

# THE STATE OF CHOICE IN OHIO



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Pro-Choice Ohio Foundation

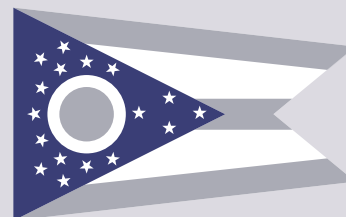
# EXECUTIVE SUMMARY

**Ohio is known for having some of the strictest and most unnecessary regulations on abortion care in the country.**

Since John Kasich took office as Governor of Ohio in 2011 he has enacted 17 anti-choice provisions that have severely affected access to reproductive health care throughout the State. There are only nine abortion clinics left in Ohio, leaving 91% of counties without an abortion provider (NARAL Pro-Choice Ohio, 2016). Because many healthcare plans are banned from covering abortions, while mandatory waiting periods as well as clinic closings have made travel costs alone unmanageable for some women, abortion care is financially out of reach for many women. Evaluating the State of Choice does not stop at simply looking at abortion statistics. Birth and fertility rate, contraception access, sexual education, prenatal care, adequate OB/GYN services, domestic and sexual violence rates and response programs, paid family leave, the state of foster care and a whole host of other issues impact reproductive decisions and create a clearer picture of the safety conditions of women in Ohio. The purpose of this report is to make Ohio specific data on all issues related to choice accessible in one consolidated resource. This report does not include original research but rather is a collection of information, data and statistics from other sources, including private and public health research projects, Ohio Department of Health collected data, and national government statistics collection sources. The report is intended to create as comprehensive as possible a picture of the state of reproductive choice in Ohio, with currently available data sources.

Most of the research presented in this article reports only along the gender binary, categorizing groups as either female or male. The erasure

of transgender and non-binary individuals is a problem with this research; therefore the information in this report should not be considered complete.<sup>1</sup> There is virtually no Ohio-specific data on reproductive care and choice for transgender and non-binary people. There should be more research done on the reproductive needs and barriers to choice that the Ohio transgender and non-binary community face.



There are limitations to the data in the report. In many cases the data available is at best a couple years old and in the worst cases almost a decade out of date. It will be useful to have this older data as a baseline to compare with new numbers as studies are released. However it is difficult to evaluate the current situation in some areas related to choice such as, for example, paid family leave, where the most recent Ohio-specific statistics are from 2007. Furthermore, socio-economic status is either not tracked or under-covered in many of the studies across all of the reproductive issues included in this report. Financial obstacles are one of the biggest barriers to access and control. The lack of demographic information related to economic status or income is a problem in evaluating who has reproductive choice in Ohio. Additionally, data in this first report is limited to the physical health and wellbeing of women. It is our hope that future issues of the report will also include information on mental health and substance use and abuse as it relates to women's health in our state.

# ABORTION ACCESS

Ohio is known as an epicenter for health services, with world-class facilities such as the Cleveland Clinic and The Ohio State University Medical Center; yet women are being forced to leave the state to access abortion care. Ohio's total numbers of induced abortions decreased in recent years while at the same time Michigan's abortion numbers have increased. From 2012 to 2014 the total number of abortions in Michigan increased 18.2 % (Michigan Department of Community Health, 2014 and 2015). The number of out-of-state residents receiving abortion care in Michigan also increased from 531 in 2012 to 1,300 in 2014 (Michigan Department of Community Health, 2014 and 2015). The number of abortions in Lucas County, which borders Michigan and where one of Ohio's larger cities, Toledo, is located, decreased from 2,563 in 2010 to only 733 in 2014, the largest decrease in the state (ODH, 2015). These statistics indicate that Ohio women are having to cross state lines to receive necessary health services, increasing their travel time, expenses, and time away from work and school.

Women in Ohio are also having abortions at later stages in their pregnancy, indicating that recent changes in access could be causing women to delay care. From 2008 to 2014, the percentage of abortions that took place before nine weeks of pregnancy dropped from around 56% to 52%; however during that same time period the percentage of abortions that took place between nine and 12 weeks of pregnancy increased from around 28% to 31%, and the percentage that took place between 13 and 18 weeks increased from 12% to 14%. These numbers suggest that women may be having to delay care, making procedures more costly and resulting in potentially more side effects. This postponing of abortion care is a new emerging trend in Ohio, illustrating a potential developing crisis in access to reproductive health access.

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Another substantial change in abortion access in Ohio is the decrease in use of the medication abortion method, known as the RU 486/ mifepristone and misoprostol or “abortion pill.” Between 2010 and 2011, medication abortions declined from almost 21% of total abortions to only 5%. This drop in the use of the medication abortion method can be attributed to new stringent regulations that affected access. In 2004 the Ohio legislature passed a law requiring Ohio follow the outdated FDA protocol rather than the newer evidence-based protocol for medication abortions. An Ohio court decision in 2011 upheld the law and required the use of the FDA protocol, most likely explaining the shift away from medication abortions in the state. In March of 2016 the FDA changed the protocol, necessitating significantly less amounts of mifepristone (200mg instead of 600mg), fewer doctor visits, and extending the length in pregnancy that the method can be used (up to 70 days). These changes will most likely improve access to abortion because they provide more options for women, facilitating greater control over their bodies.

Contrary to many myths propagated by the anti-choice movement, abortions in Ohio are safe. One positive trend in the state of choice is the consistently low complication rate for legal abortions, with the year with the highest rate at less than half of one percent of the procedures resulting in complications (Ohio Department of Health). The abortion complication rate is substantially lower than the maternal morbidity rate, which measures complications during pregnancy, meaning that the health risks rising from abortion are much lower than the complications surrounding childbirth.

# CONTRACEPTION

Although health insurance is required to cover some contraception options, Ohio women are still in need. The Patient Protection and Affordable Care Act, colloquially known as Obamacare, directly caused an increase in coverage for contraception through health insurance across the nation (Guttmacher 2014). The Affordable Care Act was signed into law in March of 2010, though coverage without cost-sharing for contraception was not instituted until August 1, 2011 (US department of Health and Human Services, 2011). The Act does not require that all brands of birth control be covered, meaning some women still face the financial burden of controlling their reproductive destinies. The ACA also exempts religious organizations from the requirement that health plans cover contraceptive services, creating obstacles for female employees at those organizations (HRSA). Furthermore, there are still women in Ohio who are uninsured. Ohio falls far below the national average for meeting the need for publicly funded contraceptive services. Although the need for publicly funded contraceptive services increased by three percent between 2010 and 2013, the percent of need met by publicly funded contraceptive providers decreased from 22% to 15% in the same time period (Frost, Frohwirth, Zolna, 2013). These numbers indicate that there are still many women who are in need of contraceptive services, facing barriers to control over their bodies.

## HEALTH CRISIS FOR BLACK & HISPANIC WOMEN

The compiled data and statistics in this report illustrate a reproductive health crisis for Black and Hispanic women in Ohio. The unique challenges Black and Hispanic women face span across the spectrum of reproductive needs and issues,

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starting at a very young age. The teen birth rate has decreased across the board for all young women and girls in Ohio over the past decade, however the teen birth rate remains substantially higher for Black and Hispanic teens. In 2013 the teen birth rate (defined as births per 1,000 females age 15 to 19) was 49 for Black teens, 43 for Hispanic teens and 22 for white teens (National Kids Count, 2014). This disparity in teen birth rates demonstrates a resource gap for young Black and Hispanic teens that impacts their ability to advance in their education, careers, and communities.

During and after pregnancy Black and Hispanic women in Ohio face additional obstacles, which are adding to the health crisis for these communities. Access to adequate and affordable prenatal care is essential to continuing a healthy pregnancy and assisting women in controlling their reproductive lives. According to Amnesty International 19.3% of women of color in Ohio in 2010 did not receive prenatal care or their prenatal care was delayed (Amnesty International, 2010). For the same year, 12.2% of all women in Ohio (including white women) did not receive or delayed prenatal care (Amnesty International, 2010). Unfortunately, the 2010 numbers are the most recent data tracking the accessibility of prenatal based on race and ethnicity. The available statistics thus suggest that it is more difficult for women of color in Ohio to obtain the same level of prenatal care as white women. Black infants consistently have the highest rates of low birth weights<sup>2</sup> in Ohio, potentially due in part to the racial disparity in prenatal care access. For example, 13.3% of Black infants born in 2013 in Ohio had a low birth weight compared to 7.4% of the white infants, who consistently have the lowest rate of low birth weights (National Kids Count, 2014).



## HEALTH CRISIS FOR BLACK & HISPANIC WOMEN CONTINUED



The trend of Black women and Black infants facing disproportionate issues in pregnancy and after delivery continues with infant mortality rates. Unfortunately, Ohio is known for having particularly high infant mortality rates in the United States, nationally ranked 44th (United Health Foundation, 2016). However for Black infants the rate is double the state average. In 2014 the infant mortality rate<sup>3</sup> for white infants was 5.3 while for black infants it was 14.3 (Ohio Department of Health, 2015). The disparity in these numbers reveals a clear and devastating health inequality between white residents and Black residents in Ohio. While there are numerous and complex causes for this difference, it is evident that comprehensive policy reform is necessary to address this reproductive health crisis for Black infants in particular.

Reproductive health does not begin and end with pregnancy and delivery but rather includes broader health issues, such as cancer and sexually transmitted infections. The reproductive health inequities for Black and Hispanic women are found in these areas as well. According to the Ohio Cancer Incidence Surveillance System, “Hispanic women have more than twice the risk of developing cervical cancer compared to non-Hispanic white women, and African American women have 1.5 times the risk of non-Hispanic white women” (OCISS, 2014). The differences in these risks indicates potential barriers to screening and treatment that Hispanic and Black women face that white women do not. The HIV infection rates in Ohio also indicate unique reproductive health dangers for Black and Hispanic women. In 2014 the diagnosis of HIV infection rate, defined as occurrence of infection per 100,000 females, was 0.9 for white women, while for Hispanic women it was 4.6 and for Black women it was 10.9 (Ohio Department of Health, 2015). Although the rate of HIV infection diagnosis for Black women has decreased, it is consistently substantially higher than the rate for women of other racial and ethnic backgrounds. These numbers are troubling because they illustrate that Black women in Ohio are facing larger threats to their reproductive health and wellbeing. The causes of these threats to Black and Hispanic women’s reproductive safety are multifaceted, however it is clear that Ohio must allocate more resources to address the needs of these women.

## CONCLUSION

Although there are some positive trends in the state of choice for Ohio, there needs to be extensive policy change to grapple with the large obstacles and problems that women, particularly Black and Hispanic women, in Ohio face. This report covers more issues than abortion rights, contraception access and the unique health crisis for Black and Hispanic women highlighted above. The insufficient response from law enforcement to domestic violence and sexual assault, the push toward abstinence-only sexual education in schools, lack of state funding to support the foster care system, the fact that very few employees have access to paid family leave and the invisible reproductive struggle of women and girls in prison are all important features negatively impacting the state of choice in Ohio. The findings from this extensive search for data on choice in Ohio reveal many overlapping issues that should be investigated further. This report intends to create one consolidated resource that can be used as a base line to track some of these issues in years to come, as well as providing a comprehensive look at choice and reproductive health, based upon currently available data. Policies need to address, and in some cases, such as abortion, entirely change in order to improve the state of choice from its current dire condition.



# THE STATE OF ABORTION

Ohio has some of the most restrictive regulations on abortions in the country. Recently, clinics have had to comply with stringent and medically unnecessary provisions and many providers have been forced to close. The overall number of abortions in Ohio decreased from 2009 to 2014. Recently, anti-choice organizations and legislators have tried to argue that this decrease is due to the effectiveness of restrictive abortion legislation. However, the decrease in the number of abortions needs to be placed in the context of the accessibility of these procedures as well as the overall birth rate in Ohio. The number of births has decreased from 2005 to 2014. The birthrate also decreased by 7.6% from 2007 to 2010.<sup>4</sup> Similarly, the fertility rate in Ohio has decreased by 4.2% from 2005 to 2010. The number of abortions in Ohio dropped around 26% from 2009 to 2014 (Ohio Department of Health, 2014).

	2014	2013	2012	2011	2010	2009	2008	2007	2006
Induced abortion	21,186	23,216	25,473	24,764	28,123	28,721	21,186	23,216	25,473
Birth number	x	13,8936	x	x	139,034	144,569	148,592	150,784	150510
Birth rate	x	x	x	x	12.1	12.5	12.9	13.1	13.1
Fertility rate	x	62.7	x	x	62.2	63.7	65	65.4	64.6

While it is impossible to completely explain the decrease in abortion through decreases in birth and fertility rates in Ohio, it is critical to examine these two figures, abortion and birth/fertility, in relationship with one another.

## GESTATIONAL AGE

The Ohio Abortion Report, annually published by the Ohio Department of Health, tracks different demographic information as well as important characteristics about the abortions performed. The report records gestational age, which refers to how many weeks into the pregnancy the woman is at the time of the procedure. Between 2013 and 2014,

Gestation	2014	2013	2012	2011	2010	2009	2008
Under 9	52.30%	57.10%	56.40%	57.00%	57.90%	56.60%	56.30%
9-12	31.30%	28.60%	28.30%	27.90%	27.30%	27.80%	27.90%
13-18	14.00%	12.20%	13.50%	12.40%	12.10%	x	x
13- 19	x	x	x	x	x	12.50%	13%
19-20	1.80%	1.50%	1.40%	2.10%	2.20%	x	x
20	x	x	x	x	x	0.50%	x
21+	0.60%	0.10%	0.30%	0.60%	0.50%	1.70%	x



the Ohio Abortion Report showed an emerging trend. The percentage of abortions that take place under nine weeks of gestation decreased while the percentage of abortions that take place between nine and 12 weeks as well as between 13 and 19 weeks increased. Some fluctuations in this rate have occurred previously, but none have been

as prominent as the change from 2013 to 2014. The 2014 statistics could indicate that women are delaying abortions to later stages in their pregnancy. Delaying abortion care often means the procedure will be more expensive and increases the risk of complications.

## AGE OF THE WOMAN

The majority of women who have abortions in Ohio are between the ages of 25 and 55 years old, with the second largest age group being 20 to 24 years. This data challenges the notion that the majority of women seeking abortion care are in their teens and early twenties. The percentage of abortions accessed by women in the under nineteen-age group consistently decreased between 2010 and 2014. This number indicates that fewer teenage women are having abortions. In order to understand the decrease in the teenage demographic it is important to look at teen pregnancy rates. Unfortunately, the most recent data on teen pregnancy rates in Ohio are from 2010. Teen pregnancy rates, pregnancy per 1,000 women, dropped between 2006 and 2010.

There are more recent figures on teen birth rates, as current as 2014. The teen birth rates also largely declined from 2008 to 2014 (The National Campaign, 2016 and National Kids Count, 2014). According to the annual Youth Risk Behavioral Study, the rate of teens having sex<sup>5</sup> remained steady between 2003 and 2013. Because the rate of sexual activity has remained constant, both the drop in the numbers of teens having an abortion and the drop in giving birth cannot be explained by fewer teens having sex. Instead, this drop is most likely attributable to more teens using effective forms of birth control and condoms (Ohio Department of Health, 2013).

### Teen pregnancy rate

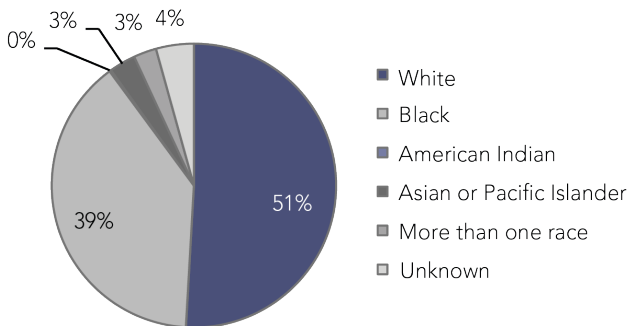
	2010	2009	2008	2007	2006
Age 10-14 - rate	1.1	1.2	1.3	1.4	1.6
Age 15-17 - rate	29	32.6	38.7	39.6	39.7
Age 18-19 - rate	93.3	103	108	110.2	108
Age 10-19 - rate	29	32.3	34.6	34.9	66
Age 10-14 - rate	1.1	1.2	1.3	1.4	1.6

# RACE & ETHNICITY

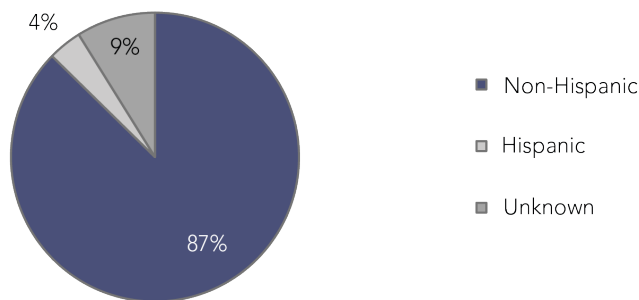
The reports on abortion care from 2010 and 2014 show clear racial differences in abortion care demographics. Black women in Ohio made up around 38% of the patients receiving abortion care, while Black people are only about 13% of the overall Ohio population. White women made up around 53% of the patients receiving abortion care during the same period, despite constituting about 80% of the Ohio population. The percentages of American Indian, Asian or Pacific Islander, Hispanic, and women who identify as more than one race who terminated their pregnancies between 2010 and 2014 are largely proportional to Ohio population demographics at large. Systemic racial inequality contributes to the demographic difference in abortion rates that is most prominently seen between white

and Black women. Racial differences in access to contraception, comprehensive sexual education, other health services, and socio-economic status pose different reproductive obstacles for Black women than white women. Hispanic and Black women have higher rates of unintended pregnancy in Ohio. Between 2009 and 2010 around 40% of white women's pregnancies were unintended, compared to around 60% of Hispanic women's pregnancies and around 70% of black women's pregnancies (Ohio Department of Health, 2014). These differences in unintended pregnancy rates illustrate the disparity in access to reproductive choice and also contribute to their higher rates of abortion (Ohio Department of Health, 2014).

**Induced Abortions by Race - 2014**



**Induced Abortions by Ethnicity - 2014**



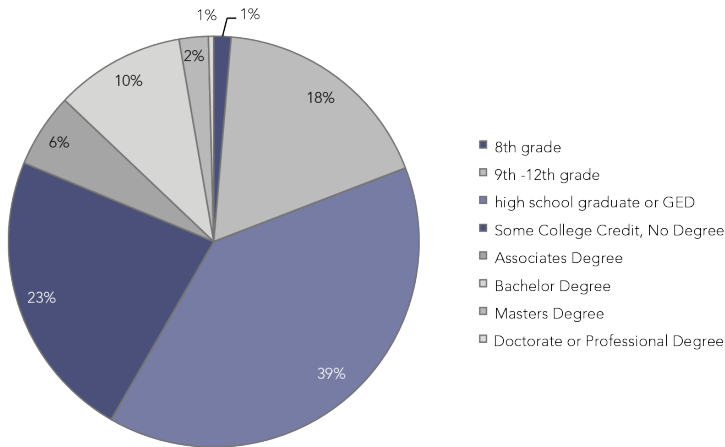
# EDUCATIONAL LEVEL

Level of education is another important factor in analyzing abortion demographics. Data from the Ohio Abortion Reports from 2010 to 2014 show that women who graduated high school or received a GED made up the largest percentage of the total abortions in Ohio (Ohio Department of

Health, 2011, 2012, 2013, 2014, 2015). However, since 2012 the percent of abortions for the high school graduate group has decreased by 4% (Ohio Department of Health, 2013, 2014, 2015).



## Induced Abortions by Educational Status - 2012



The Ohio Abortion Report does not track economic indicators but education level often correlates with income level (Bureau of Labor Statics, 2016). The level of education figures may suggest an emerging trend that women with a lower educational attainment are having more difficulty accessing abortion care.

## STATE RESIDENCY

The percentage of total abortions performed in Ohio for out of state residents decreased from 2003 to 2014. The number of abortions for Ohio residents has decreased by 37.8% since 2003, while the number of abortions for non-residents has decreased by 62.8% in the same timeframe (Ohio Department of Health, 2007-2015). These percentages suggest that women from other states who once turned to Ohio for abortion care no longer seek services in the state.

Solely focusing on residency and abortion rates in Ohio creates a partial picture of what is actually happening to women in the state. Clinic shutdown, TRAP laws<sup>6</sup>, mandatory wait times, parental consent requirements, and increased medical costs are forcing women to travel outside of Ohio to receive reproductive care. In fact, while Ohio's total number of induced abortions decreased in recent years, Michigan's abortion numbers have increased within the same timeframe. From 2012 to 2014, the number of abortions in Michigan

spiked 18.2% (Michigan Department of Community Health, 2014 and 2015). The number of out-of-state residents receiving abortion care in Michigan also increased from 708 in 2013 to 1,300 in 2014 (Gross, 2015). The rise in both the total number of abortions and the number of out-of-state residents having abortions in Michigan suggests that women who cannot access care in Ohio are traveling to Michigan for abortion care. Furthermore, the number of abortions in Lucas County, where one of Ohio's larger cities, Toledo, is located, decreased from 2,563 in 2010 to only 733 in 2014 (ODH, 2015). Lucas County is located on the border with Michigan. Although the drastic decrease in abortions in Lucas County cannot completely account for the increase in Michigan's non-resident or total abortion numbers, it is clear that there is a connection between these statistics. This bigger picture reveals that Ohio anti-choice legislation is only reducing the accessibility of abortion, and not the need for safe and legal procedures.

Residency – percentage

	2014	2013	2012	2011	2010	2009	2008	2007	2006
Ohio resident	94.50%	94.80%	94.50%	93.90%	93.60%	93.90%	93.40%	93.70%	93.50%
Out of state resident	5.50%	5.20%	5.50%	6.10%	6.40%	6.10%	6.60%	6.30%	6.50%

## MARRIAGE & FAMILY STATUS

There are many stereotypes about women who need abortions, particularly that they are unmarried, young, and have not had children prior to the abortion. In 2014, 35.7% of women receiving abortion care already had two or more children, 35.2% of women had no children and 26.8% of women had one child (ODH, 2015). In 2014, 68.7% of women who had an abortion had never been married, 10.1% were married, 2.6% were separated, 5.4% were divorced and 0.3% were widowed (ODH, 2015). These statistics, which have remained fairly consistent over the past decade, indicate that Ohio women who have abortions have a variety of different family backgrounds and situations with different considerations that inform their decisions (ODH, 2015).

## METHOD OF TERMINATION

There are many different safe and legal methods for terminating a pregnancy in the United States. Curettage suction is the most frequently used method of termination in Ohio. In 2014 this method accounted for almost 83%, or 17,529 out of the total 21,186 abortions in Ohio (Ohio Department of Health, 2015).

Medication abortion, or the “abortion pill,” accounted for around 21% of the total abortions performed in Ohio in 2009 and 2010. Between 2010 and 2011, the medication abortion method use dropped to only 5% of the total abortions (Ohio Department of Health, 2012, 2011). In 2004, the Ohio legislature passed a regulation that restricted the use of the RU-486 medication abortion protocol unless the provider used it in strict accordance with FDA regulations, instead of the evidence-based regimen supported by American College of Obstetricians and Gynecologists, National Abortion Federation, and Planned Parenthood Federation of America. The evidence-based regimen allowed for a lower dose of mifepristone, fewer clinic visits, and can be used up to 63 days after the woman’s last menstrual period versus the 49 days limit required by the FDA (Guttmacher Institute, 2016). The evidence-based protocol is less expensive, allows for more options, and results in fewer side

effects, less travel time, and fewer missed work hours. Furthermore, several studies indicate that the evidence-based protocol is 95-99% effective, while the FDA regimen is 92% effective (Guttmacher Institute, 2016). In 2011 an Ohio court upheld the 2004 law, thus requiring compliance with the outdated FDA regulations on medication abortions. This court decision could be one of the reasons that there was such a substantial decrease in medication abortions between 2010 and 2011 numbers.

On March 30, 2016 the FDA changed protocol for RU-486, which greatly impacts access to this method of termination in Ohio. The new FDA regulations now allow use of medication abortions through 70 days of gestation (instead of 49 days), allow fewer clinic visits, and recommend a significantly lower dose of mifepristone, 200mg instead of 600mg (FDA, 2016). These changes in FDA policy will make medication abortions much more accessible by lowering cost, travel time, side effects, and permitting the use longer in pregnancy. The new protocol will give Ohio women more options and control over their reproductive destiny. Future reports will follow how this impacts on the number of women that choose medication abortion to terminate their pregnancies.



# COMPLICATION RATES

When performed in a medical office by trained medical providers, abortions are an incredibly safe procedure with a very low risk of complication. Abortions are considerably safer than both carrying a pregnancy to term and childbirth. In Ohio there are two forms that record abortion complications: the Confidential Abortion Report (completed at the time the abortion is performed) and the Post Abortion Care Report for Complications (completed by the medical professional who treated the complication). The data on complications can vary between these two sources. According to the Confidential Abortion Report, in 2014 a total of 0.17% of abortions had complications (Ohio Department of Health, 2015). Because some complications do not occur immediately following the procedure, the Post Abortion Care Report for Complications had a slightly higher number: 0.27% of abortions had complications (Ohio Department of Health, 2015). Table 3 outlines the very low numbers of specific complications since 2010 recorded by both forms.

**Abortion Complications by number– Confidential Abortion Report**

	2014	2013	2012	2011	2010
Total (percentage)	0.17%	0.05%	0.19%	0.28%	0.30%
Perforation of Uterus	1	0	0	1	0
Cervical Laceration	4	4	26	9	11
Hemorrhage	4	2	3	28	39
Incomplete Abortion	0	0	0	11	4
Hematometra	0	1	6	6	12
Anesthetic	0	0	0	1	2
Failed Abortion	0	1	3	1	1
Infection	0	1	0	6	1
Death	0	0	0	0	0
Other	27	4	12	6	20

# CONTRACEPTIVE USE

Following the abortion procedure, medical providers recommend and provide information about contraception options to patients. In 2014, 98.8% of women who had abortions received a recommendation for or information on contraception (Ohio Department of Health, 2015).

Oral contraception or birth control pills were the number one recommended form of contraception, followed by male condoms. In 2014 three types of contraception, the hormone implant, hormone patch, and Depo-Provera (hormone shot), were recommended at higher numbers than



compared to 2013 (Ohio Department of Health, 2015, 2014). The implant was recommended to 730 patients in 2014 versus 293 in 2013. The patch was recommended to 364 patients in 2014 versus 122 in 2013. Depo-Provera was recommended to 1,663 patients in 2014 versus 1,573 in 2013. Furthermore the total number of abortions decreased from 23,216 in 2013 to 21,186 in 2014, meaning that the increase in recommendations for these types of contraception are even more noteworthy (Ohio Department of Health, 2015, 2014).

The Ohio Abortion Report also tracks the number of women having abortions who used some type of contraception at the time of conception. Data from 2014 indicates that nearly a quarter of the women terminating their pregnancies were using some type of contraception at the time of conception (Ohio Department of Health, 2015). These forms of contraception include the withdrawal and ovulation rhythm methods, which are considered to be the least effective forms of birth control, through more effective methods like birth control pills and implants (CDC, 2011). These numbers demonstrate the need for both comprehensive sexual education, to ensure people know how to effectively use birth control, and

## Contraceptive History at Time of Conception

	2014	2013	2012	2011
Total - Yes, Any Type #	5,124	5,569	6,753	7,041
Total - Yes, Any Type - Percent	24.00%	24.00%	26.50%	28.40%
Cervical Cap	6	6	13	x
Hormone Implant	7	18	11	x
IUD	117	86	90	x
Condom, Male	2,083	2,467	3,098	x
Oral Contraceptive	1,950	1,956	2,041	x
Vaginal Ring	282	301	425	x
Injection	278	243	264	x
Condom, Female	26	51	99	x
Foam	35	36	49	x
Diaphragm	7	11	11	x
Hormone Patch	34	53	51	x
Rhythm	61	67	66	x
DepoProvera	28	42	0	x
Plan B	18	25	X	x
Abstinence	0	X	X	x
Withdrawal	84	X	X	x
Partner Vasectomy	0	X	X	x
Tubal Ligation	0	X	X	x
Mirena	0	X	X	x
Emergency Contraceptive	0	X	X	x
Essure	0	X	X	x
Own MD	0	X	X	x
Own Plans	0	X	X	x
Other	159	216	361	x

accessible, safe and legal abortion care even when contraception is used. These statistics challenge the myth that women receiving abortions are irresponsible, do not want to use birth control, or use abortion as a primary form of contraception. Women become pregnant from a variety of situations with various reasons for using or not using contraception methods.

## COST OF PROCEDURE

Financial barriers pose some of the biggest obstacles to women's access to abortion care. The cost of an abortion generally depends on how far along the pregnancy is, the general health of the mother, the body mass index (BMI) of the mother, the method of abortion, and the location where the abortion is performed. The Ohio Abortion Report that tracks and compiles the majority of the data on abortions in Ohio does not gather data on socio-economic status or income level. There are no reports that correlate income level and abortion access that are specific to Ohio data; therefore it is difficult to accurately evaluate abortion access.

Ohio and federal law forbids Medicaid coverage for abortion unless the pregnancy was the result of rape or incest, or the woman's life is at risk. Abortion coverage is also forbidden in the insurance plans of state and local government employees. Ohio law also forbids qualified health insurance plans from covering abortion procedures (LAWriter, 2012)<sup>7</sup>. This leaves many women in the position of not being able to afford the abortion they need. Some women can qualify for financial

assistance from the clinic, which is generally funded by private non-profit organizations, such as Women Have Options Ohio Abortion Fund (WHO/O). These funds are essential for the accessibility of abortion services. The right to have an abortion is hollow if the woman does not have access because they cannot pay for the procedure.

Abortions can be financially out of reach for many women. The base cost for a medication abortion or the abortion pill ranges from \$400 to \$800 depending on the clinic. The base price for an abortion through 12 weeks' gestation is around \$400 to \$500. The starting price through 13 and 14 weeks' gestation is around \$500 to almost \$700. The price through 15 and 16 weeks' gestation is around \$450 to \$800. The cost through 17 and 18 weeks' gestation is around \$800. Any abortion past 19 weeks' gestation will most likely be over \$1,000. Differential pricing at clinics is most likely due to the prohibition on Medicaid and insurance funding as well as Ohio's demanding regulations on abortion providers that require expensive and unnecessary accommodations.

## PROVIDER SHUT DOWN

There were 16 clinics open in Ohio in January 2011. As of April 2016 there are only nine clinics left in the state. Many of these closures can be attributed to the numerous TRAP laws passed since 2011, lack of funding, anti-choice smear campaigns, and other legislation aimed at restricting access to abortion care. Another emerging trend is that private hospitals that formerly performed abortions, particularly in the case of severe fetal anomalies, are now refusing to provide those services. For example, in November 2015 The Christ Hospital, a private hospital in the greater Cincinnati area, instituted a new policy that bans physicians from providing abortions except "in situations deemed to be a threat to the life of the mother" (Balmert and Thompson, 2016). The Christ Hospital was one of the last options for women seeking abortion care in that region of Ohio. Most of the abortions performed at the hospital were cases in which there were severe fetal anomalies that made it unlikely that the fetus would survive birth, but that did not threaten the life of the mother. Policies such as these prevent doctors from being able to provide the medical services that they believe are best for their patients, and forces them to send their patients elsewhere for the care they need.

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[Women Have Options Ohio Foundation](#)

# THE STATE OF PREGNANCY & DELIVERY

## PRENATAL AND POSTPARTUM CARE

Ensuring that Ohioans have access to the services they need during pregnancy and delivery is critical to the state of choice in Ohio. The accessibility of adequate prenatal care for all Ohio women is a crucial part of having real reproductive health options. Between 2009 and 2011 an average of 83.7% of Ohio women who were pregnant started prenatal care within the first trimester of their pregnancy (Ohio Department of Health, 2014). Amnesty International reported that in 2010, 12.2% of all women and 19.3% of women of color in Ohio who were pregnant did not receive prenatal care or their prenatal care was delayed, demonstrating a racial disparity in access to care (Amnesty International, 2010). These numbers indicate that there are barriers to accessing necessary care during pregnancy in Ohio. Between 2009 and 2011, an average of 52% of pregnant women were covered through their employment, an average of 44% were covered through Medicaid, and 3.3% were uninsured (Ohio Department of Health, 2014). In Ohio becoming pregnant does not qualify as a life event that would make an individual eligible to obtain new insurance outside of the open enrollment period. This policy leaves vulnerable women without the coverage they need to have a healthy pregnancy.

The majority of prenatal care providers discuss a range of issues related to healthy pregnancies, including the effects of alcohol and smoking on the fetus, breastfeeding, depression during and after pregnancies, symptoms of preterm labor, and HIV testing. Unfortunately, a shockingly low number of prenatal care programs in Ohio discussed or provided resources that address physical abuse and domestic violence. Data show that from 2006 to 2011 (the latest available data) less than half of the providers discussed these forms of violence (Ohio Department of Health, 2014). An average of 5.2% of women who became pregnant between 2009 and 2011 reported being abused by their partner during the pregnancy (Ohio Department of Health, 2014).

Postpartum care is essential to a healthy pregnancy because it impacts women's safety and wellbeing when recovering from pregnancy and childbirth. From 2009 through 2011, on average around 91% of women who gave birth received at least one postpartum check-up (Ohio Department of Health, 2014). In the same time period, an average of 12.4% of women who gave birth experienced symptoms of postpartum depression (Ohio Department of Health, 2014).

## UNINTENDED PREGNANCY RATES

In 2010 the unintended pregnancy rate in Ohio was 49, representing the number of women who had an unintended pregnancy out of 1,000 women aged 15-44 (Guttmacher Institute, 2014). More than half, 55%, of total pregnancies in Ohio in 2010 were unintended (Guttmacher Institute 2014). Clearly, the high rate of unintended pregnancy points to a need for better sexual education and improved contraception access. Unfortunately the 2010 statistics are the most recent data on the question of unintended



pregnancy in Ohio, which creates a gap in understanding the current state of choice. Furthermore this statistic is from before the Affordable Care Act's mandate for contraception coverage without co-pays was instituted, which most likely decreased the unintended pregnancy rate. It is difficult to evaluate abortion rates without having an accurate and recent picture of the rate of unintended pregnancy.

## LOW-BIRTH WEIGHT / PRETERM BIRTHS

Low-birth weight and preterm births illustrate potential problems in Ohio's state of pregnancy and delivery. In 2013, 12% of total births in Ohio were preterm births, defined as babies born with gestational age of less than 37 weeks (National Kids Count, 2015). The percentage of preterm births remained consistently around 12% from 2009 to 2013, the most recent year for which data is available. Nationally, 11.4% of the total births in 2013 were classified as preterm (National Kids Count, 2015). From 2009 to 2013 about 8.6% of the total births in Ohio were categorized as low birth weight, defined as live births weighing less than 5.5 lbs (National Kids Count, 2015). Nationally, 8% of births in 2013 were classified as low birth weight (National Kids Count, 2015). From 2009 to 2013, about 1.7% of total births in Ohio were reported as very low birth weights or live births weighing less than 3.4 lbs (National Kids Count, 2015). Nationally, from 2009 to 2013 about 1.4% of total births were reported as very low birth weights (National Kids Count, 2015). Race and ethnicity are

the most carefully tracked demographic information regarding preterm and low birth weight data. From 2009 through 2013, the percent of low birth weights for Black babies was almost twice as much as the percent for white, Hispanic, and Asian or Pacific Islander babies (National Kids Count, 2015). The percent of low birth weights were higher among American Indian babies than other racial demographics, but still consistently lower than that of Black babies.

**Low Weight of Birth by Race and Ethnicity**

	2013	2012	2011	2010	2009
White - #	7,700	7,717	7,929	7,858	8,174
White - percent	7.40%	7.40%	7.60%	7.50%	7.50%
Black or African American - #	3,305	3,347	3,232	3,303	3,431
Black or African American - percent	13.30%	13.70%	13.40%	13.60%	13.60%
Hispanic - number	526	490	498	469	509
Hispanic - percent	8.10%	7.50%	7.90%	7.40%	7.40%
Asian or Pacific Islander - number	322	334	278	303	286
Asian or Pacific Islander - percent	8.20%	8.60%	7.90%	8.40%	8.10%
American Indian -#	38	22	28	29	23
American Indian - percent	11.90%	7.40%	10.30%	10.20%	8.00%



# MATERNAL MORBIDITY & MORTALITY

There are many complications and health risks associated with pregnancy and childbirth. Maternal morbidity and mortality levels are essential considerations when deciding whether to become pregnant or continue a pregnancy, because they directly impact the wellbeing and safety of women during the reproductive process. In 2010 the maternal mortality rate, defined as number of deaths per 100,000 births, was 8.4 (Amnesty International 2010). In 2010 Amnesty International ranked Ohio 18th nationally in maternal mortality (Amnesty International, 2010). The Ohio Pregnancy-Associated Mortality Review (PAMR) reports on pregnancy-associated deaths which are defined as, “death during pregnancy or within one year of the end of pregnancy, regardless of cause,” as well as pregnancy-related deaths, which refer to “death during or within one year of pregnancy that is related to pregnancy” (Ohio Department of Health, 2015). The rate of both pregnancy-associated and pregnancy-related deaths spiked in 2009 to 50.5 (associated) and 20.1 (related) deaths per 100,000 live births (Ohio Department of Health, 2015). Both rates have decreased since 2009. In 2012 the pregnancy-associated death rate was 39.1 and the pregnancy-related death rate was 15.2 (Ohio Department of Health, 2015).

There are many different causes of maternal mortality. Hemorrhaging, sepsis or infection, hypertensive disorders, prolonged or obstructed labor, and indirect causes, such as pre-existing medical conditions that increase the risk of maternal death, are the leading causes of maternal mortality nationally (Columbia University Mailman School of Public Health). Maternal mortality is difficult to accurately track, given that a death directly caused from childbirth can take place much later than the delivery, at a different hospital or geographic location than the childbirth. Therefore the actual mortality rate could be higher than these statistics show.

Along with maternal mortality, it is important to look at pregnancy complications and maternal morbidities. The World Health Organization’s Maternal Morbidity Working Group defines maternal morbidity as “any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s wellbeing” (World Health Organization, 2013). The Ohio Department of Health tracks maternal morbidity through its Pregnancy Risk Assessment Monitoring System (PRAMS) program. From 2009 through 2011, the most common morbidity causes were as follows: kidney or bladder infection (20.8%), preterm labor (21.1%), vaginal bleeding (19.4%), high blood pressure (14.3%), gestational diabetes (10%), and premature ruptured membranes (5%) (Ohio Department of Health, 2014).

## TEEN PREGNANCY

The Ohio teen pregnancy rate, referring to the number of pregnancies per 1,000 women, for the 10 to 14, 15 to 17, and 18 to 19 aged groups decreased from 2006 to 2010 (Ohio Department of Health, 2012). The Ohio teen birth rate, referring to the number of births per 1,000 women for teens age 10 to 19, also decreased

dramatically from 2006 through 2013. The 18 to 19 aged group has the highest birth rate compared to the younger teenage groups (Ohio Department of Health, 2012). These numbers indicate a decrease in the number of teenagers who become pregnant in Ohio. Ohio teen birth rates are similar to national teen birth rates, which



have also decreased (National Kids Data Center, 2014). While teen pregnancy and birthrates have decreased, the Ohio Department of Health found that “from 2003 to 2013 there was no significant change in the percentage of [high school] students who have currently had sexual intercourse” (Ohio Department of Health, 2013). The steady level of teenage sexual activity suggests that the decrease in teen pregnancy and birthrates is due to other factors, such as increased use of contraception and better sexual education.

Analysis of demographic information in regards to teen pregnancy is important for best evaluating where resources such as comprehensive sexual education, subsidized sexual health services, and access to contraception, are falling short

or lacking. Unfortunately, statistical information about socio-economic class or income correlated with teen pregnancy or birth rates is virtually non-existent. Race and ethnicity are the most fully reported demographic information for teen pregnancy and births. The teen birth rates in Ohio from 2009 through 2013 were lowest for Asian and Pacific Islander teens and highest for Black and Hispanic teens (National Kids Count, 2016). White and American Indian teens had roughly similar teen birth rates from 2009 through 2013; their birth rates were about half those of Black and Hispanic teens (National Kids Count, 2016). For all racial and ethnic groups the teen birth rates decreased each year between 2009 and 2013 (National Kids Count, 2016).

### Teen birth rate by race and ethnicity

	2013	2012	2011	2010	2009
White	22	24	25	28	31
Black or African American	49	56	58	62	74
Hispanic	43	47	50	57	75
Asian and Pacific Islander	9	7	9	11	12
American Indian	21	32	21	19	31

## INFANT MORTALITY

Ohio is known for its high infant mortality rate, which has remained higher than the national average for the past seven years (Ohio Department of Health, 2015, Xu, 2016). Infant mortality refers to the death of an infant before its first birthday. The infant mortality rate in Ohio has not improved much over the past decade [Table 7: Insert Chart]. Maternal age and racial/ethnic demographics impact infant mortality numbers. The teenaged groups, ages 15 to 17 and 18 to 19, have the highest risk for infant mortality at 10.3 deaths per 1,000 births in 2010, while the 30-34 aged group has the lowest risk at six deaths per 1,000 births in

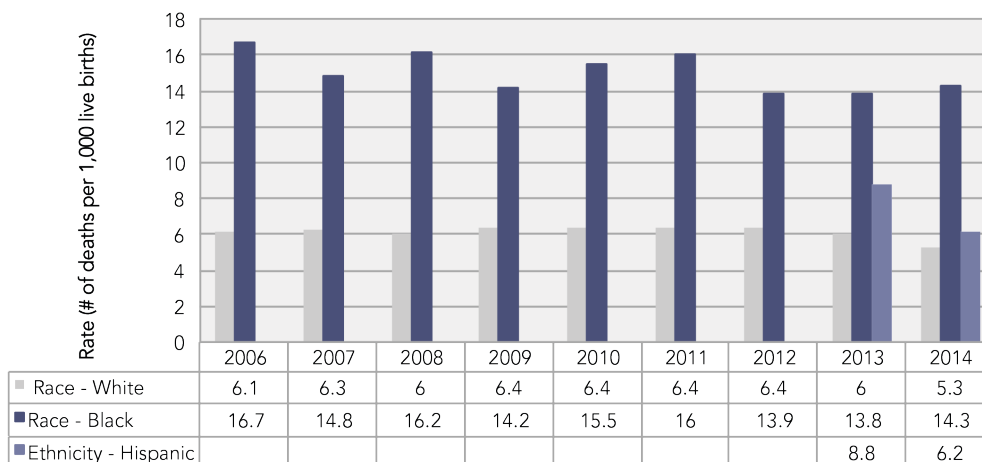
2010 (Ohio Department of Health, 2015). The Ohio Department of Health statistics reveal that the infant mortality rate for Black women has consistently been twice as high as any other racial or ethnic group in Ohio (2015). Neonatal death rates, cases in which the infant dies within the first 28 days of life, reflect the same racial difference, with Black women’s rates being twice as high as white women’s. The racial disparity in infant mortality is a clear illustration that Black women face obstacles that do not exist for white women. Lack of access to reproductive health care, higher unintended pregnancy rates, and systematic structural racism all



play a role in increasing the infant mortality rate for Black babies.

As of 2013, the biggest causes of neonatal deaths and infant mortality were: prematurity (47%), sleep issues (15%), and birth defects (13.8%), with other causes making up the remaining 24.6% (Ohio Department of Health, 2015).

## Infant Mortality Rate by Race and Ethnicity



## CRISIS PREGNANCY CENTERS OR FAKE CLINICS

Crisis pregnancy centers or CPCs are unregulated anti-choice facilities that are promoted as providing assistance to pregnant women and girls, when in reality their primary purpose is to counsel women away from abortion. CPCs often represent themselves as medical clinics, although they are not licensed and often do not have any medically trained staff. These fake clinics purport to provide impartial counseling, information, and free ultrasounds while they consistently strive to dissuade pregnant women and girls from having abortions. Moreover, CPCs present women with misleading, incomplete and factually incorrect information about pregnancy and abortions, such as stating that abortion causes breast cancer and increases the risk of suicide. Through these actions, CPCs pose a threat to reproductive choice and to the wellbeing and safety of women and girls in Ohio (NARAL Pro-Choice Ohio Foundation, 2013).

While there are only nine abortion clinics across Ohio, there are hundreds of crisis pregnancy centers. Some of these crisis pregnancy centers

receive public subsidies through state funding. The Ohio Parenting and Pregnancy Program subsidizes crisis pregnancy centers and any other non-profit organization whose primary purpose is "to promote childbirth, rather than abortion, through counseling and other services" (LAWriter ORC, 2013). The Ohio Parenting and Pregnancy Program is a grant program created by the Ohio legislature to funnel money into these anti-choice organizations that seek to curtail women's ability to exercise full control over their own bodies and reproductive lives. This program is funded with Temporary Assistance to Needy Families (TANF). TANF is a federal grant program that is supposed to provide financial assistance to families in need. However, since 2013 Ohio has reallocated some of this money to directly subsidize crisis pregnancy centers through the Parenting and Pregnancy Support Program. In the 2016-2017 State Budget, the Parenting and Pregnancy Support Program funds Elizabeth's New Life Center, Heartbeat of Toledo, Oasis of Hope, and Family and Youth Initiatives (Ohio Right to Life, 2015).

The Ohio "Choose Life" fund is another way the state funnels money to CPCs. Fees from the purchase of "Choose Life" license plates from the Department of Motor Vehicles are paid into the fund. Both the license plates and the fund were instituted in 2005, and the legislation governing the fund was amended in 2015 (LAWriter, 2015).

**For the state's fiscal year 2012 (July 1, 2011-June 30, 2012), recipients of the "Choose Life" public funds included the following:**

Community Pregnancy Center, Hannah's Home, Pregnancy Resource Center of Clark County, and Pregnancy Decision Health Centers. Pregnancy Decision Health Centers have six facilities: Franklinton Caring Center, Campus Caring Center, Lancaster Caring Center, Linden Caring Center, North Caring Center and West Caring Center (Ohio Choose Life Inc. 2012).

Numerous other public funds, such as federal grants for abstinence-only education, also subsidize CPCs.

**The following programs received public funding through these other funding programs:**

Oasis of Hope PPSC: Pregnancy Care Center; Elizabeth's New Life Centers, which include six centers located in Dayton, East Dayton, Kettering, Lebanon, Sharonville, and Sidney; Heartbeat of Toledo, which has two centers in Toledo; and Family & Youth Initiatives, which has three locations in Fairborn, New Carlisle, and Springfield. Family & Youth Initiatives is also known as the Women's Care Network (Ohio Right to Life, 2015).

## THE STATE OF CONTRACEPTION

Evaluating need for contraception and access to it, is one of the most important factors in understanding the state of choice in Ohio. The Affordable Care Act, colloquially known as Obamacare, directly caused an increase in coverage for contraception through health insurance. The Patient Protection and Affordable Care Act was signed into law in March of 2010, though coverage for contraception without cost sharing was not instituted until August 1, 2011. Even then, "grandfathered" plans are exempt from implementing the change until the plan undergoes significant changes. (US department of Health and Human Services, 2011). In 2014, 26% of people with insurance coverage were insured under a "grandfathered" plan and thus did not have guaranteed access to contraceptives without cost sharing (Kaiser Family Foundation, 2015). The ACA alleviated much of the financial strain on women with regard to controlling their reproduction. The Act requires that at least one method from each of the 18 different categories of birth control be covered with no cost sharing. This means that if a woman cannot use that one kind of birth control covered on her insurance plan, she could still be paying out of pocket to prevent pregnancy. The



ACA also exempts religious organizations from the contraceptive care requirement in their health plans, creating obstacles for female employees at those organizations (HRSA). Furthermore, short-term health insurance, which primarily covers only major illness and accidents, is not obligated to cover contraception. Finally, there are also still women in Ohio without health insurance, even after passage of the Affordable Care Act.

Many women in Ohio need contraception<sup>8</sup>, both generally and publicly funded. This number of women in need of contraception does not refer to the number of women who cannot access contraception. In 2013 a total of 1,290,050 women were in need of contraceptive supplies and services, out of a total of 2,365,430 women, ages 13-44 (Frost, Frohwirth, and Zolna, 2015). Among women aged 20-44, 537,610 of those in need of contraceptive services or supplies were living above 250% of the federal poverty line, while 560,380 were living below that income marker (Frost, Frohwirth, and Zolna, 2015). A total of 986,770 white women, 185,490 non-Hispanic Black women, and 49,240 Hispanic women were in need of contraception (Frost, Frohwirth, and Zolna, 2015). That same year, a total of 729,680 women were in need of publicly-funded contraceptive supplies and services, “because they needed contraceptive services and supplies, and were either adult women with a family income under 250% of the federal poverty level or were younger than 20” (Frost, Frohwirth, and Zolna, 2015). Therefore the number of women in need of publicly-funded contraception also reflects socio-economic and age demographic information. The number of women in need of publicly-funded contraceptive supplies and services demonstrates a three percent increase in need from 710,200 in 2010, although the overall population of women in this age range decreased by one percent. (Frost, Frohwirth and Zolna, 2015).

Being able to afford contraception can be one of the largest barriers to access. In 2013, 20% of the total women in need of publicly-funded contraception were uninsured (Frost, Frohwirth and Zolna, 2015). The Guttmacher Institute reported that 19% of white women, 18% of Black women, and 34% of Hispanic women that were

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in need of publicly-funded contraception were uninsured (Frost, Frohwirth and Zolna, 2015). These percentages demonstrate a large socio-economic barrier to access for women of different racial and ethnic groups, but particularly for Hispanic women living in Ohio. Furthermore, the percent of need met by publicly funded providers dropped from 22% in 2010 to 15% in 2013 (Frost, Frohwirth, and Zolna, 2015). The percent of need met by Title X clinics dropped from 14% in 2010 to only 9% in 2013 (Frost, Frohwirth, and Zolna, 2015). Title X is a federal grant project that provides funding to both public and private non-profit organizations for family planning and preventative health services. It is part of the United States Public Service Act, which was enacted in the 1970s. Increased access to contraception through the Affordable Care Act may be one factor that explains why the need met by public providers has decreased. These numbers put Ohio much lower than the national average percentage of total contraceptive needs met by publicly supported providers in 2013, which was 42% (Guttmacher 2014). This indicates that only a fraction of contraceptive need is being met through public services. This lack of coverage should be an indicator of the need to allocate resources to publicly-funded reproductive services.



# THE STATE OF SEXUAL EDUCATION

A critical part of choice is access to medically accurate and comprehensive sexual education about reproduction and reproductive health care in a positive and non-shaming environment. Without comprehensive and accurate information, reproductive choice is not a reality. Sexual education programs taught in Ohio schools are required to stress abstinence-only before marriage, and are not obligated to include any information about contraception, sexual orientation, avoiding coercion in intimate relationships, family communication, or healthy decision making (Guttmacher Institute, 2016). Avoiding these important topics not only increases the risk of contracting STDs and unplanned pregnancies, but also leaves young people more vulnerable to sexual abuse and depression. Furthermore, sexual education programs must include and stress abstinence as the means of prevention of HIV/AIDS, but do not need to include information about effective condom use, thus putting people at risk of exposure to fatal diseases (Guttmacher Institute, 2016). If young children are not taught in a comprehensive way about sexuality, it becomes more difficult for them to develop a language to express themselves and to know the difference between sexual exploitation and healthy relationships. Although the specific content for sexual education is up to the each school district, Ohio requirements clearly stress abstinence-only education, putting youth at risk.

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There are several federal grants and state funds that subsidize abstinence-only education. The main funding sources are Community-Based Abstinence Education (CBAE), Adolescent Family Life Act (AFLA), Competitive Abstinence Education (CAE), and Title V Abstinence-Only-Until-Marriage, which is a federal grant that requires that Ohio state funds match \$3 for every \$4 federal (SIECUS). In the fiscal year of 2008,

grant money allocated \$6,376,091 towards abstinence-only education; many of these grants extended through 2011, 2012, and 2013 (SIECUS).

In the fiscal year of 2014, \$2,130,799 was allocated toward abstinence only education (SIECUS).

The recipients of these grants are as follows: Abstinence the Better Choice (ABC) Inc.,

Abstinence 'Til Marriage (ATM) Education Inc., Central Ohio Youth for Christ; Elizabeth Helps, Empowered by the Truth, Elizabeth's New Life Center (an anti-choice crisis pregnancy center), Operation Keepsake Inc., The RIDGE Project Inc., Saint Vincent Mercy Medical Center, and Catholic Social Services of Miami Valley. The RIDGE Project collaborates with and funds two anti-choice crisis pregnancy centers: Women's Resource Center of Hancock County and the Community Pregnancy Centers of Northwest Ohio.

These abstinence-only education programs are based around shaming sexuality and teaching young women and girls that their value lies in their virginity through practices such as father/daughter purity balls, story scenarios that teach



young women that they have no value if they are sexually active, and discussion groups that instill sexist stereotypes. For example, Elizabeth's New Life Center, which received \$120,000 in federal grants between 2005 and 2013, teaches eighth grade students through a "Gender Approach Project" (SIECUS). The project separates males and females for discussions; for girls the topic is, "Do you want to be treated liked a Treasure or a Target?" whereas boys discuss, "Do you want to act like a Protector or a Predator?" (SIECUS). The curriculum of Abstinence 'Til Marriage (ATM) Education Inc. (which received \$600,000 from 2006 to 2011) takes shaming young women to a whole new level. In one scenario, "The Party Room," high school student Rochelle accuses another high school student, Jason, of raping her (SIECUS). ATM Education then shames the alleged victim, saying, "Did you think a rape occurred? Answer: We don't really know if Rochelle consented to have sex with Jason...Unfortunately, we are left judging Ro's honesty by her character and her actions...Monica implied Rochelle had a promiscuous reputation and the whole school seemed to know it" (SIECUS). This approach teaches students that "promiscuous" women have no legitimate standing when they accuse someone of sexual assault. Messages like these are contrary to what Ohio's youth should be learning in order to develop healthy relationships with regard to sexuality.

In more recent years, some federal funding has supported comprehensive, evidence-based sexual education programs. The Division of Adolescent and School Health (DASH) grant for comprehensive sexual health education allocated \$225,000 in 2013 and \$314,882 in 2014 to the

Cleveland Metropolitan School District (SIECUS). DASH also funded the Cleveland Metropolitan School District and the Ohio Department of Health to collect and report the Youth Risk Behavior Survey and School Health Profile data, with a total of \$115,000 in 2013 and \$114,970 in 2014 (SIECUS). The Ohio Department of Health received \$1,751,490 in 2014 and \$1,788,594 in 2013 through the Personal Responsibility Education Program (PREP) grant, which subsidizes science-based comprehensive sexual education that includes both abstinence and contraception information.<sup>9</sup> Prior to 2013, there is a lack of clear evidence of any state or federal support for comprehensive sexual education programs.

In recent years federal grants also financed education and research programs to prevent teen pregnancy. The President's Teen Pregnancy Prevention Initiative (TPPI) Tier 1 grant funded the YWCA of Hamilton County for the purposes of "replicat[ing] evidence-based programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors" (SIECUS). The organization received a \$405,575 grant for 2010 through 2014. The Personal Responsibility Education Innovative Strategies Program (PREIS) grant "supports research and demonstration projects that implement innovative strategies for preventing pregnancy among youth ages 10-19 who are homeless, in foster care, live in areas with high teen birth rates, come from racial or ethnic minority groups, or have HIV/AIDS" (Family & Youth Services Bureau, 2015). The Ohio Health Research and Innovation Institute received a \$560,344 grant for 2010 through 2014 through PREIS (SIECUS).



# THE STATE OF SCREENING & TREATMENT

## ACCESS TO CARE

Financial barriers are one of the biggest obstacles to receiving health services. The hostile political environment in Ohio has exacerbated economic hurdles to accessing reproductive health care, with anti-choice lawmakers recently enacting policies such as defunding Planned Parenthood, which provides more affordable care to thousands of Ohioans. Health insurance is an important factor in reproductive choice because it enables access to contraceptive options, OB/Gyn services, prenatal care, general health assistance, and future health security for a potential child. In 2014, 63% of Ohio women ages 19 to 64 had some type of health insurance through their employment; 5% were insured in a non-group plan; 19% were insured through Medicaid; 4% were insured through other public programs; and 9% were uninsured (Kaiser Family Foundation, 2014). From 2011 to 2012, 16% of Ohio women ages 18-64 were uninsured, demonstrating a clear increase in coverage in subsequent years (Kaiser Family Foundation, 2013).

The transgender community is often neglected in statistics and data on reproductive choice and health access in Ohio. Health policies are often so cisgender-oriented that sometimes they fall short of even being able to locate and describe the disparities in health care access between cisgender and transgender individuals.<sup>10</sup> For example, many health care providers assign care coverage based on gender identification, meaning that trans-men who still have female reproductive organs are not covered for gynecological and obstetric service, such as pap smears (ACLU Ohio, 2009). Additionally, some trans-men can biologically give birth but are often overlooked with regards to their specific reproductive health service needs.

The accessibility of sex reassignment surgery and hormone treatment directly impacts transgender individuals' ability to control their bodies and change their physical appearance to match their gender identity, meaning that these issues are paramount to evaluating the state of choice in Ohio. Currently, only five states have extended Medicaid coverage to transition-related health services, and Ohio is not one (Levasseur, 2014). In 2014, the U.S. Department of Health and Human Services Departmental Appeals Board reversed Medicare's earlier exclusion of sex reassignment surgery, noting that the old policy was based on outdated science and did not reflect current understanding or standards of care (NCTE). Moreover, while transgender people may face initial denial of coverage for hormone therapy or reassignment surgery based on gender markers in their Social Security record, there are mechanisms to address inappropriate denials that include the use of a special billing code, the amendment of the markers in the Social Security record, and appealing the decision (NCTE). Private insurance policies vary; however coverage is often denied because many providers classify these surgeries as "cosmetic," "experimental" or not medically necessary (ACLU Ohio, 2009). Many transgender people also experience difficulty obtaining insurance coverage for hormone treatments and other prescription drugs to facilitate their transition (ACLU Ohio, 2009). These policies place an economic burden on the transgender community to finance expensive health services, removing their control over their bodies and in many cases their reproductive lives.



# CANCER

Cancer screening rates do not provide a complete picture of women's access to reproductive health care, although they are useful for evaluating access to basic services. In 2014, a total of 81.5% of Ohio adult women received cervical screening that met cancer-screening guidelines (OCISS, 2015). The Ohio Cancer Incidence Surveillance System 2014 regional data on cervical cancer screening indicates that women living in Appalachian counties have the least access to services with only 76.7% receiving screening followed by 80% in rural areas, 81.8% in suburban regions and 83.3% in metropolitan areas (OCISS, 2015). In 2014, a total of 75.8% of Ohio adult women obtained breast screening that met cancer-screening guidelines (OCISS, 2015). Similar to cervical screening, the 2014 data demonstrates that rural women have the least access with only 72.2% followed by 72.5% in suburban areas, 76.7% in rural regions and 77% in metropolitan areas (OCISS, 2015). These numbers demonstrate that even though a majority of Ohio women obtain recommended screening, a moderate portion do not.

In June of 2006, the FDA approved the Gardasil vaccine for the prevention of HPV-related cancers including cervical cancer, which is the most prevalent HPV-related cancer. As of 2014, it was estimated that only 30-39.7% of girls age 13 to 17 had completed the three-dose HPV vaccine series (Kaiser Family Foundation, 2015). The national average for vaccine series completion for the same demographic is roughly 40%, putting Ohio somewhat behind national access (CDC, 2015). There is not Ohio-specific data on males completing the HPV vaccine series. Much of the targeting for the vaccine and HPV screening has been focused on women and girls, although men and boys can carry and transmit the virus. They can also contract various forms of HPV-related cancer, such as anal, penile and oropharyngeal (throat and mouth). Nationally only about 22% of males age 13-17 have completed the HPV three-

“As of 2014, it was estimated that only 30-39.7% of girls age 13 to 17 had completed the three-dose HPV vaccine series (Kaiser Family Foundation, 2015).”

dose vaccine series (CDC, 2015). To discern the complete picture on access to the vaccine, Ohio needs to start tracking and reporting the number of males who have been vaccinated.

Because the vaccine is relatively new and must be given before exposure, HPV is still the most prevalent sexually transmitted infection in the U.S. (CDC, 2014). The CDC reports on Ohio-specific rates of cancers related to HPV. In 2010, which is the most recent data, the cervical cancer related to HPV rate was an estimated 6.66-7.87 cases per 100,000 females (CDC, 2014). The vaginal cancer related to HPV rate was an estimated 0.29-0.39 (CDC, 2014). The vulvar cancer rate related to HPV was estimated at 1.9-2.2 (CDC, 2014). The anal cancer rate associated with HPV for females was estimated at 1.61-1.81, while for males it was an estimated 0.95-1.12 (CDC, 2014). The oropharyngeal (throat and mouth) cancer associated with HPV for males was 6.09-7.03 while for females it was much lower at a rate of 1.37-1.59 (CDC, 2014). The penile cancer associated with HPV was an estimated rate of 0.71-0.85 (CDC, 2014). These rates indicate that cervical cancer in females and oropharyngeal cancer in males are the most prevalent HPV related cancers.

From 2008-2012 in Ohio, the annual average incident rate for cervical cancer was 7.5 cases per 100,000 women, representing an annual average of 460 cases state-wide (ODH, 2015). During that same time period, the average mortality rate for cervical cancer was 2.6 (ODH, 2015). From 2006-





2010, the annual average rate of new cases of cervical cancer for white women was 7.6, while for Black women it was an average of 8.8 (OCISS, 2014). According to the Ohio Cancer Incidence Surveillance System, “Hispanic women have more than twice the risk of developing cervical cancer compared to non-Hispanic white women, and African American women have 1.5 times the risk of non-Hispanic white women” (OCISS, 2014). From 2006-2010, 52% of cervical cancer was detected in late stages of development (OCISS, 2014). Cervical cancer, when diagnosed in its early stages, is one of the most treatable cancers, but the later it is diagnosed, the lower the survival rate (OCISS, 2014).

The Ohio Department of Health’s cancer profile for 2015 tracks the incidence and mortality of breast cancer across Ohio. Between 2008 and 2012, the breast cancer incidence rate was an estimated average of 120.9 cases per 100,000 females (ODH, 2015). The breast cancer incidence rate decreased from 2000 to 2012. For the 2000 to 2004 period, the estimated breast cancer incidence rate was 123.7 (OCISS, 2007). The national incidence rate from 2008 to 2012 was an estimated 124.8, meaning that Ohio was slightly lower than the national incidence for those years (ODH, 2015). Ohio’s average mortality rate for breast cancer from 2008 to 2012 was 23.6, representing around 1,775 deaths (ODH, 2015). However the national mortality rate for breast cancer for the same time period was 21.9, slightly lower than the Ohio rate (ODH, 2015). There was a decrease in the breast cancer mortality rate between 2000 and 2012 in Ohio. From 2000 to 2004, the estimated annual breast cancer mortality rate was 27.9, while from

2006 to 2010 that rate dropped to 24.7 (OCISS, 2007 and OCISS, 2015).

Incidence rates for both ovarian and uterine cancer are much lower than breast cancer. Between 2008 and 2010, Ohio’s average annual ovarian cancer incidence rate was 11.9 cases per 100,000 females, while nationally it was 12.1 (ODH, 2015). In the same time period, the state’s ovarian cancer annual mortality rate averaged 7.9, representing 597 deaths per year (ODH, 2015). Although breast cancer has a much higher incidence rate than ovarian cancer, the mortality rate for breast cancer is much lower. In 2012 in Ohio there were 2,030 new invasive cases of uterine cancer, signifying a rate of 26.9 per 100,000 females (ODH: Office of Health Improvement and Wellness, 2015). The mortality rate in Ohio for uterine cancer in 2012 was 4.9 (ODH: Office of Health Improvement and Wellness, 2015).

“Hispanic women have more than twice the risk of developing cervical cancer compared to non-Hispanic white women, and African American women have 1.5 times the risk of non-Hispanic white women” (OCISS, 2014).”

## SEXUALLY TRANSMITTED INFECTION RATES

Sexually Transmitted Infections (STI) rates are a critical component of the state of choice. STIs impact fertility and cause a myriad of other physical health issues. These infections can also change people’s relationships to their partners and their future sexuality because of entrenched societal associations of STIs with promiscuity, shame, and guilt. Tracking STIs is thus necessary for creating a holistic picture of reproductive choice in Ohio. It should be noted that the data presented here does not depict all cases of STIs, but instead is representative of all known cases reported to the Ohio Department of Health.



In 2014, 54,301 cases of chlamydia were reported to the Ohio Department of Health (United States Census, 2014, ODH, 2015). The rate of chlamydia cases, defined as the number of cases per 100,000 people, has increased from 443.7 in 2010 to the 469.3 in 2014. Women in Ohio are substantially more likely than men to contract chlamydia, with the number of cases in women being almost double the number in men (ODH, 2015). Since 2010, the Black population in Ohio has had the highest number of cases of chlamydia, followed by the white population (ODH, 2015). The higher number of cases for the Black population is more statistically significant because they comprise a smaller percentage of the population than white people. The rate of cases amongst the Black population was 1,283.6 in 2014, while for whites it was 175.5 (ODH, 2015). In Ohio younger age groups seem to have highest rates of chlamydia, with the highest numbers in the 20 to 24 range followed by the 15 to 19 age range (ODH, 2015). In 2014 there were 16,041 cases of gonorrhea reported to the Ohio Department of Health (ODH, 2015). The rate of gonorrhea decreased in Ohio between 2013 and 2014 from 144 to 138.6 cases per 100,000 people (ODH, 2015). The incidence of gonorrhea is consistently higher in women than men, although there is not as great of a difference between the sexes as seen with chlamydia (ODH, 2015). Black people had the highest number of cases from 2010 to 2014, followed by white populations (ODH, 2015). The rate of gonorrhea decreased amongst Blacks from 666.1 in 2010 to 534.6 in 2014, while the rate increased in the white population from 29.2 in 2010, to 38.7 in 2014 (ODH, 2015). Although whites have the second highest number of cases of gonorrhea in Ohio, Hispanic populations have a much higher rate at 57.5 in 2014 (ODH, 2015). Younger age groups in Ohio have higher rates and number of cases of gonorrhea than older groups, with the 20-24 group having the highest figures, followed by those aged 15-19 (ODH, 2015).

There were 1,220 syphilis cases reported to the Ohio Department of Health in 2014, putting the rate at 10.5 cases per 100,000 people (ODH, 2015). Men were far more likely to report incidents of syphilis, with the number of cases for men being two or three times higher than for

women. In 2014 the rate of syphilis was 16.9 for men and 4.5 for women in Ohio (ODH, 2015). Black people consistently had the highest number of cases and rates of syphilis, with a rate of 44.5 in 2014 (ODH, 2015). The Hispanic population has higher rates of syphilis than white people, though there are more cases reported amongst white people. In 2014 the rate of cases was 12.3 for Hispanic people, an increase from 7.9 in 2010 (ODH, 2015). For white people, the rate was 4.7 in 2014 (ODH, 2015). Ohioans in their twenties have the highest rates of syphilis with the 20-24 group reporting the highest numbers followed by the 25-29 aged range (ODH, 2015).

In 2014 there were 950 newly diagnosed cases of HIV infection in Ohio, representing a rate of 8.2 per 100,000 people (Ohio Department of Health HIV/AIDS Surveillance Program, 2014). These cases of HIV infection include "persons newly diagnosed with HIV (not AIDS), persons previously diagnosed with HIV who are now newly diagnosed with AIDS, and persons concurrently diagnosed with HIV and AIDS at initial diagnosis" (ODH HIV/AIDS Surveillance Program, 2014). In 2014 there were 709 newly diagnosed cases of HIV (not AIDS), 179 newly diagnosed cases of HIV & later AIDS, and 62 newly diagnosed cases of AIDS in Ohio (ODH HIV/AIDS Surveillance Program, 2014). Since 2010 there has been a decrease in the number of cases of AIDS and HIV & later AIDS (ODH HIV/AIDS Surveillance Program, 2014). Sexual contact is not the only means of transmission of HIV. Injection drug use is also a significant cause of new infections of the virus. In Ohio, 73% of diagnosed HIV cases in men and 65% of cases in women were transmitted through sexual contact (ODH HIV/AIDS Surveillance Program, 2014).

Gender and race are significant factors in HIV infection rates in Ohio. Black men have the highest rate of newly diagnosed HIV infection at 60.5 per 100,000, accounting for 43% of cases in Ohio in 2014 (ODH HIV/AIDS Surveillance Program, 2014). That same year, white men were the second largest demographic group, comprising 33% of cases. However, their HIV infection diagnosis rate of 6.9 was lower than Hispanic males who had a 28.5 rate (ODH HIV/AIDS Surveillance Program,



2014). Asian and Pacific Islander males made up about 1% of the HIV infection diagnoses in 2014, with a rate of 5.3 (ODH HIV/AIDS Surveillance Program, 2014).

Females have much lower rates and numbers of HIV infection diagnoses than males in their same racial or ethnic demographic. Black women have the highest rate of their gender at 10.9, and make up 9% of cases in Ohio, followed by Hispanic women with a rate of 4.6, representing 1% of cases (ODH HIV/AIDS Surveillance Program, 2014).<sup>11</sup> White women make up 4% of total newly diagnosed HIV infections, with a rate of 0.9 (ODH HIV/AIDS Surveillance Program, 2014). Asian and Pacific Islanders, American Indian, and Alaska Native women have the lowest numbers, making

up less than one percent of the cases, with no rate reported for 2014 (ODH HIV/AIDS Surveillance Program, 2014).

The most recent data in Ohio suggest that people in their twenties are at the highest risk of contracting HIV. In 2014, the largest groups of people newly diagnosed with HIV were those aged 20 to 24, followed by the 25 to 29 group (ODH HIV/AIDS Surveillance Program, 2014). Together, these groups comprised 42% of the newly diagnosed cases in Ohio in 2014 (ODH HIV/AIDS Surveillance Program, 2014). Individuals in the 30 to 34 and the 45 to 49 age ranges were the most likely to be diagnosed with both HIV and AIDS at the time of initial diagnosis (ODH HIV/AIDS Surveillance Program, 2014).

## THE STATE OF DOMESTIC VIOLENCE & SEXUAL ASSAULT

Domestic violence rates and effective response programs are necessary considerations in an analysis of choice and reproductive health. Women in unsafe home situations or with coercive or violent partners face greater obstacles to exercising autonomous control over their bodies and reproductive lives. In 2014, a conservative estimate of cases of intimate partner violence was 65,000 among women ages 18 to 64 (Ohio Colleges of Medicine Government Resource Center, 2014). In 2013 there were 66,503 domestic violence calls to Ohio law enforcement; 26,614 of those calls resulted in no charges (Ohio Domestic Violence Network, 2013). The actual rates of domestic violence are probably much higher than these numbers suggest, given the propensity for victims to be discouraged from reporting these crimes because of their intimate relationship with their assaulter, as well as the societal tendency to dismiss accusations. According to the Ohio Domestic Violence Network, 40,961 adults were served and 2,571 adults were sheltered at domestic violence shelters across Ohio in 2013 (ODVN, 2013). At these facilities, 20 adults had injuries that were fatal (ODVN, 2013).

Sexual assault impacts reproductive choice not only because it can directly result in pregnancy, but also because it can have a lasting affect on a person's relationship to their sexuality, affecting their control over their body. In 2013 in Ohio there were a total of 3,913 forcible rapes reported to law enforcement (ODVN, 2013). The Office of Criminal Justice Services defines forcible rape as "the carnal knowledge of a person, forcibly and/or against that person's will; or, not forcibly or against the person's will where the victim is incapable of giving consent because of his/her temporary or permanent mental or physical incapacity" (Ohio Incident Based Reporting System, 2013). The definition of "forcible rape" excludes coercion



and does not account for rape culture or the broad societal pressures that people, particularly women, experience. These cultural expectations may make individuals feel that refusing sexual intercourse is not an option, thus removing true choice and control of their bodies.

In many situations rape and sexual assault are not reported to law enforcement, and only a fraction of the incidents that are reported result in legal charges or jail time. The lack of reporting is evident in 2012 data that shows that 14 rape crisis programs in Ohio responded to 13,598 hotline calls; the year prior, 2011, there were only 7,972 incidents of sexual assault reported to law enforcement (OAESV, No date and OIBRS, 2013). Eighty-five percent of the cases reported to law enforcement involved female survivors (OIBRS, 2013). The fact that there were almost double the amount of calls to rape crisis centers than the number of sexual assaults reported to law enforcement indicates that people are not using formal avenues for redress, revealing problems that must be addressed in the justice system.

“The fact that there were almost double the amount of calls to rape crisis centers than the number of sexual assaults reported to law enforcement indicates that people are not using formal avenues for redress, revealing problems that must be addressed in the justice system.”

“The anti-choice majority in the Ohio legislature has restricted rape crisis programs’ ability to offer complete counseling to their clients through a variety of actions.”

Rape crisis centers that provide culturally-competent, non-judgmental counseling as well as comprehensive information are important resources for ensuring access to care for rape survivors. Data from 2014 show that the paid staff at eighteen rape crisis programs across Ohio are overwhelmingly white women, with 104 white women paid staff members, ten Black women, two Hispanic women, three paid employees that identify as bi-racial and no Asian American or American Indian paid staff (OAESV, 2014). This racial makeup shows an area of necessary change. It is harder for white counselors or service providers to understand the unique cultural and racial issues that people of color experience. Given racial power dynamics in America, people of color who are survivors of sexual assault may be less comfortable receiving counseling from white women, thus creating another disparity in access (OAESV, 2014).

The anti-choice majority in the Ohio legislature has restricted rape crisis programs’ ability to offer complete counseling to their clients through a variety of actions. In 2013 the Ohio Attorney General began funding rape crisis programs through a new grant opportunity. When creating the necessary funding stream for this program, the legislature forbade rape crisis programs

receiving this funding from including information about abortion in the counseling offered to clients facing pregnancy following a sexual assault. Additionally, in February of 2016 the Ohio legislature passed HB 294, which prevents state funds from going to any entity that performs or promotes non-therapeutic abortions, or any entity that contracts with someone who performs or promotes non-therapeutic abortion. One of the funding streams impacted by this new legislation is a Violence Against Women Act program on rape prevention. This legislation thus takes away funds that are aimed at combatting rape culture and educating men and boys about consent. The bill’s wording is vague enough that even a pamphlet about abortion as an option could be cause for loss of funds. The full impact of this new defunding effort will not be felt until after the bill goes into effect on May 23, 2016.

# THE STATE OF ADOPTION & FOSTER CARE

The state of the adoption and foster care systems in Ohio directly impacts on reproductive choice. A well-functioning adoption system that honors birth parents, and supports all three parties in the adoption process is critical to ensuring that women really do have the option of creating an adoption plan when they choose not to parent their biological child. Birth parents deserve the reassurance that if they decide adoption is the right path for them, or if placing the infant as a ward of the state is the only option, that there are safe and nurturing homes awaiting that child. A well-funded and well-functioning child welfare system also allows for families to become stronger when facing challenges. Parent education and support is critical to keeping families together and helping parents to be more effective.

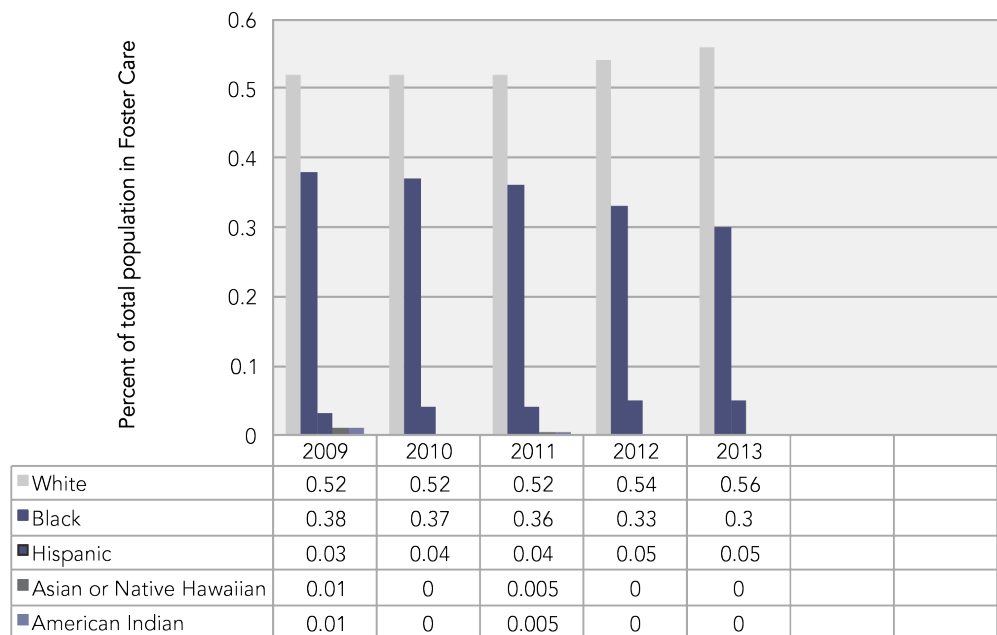
A total of \$1,006,793,629 in public expenditures was spent on child welfare in Ohio in fiscal year 2013. That year Ohio provided the lowest investment in child welfare of any state in the country, at 9 cents of every dollar spent, as opposed to the national state average of 43 cents of each dollar (PCSAO, 2015-2016). In 2013, local funding sources in Ohio increased to

52 cents of every dollar for investment in child welfare, while nationally the average is 11 cents from local spending (PCSAO, 2015-2016).

The foster care system in Ohio serves children of varied backgrounds, ethnicities and ages. In 2013 there were 12,212 children from newborn to age 20 in foster care, representing a rate of 5 children per 1,000 in that age range; of that number, 2,005

individuals age 16 to 20 were in foster care (National Kids Count, 2015). Male children constitute 54% of the children in Ohio's foster care system (National Kids Count, 2015). Although white children make up the majority of the individuals in foster care, the percentage of Black children in care relative to the overall Black population is consistently higher than for white children.

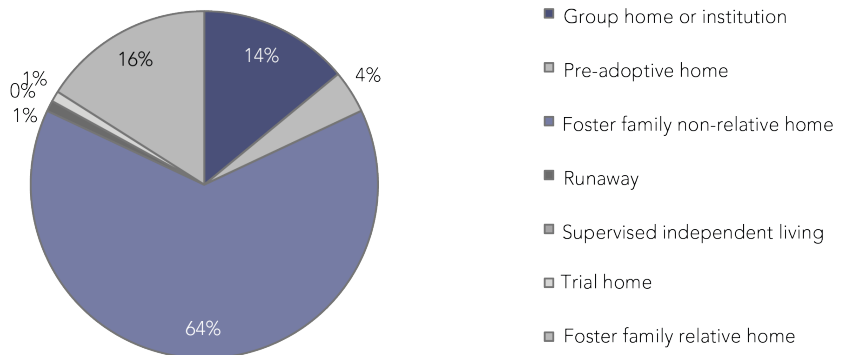
**Foster Care by Race and Ethnicity**



There are many different types of foster care situations in Ohio. The majority of children are placed in foster family homes of non-relatives, however group homes, pre-adoptive homes, runaway facilities, supervised independent living, trial home visits and foster family homes with relatives are all care placement options in the state (National Kids Count, 2015).

The amount of time individuals spend in the foster system waiting to be adopted varies (National Kids Count, 2015). In 2013 the largest group of children, making up 28% overall, waited 34 to 35 months to be adopted, followed by 26% waiting 12 to 23 months, 22% waiting three to four years, 15% waiting five or more years and 9% waiting less than 12 months (National Kids Count, 2015). The percentage of children in foster care waiting five or more years to be adopted has decreased from 20% in 2009 to the 15% reported

### Foster Care by Placement Type - 2013



above in 2013 (National Kids Count, 2015).

It is not possible to evaluate the state of private adoption in Ohio. There are limited statistics and data on the private adoption system about who is involved, what the cost looks like and how many children are placed in homes through this mechanism.

## THE STATE OF FAMILY LEAVE

Family leave is an essential factor in the health and well-being of women and families. People who want to become parents need to have adequate time and finances to care for a newborn infant. The reassurance of paid family leave is crucial for new mothers that may need to physically and/or medically recover from childbirth, pregnancy complications or cesarean sections. Fathers also need guaranteed paid family leave in order to take a prominent role in childrearing, so that women are not expected to bear the whole burden, and so that two men adopting a child together can adequately care for their baby. For individuals to have a legitimate choice about whether to have children, they need to have job security and know that they can smoothly transition back to their jobs after having a baby. Family leave also allows for individuals to take care of sick family members and to take care of themselves at times of extended illness.

There are almost no recent Ohio-specific data on family leave, making it difficult to evaluate the state of choice on this question. The most recent statistics are from 2007 and reveal a real problem with access to paid leave. In 2007, 4.55 million employees in Ohio were guaranteed access to unpaid family leave (Woodrum, 2007). That same year, only 440,000 workers out of all employees in Ohio had access to paid family leave (Woodrum, 2007). Just 53,000 people in management and professional fields, 92,000 people in service industry jobs, 39,000 people in sales and office fields, 65,000 people in natural resources, construction, and maintenance, and 41,000 employees in production, transportation, and material moving had access to paid family leave (Woodrum, 2007).

# THE STATE OF CHOICE FOR INCARCERATED WOMEN

There is little to no research or information available about reproductive wellbeing and choice for incarcerated women in Ohio. A complete gap exists in reporting on inmates' access to adequate menstrual supplies, sexual education, OBGYN services, hormone therapy and sex-reassignment surgery for transgender inmates, contraception, and abortion care for all state, federal or private jails and prisons. Historically, incarcerated women and girls have faced unique coercion and forced sterilization based on racist and patriarchal eugenic beliefs, pointing to the pressing need to investigate reproductive care practices in Ohio's prison system.

While inmates have a legal right to choose to terminate a pregnancy, in practice there are many additional obstacles because of their incarceration. The ACLU of California recently published research on the state of reproductive rights in California prisons and jails, detailing the illegal and unethical practices that pregnant inmates are subjected to, such as treating abortions as "elective" (instead of "medically necessary") procedures and requesting that inmates fill out forms describing their reason to terminate their pregnancies (Burlingame, Dawson, and Goodman, 2016). The ACLU report on California also discusses the ways correctional employees try to influence inmates, for example, by encouraging women and girls with substance abuse problems or who have multiple children to terminate their pregnancies (Burlingame, Dawson, and Goodman, 2016). Although this research is not about Ohio, the infringements on incarcerated women's and girls' right to choose in California could foreseeably take place in any prison system. Ohio should investigate the state of choice for incarcerated women to make certain their rights are protected.

Many states have very few or no restrictions on shackling pregnant inmates throughout their pregnancy and during labor and delivery. Shackling

during labor and delivery is degrading, inhumane, and often painful; it is also dangerous to both the fetus and mother. According to the American Congress of Obstetricians and Gynecologists (ACOG), "shackling interferes with the ability of physicians to safely practice medicine and is 'demeaning and unnecessary'" (ACLU).

The Ohio Department of Rehabilitation and Correction's most recent policy is that pregnant inmates in labor should be handcuffed while being transported to the hospital and will be restrained with leg irons while on the hospital bed (Ohio DRC, 2009). During the actual delivery the policy mandates that "no restraints shall be applied to the pregnant inmate" (Ohio DRC, 2009). After the delivery the woman or girl is to be restrained to her bed with leg irons and shall be restrained with leg irons when walking as long as she is not holding the infant (Ohio DRC, 2009). If the child is not returning to the institution then the inmate is shackled with full restraints upon return from the hospital. Only a small amount of inmates in particular programs are permitted to have their baby return to the correctional facility and remain in their custody. Assuming the DRC's policy is followed exactly, pregnant inmates are shackled through labor until the active delivery phase and then immediately restrained post-delivery. These shackling policies pose a threat to incarcerated women and girls in Ohio.

Ohio does have a nursery program for incarcerated mothers who have children in prison that allows them to stay with their infants. The program is called the Achieving Baby Care Success (ABC'S) Nursery; it provides parenting instruction, allowing the incarcerated mothers to keep custody of their children (Ohio DRC, 2015). The program has strict qualifications for participation. As of October 2014 there were only four female inmates in the program across Ohio (Ohio DRC, 2014).



# THE STATE OF CHOICE FOR BLACK & HISPANIC WOMEN

Almost every section of this report illustrates a reproductive health crisis for Black and Hispanic women in Ohio. The racial inequality in reproductive health access should function as a lens for interpreting the entirety of the report. This section draws out some particularly problematic numbers that demonstrate a real emergency. The unique challenges Black and Hispanic women face span the spectrum of reproductive health needs and issues, starting at a very young age. The teen birth rate has decreased across the board for all young women and girls in Ohio over the past decade, however the teen birth rate remains substantially higher for Black and Hispanic teens. In 2013 the teen birth rate, births per 1,000 females age 15 to 19, was 49 for Black teens, 43 for Hispanic teens and 22 for white teens (National Kids Count, 2014). This disparity in teen birth rates suggests a resource gap for Black and Hispanic teens that impacts their ability to advance in their education, careers, and communities.

Affordability of contraceptives is a major issue for planning family size and avoiding unintended pregnancy. The Affordable Care Act makes access considerably easier for women with insurance coverage; however not all women are insured. In 2013 19% of white women, 18% of Black women, and 34% of Hispanic women who were in need of publicly supported contraception<sup>12</sup> were uninsured (Frost, Frohwirth and Zolna, 2015). According to these numbers Hispanic women in Ohio appear to be disadvantaged in terms of need for contraception and insurance coverage to attain those services.

During and after pregnancy Black and Hispanic women in Ohio face obstacles accessing care. Access to adequate and affordable prenatal care is essential to continuing a healthy pregnancy and assisting women in controlling their reproductive

lives. According to Amnesty International, 19.3% of women of color in Ohio in 2010 did not receive prenatal care or their prenatal care was delayed (Amnesty International, 2010). For the same year 12.2% of all women in Ohio including white women did not receive or delayed prenatal care (Amnesty International, 2010). Unfortunately, the 2010 numbers are the most recent data tracking the accessibility of prenatal care based on race and ethnicity. Analysis of the statistics available shows it is more difficult for women of color in Ohio to obtain the same level of prenatal care as white women. Delaying or not having prenatal

“The unique challenges Black and Hispanic women face span the spectrum of reproductive health needs and issues, starting at a very young age.”

care influences pregnancies from the beginning, impacting the health status of woman and their infants. Black infants consistently have the highest rates of low birth weights in Ohio, in part due to the racial disparity in prenatal care access. Low birth weight is defined as a live birth weighing less than 2,500 grams or 5.5 pounds. In 2013, 13.3% of Black infants born in Ohio had a low birth weight compared to 7.4% of the white infants, who consistently have the lowest rate of low birth weights (National Kids Count, 2014). The trend of Black women and Black infants facing the worst issues in pregnancy and delivery continues with infant mortality. Ohio is known for having particularly high infant mortality rates in the United States, nationally ranked 44th (United Health Foundation, 2016). However for Black infants the rate is double the state average. In 2014 the





infant mortality rate, calculated as the number of deaths per 1,000 births within the first year of life, for white infants was 5.3 while for Black infants it was 14.3 (Ohio Department of Health, 2015). The racial disparity in these numbers reveals a clear and devastating health inequality between white residents and Black residents in Ohio. The reasons for this disparity are varied and complex. It is evident that comprehensive policy reform is necessary to address this reproductive health crisis for Black women in particular.

Rates of cancer and sexually transmitted infections are also key indicators of the state of choice in Ohio. The reproductive health inequality for Black and Hispanic women continues into these health indicators as well. According to the Ohio Cancer Incidence Surveillance System, "Hispanic women have more than twice the risk of developing cervical cancer compared to non-Hispanic white women, and African American women have 1.5 times the risk of non-Hispanic white women" (OCISS, 2014). These differences indicate potential barriers to screening and treatment that Hispanic and Black women face that white women do not. Those disparities in prevention, screening, and treatment also impact upon disparities in the rate of sexually transmitted infections. In 2014 the rate of diagnosis of HIV (defined as the number of

"It is evident that comprehensive policy reform is necessary to address this reproductive health crisis for Black women in particular."

infections per 100,000 females) for white women was 0.9, for Hispanic women it was 4.6 and for Black women it was 10.9 (Ohio Department of Health, 2015). Although the HIV infection rate for Black women has decreased, it remains consistently higher than the rate for women of other racial and ethnic backgrounds. These numbers are troubling because they illustrate that Black women in Ohio are facing greater threats to their reproductive health and wellbeing. While the causes of these threats to Black and Hispanic women's reproductive safety are multifaceted, it is clear that Ohio must allocate more resources to focus on the needs of these women.



# CONCLUSION & RECOMMENDATIONS

The state of choice in Ohio is multifaceted and complex, with different issues and sets of problems contributing to individuals', particularly women's, reproductive control. Access is the most important feature of choice. A legal right to bodily autonomy is meaningless in practice without access to safe and legal abortion, contraception, comprehensive and medically accurate sexual education, proper neonatal care, comprehensive OBGYN services, programs to prevent and recover from domestic violence or sexual assault,

“A legal right to bodily autonomy is meaningless in practice without access to safe and legal abortion, contraception, comprehensive and medically accurate sexual education, proper neonatal care, comprehensive OBGYN services, programs to prevent and recover from domestic violence or sexual assault, a strong foster care system, and paid family leave.”

a strong foster care system, and paid family leave. This report presents a comprehensive picture of existing data and statics that relate to all of these facets of reproductive health and choice. It is meant to create a resource of compiled statistics related to choice in one location, not only to create a baseline for future projects but also to encourage an understanding of the

interrelatedness of these subjects when evaluating the state of choice, and to make suggestions for additional areas of research on these issues.

There are little to no Ohio-specific data or statistics on several important areas that impact reproductive choice, safety and wellbeing. There is virtually no information available on the unique reproductive health needs of transgender and non-binary individuals in our state. Data on socio-economic status or income level as it relates to issues of reproductive choice are almost totally lacking. The Ohio Abortion Report, which provides the most recent and complete data on abortion in Ohio, does not include any direct marker of income or economic status in its demographic information. Similarly, there is scant information on income correlated with infant mortality, teen pregnancy, STI prevalence, access to OBGYN services including cancer screenings, sexual assault or domestic violence. There is also no Ohio-specific research examining the economic prosperity level of a school district correlated with the type of sexual education programs implemented in that district. Ohio-specific research on how far and by what means women travel for abortion care is almost non-existent. With fewer and fewer providers left in Ohio, distance presents a substantial obstacle to obtaining an abortion. More research should be done to investigate where in Ohio that burden is greatest.

As is detailed in section nine of this report, further research into the state of reproductive choice for incarcerated women and girls in Ohio is needed. Specifically, there is inadequate information on abortion and contraception access for this group of females, and no Ohio-specific research on shackling during pregnancy. Ohio policy includes limited regulations on the use of restraints during labor and delivery, but there is no research on whether corrections officers and other employees



strictly adhere to official policies. Furthermore, transgender and non-binary individuals face unique problems in prisons. Federal prison policy requires that correctional institutions give inmates the same level of hormones that they were taking before entering custody (ACLU Ohio, 2009). State and privately managed prisons do not have this mandate, thus jeopardizing the health and wellbeing of transgender inmates (ACLU Ohio, 2009). Clearly, more Ohio-specific research is warranted to better evaluate the state of reproductive choice and care access for transgender inmates.

Finally, the fact that restrictive anti-choice legislation has shuttered clinics across the state means that there is a lack of access to safe, legal abortion care in our state. Closing abortion clinics does not reduce the need for abortion, but it does leave women without access to the health care services that they need. There is a near-total lack of Ohio-specific data on the incidence of unregulated abortion, and how it impacts the health and well-being of women. The dark truth is that when clinics close and regulations become stricter, women may turn to other methods of

abortion that endanger their lives, health and wellbeing. While official data on illegal abortions in Ohio is lacking, there is no shortage of stories and anecdotal evidence that this practice occurs. Further research on what is happening to Ohio women as clinics close is critical to creating a full picture of this reproductive health and rights crisis.

The findings from this extensive search for data on choice in Ohio reveal many overlapping issues that should be investigated further. This report intends to create one consolidated resource that can be used as a base line to track some of these issues in years to come, as well as providing a comprehensive look at choice and reproductive health, based upon currently available data. Policies need to address, and in some cases, such as abortion, entirely change in order to improve the state of choice from its current dire condition. We hope that this report is useful in the identification of these necessary policy changes, and starts a conversation of what needs to be done to ensure full access to health care for the women of Ohio.



# NOTES

1. Transgender refers to an individual whose gender identity does not match the gender or sex that they were assigned at birth. Non-binary refers to an individual who feels that their gender does not fit into the gender binary of male and female. Cisgender refers to an individual whose gender identity matches the gender or sex that they were assigned at birth.
2. Low birth weight is defined as a live birth weighing less than 2,500 grams or 5.5 pounds.
3. Infant mortality rate is defined as the number of deaths per 1,000 births within the first year of life.
4. Fertility rate refers to the number of births per 100,000 women. Fertility rate is measured by "number of children who would be born per woman (or per 1,000 women) if she/they were to pass through the childbearing years bearing children" (Measure Evaluation, no date).
5. Teens having sex is defined as sexual activity in the three months before the survey.
6. A TRAP law is any law that specifically regulates abortion care in a way that other medical providers of similar services are not regulated. For example Ohio bans public hospitals from entering into a transfer agreement with abortion clinics, but other ambulatory surgical facilities can obtain a transfer agreement with a public hospital.
7. A "qualified health plan" refers to any qualified health plan as defined in section 1301 of the "Patient Protection and Affordable Care Act," 42 U.S.C. 18021, offered in this state through an exchange created under that act.
8. For the purposes of this data, a woman is defined as in need of contraception if she is sexually active (referring to voluntary vaginal intercourse including both "currently sexually active women and those likely to be sexually active during the next 12 months)," able to conceive, and not trying to become pregnant any time during the past year (Frost, Frohwirth, and Zolna, 2015).
9. This PREP funding was included in HB 294 (130 Ohio General Assembly) as one of the funding sources that would no longer be available to any entity that performs or promotes non-therapeutic abortion, or anyone who contracts with someone who performs or promotes non-therapeutic abortion.
10. Cis-oriented policies refer to policies that are written or structured to only consider the needs of cisgender people. Cisgender refers to an individual whose gender identity matches the gender or sex that they were assigned at birth. Transgender refers to an individual whose gender identity does not match the gender or sex that they were assigned at birth.
11. "HIV & later AIDS" refers to "a diagnosis of HIV and an AIDS diagnosis within 12 months" (ODH HIV/AIDS Surveillance Program, 2014).
12. Women in need of publicly-supported contraception are defined as sexually active, able to conceive, not trying to become pregnant and under the federal poverty line or under the age of 20 (Frost, Frohwirth and Zolna, 2015).
13. "HIV & later AIDS" refers to "a diagnosis of HIV and an AIDS diagnosis within 12 months" (ODH HIV/AIDS Surveillance Program, 2014).



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Official data on illegal abortions in Ohio is lacking, there is no shortage of stories and anecdotal evidence that this practice occurs. Further research on what is happening to Ohio women as clinics close is critical to creating a full picture of this reproductive health and rights crisis.



The findings from this extensive search for data on choice in Ohio reveal many overlapping issues that should be investigated further. This report intends to create one consolidated resource that can be used as a base line to track some of these issues in years to come, as well as providing a comprehensive look.



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The mission of the NARAL Pro-Choice Ohio Foundation is to support and protect the right of every woman to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing safe, legal abortion.



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