGH THE CONTINUUM OF PREGNANCY, BIRTH, AND THE POSTPARTUM PERIOD

Despite possessing ample knowledge and technology to provide exceptional health care, the United States lags behind other industrial nations in providing quality care to women throughout the reproductive continuum. Maternal and child health are affected by events along a life-course continuum, beginning with preconception care and continuing through the prenatal, perinatal, postnatal, postpartum, and interconception periods.ⁱ Across the reproductive health continuum, poor maternal and infant health outcomes are consistently tied to adverse socioeconomic factors and systemic barriers.¹ Adverse maternal and child health outcomes result in medical and socioeconomic burdens for women, their families, and their communities, particularly for low-income people of color. U.S. cities bear the brunt of this burden; city fertility rates are higher than the national average, and rates for key outcomes such as low birthweight and infant mortality exceed national averages, resulting in an urban reproductive health deficit with far-reaching consequences.² Addressing women's health throughout the continuum ensures that all women will achieve and maintain optimal health before, during, and beyond their reproductive years, regardless of their childbearing plans.

THE NECESSITY AND SCOPE OF COMPREHENSIVE PRENATAL CARE

Prenatal care remains the most common health intervention targeted at improving birth outcomes and overall maternal-child health. The initiation of attentive, culturally competent prenatal care in the first trimester, followed by at least thirteen prenatal visitsⁱⁱ throughout a full-term pregnancy, can result in improved birth outcomes with fewer complications, the reduction of maternal smoking rates, increased childrearing education, and a preemptive approach to decreasing the costly maternal health care associated with low birthweight and preterm births.³ Conversely, late or no prenatal care has been associated with a wide range of poor pregnancy outcomes, including a 40% increase in neonatal death, maternal health complications, and future health problems for children.⁴

Marked disparities exist regarding the provision of prenatal care. Low-income women of color bear the brunt of this burden, often entering prenatal care later, having fewer total visits, and experiencing less attentive care than white women of higher socioeconomic levels in the same city.⁵ Additionally, recent research surrounding the efficacy of prenatal care suggests that even when women of color do receive best-practice prenatal care, nine months cannot mediate the lifetime of health inequities many of them have faced.⁶

i Health care during the *preconception* period has been emphasized recently by the CDC as a critical avenue for improving the overall health of women throughout the life cycle, as well as pregnancy outcomes should a woman decide to become pregnant. It is important to note that preconception care refers to the reproductive health and overall wellness of women regardless of their choice to bear children. For those women who do give birth, *prenatal* refers to the period of pregnancy before birth, *perinatal* refers to the time around birth, *postnatal* and *postpartum* refers to the period after birth, and *interconception* refers to the period between one birth and a subsequent pregnancy. Together, these five terms cover the wide expanse of the *reproductive health continuum*.

ii The American College of Obstetricians and Gynecologists recommends a minimum of thirteen prenatal visits beginning in the first trimester of pregnancy.

PERINATAL TRENDS: LOW BIRTHWEIGHT, MATERNAL AND INFANT MORTALITY

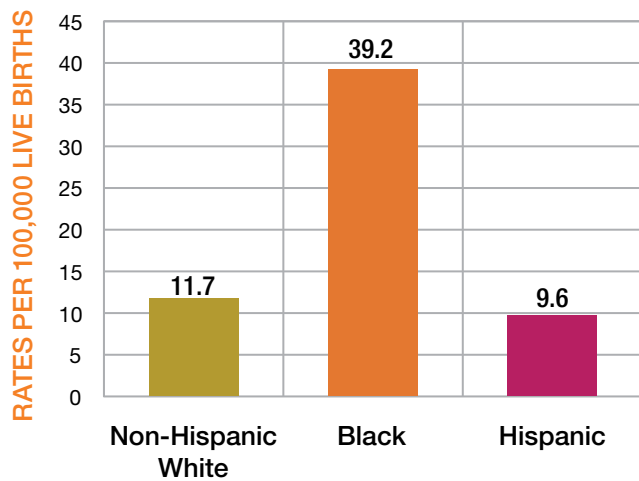
Sufficient knowledge and technology exist to facilitate safe and healthy full-term births.⁷ However, an overreliance on interventions has resulted in nearly one-third of all U.S. births utilizing Cesarean sections, a rate significantly higher than World Health Organization need-based projections.⁸ Furthermore, key outcomes such as maternal mortality, infant mortality, and preterm births show little or no progress. Given that many maternal deathsⁱⁱⁱ could be prevented with timely reproductive health care, high maternal mortality rates indicate poor provision of care and subsequently an overall shortfall in women's health.⁹

The U.S. maternal mortality rate of 12.1 per 100,000 live births falls behind many other industrialized nations, and urban populations are faring much worse, particularly in low-income neighborhoods.¹⁰ For example, the 2005 maternal mortality rate for New York City was 25.1 deaths per 100,000, while the rate for primarily low-income Kings County was 33.5.¹¹ Overall, it is non-Hispanic Black women who bear the highest burden with a national maternal mortality rate of 39.2 per 100,000 births, three times that of non-Hispanic White women (11.7 per 100,000). Hispanic women have the lowest rate of maternal mortality (9.6 per 100,000) despite the many socioeconomic parallels between Hispanic and African American women.¹² This trend is most notable among first-generation Mexican and

Central American immigrants and has been attributed to the prevalence of a healthy traditional diet, strong cultural support for pregnant women, and multigenerational community networks that provide care and information to new mothers.¹³ However, these reproductive health outcomes worsen as continuing generations of children are born in the United States, from the combined effects of acculturation, health behaviors, and lack of access to health care.¹⁴

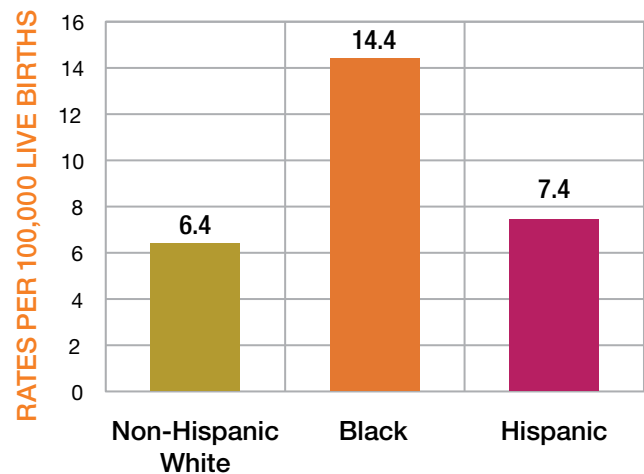
As with maternal mortality, high rates of infant mortality often reflect poor maternal health and lack of quality prenatal care, which impede fetal development and infant health. The 2006 national infant mortality rate of 6.9 per 1,000 live births places the United States thirty-third out of 195 nations, far behind most other developed nations.¹⁵ U.S. cities fare even worse. In 2003, U.S. cities had an average of 7.9 deaths per 1,000 live births, with marked racial and ethnic disparities. The average urban non-Hispanic Black infant mortality rate was 14.4 per 1,000 live births, over twice the average rate for non-Hispanic White infants (6.4 per 1,000) and nearly twice the Hispanic rate (7.4 per 1,000).¹⁶ Overall, cities are falling drastically short of the Healthy People 2010 infant mortality goal of 4.5 per 1,000 live births, and urban non-Hispanic Black populations are bearing an immense burden in comparison to the national average.¹⁷

U.S. MATERNAL MORTALITY RATES BY RACE AND ETHNICITY



Source: U.S. Department of Health and Human Services

U.S. URBAN INFANT MORTALITY RATES BY RACE AND ETHNICITY



Source: Nanette Benbow, ed.

iii The following data are based on the World Health Organization's definition of *maternal death*: the death of a woman while pregnant or within forty-two days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management but not from accidental or incidental causes.

In 2005, 36.5% of infant deaths were associated with preterm births.¹⁸ Known maternal risk factors for preterm births and low birthweight include prenatal smoking and substance abuse, high blood pressure, diabetes, and prenatal stress.¹⁹ Even with these known risk factors, adverse birth outcomes are increasing and disparities are widening. Preterm births (before thirty-seven weeks of gestation) accounted for 12.5% of all births in 2005, an increase of 30% since 1981.²⁰ A 2005 review of reproductive health trends in high-poverty urban neighborhoods found the urban prevalence of babies born with low birthweight (8.9% of all births) higher than the national average (7.9% of all births), and a distinct disparity persisted between high-poverty neighborhoods and other

neighborhoods in the same city.²¹ Marked racial disparities also exist among preterm births, with the highest rate found among non-Hispanic Black populations. In 2003, 17.8% of all non-Hispanic Black births occurred before thirty-seven weeks of gestation in contrast to 11.5% for non-Hispanic White women.²² Among urban populations of color, these disparities are compounded. In a 2008 study of U.S. metropolitan areas, non-Hispanic Black women were nearly three times more likely (34.8 per 1,000 births) to have a very preterm birth (before thirty-two weeks of gestation) than non-Hispanic White women (12.3 per 1,000 births) and twice as likely as Hispanic women (15.7 per 1,000 births).²³

RACIAL AND GEOGRAPHIC DISPARITIES IN BREASTFEEDING

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend exclusive breastfeeding for six months following birth. Yet in 2004, 23% of children in the United States received supplemental formula within two days of birth.²⁴ Breastfeeding provides numerous benefits for both women and infants, including bolstered infant immune and digestive systems, lower rates of infant hospitalization, increased mother-child bonding, facility of postpartum weight loss, and reduced risk of postpartum depression as well as breast and ovarian cancers.²⁵ Unfortunately, strong economic, racial,

and geographic disparities persist in breastfeeding practices. New mothers residing on the West Coast are approximately two to three times more likely to initiate breastfeeding than those in many parts of New England and 2.5 to 5.15 times more likely to initiate breastfeeding than those residing in most southern states.²⁶ These geographic disparities are then exaggerated along racial and economic lines.²⁷ A 2008 study found that non-Hispanic White women are twice as likely to breastfeed as Non-Hispanic Black women and 1.5 times more likely to breastfeed than Hispanic women who do not speak Spanish in the home.²⁸

PROMOTING OVERALL WELLNESS THROUGH PRECONCEPTION CARE

While the provision of best-practice health care throughout the prenatal, perinatal, and postpartum periods is a necessary component in achieving healthy births, it has not proven sufficient in improving health and abolishing maternal and child health disparities.²⁹ Current research suggests that the many preconception stressors women face prior to pregnancy, such as racial discrimination, poverty, environmental toxics, and sexually transmitted infections, are linked to the risk of poor birth outcomes.³⁰ Furthermore, nearly 50% of all pregnancies in the United States are unplanned, which is often associated with delayed initiation of prenatal care, inadequate consumption of folic acid, increased fetal exposure to potential teratogens,^{iv} increased likelihood of postpartum

depression, and lower rates of breastfeeding.³¹ The preponderance of unplanned pregnancies and preconception stressors conflate to create a large reproductive, maternal, and sexual health burden for women. Preconception care aims to address this burden by improving the health of women throughout their lifetimes, thus fostering overall wellness and helping to ensure favorable outcomes should a woman decide to become pregnant.³² Preconception care that emphasizes overall wellness and health education, consistent screenings, and family planning is particularly important for non-Hispanic Black communities, which consistently have some of the worst reproductive health outcomes in the nation regardless of socioeconomic status.³³



iv Teratogens are any agents that can cause birth defects.

RECOMMENDATIONS TO ENSURE HEALTH THROUGH THE CONTINUUM OF PREGNANCY, BIRTH, AND THE POSTPARTUM PERIOD

Investing in and promoting reproductive health throughout the life-course continuum reduces the incidence of adverse outcomes for both women and their children, creating a foundation of good health within our communities. Successfully achieving optimal urban maternal health requires dynamic approaches to health care along the continuum and strong political commitment at the city and county levels. As evidenced in many urban areas, innovative and creative thinking and collaboration can facilitate the implementation of safe reproductive health interventions and ensure their sustainable integration into the health care system.

WE CALL ON LOCAL LEADERS TO ENSURE HEALTH THROUGH THE CONTINUUM OF PREGNANCY, BIRTH, AND THE POSTPARTUM PERIOD BY:

Recognizing the role that overall health has on producing healthy pregnancies in public health care delivery. Healthy pregnancies require good overall health throughout a woman's life. In order to achieve healthy pregnancies and births, preconception health education and services, as well as prenatal care, must be easily accessible throughout the health care system. Further, services must be made available to first-time mothers needing support to help them and their infants achieve optimal health during the postpartum period. Better pregnancy outcomes will produce healthier communities and signal an improvement in overall women's health.

- We urge local leaders to integrate preconception and prenatal health education and care into primary and other public health care settings.

Supporting home-visiting programs that support mothers and help them to succeed as parents and experience healthy outcomes for themselves and their infants. Programs that utilize home-visitation strategies, such as the nurse-family partnership program, show promise for improving reproductive and maternal health. Developed thirty years ago, the nurse-family partnership program focuses on providing support for low-income and young mothers during pregnancy and the postpartum period. These interventions have proven to improve prenatal health, reduce subsequent unintended pregnancies, and also increase rates of employment.³⁴

- We urge local leaders to support and expand local nurse-family partnership programs that target women experiencing adverse pregnancy and birth outcomes.

Supporting public education campaigns that empower women to make fully informed decisions about their pregnancies. In order for women to have positive pregnancy and birthing experiences, they need educational resources to help them make informed decisions about their maternal health care.³⁵

- We urge local leaders to collaborate with local advocacy groups to create resources that educate their communities about local birthing options and other pregnancy-related services.

Ensuring, affirming, and protecting a mother's right to breastfeed. Local officials need to protect the rights of mothers to breastfeed if they choose. Breastfeeding provides numerous health benefits to infants but also provides many positive mental and physical health benefits for breastfeeding mothers.

- We urge local leaders to implement policies that promote the ability of women to breastfeed, especially at work, at school, and in public spaces.

LOCAL EXAMPLES:

- The Preconception Care Health Collaborative in **Los Angeles County** is working to improve women's health by integrating preconception care into the Department of Public Health's general public health practice.
- **Dane County, WI**, has passed a municipal ordinance that protects a mother's right to breastfeed or express milk in public places or accommodations.
- In **New York City**, the Department of Health and Mental Hygiene's nurse-family partnership coordinates a home-visiting program for low-income, first-time mothers, their infants, and families that focuses on preventive health practices and parenting skills.
- In **Contra Costa, CA**, the county's Building Economic Security Today (BEST) program is teaching financial skills as a way to address the social determinants of health to ultimately improve infant mortality rates.

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ADVANCE HIV/AIDS AND SEXUALLY TRANSMITTED INFECTION PREVENTION AND TREATMENT





ADVANCE HIV/AIDS AND SEXUALLY TRANSMITTED INFECTION PREVENTION AND TREATMENT

Despite the existence of effective testing and treatment technology, high rates of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), persist in the United States. The rates reflect a lack of effective access to services and education connected to underlying inequities in our society. In addition, a myriad of other social determinants that affect individuals' risk behaviors impact the continually high rates of STIs. In 2007, 1,108,374 cases of Chlamydia were reported to the CDC, a 7.5% increase from 2006 and the largest number of cases ever documented for any condition.ⁱ¹ Syphilis rates have increased every year since 2001, despite the success of the National Plan to Eliminate Syphilis in the 1990s,² and HIV rates continue to rise, particularly in communities of color.³ Many of these sexually transmitted infections (STIs) go unscreened and untreated, perpetuating the spread of disease and often resulting in severe health outcomes such as infertility, pelvic inflammatory disease, birth defects, organ damage, and death.⁴

IMPACT OF STIs AND AIDS IN URBAN AREAS

STIs and acquired immunodeficiency syndrome (AIDS)ⁱⁱ affect people of all ages and backgrounds; however, young people, women, and people of color bear a disproportionate burden of disease.ⁱⁱⁱ In urban areas, where average rates of STDs can be 1.5 to 3 times higher than national averages, socioeconomic and racial disparities become even more pronounced due to the overall prevalence of STDs.^{iv5} AIDS cases have been primarily concentrated in large U.S. metropolitan areas (81% in 2006),⁶ with the ten largest metropolitan areas accounting for 53% of cumulative reported AIDS cases.⁷ Overall, the prevalence of both HIV and AIDS cases in cities is more than twice the national

rates, creating a significant sexual health burden in urban areas.⁸ City incidence averages for gonorrhea, Chlamydia, and syphilis are approximately two to four times higher than national rates (279 versus 115.6 per 100,000, 647.5 versus 332.5 per 100,000, and 12.6 versus 3 per 100,000, respectively).⁹ While some of the disparity in data may be attributed to increased facility of screening in urban areas, the prevalence of STDs in cities cannot be ignored. Urban areas are poised to reduce STDs in their communities through increasing access to education and services, as well as local leadership that works to reduce systemic inequities that perpetuate health disparities.

IMPACT OF STIs AND AIDS ON WOMEN

Nationally, Chlamydia rates among women are increasing (from 510.8 cases per 100,000 to 543.6 per 100,000 between 2006 and 2007), and gonorrhea rates among women remain significantly higher than the Healthy People 2010 target (121.9 per 100,000 versus 19.0 per 100,000).¹⁰ Women represent a growing share of new AIDS cases in the United States, rising from 8% in 1995 to 27% in 2008.¹¹ Teenage girls ages 14–19 bear a large share of the STI burden among females—one in four (26%) has an STI.^{v12} STIs such as

Chlamydia, gonorrhea, and the human papillomavirus (HPV) often remain asymptomatic in women. This puts women at a high risk for the long-term effects of STIs, including ectopic pregnancies, infertility, and cervical dysplasia.¹³ Additionally, asymptomatic STIs also increase the risk of women unknowingly transmitting infections to infants during delivery, which can lead to subsequent health complications for the mother and infant.¹⁴

i Increased levels of testing and higher test sensitivity may be responsible for some of the increase.

ii AIDS refers to disease resulting from HIV infection. For the purposes of this document, the term STIs refers to sexually transmitted infections, including HIV, whereas the term STDs refers to sexually transmitted infections and diseases, including AIDS.

iii Gay men also bear a disproportionate burden of sexually transmitted diseases, including HIV. However, due to the particular reproductive health focus of the Agenda, this disparity is not discussed at length within the document. For additional information regarding the impact of STDs on gay men, please see <http://www.cdc.gov/hiv/topics/msm/resources/factsheets/msm.htm>.

iv Increased city rates may be partially due to higher levels of testing in urban areas.

IMPACT OF STIs AND AIDS ON YOUTH

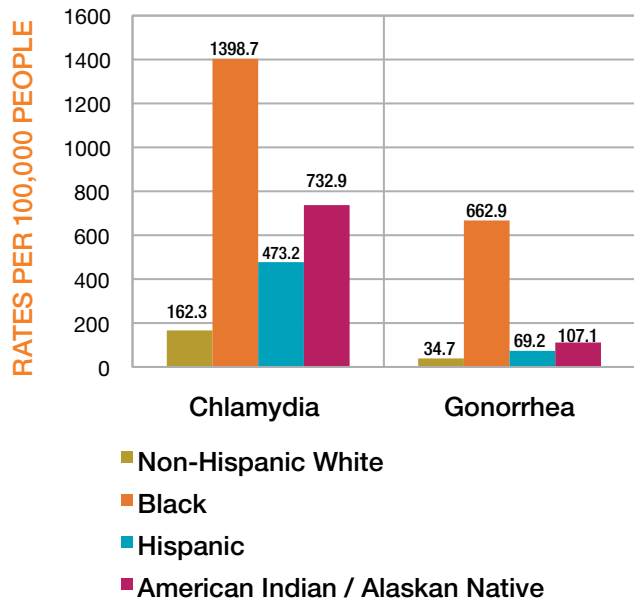
A recent CDC study found that 35% of adolescent females who reported receiving contraception did not receive concurrent STI screening, treatment, or counseling.¹⁵ The lack of consistent screening and education surrounding STIs is reflected in the overall rate of infection among young people. Close to half of all STIs occur in young people, yet they represent only 25% of the sexually active population.¹⁶ Young people of color carry a particularly large share of this burden.

DISPROPORTIONATE IMPACT OF STIs AND AIDS ON PEOPLE OF COLOR

Rates of Chlamydia and gonorrhea are markedly higher among people of color, particularly African Americans, further signifying widespread societal disparities along racial lines.²⁰ In 2007, non-Hispanic Black people comprised 48% of all reported Chlamydia cases and approximately 70% of all reported cases of gonorrhea; the Chlamydia rate among non-Hispanic Blacks is eight times higher than among Whites and the gonorrhea rate among non-Hispanic Blacks is nineteen times higher than among Whites.²¹ This disparity translates to 95.6% of all African American communities having a gonorrhea rate of over 100 per 100,000, while only 0.5% of White communities suffer the same public health issue.²² Additionally, people of color are disproportionately affected by HIV/AIDS, representing the majority of new AIDS cases (70%), people living with AIDS (64%), and AIDS deaths (72%) in 2006.²³ The AIDS case rate per 100,000 for African Americans is almost nine times that of non-Hispanic Whites.²⁴ As of 2005, African American women had over twenty-two times the AIDS case rate as non-Hispanic White women.²⁵ Furthermore, African American women continue to experience higher perinatal HIV transmission than other populations.²⁶ While the prevalence of HIV cases among African Americans is of marked importance, it must also be noted that African Americans often enter treatment with an advanced stage of HIV disease.²⁷

Male and female youth of color are two to seven times more likely to contract gonorrhea and Chlamydia than White youth.¹⁷ For example, Non-Hispanic Black youth comprise over two-thirds of HIV/AIDS cases for ages 13–19, but make up only 17% of the teen population.¹⁸ One study found that 48% of non-Hispanic Black female adolescents ages 14–19 had an STI.¹⁹

CHLAMYDIA AND GONORRHEA RATES BY RACE AND ETHNICITY



Source: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance, 2007.

v See “Empower Young People to Make Healthy Decisions” for further discussion of STIs among young people.

INTERSECTIONAL ISSUES THAT CREATE DISPROPORTIONATE IMPACT OF STDs ON AFRICAN AMERICANS IN URBAN AREAS

On a systemic level, the urban communities hardest hit by STDs tend to lie at the intersection of racial inequality, poverty, incarceration, intravenous drug use, and homelessness.²⁸ African Americans are much more likely to live in low-income neighborhoods, which in turn suffer higher rates of unstable housing, incarceration, unemployment, and intravenous drug use.²⁹ Furthermore, these neighborhoods tend to be relatively segregated, creating high-risk consequences even for those who participate in low-risk behaviors.³⁰ Washington, D.C., is a prime example of how poverty and racial segregation affect STDs. African Americans make up 60% of the city's population, 57% of whom live in the three poorest wards.³¹ Comparison of AIDS case rates between these wards and overall city averages reflect this racial and socioeconomic segregation. The AIDS case rate for African American women in the predominantly low-income Ward 8 is 83 per 10,000 in comparison to 63 per 10,000 for women in the overall city.³² Similar disparities exist among the largest U.S. cities, where African Americans are much more likely to live in extreme poverty and thus bear corresponding reproductive health burdens.³³

The impact of incarceration on the STD epidemic, particularly HIV/AIDS, is markedly felt among low-income urban communities of color. Nationwide, 41% of all prisoners are African American and 90% of prisoners are male.³⁴ Furthermore, the high prevalence of HIV/AIDS cases among the incarcerated in conjunction with the high-risk behaviors often found inside correctional facilities, such as unprotected sex, intravenous drug use, and illicit tattooing, creates a huge STD health burden for the home communities of the incarcerated.^{vi35} Given that a disproportionate number of the incarcerated are African American men, and a disproportionate percentage of African American men live in racially segregated, impoverished communities, low-income communities of color bear the brunt of this health burden.



vi In 1997, approximately one-quarter of people living with HIV passed through a correctional facility.

RECOMMENDATIONS TO ADVANCE HIV/AIDS AND SEXUALLY TRANSMITTED INFECTION PREVENTION AND TREATMENT

While gross disparities in STI and STD rates exist among populations and within urban areas, there are clear opportunities for local leaders to destigmatize and decrease the incidence and effects of STDs by raising public awareness, making condoms free or more accessible, and increasing access to screenings and treatments. Other local efforts to reduce poverty and systemic inequity will also have a positive effect on addressing the continued high incidence of STDs and disparities among populations.

WE CALL ON LOCAL LEADERS TO ADVANCE HIV/AIDS AND SEXUALLY TRANSMITTED INFECTION PREVENTION AND TREATMENT BY:

Supporting local education campaigns and programs to reduce stigmatization, encourage screening and treatment, and promote harm reduction and safer sex practices. The STD epidemic in the United States suffers from silence and stigma. Widespread campaigns led by local elected and public health officials and partnering advocacy groups can raise awareness about the particular local disparities and reframe prevention and treatment through destigmatization. Further, by making condoms free or more widely accessible, and available in ubiquitous and accessible venues, communities can prioritize prevention while also removing stigma and promoting positive messages about sexuality.

- We urge local leaders to create or expand awareness campaigns and continue to make prevention and treatment a city or county priority by supporting local resources that help direct residents to screening and treatment services.
- We urge local leaders to create and support local condom campaigns, making branded condoms free to a wide variety of organizations and clinics designed to reach populations at higher risk for STIs.
- We urge local leaders to support syringe exchange programs in their communities.
- We urge local leaders to affirm the dignity of urban residents living with HIV and AIDS by providing comprehensive health care, housing, and employment support services.

Encouraging routine and free STI screenings in reproductive and sexual health care visits as well as in primary and school-based health care settings.

Despite the high incidence of STIs in the United States, routine screening is not utilized often enough, especially among populations that are at risk. Respectful and culturally competent routine screening that is confidential and includes a patient's consent is a critical way to reduce STIs.

- We urge local leaders to work with public health care settings to ensure that, where possible, free routine STI screenings are offered in a variety of health care settings.

Identifying potential barriers to treatment and promoting expedited partner therapy. When left untreated, STIs can spread infection among partners and lead to infertility and ectopic pregnancies. Local advocacy groups and public health officials can take a local approach to designing and implementing successful plans for getting sexually active residents screened and treated. For women who do enter the health care system for screening and test positive, systems should be in place to facilitate the treatment of their partners in order to avoid reinfection and perpetuation of a cycle of infection and illness.

- We urge local leaders to create or expand systems that allow for expedited partner therapy.

LOCAL EXAMPLES:

- **Los Angeles County** has the first publicly run program in the nation to screen for Chlamydia and gonorrhea in young women through a website where they can order home-testing kits, find out their results, and obtain referrals for treatment.
- **New York City** launched an official city condom in 2007. Called the NYC Condom, it continues to be distributed free of charge along with social marketing and educational materials throughout all five boroughs to encourage safe sex.
- **Baltimore** established an Expedited Partner Therapy pilot program in 2007, which allows physicians to distribute antibiotic packs to patients diagnosed with certain STIs. The packs can be passed along to sexual partners who might also be infected without requiring an office visit for the partner.

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**PRESERVE SAFETY NET
REPRODUCTIVE, SEXUAL,
AND MATERNAL HEALTH
CARE SERVICES**





PRESERVE SAFETY NET REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH CARE SERVICES

Many U.S. women rely on safety netⁱ providers for reproductive, sexual, and maternal health care. The Institute of Medicine defines the safety net as “those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.”¹ In 2007, over 45 million Americans did not have health insurance and 39.6 million were covered by Medicaid, making the safety net a primary source of health care for nearly one-third of the U.S. population.² Furthermore, since 2007 the number of unemployed has increased by seven million, adversely affecting the health coverage of those with employer-based insurance and increasing the demand on the safety net.³ The National Association of Community Health Centers reports that sixty million Americans now lack adequate access to primary care.⁴ Even with comprehensive health care reform, without sufficient health care providers willing to serve communities most in need, improved health insurance will not necessarily result in improved access to health care.⁵ Overall, providers are limited, funding is scarce for safety net services, Medicaid budgets are strapped, unemployment is on the rise, and health care disparities for the impoverished and marginalized persist, making the preservation of the safety net a tenuous yet vital task. Local communities, where the impact of the safety net can be felt most acutely, are perfectly positioned to improve the health of residents by strategizing together on how to preserve the safety net for those most in need.

THE IMPACT OF INSURANCE COVERAGE

Having comprehensive health insurance greatly impacts access and ability to achieve optimal health. Nationally, almost half of poor women in their reproductive years are uninsured.⁶ Even more are considered underinsured, meaning their health coverage is inadequate and forces them to incur out-of-pocket costs or not seek care at all. A recent survey revealed that 45% of all U.S. women were either uninsured or underinsured.⁷ Uninsured women are also less likely to receive

recommended preventive care, including Pap testing, and more likely forego prescription medication.⁸ People of color, especially Latinos, are more likely to be uninsured or rely on public insurance for their health care.⁹ While women of color comprise 32% of the U.S. population, they represent 51% of U.S. uninsured women.¹⁰ When able to access care at all, these women often rely on safety net providers for reproductive, sexual, and maternal health care services.

THE NEED FOR A STRONG URBAN SAFETY NET

Urban safety net providers, such as Community Health Centers, Federally Qualified Health Centers, public hospitals, and local health departments, play a pivotal role in maintaining the health of urban communities.¹¹ On average, cities are home to the highest number of residents who live under the federal poverty level, as well as communities of color and residents who speak English less than “very well.”¹² The result is a culturally and linguistically diverse population

dependent upon safety net services.¹³ In 2007, 16.5% of the population in central cities lived below the federal poverty rate,ⁱⁱ and 18.5% of the population in central cities lacked health insurance.¹⁴ In comparison to national averages, communities of color have higher proportions of uninsured and underinsured residents, particularly among Hispanic communities, where 32.1% of the population was uninsured in 2007.¹⁵ Many recent immigrants do not qualify for

i Definitive data pertaining to the safety net has been difficult to compile given the many nebulous definitions of safety net provider and the complex interplay of socioeconomic factors that affect health outcomes of vulnerable and marginalized populations.

ii The U.S. Census Bureau uses a graduated scale and markedly conservative scale for poverty thresholds based on family size and composition. For example, in 2007 a family of four with two children could make no more than \$21,736 combined income per year to be classified as “in poverty,” while a single person under 65 years of age with no children had a threshold of \$10,787 per year. Geographic region is not taken into consideration.

Medicaid-covered family planning services, and 33.2% of the foreign-born population lacks health coverage.¹⁶ Additionally, suburban communities that traditionally have fewer safety net providers are increasingly impoverished and therefore dependent on the urban safety net for services.¹⁷ Urban centers are well positioned to serve this expansive population given their long history of providing services to vulnerable and diverse populations.¹⁸ However, the expansive urban safety net demand creates a large economic and health care burden that is disproportionately carried by cities.¹⁹

The need for safety net health services is growing. Between 1997 and 2007, the number of patients seen at safety net health centers increased by 95% and has currently reached

THE ROLE OF THE SAFETY NET FOR REPRODUCTIVE HEALTH SERVICES

At a national level, with approximately one-quarter of people of reproductive age uninsured and an even larger proportion among the impoverished, the demand for reproductive, sexual, and maternal health care from safety net providers, such as these local health departments, is overwhelming.²⁴ In the United States, 17.5 million women are in need of publicly supported contraception.²⁵ A critical source of support for these services is a federal program specifically for family planning, Title X of the Public Health Service Act. Funding from the Title X program supports a network of centers providing family planning counseling and services to women and men as well as preventive care such as cancer screenings. In 2006, 66% of the contraceptive visits to publicly funded centers occurred at a Title X-funded center.²⁶ Further, the

THE ROLE OF HOSPITALS

Throughout the United States, county governments run over 1,100 public hospitals.³⁰ For women who do not have access to a regular reproductive health provider, and for pregnant and birthing women, hospitals are a critical source of care. Without adequate preventive and primary care, emergency departments serve as “the safety net of the safety net,” providing acute care that often could have been avoided.³¹ Safety net hospitals account for 10% of all hospitals, yet cover nearly one-third of uninsured hospital stays.³² These hospitals, particularly urban public hospitals, tend to have higher percentages of patients suffering from chronic disease and Medicaid patients than privately insured patients.³³ This combination makes safety net hospital patients significantly more costly to treat overall and inhibits safety net hospitals from cross-subsidizing services for the uninsured via their insured patient load.³⁴ Additionally, many non-profit and private hospitals are attracting healthier Medicaid patients, leaving public and other primary safety net hospitals responsible for the sickest and most expensive Medicaid patients.³⁵ In light of the many barriers impeding the provision of quality safety net services, it is not surprising

over eighteen million people.²⁰ These health centers play a central role in ambulatory reproductive, sexual, and maternal health care for women.²¹ This is particularly true in cities, where nearly one-third of health center visits pertain to women’s health (ages 15–44).²² School-based health clinics and local health departments also assist in the provision of reproductive health care through family planning services, distribution of contraceptives and pregnancy tests, sexually transmitted infection screening, and educational outreach. However, Community Health Centers, school-based health centers, and local health departments often cannot meet many health care needs of the medically disenfranchised in their area due to budget and capacity constraints.²³

positive impact of Title X-funded services reaches far beyond contraception; the majority of women who receive care at a family planning center consider it their usual source of care, highlighting the critical role of Title X in supporting the safety net.²⁷

There are also 2,293 local health departments throughout the United States. Fifty-eight percent of these local health departments provide family planning services, 75% provide treatment for sexually transmitted diseases, and 42% provide prenatal care.²⁸ Local health departments located in larger areas are more likely to provide reproductive, sexual, and maternal health services.²⁹

that a 2003 study of metropolitan-area safety net providers found higher safety net demand correlates to worse health outcomes in areas such as late or no prenatal care, low birthweight, and preterm births.³⁶ Without sufficient funding and support, the safety net cannot facilitate access to quality reproductive, sexual, and maternal health care for the millions of medically underserved.³⁷

Demographic and fiscal disparities between health care providers result in safety net institutions that are financially vulnerable and unable to make quality improvements due to lack of capital, thus stifling growth and quality of service.³⁸ This cycle is exacerbated by recent pay-for-performance trends, where poor performance by safety net providers due to large indigent and uninsured health care burdens compromises their eligibility for financing.³⁹ Over a third of safety net hospitals have negative total income margins, and many public hospitals are either closing or merging with private entities.⁴⁰ Between 1996 and 2002, 16% of public city hospitals and 27% of public suburban hospitals closed, while only 11% of for-profit hospitals closed in both urban and suburban areas.⁴¹

Religious health care systems are playing a growing role in providing safety net health care as public hospitals are closing or merging with religiously affiliated groups. This growing presence of religiously affiliated hospitals reduces women's access to critical reproductive health care services, such as contraceptive services, abortion care, and infertility services and counseling. Furthermore, a notable proportion of private hospitals is owned by charitable religious organizations

(13%).⁴² For many hospitals, this affiliation limits the scope of available reproductive health services based on religious doctrine, despite the substantial government funding these hospitals receive through Medicaid and other public funds.⁴³ As an increasing number of public hospitals close, the proportion of religiously affiliated private hospitals expands, resulting in an immediate reproductive health deficit in the communities they serve.

HOW THE SAFETY NET IS FINANCED

Funding for safety net services consists of a patchwork of funding from federal, state, and local sources that varies in composition from state to state.⁴⁴ While state and federal decisions greatly affect the health care of urban residents, many safety net services are primarily locally run and funded at the county and city levels. Thirty-nine percent of unreimbursed safety net services are supported by state and local subsidies and twenty-eight states require that counties share in the cost of non-federal Medicaid expenses (43% of total Medicaid expenses).⁴⁵ Although most counties in most

states are able to levy taxes to help finance safety net services, their ability to do so is limited. Many local governments are left with a huge fiscal burden.⁴⁶ As urban fiscal conditions worsen, city budgets are increasingly unable to meet current needs and many are being forced to make across-the-board service cuts, including the closing of centers providing reproductive health services.⁴⁷ Growing numbers of uninsured and unemployed residents put further pressure on safety net services, stretching limited local funding even farther.⁴⁸



RECOMMENDATIONS TO PRESERVE SAFETY NET REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH CARE SERVICES

The steady loss of safety net services and the increased reliance by surrounding residents on the existing urban health care safety net unduly burden urban communities. Reproductive, sexual, and maternal health services are important components of safety net services. Despite the unfair burden placed on urban areas to serve those in need without adequate financing, local communities must continue to provide and share responsibility for these vital safety net services.

WE CALL ON LOCAL LEADERS TO PRESERVE SAFETY NET REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH CARE SERVICES BY:

Tackling the growing trend of safety net health center closures. As the need for safety net health services rises, closures continue among the centers that primarily serve low-income residents. These closures leave communities without vital health care services. Urban public hospitals are critical health care providers for poor urban residents as well as the growing numbers of suburban residents who are in need of safety net health services.

- We urge local leaders to stop the closure of urban public hospitals or, when that proves impossible, to address the subsequent increase in demand in surrounding Community Health Centers.

Addressing the impact that hospital mergers have on reducing access to reproductive health care. Local government and advocacy groups can work to reduce the negative impact that hospital mergers have on reproductive health services in the community.

- We urge local leaders to prevent hospital mergers that will limit access to reproductive health services.

Advocating for increases in state and federal funding for safety net services. As this brief outlines, local safety net services often rely on financial support from state and federal sources. In order to best provide services to urban underserved residents, state and federal funding must be increased.

- We urge local elected and public health officials to call on their state and federal governments to expand Medicaid coverage and increase funding for local safety net services such as Community Health Centers and Title X clinics.

LOCAL EXAMPLES:

- In **Prince George County, MD**, community advocates successfully prevented the sale of the county's public hospital system to a Catholic health care system, which would have resulted in the loss of abortion, HIV/AIDS counseling and other critical reproductive health care services.
- In **Seattle**, following announcements that due to budget shortfalls, King County would be forced to close family planning clinics, community advocates worked with the Metropolitan King County Council to successfully continue county support for family planning safety net services.

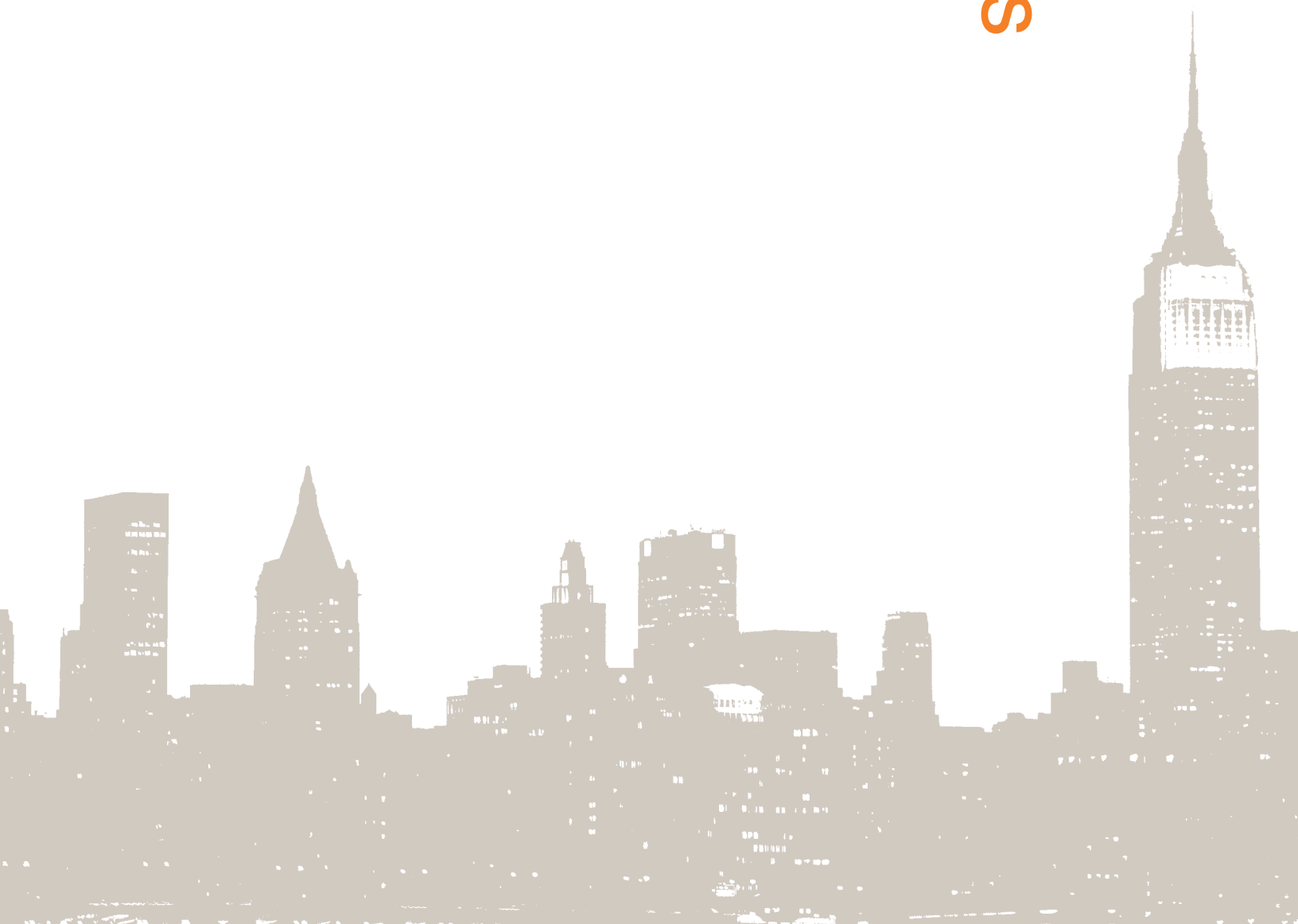
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**PROMOTE HEALTHY,
CONSENSUAL, AND
SAFE RELATIONSHIPS**





PROMOTE HEALTHY, CONSENSUAL, AND SAFE RELATIONSHIPS

Exposure to violence and abuse can greatly affect a woman's overall health and access to information and services. Intimate partner violence (IPV) is defined by the Centers for Disease Control and Prevention (CDC) as "abuse that occurs between two people in a close relationship," including current and former spouses and dating partners. IPV encompasses a wide spectrum of violence that can manifest as physical, sexual, or emotional abuse, such as the use of physical force, rape, threats of abuse, intimidation, isolation, and stalking.¹ The National Violence Against Women Survey found that approximately 25% of women and 8% of men have experienced some form of IPV in their lifetimes, highlighting the widespread incidence of IPV in the United States and the particularly large burden carried by women.² Between 1993 and 2005, urban residents reported the highest average annual rates of IPV.³ Approximately 40% more IPV occurred in urban areas than in suburban and rural areas, and the bulk of those victimized were women.⁴ Local advocates and public officials in urban areas can and must come together to work in coalition to address these disparities in violence occurring within their communities.

WOMEN AT GREATER RISK

Each year, 1.5 million women and more than 800,000 men experience intimate partner-related rapes and physical assaults.⁵ Given that many of those victimized experience multiple incidences of IPV, overall annual perpetration rates are substantially higher (4.8 million intimate partner-related assaults against women and 2.9 million against men annually).⁶ While IPV is a gender-neutral crime, these data indicate that women are at a much higher risk of IPV than men. This is particularly true when comparing lifetime rape prevalence by victim-offender relationship, where women are 19.3% more likely to be raped by a current or former intimate partner than are men.⁷ The direct effects of IPV include increased risk of death and injury ranging from minor injuries to permanent disability.⁸ Additionally, various negative health behaviors have been linked to IPV, such as drug use, alcohol abuse, unhealthy weight-loss behaviors, and smoking.⁹ Such negative health behaviors can be symptomatic of greater mental health issues, most specifically trauma.

Victims of IPV are more likely to show signs of certain injuries, such as scratches, bruises, and welts, along with an increased likelihood of injury to the head, neck, and face.¹⁰ However, because many IPV injuries have low causal specificity, clinical studies have been unsuccessful in establishing diagnostic patterns, making symptomatic screening for IPV difficult.¹¹ Furthermore, many women do not seek medical care while showing signs of abuse. The National Violence Against Women Survey reports that only 28% to 31% of women injured by IPV received medical care after their most recent intimate partner injury.¹² Furthermore, few women report ever having been screened for IPV and only 17% of prenatal providers screen patients on their first visit and 5% screen on subsequent visits.¹³ Undetected IPV has been shown to result in costly diagnostic medical care; in 2003, the CDC estimated that IPV costs the United States nearly \$4 billion in direct medical costs.¹⁴ City and county health departments, emergency departments, and social services such as shelters and hotlines play a critical role in the provision of care for victims of IPV.¹⁵

INTIMATE PARTNER VIOLENCE AND REPRODUCTIVE HEALTH

Many of those victimized by IPV are of reproductive age, which can result in a number of poor reproductive and sexual health outcomes.¹⁶ Women who experience IPV have an increased risk of contracting sexually transmitted infections and urinary tract infections.¹⁷ IPV may also result in decreased agency surrounding partner negotiation of contraception and an overall rise in high-risk sexual behavior, such as multiple sexual partners.¹⁸ Approximately 5.8% of women report being physically abused by an intimate partner while pregnant or in the year preceding pregnancy.¹⁹

RACIAL AND ETHNIC DISPARITIES

Significant racial and ethnic disparities exist among reports of IPV. African Americans and American Indians/Alaska Natives report higher rates of IPV (29.1% and 37.5%, respectively), while Asian Pacific Islander women and men tend to report lower rates of IPV (3.0%) when compared to women and men of other racial backgrounds.²² However, the underlying reasons behind these disparities remain unclear due to the complex interplay of social, demographic,

environmental, and cultural factors that may affect both the incidence of IPV and a respondent's willingness to disclose information regarding IPV.²³ Furthermore, socioeconomic, ethnic, and racial marginalization shape the nature of social services provided to IPV victims of color, particularly immigrants.²⁴ For instance, women of color are more likely to be classified as substance abusers and to be directed to homeless shelters even when they need IPV-related services.²⁵

INTIMATE PARTNER VIOLENCE AND YOUTH

IPV rates are markedly high among teenagers, although research suggests that teens are far less likely to report crimes against them than all other age groups, indicating that actual rates of teen IPV may very well be higher.²⁶ The CDC reports that within a twelve-month period, one in eleven teens (grades 9–12) has experienced physical dating violence, and one in four teens reports verbal, physical, emotional, or sexual abuse.²⁷ Physical dating violence and victimization among high school students correlate to subsequent

engagement in multiple risk behaviors such as sexual intercourse, attempted suicide, episodic heavy drinking, and physical fighting.²⁸ Furthermore, adolescents who have been physically or sexually assaulted are at a higher risk for STIs, revictimization, and pregnancy.²⁹ A recent study reports that approximately one-quarter of teenage girls (ages 15–20) who experience IPV have intimate partners who are actively attempting to get them pregnant through non-use, misuse, or sabotage of contraceptives.³⁰

INTIMATE PARTNER VIOLENCE AMONG SAME-SEX PARTNERS

Research is limited regarding IPV among same-sex partners. As of 2008, the National Violence Against Women Survey was the only population-based study to include female same-sex IPV.³¹ The survey did not specifically ask respondents about their sexual orientation, but did compile data on same-sex intimate cohabitants. Of those surveyed who

reported living with a same-sex intimate partner in their lifetime, 11.4% of women reported a lifetime prevalence of IPV by a female intimate cohabitating partner and 10.8% of men reported a lifetime prevalence of IPV by a male intimate cohabitating partner.³²



i *Maltreatment* is defined as both neglect and forms of physical abuse.

RECOMMENDATIONS TO PROMOTE HEALTHY, CONSENSUAL, AND SAFE RELATIONSHIPS

Communities must work to eliminate intimate partner and sexual violence, incidences of which greatly impact many aspects of community life and health. Women and youth, who are at particular risk of experiencing intimate partner and sexual violence, need the commitment of local officials and advocates who can integrate programmatic and policy change into the variety of local services that impact survivors, including law enforcement, health care provision, and schools.

WE CALL ON LOCAL LEADERS TO PROMOTE HEALTHY, CONSENSUAL, AND SAFE RELATIONSHIPS BY:

Ensuring that victims of intimate partner violence are treated with respect and dignity by local law enforcement and emergency room staff. Those experiencing violence are particularly vulnerable to interaction with law enforcement or emergency room staff and are more likely to be in acute crisis. Feeling respected during contact with law enforcement and health care providers is critical to the physical and mental health of IPV survivors.

- We urge local public health and elected leaders to collaborate with local advocacy groups to create standards and train law enforcement and emergency room staff on how to best serve domestic violence and sexual assault survivors.
- We urge local officials to ensure that rape kits are processed in a timely manner.
- We urge local leaders to enforce or expand policies that make emergency contraception available to sexual assault survivors in the emergency room.

Integrating screening into public health care delivery settings. While the experience of violence is pervasive, screening and prevention education are not systematically provided. Reproductive health care providers play an important role in screening for intimate partner and sexual assault. The American College of Obstetricians and Gynecology and the Centers for Disease Control recommend regularly screening for violence during health care visits.³³

- We urge local leaders to work with health care providers to standardize and increase voluntary risk factor screening into all public health care provision.
- We urge local leaders to ensure adequate mental health recovery services are available for survivors and their families.

Targeting education and awareness campaigns for youth and other communities that are at higher risk for abuse.

Disparities remain between populations who report intimate partner violence. Localities have an opportunity to address the unique disparities within their communities, designing community-specific education and awareness campaigns that are more likely to be successful and change social norms that make violence and abusive behavior acceptable. In particular, local public health and education officials can address the rising problem of teen dating violence by working with local advocacy groups that have expertise based on the development of successful communication and education strategies to reach youth in the community.

- We urge local public health and elected leaders to work in coalition with local advocacy groups, as well as local schools, to design culturally competent and youth-friendly awareness campaigns to address intimate partner and sexual violence.

LOCAL EXAMPLES:

- **The Multnomah County Health Department in Oregon** instituted a program of home visits that were used to screen women for signs of intimate partner violence during prenatal and postpartum periods.
- To cover a gap in IPV screening for pregnant women, **the Boston Public Health Commission** has instituted a Preconceptional Screening and Assessment Project that provides a behavioral risk screening instrument as well as provider training at several community health sites.
- In **Seattle, Public Health—Seattle & King County** is working to increase IPV detection using teams of nurses, social workers, and nutritionists who screen pregnant women and educate them on the risk of violence twice before the birth and once after.

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**INTEGRATE STRATEGIES TO
IMPROVE ENVIRONMENTAL
AND REPRODUCTIVE JUSTICE**





INTEGRATE STRATEGIES TO IMPROVE ENVIRONMENTAL AND REPRODUCTIVE JUSTICE

Reproductive justice recognizes the impact that environments—both our living and working environments—have on health and the importance of ensuring that women and their families live in healthy communities. The Environmental Protection Agency defines environmental justice as “the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies.”¹ The environmental justice and reproductive justice movements are particularly linked around toxics that impact pregnancy and fertility. Low-income women and children living in urban areas are disproportionately exposed to environmental toxics, many of which adversely impact overall health and reproductive, maternal, and child health in particular. The increasing attention on the effects of chemical exposures on health, as well as new efforts to “green” cities, provides a ripe opportunity to integrate environmental and reproductive justice education and advocacy strategies. Through strategic collaborations between the reproductive and environmental justice movements, we move closer toward our shared goal that every woman be able to bear and raise healthy children and live in healthy communities.

URBAN TOXICS AND REPRODUCTIVE HEALTH

There are numerous toxic chemicals in the urban environment. Residents can be exposed to these chemicals from a variety of sources, including but not limited to air pollution and contaminated water, as well as the workplace, home, and schools. While many of these toxics have deleterious effects on health, there are some prevalent in urban areas that have particular reproductive health effects. These toxics include lead, air pollutants, insecticides, and pesticides.

The United States is suffering from an affordable housing crisis, and urban low-income residents are disproportionately affected by the consequences.² Urban residents living in public housing or low-income neighborhoods often lack control over their housing environments and location and may experience increased levels of toxic exposures including lead, air pollutants, insecticides, and pesticides. For instance, living in neighborhoods with high traffic density, which are more prevalent in urban environments, can lead to increased exposure to toxicants that have an adverse impact on reproductive health. Sources of pollution can include industrial facilities, diesel bus depots, and large roadways. In Los Angeles, a study found that air pollution from heavy-traffic roadways led to low birthweight and preterm births.³ Another study determined that the clearest indicator in

determining environmental lead exposure was living in an area with highly traveled roads.⁴ In addition to its well-known neurological health effects on children, lead poisoning can lead to miscarriage and birth defects.⁵ Prenatal exposure to lead has been linked to delays in the onset of puberty and to menstrual cycle irregularities.⁶

Urban low-income residents are also often exposed to lead and pesticides inside their homes. Low-income and children of color are more likely to have been exposed to lead, either from peeling indoor paint or lead dust settled in soil outside.⁷ Other toxicants inside urban homes include pesticides used to control insects such as cockroaches and rodenticides used to control rodents. One study that surveyed women of color living in low-income urban neighborhoods found that 100% of the pregnant women had been exposed to insecticides and/or pesticides.⁸ Research suggests that some pesticides and insecticides may be linked to reproductive health problems, including reduced fertility, miscarriage, and menstrual irregularities.⁹ Toxic exposures can be reduced if landlords and housing officials are willing to use integrated pest management, which addresses pest problems by cleaning food residue, sealing cracks in apartments and, when necessary, using the least toxic pesticides available.¹⁰

OCCUPATIONAL HAZARDS

Women living in cities can also be exposed to harmful chemicals at work. Females working in dry cleaners were found to have an increased risk of ovarian cancer and miscarriage.¹¹ Women employed as janitors have a heightened risk of stillbirth and preterm delivery, while women working in the food service industry have an increased risk of preterm

delivery and stillbirth.¹² Nail technicians and cosmetologists are often exposed to chemicals that can cause reproductive harm. One study found an increased risk of miscarriage among cosmetologists in salons where manicuring or nail sculpturing was performed.¹³

DISPROPORTIONATE BURDEN ON PEOPLE OF COLOR

Low-income people and people of color live in communities that are disproportionately exposed to harmful toxics. For example, in Birmingham, Alabama, the low-income population's share of the health risk from toxic air pollution is 24% even though low-income people represent only 13% of the overall population.¹⁴ In Chicago, the share of the health risk from toxic air pollution for people of color is

61%, although their share of the population is 42%.¹⁵ One study of forty-four large metropolitan areas determined that in each area analyzed, Black residents were more likely to live in an area with high toxic levels than White residents.¹⁶ Additionally, studies have shown that White mothers are less likely to live in areas with high air pollution than mothers who are women of color.¹⁷



RECOMMENDATIONS TO INTEGRATE STRATEGIES TO IMPROVE ENVIRONMENTAL AND REPRODUCTIVE JUSTICE

Local advocates can improve reproductive, maternal, and child health by reducing the burden of environmental contaminants in urban low-income communities and workplaces. Local officials often oversee urban infrastructure, including public transportation and housing, where a significant amount of exposure to toxics occurs. Building the social, political, and economic power of low-income women and women of color most affected by environmental toxics will be essential to promoting reproductive and environmental justice in these communities.¹⁸

WE CALL ON LOCAL LEADERS TO INTEGRATE STRATEGIES TO IMPROVE ENVIRONMENTAL AND REPRODUCTIVE JUSTICE BY:

Employing reproductive health and justice frameworks into local environmental initiatives. Because of mounting environmental concerns, more and more local governments are promoting green environmental initiatives. While these local environmental efforts are essential to creating and supporting healthy and sustainable communities, reproductive health and justice must be priorities within these initiatives in order to truly foster health and sustainability. Efforts to advance climate justice must also take into account workers' rights and health in efforts to reduce greenhouse gasses and promote green policies.¹⁹

- We urge local leaders to create or expand local greening and climate change initiatives to include goals for the reproductive health and justice of workers and residents.
- We urge local leaders to ensure that efforts to regulate toxic exposures take into account workers' rights and do not threaten people's livelihoods.

Reducing the toxics prevalent in the urban environment.

Toxics in the urban environment must be reduced in order to foster health for ourselves and the Earth. The health of women and children living in urban communities is currently being harmed by the prevalence of toxics. This is particularly true for urban women and children living in low-income neighborhoods or public housing, where toxics are often concentrated.

- We urge local leaders to promote local policies that reduce air pollution and its effects on urban women and children.
- We urge local leaders to reduce toxic exposures by implementing integrated pest management programs in public housing facilities, public schools, and public buildings, parks, and playgrounds.
- We urge local leaders to call on Congress to pass comprehensive chemical reform, which would regulate how chemicals are approved for use.

Integrating environmental health screenings and health history collection into the provision of reproductive and maternal health care. There is growing evidence that toxics adversely affect reproductive, maternal, and child health. Reproductive health care providers have an opportunity to educate women about the effects of their environments on their reproductive health.

- We urge local leaders to work with local public health programs and service providers to screen and educate women about the adverse effects that toxics can have on their reproductive and maternal health.
- We urge local leaders to provide training to health care providers about the impact of chemicals on reproductive health.

LOCAL EXAMPLES:

- **Santa Cruz, CA** has adopted a landmark Green Business standard for the types of products that may be used in nail salons that wish to be labeled green.
- **New York City** passed legislation phasing out the city's use of carcinogenic pesticides and requiring 48-hour notice of the commercial use of pesticides to neighbors.

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**SAFEGUARD AND EXPAND THE
RIGHTS OF IMMIGRANTS TO
REPRODUCTIVE HEALTH CARE**





SAFEGUARD AND EXPAND THE RIGHTS OF IMMIGRANTS TO REPRODUCTIVE HEALTH CARE

For centuries, new immigrants have shaped and developed the urban communities of the United States. Immigrant families are vital players in local economies and contribute to the diverse fabric of society. Unfortunately, too often immigrants, especially undocumented immigrants, are marginalized and lack access to basic health care services. This lack of access can often be bolstered by fear of utilizing public services, fear that is often shaped by the attitudes and policies of local law enforcement. The challenges to accessing reproductive health information and services, combined with disproportionately high rates of poverty, lead to poorer reproductive health outcomes for many immigrant women. Although federal law governs immigration policy at a macro level, localities have an important responsibility to reduce the barriers to accessing care and the reproductive health disparities experienced by many immigrant women living in urban communities.

URBAN AREAS ARE HOME TO MANY IMMIGRANT FAMILIES

Urban areas are home to the majority of all immigrants living in the United States.¹ More than 50% of foreign-born residents are concentrated in ten major U.S. metropolitan areas: New York, Los Angeles, Miami, Chicago, San Francisco, Houston, Dallas-Fort Worth, Washington, D.C., Riverside-San Bernardino, and Phoenix.² Since the 1980s, however, immigrants have started to move away from the

city centers to the metropolitan suburbs. By 2007, a majority of foreign-born U.S. residents resided in large metropolitan suburbs. As such, metropolitan areas and surrounding suburbs play an increasingly critical role in providing health care services that meet the needs of a diverse and often-marginalized population.³

BARRIERS TO ACCESS AMONG IMMIGRANT WOMEN

Immigrant women face a range of access barriers when seeking reproductive health care services, the most compelling being language and cultural barriers. Differences in language and culture between an immigrant patient and a provider can breed miscommunication, mistrust, and, at worst, misdiagnosis. Language barriers can also lead to delay or denial of needed services and provision of lower-quality services.⁴ Although every urban public hospital or clinic receiving federal funds, especially those with a high foreign-born patient volume, is required under federal law to provide adequate translation services,⁵ too often notices, forms, and services are inadequately translated. For example, it was recently reported that a non-English-speaking woman was wrongfully sterilized following labor and delivery in a major New York City hospital for lack of available translated consent forms and interpreters.⁶ More common is the breach of confidentiality associated with the use of children as translators for non-English- and limited-English-speaking female patients, even in the context of obstetric/gynecological visits.

Another challenge stems from the scarcity of providers representing the diverse cultural spectrum of patients visiting health care providers in urban centers. Studies indicate that trust and communication between providers and patients are strengthened when they share cultural backgrounds.⁷ Culturally competent care is especially important in the context of reproductive health care, as it may help to break down cultural barriers that may prevent some immigrant women from seeking particular services.

Lack of insurance is another significant barrier for many immigrant women. Nearly 32% of all immigrants are uninsured, as compared to 12% of those who are U.S.-born.⁸ Many immigrant women do not have employer-based health insurance and are unable to access public health programs. Federal Medicaid law restricts health coverage for immigrants residing in the United States for less than five years.⁹ However, the 2009 Children's Health Insurance Program Reauthorization Act allows states to use federal dollars to cover pregnant immigrant women and children who have resided in the United States for less than five years.¹⁰

Despite this recent change, many immigrant women are still unable to obtain critical preventive care. Undocumented immigrants living in the shadows are the most underserved and least likely to have health coverage. Under federal law and most state law, undocumented immigrants qualify only

REPRODUCTIVE HEALTH OUTCOMES FOR IMMIGRANT WOMEN

Immigrant women are less likely to receive preventive reproductive health care, including Pap tests, contraceptives, HIV treatment, and comprehensive sexuality education. As a result, they disproportionately experience a range of poor reproductive health indicators. Immigrant women have higher rates of unintended pregnancy and teen pregnancy than the national average. For example, Latina immigrants ages 15–19 have the highest birth rate in the United States.¹² Asian Pacific Islander immigrant women have high rates of cervical

IMMIGRATION DETENTION FACILITIES

Over the last several years, the federal government’s focus on immigration policy enforcement has forced many localities to participate in the detention of immigrants who have been arrested for violating federal law. Nearly 30,000 men, women, and children are currently detained by the U.S. Department of Homeland Security’s Immigration and Customs Enforcement (ICE), a 73% increase in detention of immigrants since 2005.¹⁶ ICE contracts with state prisons, local jails, and private detention facilities to operate 350 facilities housing detained immigrants across America. Roughly 10% of detained immigrants are women. Most of these detainees are held for civil—not criminal—cause, yet detainees experience prison-like conditions.¹⁷ ICE’s Division of Immigration Health Services (DIHS) is in charge of health care provision to detained immigrants, providing services both directly and through contractors.

Because detainees are held in these facilities while awaiting deportation, health care is focused on emergency care and ensuring that detainees are able to be deported. The

for emergency services at hospitals, including labor and delivery.¹¹ Although a few states offer coverage for pregnant undocumented women, fear of deportation prevents many from accessing care.

cancer.¹³ Latinas represent a growing proportion of the HIV cases, making up 13.9% of the cases in 2004.¹⁴

On a positive note, recent Hispanic immigrants often have healthy pregnancies despite the challenges in accessing prenatal care. Studies suggest that the “prenatal paradox” may be explained by cultural norms that reinforce healthy behaviors during pregnancy, such as not smoking or drinking, eating nutritiously, and having strong familial support.¹⁵

DIHS Medical Dental Detainee Covered Services Package, which determines rules for access to off-site specialists, says that requests for non-emergency care will be considered if foregoing treatment would “cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status.”¹⁸ A study of health care provision at immigration detention facilities conducted by Human Rights Watch found that women’s care and treatment were often delayed and sometimes denied. Confidentiality of medical information was often breached, and women had trouble directly accessing facility health clinics and convincing security guards that they needed medical attention. In addition, interpreters, needed because of the extremely high levels of non-English speakers in correctional facilities, were not always available during exams. Some women feared retaliation or negative consequences to their immigration cases if they sought care. Some reported not having the option to refuse medication or receiving other inappropriate treatment.¹⁹



RECOMMENDATIONS TO SAFEGUARD AND EXPAND THE RIGHTS OF IMMIGRANTS TO REPRODUCTIVE HEALTH CARE

Immigrant populations are more likely to live in metropolitan areas, which contributes to these areas' economy and cultural diversity. However, immigrant women are falling through the cracks of the health care system. There are great opportunities for local leaders to offer critical support to their local immigrant communities by protecting their rights to health care and expanding their access to services.

WE CALL ON LOCAL LEADERS TO SAFEGUARD AND EXPAND THE RIGHTS OF IMMIGRANTS TO REPRODUCTIVE HEALTH CARE BY:

Implementing local initiatives to improve culturally competent and confidential reproductive, sexual, and maternal health care. Reproductive, sexual, and maternal health care issues are often the most personal and sensitive health topics individuals face. Cultural and linguistic barriers create unfair burdens on immigrant women's ability to access quality care. It is essential that health care center and hospital notices be provided in a culturally sensitive manner and in a multitude of languages. Furthermore, translation services should ideally be offered with on-site translators or, at a minimum, through a 24/7 language-line service.

- We urge local leaders to ensure translators and interpreters are available to women accessing clinics and hospitals as well as public health services.
- We urge local leaders to improve access by promoting the integration of reproductive health care services throughout public health and medical services more commonly sought by immigrant women.

Increasing local services available to immigrant populations and providing education to local immigrant communities about their rights to health care and how to access care. Immigrants, in particular undocumented immigrants, remain at the greatest risk for falling through the public health care safety net. While federal restrictions limit access to many health care services, localities can put systems in place to ensure that immigrant women are not forced to forego care. Furthermore, immigrants should be provided information about what services are available to them in their communities as well as their right to access these services without fear of interference from law enforcement.

- We urge local governments to utilize local funds and expand local services to increase access for undocumented women.
- We urge local leaders to create resources for local immigrant populations about available reproductive, sexual, and maternal health care in their communities.

Ensuring that local law enforcement resources are used to keep people safe rather than criminalize immigrants.

Local communities have the opportunity to create safer spaces for immigrants through law enforcement policies that do not foster distrust and fear of public services. Creating these standards will reduce access barriers to care and support healthier communities.

- We urge local leaders to create local policies that clarify the role of local law enforcement and ensure that immigrant women who seek services will not be criminalized.

Advocating for the federal government to expand immigrant women's rights. The federal restrictions on Medicaid coverage for undocumented and recent immigrants have a broad impact on the health care of immigrant women. Furthermore, federal immigration policy adversely affects the reproductive health of immigrant women.²⁰

- We urge local elected and public health officials to call on the federal government to remove Medicaid eligibility restrictions for immigrant women.
- We urge local elected and public health officials to call on the federal government to ensure the rights and health needs of women being detained in immigrant detention facilities are being met.
- We urge local elected and public health officials to call on the federal government to pass comprehensive immigration reform, including a clear path to citizenship and access to basic services, and to stop criminalizing immigrant women and their families.

LOCAL EXAMPLES:

- ❏ In **Atlanta, Fulton County** Department of Health and Human Services recognized the growing health care needs among Latina immigrants and provided case management that enrolls any pregnant woman residing in Fulton County, including immigrant women, for services during the prenatal and perinatal period.
- ❏ In **Philadelphia**, the city solicitor wrote a memorandum to all city departments stating that city services and benefits must be provided to all residents regardless of immigration status.
- ❏ In **Newark, NJ**, the City Council passed a resolution stating that no person will be denied city services or benefits based on immigration status.

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IMPROVE REPRODUCTIVE HEALTH SERVICES FOR HOMELESS WOMEN





IMPROVE REPRODUCTIVE HEALTH SERVICES FOR HOMELESS WOMEN

Homelessness remains a serious challenge throughout the United States, an outcome of extreme poverty, the continued need for more affordable housing, and the lack of opportunity and services for those experiencing various disabilities.¹ Estimates show that between 2.3 and 3.5 million people are likely to experience homelessness each year, including 1.35 million children.² Recent reports show that nearly 1.6 million people used emergency shelter or transitional housing programs between October 2007 and September 2008.³ Although women comprise only 36% of the adult sheltered homeless population, they represent 81% of the adults who become homeless with children.⁴ Homeless women are often quite literally living at the margins of their communities; it is not surprising that reproductive, sexual, and maternal health concerns are prevalent among homeless women. As urban communities strive to address homelessness, they must recognize and incorporate reproductive, sexual, and maternal health issues.

HOMELESSNESS IN URBAN AREAS

While not exclusively an urban challenge, homelessness is often centralized in urban areas. In 2008, more than two-thirds of homeless people who were sheltered lived in the center of urban areas.⁵ African Americans are disproportionately represented in the homeless population. African Americans comprised 41.7% of the sheltered homeless population in 2008, but made up only 12.4% of the overall U.S. population in 2007. This may be partly explained by the disproportionate representation of African Americans in urban areas.⁶

Poverty and lack of affordable housing are primary causes of homelessness. Paying fair market rent is unaffordable for many low-income workers, and subsidized housing is difficult to obtain.⁷ The lack of affordable housing has been reported as a cause of both hunger and homelessness; in a recent survey of the mayors in twenty-five major U.S. cities, 77%

reported that more affordable housing would be most helpful in addressing a hunger problem, and 72% reported that a lack of affordable housing is one of the three main causes of family homelessness.⁸ A recent increase in the number of people who are homeless suggests that the current economic downturn might be another cause. In the same recent survey of mayors, 83% of them report an increase in homelessness in their cities over the past year.⁹ Twelve of the cities reported an increase in homelessness due to foreclosures, citing the loss of housing for tenants who rented in buildings that became foreclosed.¹⁰

Apart from the lack of affordable housing and unemployment, domestic violence is often cited as a cause of homelessness. Twenty-eight percent of city mayors in 2008 listed domestic violence as a cause of family homelessness.¹¹ In another study, domestic violence was the second most cited cause of homelessness for families.¹²

HEALTH CONCERNS FOR HOMELESS WOMEN IN THE UNITED STATES

Homeless women experience multiple barriers to contraceptive use. Some barriers include perceptions of side effects and potential health risks, a partner's opposition to contraceptive methods, and cost.¹³ Lack of choice and agency regarding the context of contraception, sexual partners, and location where sex takes place also affect homeless women's reproductive health.¹⁴ Although homeless women are in need of reproductive health care, fewer than half of family planning agencies report regularly providing programs tailored to homeless women.¹⁵

One study that compared homeless families and housed families on public assistance in New York City determined that a higher percentage of homeless women were pregnant or had recently given birth; 35% of the homeless women were pregnant and 26% had given birth in the past year, whereas 6% of the housed women were pregnant and 11% had given birth in the past year. The study suggests that pregnancy might be a risk factor for homelessness.¹⁶ Stress, lack of prenatal care, and poor nutrition often lead to a higher risk for pregnancy complications among homeless women.¹⁷ Lack

of regular health care for homeless mothers can lead to other serious health problems. Studies have shown that mothers who are homeless were more likely to be hospitalized and more likely to visit the emergency room than mothers who were not homeless.¹⁸

Homeless women also experience high rates of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs). Extreme poverty, inconsistent housing,

HOMELESS YOUTH

Previous estimates concluded that in 1999, around 1,682,900 youth had a runaway or a “throwaway” episodeⁱⁱ; around two-thirds of these episodes were experienced by youth ages 15–17.²² LGBTQ (gay, lesbian, bisexual, transgender, queer and questioning) adolescents are more likely to leave home, experience victimization and substance abuse, and have higher numbers of sexual partners than their heterosexual homeless peers.²³

Pregnancy rates for homeless teens are significantly higher than their housed counterparts. Forty-eight percent of youth living on the streets and 33% of youth living in shelters have ever been pregnant, compared with less than 10% of youth living at home.²⁴ The reasons for the higher rates of teen pregnancy are varied but may include higher-risk sexual behavior, previous sexual victimization, and a lack of information or access to contraception. A survey of mothers in New York City homeless shelters suggested that many teen mothers did not have a comprehensive understanding

and higher risk of intravenous drug use can lead to their disproportionate risk for HIV.¹⁹ Additionally, homeless women have limited access to medical care, which makes it more likely that their infections will remain untreated.²⁰ High rates of STIs for homeless women may also be linked to a high number of sexual partners, engagement in survival sexⁱ, and inconsistent condom use. One study found that only 24% of surveyed homeless individuals always used a condom.²¹

of contraception. Half of the teen mothers reported that they did not think that birth control was important and 42% did not know how to use birth control. Additionally, 41% of those surveyed did not realize they were pregnant until their second trimester.²⁵

Sexual victimization is common among homeless teens. In a 2004 study, 35% of homeless youth were found to have been sexually victimized.²⁶ The Department of Health and Human Services found that 21% to 42% of runaway youth were abused before leaving home. That number was significantly higher than the level of sexual abuse reported by youth in the general population, which was between 1% and 3%.²⁷ Sexually abused teens were more likely to engage in survival sex.²⁸ One study determined that 27.5% of the homeless youth living in the street and 9.5% of those living in shelters reported engaging in survival sex.²⁹ Another study found that runaway youth were six to twelve times more likely to experience infection with HIV.³⁰



i *Survival sex* is a term used to describe sexual exchanges that are sold to meet subsistence needs.

ii *“Throwaway” episode* refers to youth who are told to leave by a parent or guardian or are not allowed to return home by a parent or guardian.

RECOMMENDATIONS TO IMPROVE REPRODUCTIVE HEALTH SERVICES FOR HOMELESS WOMEN

Homelessness is clearly an enormous challenge and concern for urban areas, where the largest portion of homeless people in the United States is located. Local advocacy groups, health care providers, and elected and public health officials must continue to work collectively to address this growing crisis and begin to prioritize the unique reproductive health issues facing homeless women and teens.

WE CALL ON LOCAL LEADERS TO IMPROVE REPRODUCTIVE HEALTH SERVICES FOR HOMELESS WOMEN BY:

Targeting reproductive, sexual, and maternal health outreach and education efforts to homeless women and youth. Homeless women and youth have reduced access to health care services and information and are at increased risk for adverse reproductive, sexual, and maternal health outcomes. Homeless women and youth are also often engaging in high-risk sexual activity while being marginalized from the provision of health care services.

- We urge local leaders to create and support programs that utilize mobile medical units to reach women and youth who are homeless.
- We urge local leaders to integrate quality reproductive, sexual, and maternal health care and referrals into shelter services.

Incorporating reproductive health and justice frameworks into local city or county initiatives that work to end homelessness. Many localities have started initiatives to end homelessness.³¹ It is imperative that reproductive, sexual, and maternal health concerns are prioritized within local efforts.

- We urge local leaders to make homeless women's health a priority by employing reproductive health and justice frameworks in their efforts to end homelessness within their communities.

LOCAL EXAMPLES:

- **The County of Los Angeles**, in partnership with local organizations, opened the Center for Community Health Downtown Los Angeles, a health care center that provides integrated care for homeless individuals living on Skid Row. The Center will offer a range of health services, including HIV testing and treatment.

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PROTECT THE RIGHTS OF INCARCERATED WOMEN TO REPRODUCTIVE HEALTH CARE





PROTECT THE RIGHTS OF INCARCERATED WOMEN TO REPRODUCTIVE HEALTH CARE

In 2008, over 200,000 women were incarcerated in prisons and jails in the United States.¹ Approximately 100,000 of these women were being held in local jails.² Incarcerated women not only have the same reproductive health care needs as the general population, but are at increased risk for sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), and unplanned pregnancy and are more likely than the unincarcerated population to come from medically underserved communities.³ While prisons are governed at the federal and state levels, the county jail system is governed at the local level, meaning that health care provision in jails varies widely, has little central oversight, and leaves crucial decisions about health care provision to administrators' discretion.

STIs AND AIDS

Women who are imprisoned in America are disproportionately low income women and women of color. In 2008, Black females (with an incarceration rate of 349 per 100,000) were more than twice as likely as Hispanic females (147 per 100,000) and more than 3.5 times more likely than White females (93 per 100,000) to have been in prison or jail.⁴ Coming from medically underserved communities, incarcerated women are likely to have received minimal reproductive health care, including STI screening and treatment, Pap testing, and contraception, before incarceration.⁵ Incarcerated women have disproportionately higher rates of Chlamydia (27%) and gonorrhea (8%) compared with the general population, and 2.4% of female inmates are known to be HIV-positive or to have confirmed AIDS.⁶

Local jails, where a quarter of all inmates are released within forty-eight hours and half are released in three to five days, have the potential to target intervention to a population that quickly reenters the general population after being incarcerated.⁷ Programs like the Center for Disease Control's voluntary Rapid HIV Testing in Jail Demonstration Project showed that screening for HIV in a routine manner proved successful in testing a population that would have

otherwise had no access to screening.⁸ Routine screening for Chlamydia, gonorrhea, syphilis, and hepatitis has also proven successful in early detection.⁹ When coupled with treatment and discharge planning services, such practices benefit the individual through identification of infection and treatment and benefit the wider public through interrupting disease transmission when inmates reenter the community.

In New York City, which has the power to set its own standards for correctional facilities, the City Board of Correction sets standards containing specific provisions for reproductive health care. Jails in New York City offer to administer a Pap test, a pregnancy test, a syphilis test, and gonorrhea and Chlamydia screening to all new female inmates. These standards also require that pregnant women receive counseling, prenatal and postpartum care, and abortion care upon request.¹⁰ Such clear standards ensuring access to reproductive health care make New York City a notable exception among jails in New York State, but exemplify the potential of local initiatives to improve reproductive health care among incarcerated women.

PREGNANCY AND BIRTH

Six to ten percent of female prisoners are pregnant when taken into custody, and 1,400 women gave birth while incarcerated in 2007.¹¹ Incarcerated women face challenges specific to prenatal, postpartum, and infant care.¹² Many imprisoned women are likely to have high-risk pregnancies, which are compounded by lack of medical, nutritional, educational, environmental, and family-support services.¹³

Birth outcomes include higher risk of low birthweight and preterm birth.¹⁴ After childbirth, mothers are almost always immediately separated from their babies, which can interfere with mother-child attachment, resulting in cognitive and emotional development delays.¹⁵ More than half of the children of female prisoners never visit their mothers during the period of incarceration.¹⁶

Childbirth is especially stressful for incarcerated women, as most correctional facilities restrain women during transportation to a medical facility for childbirth and even during labor. According to the Rebecca Project for Human Rights, shackling women during childbirth—even when the woman has not committed a violent crime and is not at

risk for fleeing—is standard U.S. Marshals Service practice used in most state prisons.¹⁷ Shackling women restricts their movement during labor and presents such a serious risk to mother and infant health that the practice has been opposed by the American College of Obstetricians and Gynecologists.¹⁸

INCARCERATED WOMEN’S ACCESS TO ABORTION

In the general population, half of all pregnancies are unplanned.¹⁹ Among the incarcerated population, that percentage is likely much higher.²⁰ While no federal or state law explicitly prohibits incarcerated women from obtaining an abortion, access varies greatly from locality to locality and from institution to institution because county jails determine practices regarding incarcerated women’s access to abortion.²¹

Even when requests for abortion are granted, funding policies vary. One study found that in states where

Medicaid covers abortion, prisons are more likely to pay for abortions.²² Without coverage to pay for abortion care, female prisoners face the difficult task of securing private funds. Administrators and prison officials can also hinder inmates’ access to abortion by refusing to provide logistical support, such as scheduling appointments and arranging transportation to a facility that will perform the abortion. For prisoners, often isolated from their families and coming from disenfranchised communities, arranging for an abortion from behind bars presents multiple obstacles.



RECOMMENDATIONS TO PROTECT THE RIGHTS OF INCARCERATED WOMEN TO REPRODUCTIVE HEALTH CARE

Localities often have broad discretion to determine whether and how women incarcerated in local jails will be treated with regard to reproductive, sexual, and maternal health care. Women entering local jails are more likely to need health care and support services. Local communities must come together to provide services and information to incarcerated women.

WE CALL ON LOCAL LEADERS TO PROTECT THE RIGHTS OF INCARCERATED WOMEN TO REPRODUCTIVE HEALTH CARE BY:

Ensuring incarcerated women have access to health care. There are gaps in the health care services available to incarcerated women. Local policymakers and public health providers cannot neglect the reproductive, sexual, and maternal health needs of incarcerated women in local jails.

- We urge local policymakers to create uniform standards for local jails that ensure access to basic reproductive, sexual, and maternal health care services, including provisions for women who need to access their legal right to abortion.
- We urge local officials and advocacy groups to identify local jails without available reproductive health services in order to collaborate with community health service providers to increase access through mobile medical units.

Protecting pregnant incarcerated women's dignity by prohibiting the use of shackles on birthing women. The human rights of pregnant incarcerated women are being violated through the use of shackles during birth. Localities have the opportunity to preserve incarcerated women's dignity, both in their own community jails as well as in state correctional facilities where local residents are being held.

- We urge local elected officials to pass ordinances that prohibit the shackling of birthing women in local city or county jails and urge state legislators to ban shackling of birthing women being held in state correctional facilities.

LOCAL EXAMPLES:

- ❏ **The MOMobile program in Philadelphia**, which is operated out of the Riverside Correctional Facility, supports incarcerated women who are pregnant or have young children by providing peer support groups and case management during incarceration and for a year following release from prison.
- ❏ In **Marion County, FL**, through an innovative collaboration of county health care providers and the county sheriff's office, a non-profit organization was created to coordinate local health care providers to provide quality health care to county inmates and referrals to health care providers upon release.

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FEDERAL AND STATE RECOMMENDATIONS

Cities and counties have the ability to address reproductive, sexual, and maternal health challenges with innovative local solutions. However, federal funding and complementary policies are needed to improve the ability of urban communities to address their own health challenges. The following section highlights key recommendations for the federal and state governments to improve the reproductive, sexual, and maternal health of urban areas.

FEDERAL RECOMMENDATIONS

As the population of the United States concentrates more and more in metropolitan areas, federal policy decisions have a growing impact on urban areas. This is particularly true with respect to reproductive health policy; city fertility rates are higher than the national average, and women living in metropolitan areas are more likely to be of reproductive age. Numerous federal laws, programs, and agencies directly and indirectly support and affect the reproductive health of urban residents. However, political ideology plays a significant role in shaping policy decisions regarding reproductive health. During the George W. Bush administration, conservative ideology and religious doctrine drove policy and spending determinations related to reproductive and sexual health. For example, millions of dollars were spent on abstinence-only education despite numerous studies documenting how the programs were not effective in reducing risky sexual behavior among youth. The Obama administration has announced a commitment to promote evidence-based programs as the standard for fiscal support and policy intervention, signaling a return to prioritizing science over politics when it comes to reproductive health. Under President Obama's leadership, there is a new opportunity at the federal level to effect positive change on reproductive, sexual, and maternal health in urban communities.

WE CALL ON THE OBAMA ADMINISTRATION AND CONGRESS TO:

Address reproductive, sexual, and maternal health through the White House Office of Urban Affairs.

Recognizing that metropolitan areas in the United States continue to grow in both proportion of population and economic output,¹ on February 19, 2009, President Barack Obama signed an Executive Order establishing the first White House Office of Urban Affairs (the Office). The mission of the Office is to create an urban policy agenda and coordinate the efforts of various federal departments affecting urban America,² including the Departments of Health and Human Services, Labor, Transportation, and Housing and Urban Development, the Environmental Protection Agency, and the Small Business Administration. In order to realize this mission, the Office will reach out to officials and non-profit organizations at the state and local levels.³

- We urge the Office to meet with reproductive, sexual, and maternal health advocates, researchers, and local public health officials for input on how to effectively coordinate executive departments and agencies on urban reproductive health issues.
- We urge the Office to prioritize reproductive, sexual, and maternal health in its national urban policy agenda and when coordinating policy efforts among federal agencies.

Provide funding directly to urban areas to produce evidence-based models that can benefit communities across the United States. The federal budget is a critical source of funding for local reproductive, sexual, and maternal health programs and service providers. Without adequate support from federal programs, such as the Title X Family Planning program, many cities are hindered in what they can provide to uninsured and underinsured residents.

Urban areas are home to established and motivated local advocates, elected officials, and public health departments that are either already implementing or are poised to pilot innovative solutions to address current reproductive, sexual, and maternal health challenges. Many of these challenges require immediate action.

Providing direct funding to cities, counties, and local health departments will enable localities to address the disproportionate burden of adverse reproductive, sexual, and maternal health outcomes experienced in urban areas. Funding urban areas to pilot programs will also produce

and add to the pool of evidence-based strategies, which in turn will support the replication of sustainable and effective policies throughout the United States. Creating new funding opportunities for advocates and local officials in urban areas will enhance critical efforts to effect change that are ongoing and already supported by funding streams focused at the regional or state level.

- We urge Congress to authorize new funding available to advocates and cities and counties to support the development and implementation of evidence-based and promising local programs aimed at improving reproductive, sexual, and maternal health in urban areas.
- We urge Congress to work with local officials and advocates in each region representing various metropolitan areas to ensure that the eligibility guidelines for these funds do not exclude urban areas that serve as regional hubs but may not meet traditional urban definitions.

STATE RECOMMENDATIONS

Every state has at least one metropolitan area, and 83% of the U.S. population lives in one of these metropolitan areas.⁴ Even when the bulk of their landmass is rural, states should recognize through their policies and programs the critical role that their metropolitan areas play in the provision of reproductive health services and education.

State policy affects the health of urban residents. For example, decisions regarding the distribution of funds authorized by state health departments impact the ability of localities to address the particular reproductive, sexual, and maternal health challenges unique to their communities. Resources made available through state programs often give localities the discretion to tailor the services they provide to meet unique local needs.

WE CALL ON STATE GOVERNMENTS TO:

Prioritize urban reproductive, sexual, and maternal health issues within state health agencies. Urban centers often act as hubs for a state's reproductive, sexual, and maternal health care services, making urban health policy critical to the overall health of urban and non-urban residents alike. For states with multiple metropolitan areas, coordination on urban health issues across cities is critical to developing consistent priorities and strategies within state borders. In coordinating with local elected officials, public health departments, health care providers, and advocates from multiple urban areas, state agencies can identify and tackle those reproductive, sexual, and maternal health issues that impact the majority of the state's residents.

- We urge states to establish commissions with the purpose of developing recommendations and priorities for addressing urban reproductive, sexual, and maternal health issues at the city, county, and state levels.
- We urge states with fewer urban areas to designate leaders within agencies to coordinate urban reproductive, sexual, and maternal health priorities in state policies and programs.

Empower localities to formulate solutions to address their local reproductive, sexual, and maternal health challenges by providing funding and flexibility on local governance. Local governments, health departments, and advocates have particular expertise on the health challenges their communities face. Furthermore, localities respond to the immediate needs of their residents by providing critical safety net services.

While localities clearly play an enormous role in providing reproductive, sexual, and maternal health care to their own and surrounding residents, these responsibilities are particularly challenging given the lack of options for local governments to generate funds and levy taxes.⁵

- We urge states to target funds to support innovative reproductive, sexual, and maternal health solutions in cities and counties that will address disparities and benefit overall state health. These solutions should either be evidence-based or build on best practices that have a strong evaluation plan.
- We urge states to further empower localities to improve the health of their communities and strengthen the urban health infrastructure by authorizing localities to raise revenue to support the provision of reproductive, sexual, and maternal health services.

POWER TO ENACT LOCAL LEGISLATION

Home rule refers to a delegation of power to enact local laws or policies from the state to subordinate governmental entities, such as counties or cities. Home rule authority in some states is governed by the state constitution and in others by statute. Today, almost every state provides for some form of home rule.

Home rule laws vary widely in the scope of power they delegate to local governments. The focus of home rule power is generally on local issues that primarily or exclusively affect local residents. For example, home rule laws might establish the right of local governments to choose the form of their local government or grant authority to tap into local revenue sources.

The ability of local governments to enact laws or policies pursuant to their home rule authority is not without limits. For example, local governments cannot rely on their home rule power to adopt laws or policies that directly conflict with state or federal law. In addition, in some instances the state's governance of a specific area precludes the exercise of home rule authority in order to ensure uniform regulation of the law throughout the state. In situations in which state and local governments disagree about the boundaries of home rule authority, it is usually up to the state courts to resolve the issue. In those cases, most courts determine that any reasonable doubt over the delegation of a power should be resolved in favor of it being reserved by the state.

Local advocates and officials should consider whether home rule offers opportunities to create and advance progressive policies.

ENDNOTES

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- 2 The White House, "Executive Order: Establishment of the White House Office of Urban Affairs" (February 19, 2009).
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- 5 National Association of Counties, *Counties' Role in Health Care Delivery and Financing* (Washington, D.C.: National Association of Counties, July 2007), http://www.naco.org/Template.cfm?Section=New_Technical_Assistance&template=/ContentManagement/ContentDisplay.cfm&ContentID=24263 (accessed April 12, 2009).

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The Urban Initiative for Reproductive Health is a program of the National Institute for Reproductive Health (National Institute).

The National Institute is an innovation institute for state and local organizations working on reproductive health issues. We offer strategic guidance, hands-on support and funding to help state and local leaders remove barriers to health care, win public battles and change public policies. Together, we are helping women in communities across the country gain access to the full range of quality reproductive health care options, the freedom to exercise their reproductive rights and the opportunity to have healthy pregnancies.

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