



Ibis Reproductive Health

April - September 2009 Newsletter

In This Issue:

- Laws Requiring Parental Involvement for Abortion
- Ibis Priority Areas of Work Recognized by Governmental Bodies
- New Ibis Publications
- Ibis Course at the Harvard School of Public Health
- Clinic Dedicated to the Memory of Charlotte Ellertson
- Ibis Reports on MA Health Care Reform

About Ibis:

Ibis Reproductive Health aims to improve women's reproductive choices, autonomy, and health worldwide. We accomplish our mission by conducting original clinical and social science research, leveraging existing research, producing educational resources, and promoting policies and practices that support sexual and reproductive rights and health.



*First author, Amanda Dennis,
Project Manager at Ibis*

Laws Requiring Parental Involvement for Abortion

As of 2008, 34 states in the U.S. have laws in effect that mandate parental involvement in minors' abortions. Parental involvement laws have varied requirements in different states. Although many require the consent or notification of only one parent, usually at least 24 or 48 hours before the procedure, a handful of states mandate the involvement of both parents, and six states allow certain other adult relatives to be notified about or give permission for a young woman's abortion.

In March, Ibis and the Guttmacher Institute released a new report, "The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review." Ibis Project Manager Amanda Dennis was the lead author on the comprehensive review that analyzed the existing published research on U.S. laws restricting access to abortion for young women under the age of 18. This was the first of three reviews on U.S. abortion restrictions produced by Guttmacher and Ibis. See page three for the studies about mandatory counseling and waiting period laws and restrictions on Medicaid funding.

According to this review, parental involvement laws appear to do little to reduce teen abortion or pregnancy rates. Studies that find parental involvement laws cause a decrease in teenagers' abortion rates have often inaccurately measured state abortion rates or have major flaws in their research methodologies. Most of these studies did not measure abortions among young women who leave the state, or stop coming into the state, because of the law. This is an important trend to measure because minors in states with restrictive laws often travel outside of their home states to a place with a less restrictive law to obtain an abortion. Studies have documented such travel in Massachusetts, Mississippi, and Missouri. For example, in Massachusetts, 29% of teenagers who had abortions did so in neighboring states, most in response to a parental consent requirement. The impact of these laws on minors' travel appears to vary in different states, depending on transportation accessibility, the specifics of the requirements, the abortion regulations of surrounding states, and the state's geography.

Moreover, the review's authors concluded that, in at least one state, parental involvement laws led to an increase in teen birthrates, because teens were unable to travel the long distances necessary to access less restricted abortion services out of state. This example indicates that if more states enact these restrictions, teens may be faced with greater challenges in accessing safe and timely abortion services. "Most teens—regardless of whether or not they live in a state with a parental involvement law—do involve their parents when deciding whether to have an abortion. But the reality is you can't legislate good parent-child communication," says Dennis. "If we want to protect young women's health and safety, access to confidential reproductive health services—both contraception and abortion—is critical."

Parental involvement laws can make abortions more difficult to access for young women. Travel out of state or judicial bypass procedures can lead to delays in obtaining abortions and can increase the risks associated with a procedure that is generally very safe. However, data limitations make it hard to know how many minors experience delays. Young women with fewer resources are particularly vulnerable to these risks. To travel out of state, she must have access to transportation and must be within a reasonable distance of a state with less restrictive laws. The degree to which a teenager can do so may vary by her age, socioeconomic status, and access

to public transportation. Considering that the vast majority of states currently have parental involvement laws, this makes traveling to a state without a law very challenging. The availability of judicial bypasses varies by state. In some states, streamlined systems are easily accessible to most young women, although even in these states, some rural teens have to travel a long distance to find a judge willing to hear their case. In other states, judges rarely grant bypasses.

Many gaps in knowledge about parental involvement laws remain. The biggest difficulty in evaluating parental involvement laws is the lack of population-based data on abortions. The available data come from two main sources: the Guttmacher Institute and the Centers for Disease Control and Prevention (CDC), which aggregates state health department reports. Each source has advantages and disadvantages, but no source has a comprehensive set of data (for example, not all states report abortions to the CDC) that would be needed for a rigorous analysis. The lack of data on abortions by state of residence is another major limitation. Studies of parental involvement laws based on data by state of occurrence will overestimate the decline in abortions associated with the law, not only because resident teenagers may leave the state to have an abortion in another state, but also because nonresidents stop entering the state for an abortion. Further, no studies have evaluated minors' experiences with parental involvement laws or their opinions of them; the increased costs in obtaining abortion due to delays, travel, or bypass proceedings; or the impact on teenage girls of being forced to consult their parents. These are also important areas for future study.

Ibis Reproductive Health



Ibis Priority Areas of Work Recognized by Governmental Bodies

In June, the Human Rights Council, a political body of the United Nations, adopted a resolution naming maternal mortality as a pressing human rights issue. The resolution, which was co-sponsored by over 70 UN member states, commits governments to increase their efforts to protect women and girls. It recognizes that promotion of sexual and reproductive health and rights, such as reducing unsafe abortion and increasing access to contraception, are essential to eliminating maternal mortality, and that a human rights approach is the most sustainable one to take. Ibis applauds this important step in recognizing the global toll of unmet need for sexual and reproductive health services.

In addition, the U.S. Institute of Medicine recently convened a Committee on Initial National Priorities for Comparative Effectiveness Research to identify topics where comparative effectiveness research could make a significant impact in improving health care practice in the U.S. The committee released its report in June, and we are ecstatic that research on innovative ways to reduce unintended pregnancy was listed in the top quartile of the 100 priorities identified. These priorities will inform the allocation of the US\$1.1 billion for comparative effectiveness research that was included in the U.S. federal economic stimulus bill passed earlier in the year. The report mentions “over-the-counter access to oral contraceptives or other hormonal methods, expanding access to long-acting methods for young women, [and] providing free contraceptive methods at public clinics, pharmacies, or other locations” as strategies to consider—all areas of research at Ibis.



costs of hospital-based D&C ranged from US\$103 to US\$192, while the cost of clinic-based MVA was US\$53, and that of clinic-based medication abortion was US\$69. The results also showed that the treatment of complications related to unsafe abortion, such as sepsis, uterine perforation, or hemorrhage requiring transfusion, was very costly to the health care system, ranging from US\$600 to over US\$2,100 per complication. The study also estimated the cost-savings that might be achieved by improving access to safe, legal abortion in Mexico City, if provided mostly through outpatient services. Assuming that complications would be reduced in the context of legal abortion, the estimation was that the health care system in Mexico City would save approximately US\$1.7 million each year, reducing the cost per woman served by approximately 62%.

Using the findings from this cost study, as well as other published data, Ibis collaborated with researchers at the Harvard School of Public Health and PATH to examine the cost-effectiveness of the various safe abortion techniques compared to unsafe abortion. Consistent with the findings of the cost study, results of this study showed that any of the safe techniques was significantly more cost-effective than unsafe abortion, and that clinic-based MVA was least costly and most effective. Another finding was that enhancing access to medication abortion, especially in areas where surgical access is limited, can increase overall cost savings when the method is used in place of unsafe abortion. A shift toward safe abortion services appears to be one of the most cost-effective interventions that could be implemented in a country where unsafe abortion is prevalent.

While the public health benefits associated with reducing unsafe abortion are clear, the study also found that improved access to safe, legal abortion reduces costs to the health care system. While some of these savings might be offset by increased demand for public abortion services, per-patient costs would be dramatically reduced.

New Ibis Publications *(Ibis authors in bold)*

The Cost of Unsafe Abortion Compared to Safe Abortion Alternatives

Levin C, **Grossman D**, Berdichevsky K, Diaz C, Aracena B, Garcia SG, and Goodyear L. *Exploring the costs and economic consequences of unsafe abortion in Mexico City before legalisation*. *Reproductive Health Matters* July 2009; 17(33):120-132.

Hu D, **Grossman D**, Levin C, **Blanchard K**, and Goldie SJ. *Cost-effectiveness analysis of alternative first-trimester pregnancy termination strategies in Mexico City*. *BJOG*. May 2009; 116:768-779.

With PATH and the Population Council, Ibis undertook research to determine the cost of unsafe abortion to the health care system in Mexico City before abortion was legalized in 2007. The study used data collected at several public and private facilities in Mexico City in 2005. Before abortion was legalized, public hospitals treated women who presented with incomplete abortions by using safe abortion techniques including dilation and curettage (D&C) and manual vacuum aspiration (MVA); very rarely they also used these safe techniques to provide primary abortion care for women who qualified for legal termination of pregnancy. We also collected data on the cost of providing safe abortion care using MVA or medication abortion with misoprostol alone at a clandestine private clinic. The results of the study showed that hospital-based treatment of incomplete abortion was significantly more costly than outpatient, clinic-based care providing safe abortion. The per-patient medical

Reassessing the Evidence on Withdrawal as a Contraceptive Method

Jones RK, Fennell J, Higgins JA, and **Blanchard K**. *Better than nothing or savvy risk-reduction practice? The importance of withdrawal*. *Contraception*. June 2009; 79:407-410.

Withdrawal is often not considered a legitimate contraceptive method and many believe it is not effective. However, in a review and commentary on recent research on the method, withdrawal was found to be almost as effective as condoms at preventing pregnancy. In perfect use—if the male partner withdraws before ejaculation every time a couple has vaginal intercourse—about 4% of couples will become pregnant over the course of a year. The failure rate with typical use is estimated to be 18%. These rates are only slightly less effective than male condoms, which have perfect- and typical-use failure rates of 2% and 17%, respectively. The authors found from survey and qualitative data that withdrawal use was much more common than is often cited, and that women and men often used withdrawal in conjunction with condom use or fertility awareness methods. Although not as effective as hormonal methods or long-acting methods, withdrawal use is significantly more effective than not using a method, and it is always available and does not cost anything or require a doctor's visit. The authors recommend that providers talk with their patients about withdrawal so they have accurate information about its use.

Ibis Reproductive Health



Strategies for Reforming Nursing School Curricula

Simmonds K, Foster AM, and Zurek M. From the Outside In: A Unique Model for Stimulating Curricula Reform in Nursing Education. Journal of Nursing Education. March 2009.

This paper shares the strategies used and lessons learned by a group of advocates working to reform nursing program curricula in the United States. Reproductive health researchers and advocates created the Reproductive Options Education Consortium for Nursing (ROE Consortium) in 2002 to attempt to expand comprehensive reproductive health training for nurses in the U.S. Nurses may be expected to provide pregnancy options counseling, education, and referrals, or to assist with delivery of prenatal or abortion services, as a routine part of their work. However, educational opportunities in the epidemiologic, clinical, and ethical aspects of reproductive options are often unavailable in U.S. nursing programs. The ROE Consortium identified several strategies to shape their model of curricula reform that enabled them to work efficiently, gain the trust of the nurses and school administrators they worked with, and remain in contact with participants to ensure follow through. For example, by engaging nurses and faculty to advise the project, they were able to build credibility among their broader audience. The ROE Consortium believes these strategies could be widely applied in curricula reform efforts. In using these strategies, the ROE Consortium enrolled 114 nursing faculty participants for continuing education between 2002 and 2004, and 87% of these participants have incorporated the training materials they received into their teaching.

Literature Reviews on the Impact of Legal Restrictions on Abortion

Joyce TJ, Henshaw SK, Dennis A, Finer LB, and Blanchard K. The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review. Guttmacher Institute. May 2009—Laws that require counseling and waiting periods before abortion, but that allow counseling to be delivered over the Internet, by phone, or by mail, appear to have little impact on birth and abortion rates. But these laws may postpone the timing of some abortions. These findings imply that counseling requirements do not cause women to change their minds about having an abortion, and that waiting period requirements

do not impose significant barriers to abortion services. Currently, 24 states require women to wait, usually for 24 hours, between an initial counseling session and the abortion procedure. However, the laws in seven of these states require *in-person* counseling at least 18-24 hours prior to the procedure. Multiple studies of such a law in Mississippi have found that the requirement was associated with a decline in the state's abortion rates, an increase in the number of residents going out of state for an abortion, and delays in accessing abortion services. These findings suggest that an *in-person* counseling requirement places an additional burden on some women by forcing them to take more time off from work, arrange child care, or stay away from home overnight when the distance to the clinic is great. This sometimes results in delaying the abortion to later in pregnancy, when the procedure is less safe and more expensive—if women are able to obtain an abortion at all. According to the study authors, these laws are intended primarily to block abortion access, and the most disadvantaged women, who already have trouble accessing services, are disproportionately affected.

Henshaw SK, Joyce TJ, Dennis A, Finer LB, and Blanchard K. Restrictions on Medicaid Funding for Abortions: A Literature Review. Guttmacher Institute. July 2009—Approximately one-fourth of women who would obtain a Medicaid-funded abortion if given the option are instead forced to carry their pregnancy to term when state laws restrict Medicaid funding for abortion, because they lack the money to pay for the procedure themselves. According to the report, Medicaid funding restrictions also delay some women's abortion by two to three weeks, primarily because of difficulties women encounter in raising funds to pay for the procedure. Currently, 32 states and the District of Columbia allow Medicaid funds to be used for an abortion only in cases of rape and incest, or if the woman's life is endangered, in accordance with the federal Hyde Amendment; only 17 states have policies to use their own funds to pay for all or most medically necessary abortions. Lacking insurance coverage, some poor women need a considerable amount of time to come up with the money to pay for an abortion, and may have to pull resources from other family necessities, like food or rent, if they are able to find the funds at all. As the cost of the procedure increases with gestation, many poor

women become trapped in a vicious cycle of scrambling to raise enough money before the cost—and risk—increases further, while others are left with no recourse but to carry an unwanted pregnancy to term. The Hyde Amendment allows federal funding for abortion only in cases of rape, incest, or life endangerment. In addition, Congress has enacted legislation essentially banning coverage of abortion for women whose medical insurance is provided by the federal government, such as federal employees, military personnel, and women in federal prisons. The issue of federal funding goes to the heart of who has access to abortion in the United States and under what circumstances.

Can I Get Pregnant from Oral Sex? Sexual Health Misconceptions and Their Possible Sources

Wynn L, Foster A, and Trussell J. Can I get pregnant from oral sex? Sexual health misconceptions in e-mails to a reproductive health website. Contraception. February 2009; 79:91-97.

“Not-2-Late.com,” a website providing medically accurate information about emergency contraception, allows readers to send in questions to be answered by a reproductive health expert. This paper examines the questions posed which offer insight into the knowledge, attitudes, and biases the questioners hold about reproductive health. Over 1,100 emails were sent to the site during the one-year study period from July 2003 to June 2004. Over a quarter of these emails were classified as containing a misconception (an incorrect belief or assumption) about reproductive health processes in one of five categories: sexual acts that could lead to pregnancy, the definition of protected sex, signs and timing of pregnancy and pregnancy testing, the dangers that hormonal contraceptives pose to women and fetuses, and confusion between emergency contraception and abortion. The authors identified as possible sources for these types of misconceptions: abstinence-only sexual education, health education websites with various degrees of medical accuracy, medical assumptions about pre-ejaculatory fluid containing sperm that are not evidence-based, public health campaigns which link STI protection to condoms, and the requirement at Catholic hospitals that a pregnancy test be administered before provision of EC (for which there is no medical justification).



Ibis Reproductive Health

Ibis Course at the Harvard School of Public Health

For four years, the Ibis staff has collaboratively taught a seminar course at the Harvard School of Public Health called “International reproductive health issues: moving from theory to practice.” The seminar offers students the opportunity to learn about designing and carrying out research on reproductive health in international settings. Students benefit from the broad range of experience of Ibis staff, who share weekly case studies from their work to illustrate the various methods and perspectives of medical and social science research. Session topics in the January-March 2009 semester included contraception, emergency contraception, abortion, HIV/AIDS, and the sexual and reproductive health needs of women in refugee settings. Presenters, including some fabulous guest speakers from the reproductive health community in Boston, shared experiences from Latin America, sub-Saharan Africa, and the Middle East. The course wrapped up with presentations from the very bright and thoughtful students on their final projects. For her project, one student conducted background research for a study she plans to implement this year to assess the impact of providing free condoms on the HIV infection rate in Ghana. This student is working with a population of clients at anti-retroviral clinics in an effort to examine the efficacy of novel interventions combining treatment and prevention. We anticipate and hope that many of our students will become new contributors to the field of reproductive health research.



Clinic Dedicated to the Memory of Charlotte Ellertson

On March 27, 2009, Mexico City’s Ministry of Health dedicated a public health clinic to the memory of Charlotte Ellertson, Ibis’s founder who passed away from breast cancer in 2004. Charlotte was an energetic and innovative researcher in the field of reproductive health, and prior to founding Ibis, she spent four years as the Population Council’s Director of Reproductive Health for Latin America and the Caribbean in Mexico City. In addition to using her amazing research skills to generate evidence to support changes in policy and health care provision in Mexico, Charlotte loved the country on a personal level. Both her daughters were born in Mexico City and both have Mexican middle names, which will forever serve as treasured reminders of their mother and her time there. The Population Council and the Mexico City Ministry of Health organized a dedication ceremony to honor Charlotte’s vision, leadership, and tireless dedication to improving the lives of women, which helped promote the

Mexico City Ministry of Health officials look on at the clinic dedication ceremony in honor of Charlotte Ellertson

sexual and reproductive rights of women in Mexico City. We at Ibis continue Charlotte’s work and add our own passion to hers, and we were touched and excited by the news of this dedication.

Ibis Reports on Massachusetts Health Care Reform

In August, Ibis released a new report on the contraceptive coverage of young adult-targeted health plans in Massachusetts, research undertaken as part of the Reproductive Empowerment and Decision Making for Young Adults (REaDY) Initiative. The REaDY Initiative is a coalition of Massachusetts health service providers, advocates, and researchers collaborating on a unique, statewide project to reduce unplanned pregnancy among young adults in the wake of health care reform in the Commonwealth. Ibis's report summarizes research findings and recommendations from a systematic review of the contraceptive and other sexual and reproductive health coverage of two types of plans specifically designed to give young adults affordable health insurance in Massachusetts: the Student Health Program and the Young Adult Plans. The results of the study raise concerns that young adult-targeted health plans may not provide a full range of contraceptive services.

In September, Ibis and the Massachusetts Department of Public Health Family Planning Program released the results of an assessment of the effects of health care reform in Massachusetts on low-income women’s access to contraception. The research project included a systematic review of the government-subsidized insurance plans available to low-income Massachusetts residents, surveys and in-depth interviews with family planning providers around the Commonwealth, and English- and Spanish-language focus group discussions with low-income women. Women and providers agree that reform has increased access to both health insurance and services. Women in the study identified other positive effects, such as the ability to seek preventive care and reduced stigma from having insurance. However, some new challenges have resulted; both women and providers have difficulties finding information about insurance coverage of services, women struggle to maintain and prove eligibility for subsidized insurance plans, and family planning providers have taken on increased administrative and fiscal responsibilities.

To see either report or its executive summary, please visit www.ibisreproductivehealth.org or contact Britt Wahlin at 1-617-349-0054.

Cambridge Office:
17 Dunster Street
Suite 201
Cambridge, MA 02138
USA
1-617-349-0040
info@ibisreproductivehealth.org

San Francisco Bay Area Office:
1330 Broadway
Suite 1100
Oakland, CA 94612
USA
1-510-986-8941
sanfran@ibisreproductivehealth.org

Johannesburg Office:
First Floor, Block B, Regent Place
Cradock Ave, Rosebank 2196
Johannesburg
Republic of South Africa
27-11-447-1346
joburg@ibisreproductivehealth.org