THE STATE OF CHOICE IN OHIO

2019

NARAL PRO-CHOICE OHIO FOUNDATION
NARAL Pro-Choice Ohio is committed to recognizing the diverse gender identities of people who experience pregnancy and abortion. We often use the term "women" to discuss pregnancy and abortion in this report because the data we discuss are collected using this term. Where possible, we use the more inclusive term "people." As we discuss in our report, the lack of inclusion of transpeople in medical practice and research has harmful effects on transpeople’s access to healthcare. The recognition of trans experience is essential to achieve reproductive health equity.
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**CONTENTS**

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>CHAPTER I:</td>
<td>THE STATE OF ABORTION</td>
<td>15</td>
</tr>
<tr>
<td>CHAPTER II:</td>
<td>THE STATE OF PREGNANCY AND DELIVERY</td>
<td>25</td>
</tr>
<tr>
<td>CHAPTER III:</td>
<td>THE STATE OF CONTRACEPTION</td>
<td>35</td>
</tr>
<tr>
<td>CHAPTER IV:</td>
<td>THE STATE OF SEXUAL EDUCATION</td>
<td>38</td>
</tr>
<tr>
<td>CHAPTER V:</td>
<td>THE STATE OF SCREENING &amp; TREATMENT</td>
<td>44</td>
</tr>
<tr>
<td>CHAPTER VI:</td>
<td>THE STATE OF DOMESTIC VIOLENCE AND SEXUAL ASSAULT</td>
<td>50</td>
</tr>
<tr>
<td>CHAPTER VII:</td>
<td>THE STATE OF ADOPTION AND FOSTER CARE</td>
<td>52</td>
</tr>
<tr>
<td>CHAPTER VIII:</td>
<td>THE STATE OF FAMILY LEAVE</td>
<td>55</td>
</tr>
<tr>
<td>CHAPTER IX:</td>
<td>THE STATE OF CHOICE FOR INCARCERATED OHIOANS</td>
<td>56</td>
</tr>
<tr>
<td>CHAPTER X:</td>
<td>THE STATE OF HEALTH DISPARITIES IN REPRODUCTIVE HEALTH</td>
<td>58</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td></td>
<td>68</td>
</tr>
<tr>
<td>WORKS CITED</td>
<td></td>
<td>70</td>
</tr>
</tbody>
</table>
This is the second edition of the State of Choice; in the first edition, we identified several alarming trends in health outcomes in our state, including many disparities in health outcomes between racial groups. This updated edition finds similarly concerning trends. Although in some cases overall outcomes are showing improvement, a closer look reveals that these improvements often do not include all Ohioans. Specifically, improvements in health outcomes routinely leave behind many Black and Brown Ohioans. Although the content of this report uncovers many alarming trends and reveals a severe dearth of current data at the state level, we hope it inspires readers to create and implement change. It will take a dedicated group of researchers, advocates, constituents and policymakers to reverse the current state of choice, but the work can and must be done. We hope that this report serves as a comprehensive guide to the current state of affairs, provides a baseline to track issues, and is useful in the identification of necessary policy changes.

EXECUTIVE SUMMARY: STATE OF ABORTION ACCESS

Access to abortion has been under attack in Ohio since Governor Kasich took office in 2011. During his time in office, Kasich signed 23 attacks on abortion and other forms of reproductive health care, but it wasn’t until Governor DeWine took office in 2019 that anti–abortion advocates and their allies in the legislature finally accomplished what they had been working toward since 2011, the signing into law of a six–week abortion ban (aka the ‘heartbeat’ bill). On April 11th, 2019, surrounded by his anti–abortion allies, Governor DeWine signed Senate Bill 23 into law. Like others before it, Senate Bill 23 has been blocked by the courts and is not being enforced. But the constant attacks have taken their toll. Half of Ohio’s abortion clinics have closed since 2011, making access more difficult for patients who need care. The 2016 State of Choice report described how clinic closures may have delayed access to abortion care. In 2014 and 2015, we saw the proportion of abortions performed before nine weeks gestation decrease, while the proportion of abortions performed between nine
and 18 weeks rose, meaning more individuals were getting abortions later in their pregnancies. This trend began to reverse in 2016 and 2017, and in 2017 the proportion of abortions before nine weeks were fairly similar to those from 2013.

A contributing factor to the reversal of this trend is the Food Drug Administration’s change to the protocol for medication abortion in 2016. Before 2016, Ohio medical professionals were required to continue using the full FDA protocol, which was more expensive and less effective than the evidence-based standard. After the FDA changed its protocol to the evidence-based standard and approved the use of medication abortion through the first nine weeks of pregnancy, medication abortion became less expensive and more accessible in Ohio. The use of mifepristone increased in Ohio by 48% between 2016 and 2017. This could account for the greater proportions of abortions occurring earlier in pregnancy.

Age and race affect access to reproductive health care and sex education, and this affects abortion rates in Ohio. An overwhelming majority of abortion patients are legal adults (aged 18 and older). The abortion rate for those 17 and younger has been decreasing which corresponds with the decrease in teen pregnancy rates. Statewide, the Black/African American population accounts for 13% of the overall population, but 44% of abortion patients report Black/African American as their racial identity. Further research clarifying how the social determinants of health contribute to the over-representation of Black Ohioans in abortion rates is needed. However, it is safe to say that inequitable access to contraception, comprehensive sex education, and health services exist as a barrier for people of color in Ohio and contribute to disparities in abortion rates.

Currently, the only economic indicator that Ohio tracks with abortion rates is educational level. The vast majority of abortion patients have at least a high school diploma or GED. All too often, anti-abortion activists paint a picture of uneducated individuals making uninformed decisions when it comes to choosing abortion care. These data clearly show that associating abortion with a lack of education is an unfounded stereotype. The reality is that abortion patients are knowledgeable and fully capable of assessing what is best for their reproductive life plan.

EXECUTIVE SUMMARY:
FUNDING REPRODUCTIVE CHOICE IN OHIO–SPENDING SHOWS REAL PRIORITIES

State governments demonstrate their priorities and biases through the programs and services they choose fund and defund. This certainly holds true for reproductive health care programs across Ohio.
Since 2013, Ohio has had a direct funding stream for crisis pregnancy centers (CPCs). The state government pulls the funds for CPCs from the Temporary Assistance for Needy Families (TANF) Block Grant. The TANF block grant is meant to provide crucial financial assistance to families in need. Instead, Ohio funnels a portion of TANF funds to CPCs. Crisis pregnancy centers claim to provide impartial counseling and information, but in reality they give clients misleading, incomplete, and factually inaccurate information about pregnancy and abortion. Yet the state of Ohio has increased funding for CPCs for 2020–2021.

In July 2019, Governor Mike DeWine signed the Fiscal Year 2020–2021 state budget, boosting funding for CPCs from $500,000 per year to $3,750,000 a year — a 750% increase in funding from previous years. As funding for CPCs increased by 3.25 million dollars a year, Ohio lawmakers eliminated 2.5 million dollars for a Medicaid-based program supporting better access to long-acting, reversible contraception (also known as LARCs). Moving $2.5 million in funding for real health care services to non-medical services provided by crisis pregnancy centers shows exactly how little the Ohio government prioritizes Ohioans’ sexual and reproductive health. The majority of Ohio lawmakers would rather fund misinformation and coercion than actual health care services.

The only federal program specifically devoted to family planning is Title X, which provides grant funding to local public health departments, family planning clinics, and nonprofits so they can offer reproductive health services such as STI testing, Pap smears, breast and cervical cancer screenings, and a broad range of family planning services including contraception. The...
Guttmacher Institute reported that 55% of Ohio women ages 13-44 needed contraceptive services and supplies in 2014. More than half (56%) of these women needed publicly-supported contraceptive services and supplies, meaning they needed financial help to pay for these services either because they were under the age of 20 or had incomes below 250% of the federal poverty line. Despite the clear need for publicly-funded contraceptive services and supplies, only 14% of those in need of publicly-funded providers and services had their needs met in 2014. In 2014, a total of 65,220 women in Ohio received Title X-supported contraceptive services, a 33% decrease from 2010.

Publicly-funded clinics are especially important to meeting adolescents’ reproductive health care needs. In Ohio, 21,460 teens were served at publicly-funded clinics in 2014, which resulted in 11% of teens’ need for services met and the aversion of 5,200 pregnancies, 2,600 births and 1,700 abortions. In 2019, the Trump administration finalized new regulations that makes it even harder for young and economically-disadvantaged people to get reproductive health care. This new regulation prohibits Title X funded programs from giving referrals for abortion care. Known as the “domestic gag rule,” this new rule led to Planned Parenthood, the largest provider of services in the Title X program here in Ohio and across the nation, pulling out of the program. It is not fully known yet how this will impact access to care, but the rule change has already led to the closure of two Planned Parenthood centers in southwest Ohio.

Misplaced and biased priorities in funding are apparent in the funding for sex education programs in Ohio. Ohio has some of the highest rates of sexually-transmitted infections (STIs) in the nation. Compared to other states, Ohio had the ninth highest rate of reported chlamydia cases among people ages 15-19, the sixth highest rate of reported cases of gonorrhea, and the 23rd highest rate of reported cases of primary and secondary syphilis in the nation in 2016. The risk of sexually-transmitted infections and unintended pregnancies can be reduced through comprehensive sex education that teaches young people about safe and consensual sex. Data collected in Ohio high schools during the 2013 Youth Risk Behavior Survey (YRBS) suggests that comprehensive sex education is needed in Ohio’s schools. In 2013, the YRBS found 53.7% of female students and 44% of male students reported not using a condom during their last sexual intercourse; 12.8% of female students and 11% of male students reported not using any method to prevent pregnancy during their last sexual intercourse; 11.2% of female students and 4.3% of male students reported being physically forced to have sexual intercourse; and 13.4% of female students and 6.1% of male high school students reported experiencing sexual dating violence in the previous year.
The CDC has identified 19 critical sexual education topics as crucial to young people’s sexual health and necessary for sexual education curricula. The SIECUS State Profiles Report for Fiscal Year 2018 found that only 10.8% of Ohio secondary schools taught students all 19 critical sexual education topics in grades six, seven or eight, and 35.6% of Ohio secondary schools taught students all 19 critical sexual health education topics in grades 9, 10, 11 or 12. Many Ohio students do not get the information they need to make healthy decisions when it comes to their sexual health.

In Ohio, the funding levels for abstinence-only programs far exceed funding for comprehensive sex education programs. In 2018, the state gave $3,729,208 to abstinence-only sex education programs, compared to $498,160 for comprehensive sex education programs. These totals do not reflect additional funding that the state may have received from the Personal Responsibility Education Program Innovation Strategies grant, which funds state programs supporting “research and demonstration projects that implement innovative strategies to prevent pregnancy.” Funding levels for this program were not available for 2018.

Ohio is one of only nine states that has a child welfare program that is state-supervised but county-administered. The largest portion of funding for child welfare programs comes from local sources. Local government funding accounts for 48.1% of funding for these programs and federal funding for the remaining 41.5%. Ohio ranks last in the nation for the amount of state revenues spent on child protection funding. Ohio contributes only 10%, or 10 cents of every dollar spent, to child welfare programs in the state. The national average for state contributions to child welfare programs is 42 cents of every dollar spent. This clearly illustrates that Ohio’s state government does not adequately support children and families in crisis. With the ongoing opioid crisis, our child welfare agencies have to manage ever-growing caseloads. Our state must start investing in these programs.

In addition to the lack of adequate funding for health care and child welfare in Ohio and nationally, the United States is the only affluent country that does not offer paid parental leave. The lack of funding for these necessities shows just how far our nation and our state need to go to support the health and well-being of its children and families. Because of inaction at the federal level, a handful of states and local governments have taken initiative and enacted paid family and medical leave policies. As of 2018, six Ohio municipalities have enacted local ordinances requiring paid family and medical leave. Columbus is a national leader in taking such action. Paid family leave legislation has been introduced in both the Ohio House and Senate, but it has not yet gained significant traction. In order to truly support parents and families, we must create paid leave programs that give parents the paid time off they need.
EXECUTIVE SUMMARY: RACIAL DISPARITIES IN HEALTH

According to the Centers for Disease Control and Prevention (CDC), health disparities are “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations... health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.” This report shows how health disparities are fueled by racial, gender and economic injustice. But health disparities do not impact all non-white racial groups in the same ways. Overall among non-white racial groups, Asian American women do better than their Black, Latina and Native American counterparts. Another challenge in addressing racial disparities in health is the fact that in Ohio and nationally, most data is collected with just two racial categories, Black and white. Without comprehensive data on more racial and ethnic groups we cannot fully understand the impact of racial health disparities on communities of color. Yet even with this lack of data, efforts can be made to effectively dismantle the structures that create inequality.

The majority of data available to write this report paints an alarming picture. Black Ohioans suffer worse health outcomes than people of any other racial and ethnic identity. This pattern of racially-inequitable health outcomes is seen in rates of abortion, preterm births, low birth weight, prenatal care, infant mortality, STIs and teen pregnancy. Nationwide, Black women are three to four times more likely than white women to experience a pregnancy-related death, have higher rates of unintended pregnancies than any other racial group – partially due to inequitable access to contraceptive care and counseling – and bear the burden of abortion restrictions which increase time and money needed to access care. Income and educational attainment can improve reproductive health outcomes for whites and some non-white ethnic groups. However, these are not protective factors for Black women, who continue to experience more problems with pregnancy, healthy delivery, and a healthy first year of baby’s life. Nonetheless, it is important to closely examine the economic reality of Black Ohioans, since income status gives insight into people’s quality of life. For all Ohioans, the median household income is $54,000, but the median household income for Black Ohioans is just 59% of that amount, at $32,163. Beyond income inequality, historical policies such as redlining have a direct impact on present-day health disparities. Historically redlined districts in Cuyahoga County overlap with neighborhoods that currently have high rates of infant mortality, an issue that disproportionately impacts Black Ohioans. Income inequalities engender health disparities, and historical
discriminatory policies have set the foundation for disparities to continue. Latinx Ohioans typically have better reproductive health outcomes in comparison to Ohioans from other racial and ethnic groups. Two highlights are that STI rates are fairly low within the Latinx community, and the majority of Latinx women report getting routine mammograms. However, there are a few alarming trends in maternal health that deserve more attention, research, and funding to determine the root cause. Specifically, 11% of all births to Latinx people in Ohio were preterm births, in comparison to 9% of births to white Ohioans and 14.5% births to Black Ohioans. The percentage of Latinx babies who died before their first birthday remained the same from 2016 to 2017. Most alarming is that Latinx Ohioans had the highest rate of severe maternal morbidity; an average of 215 per 10,000 Latinx women experienced life-threatening health problems within a year of giving birth.

Xenophobia and racism play a significant role in shaping the social environment Latinx Ohioans must navigate to get reproductive health care. Since 2016, Trump’s campaign and presidency has intensified public discourse around immigration reform and furthered narratives that paint Latinx immigrants in a negative light. This sort of public discourse harms the Latinx community as a whole, regardless of immigration history and/or citizenship status, because it treats Latinx people as “outsiders” who do not belong in the US and does not honor the rich legacy and contributions of Latinx people living in America.

It is difficult to fully ascertain the state of health disparities for Asian and Pacific Islander women who reside in Ohio, because the state does not collect as much data on this population’s health outcomes as it does other ethnic groups. Asian Americans accounted for 4% of abortions in 2017. The 2015 teen birth rate for Asian and Pacific Islanders was 7 per 1,000 females age 15–19, far below the statewide rate of 23 per 1,000, and the lowest of all five racial groups reported. Although the past nine years have shown a slight increase in reported cases of chlamydia, gonorrhea and syphilis, prevalence of these STIs is still relatively low among Asian Americans compared to other Ohioans. About 8% of Asian and Pacific Islander babies born in Ohio in 2015 had a low birth weight, which was close to the statewide average of 8.5%, and is perhaps the only health indicator in which Asian Americans fare close to the overall population.

It is particularly difficult to determine the state of health disparities for American Indian women who reside in Ohio because the state collects limited data on this population’s health outcomes. American Indians accounted for 0.3% of abortions in 2017. In 2015, 9.1% of American Indian babies born in Ohio had a low birth weight, the second highest percentage after African Americans and higher than the statewide average of 8.5%.
Three conclusions can be drawn after assessing the widespread reproductive health disparities in Ohio. First, both the gender and racial wage gaps play key roles in compounding barriers to quality health care and diminishing choice, especially for women who are also racial or ethnic minorities. Almost two-thirds of Ohio’s households are dependent on a woman’s income, yet women from every racial and ethnic group have lower incomes than men from the same group.

The median income of Latinx and Black households is significantly lower than the median income of white and Asian households. For Ohio to achieve a society in which everyone has real choices when it comes to their health and having children, there must be employment opportunities that pay a living wage so that Ohioans can afford the childcare, housing, and other costs associated with supporting a family.

Second, a significant investment in Ohio’s public health infrastructure must be made to increase access to critical preventative care such as routine women’s wellness visits, STI testing and treatment, prenatal and maternity care, and gender-affirming treatment and therapy. Lastly, health inequity can be attributed to the racism and discrimination present in the medical care system. We describe the problem in Ohio, but research shows that racial bias in medical care provision is a problem all across America.

EXECUTIVE SUMMARY: CONCLUSIONS

The legal right to bodily autonomy is meaningless without the ability to make choices that affect a person’s reproductive health outcomes. Based on the findings in this report, we offer three recommendations for improving the state of choice in Ohio.

The state of Ohio must adopt a data-driven approach to state reproductive health care policies. Ohio has positioned itself as a national frontrunner for passing restrictive abortion policies, having abominable infant mortality rates, woefully inadequate funding for the child welfare system, and incarcerating women at a rate higher than the national average. Instead of basing policy decisions on data and research, Ohio legislators advance biased policies that placate their political base. Data-driven policy would be a step in creating an Ohio in which reproductive health disparities are addressed and eradicated, policy-making is transparent and comprehensive, and state funding is used responsibly towards solving problems and creating real-time solutions.

The State of Ohio must invest in research to clarify the relationship between dollars spent and changes in health outcomes in the state. It is difficult to measure the true impact of reproductive health policy without adequate data collection procedures.
in place. For several topics, data was not collected for every race and ethnicity, or data was voluntarily submitted, or datasets were completely restructured from year to year, which makes comparing and drawing conclusions extremely difficult, if not totally impossible. Because public health outcomes are so closely tied to public spending, there must be in-depth research conducted on the relationship between dollars spent and changes in health outcomes in the state. This is necessary to better understand how government funding has both contributed to the current state of choice, and is also necessary to forge funding streams that improve reproductive health outcomes for all Ohioans.

Finally, the State of Ohio must honor the reproductive autonomy of every Ohioan. Restrictive anti-choice legislation that closes clinics, censors medical providers and incites abortion stigma creates a climate in which accessing abortion is unnecessarily difficult, costly and stressful. Everybody deserves the right to the medical treatment they deem best for their body. Medical decisions should be informed by the recipient and their chosen provider, not by policymakers far removed from the lived reality of their constituents. Ohioans deserve to live in a state that honors their reproductive autonomy.
CHAPTER I: THE STATE OF ABORTION

1. ABORTION

Abortion access in Ohio is routinely under attack by anti-choice politicians. Their aim is to severely limit – if not outright ban – access to these safe and essential reproductive health care services. On April 11, 2019, Governor Mike DeWine signed Substitute Senate Bill 23 into law, which banned abortion after fetal cardiac activity can be detected. Fetal cardiac activity can typically be detected around the sixth week of gestation — before many people even realize they’re pregnant. In practice, this restriction amounts to a total ban on abortion, and it is only the most recent and blatant example of the dozens of restrictions that have been passed in Ohio in the last eight years. Each has chipped away at clinics’ operational capacity, providers’ scope of practice, and Ohioans’ access to abortion care.

Anti-choice politicians and organizations often suggest that restrictive abortion laws account for the decades-long decrease in the abortion rate. This facile argument ignores larger demographic trends. The number of births, birth rate, and fertility rate have all steadily declined in the US in the past decade.1 Put in further perspective, in 2017 the abortion rate was 8.9 per 1,000 residents age 15–44, and the birth rate was 11.7.1,2 This accounts for 144 abortions per 1,000 live births.2 Many inferences can be made about the present and future of Ohio based on the declining birth, fertility and abortion rates. But no meaningful conclusions can be drawn without a thorough, unbiased investigation of the roots of the fertility decline in Ohio and its relationship with other health indicators.

Senate Bill 23 was the fifth abortion ban signed into law in this decade. In 2011, House Bill 78 banned abortions at 24 weeks without adequate protections for women’s health, rape/incest survivors, or in the case of fatal fetal anomalies. It also enforced fetal viability testing, which ranges from minimally invasive ultrasounds to highly invasive amniocentesis. Gestational age limits on abortion were further constricted in 2016 by Senate Bill 127, which prohibited abortion when the probable post-fertilization age of the fetus is 20 weeks or more, which is equivalent to 22 weeks last menstrual period (LMP). Signed in 2018, Senate Bill 145 outlawed dilation and evacuation, the most commonly-used procedure for abortion care after 15 weeks into pregnancy; this method ban limited physicians’ ability to decide what is best for their patients. House Bill 78 and Senate Bill 127 are currently enforced. Senate Bill 145 has been partially blocked by the courts, and enforcement of House Bill 214, known as the Down Syndrome Ban, has been totally blocked by the courts as lawsuits continue challenging the constitutionality of these restrictions.3
2. GESTATIONAL AGE

Gestational age measures the number of weeks that have passed since the first day of a person’s last menstrual cycle. For people seeking abortion, it is a decisive factor in determining which abortion method is appropriate, and the cost of the procedure. Before any abortion can be performed in Ohio, gestational age is determined by use of clinical exams (3.4%), dating the last menstrual period (11.9%), ultrasound (91.9%), and other non-specified methods (0%, but three reported uses). The 2013 state budget required that an ultrasound is performed to look for a fetal heartbeat before an abortion can be performed, even if the ultrasound is not medically necessary. Ultrasounds, while not always medically necessary, are the most accurate method of determining gestational age, especially in the earliest weeks of pregnancy. In 2017, more than half (56.4%) of Ohio’s abortion patients accessed care during the first nine weeks of gestation.

An overwhelming 85.5% of abortions in Ohio occurred within the first 12 weeks, or first trimester, of pregnancy. The 2016 State of Choice report described an emerging trend in the proportion of people terminating pregnancy before and after nine weeks of pregnancy. As overall rates of abortion decreased from 2001 to 2015, a decreasing proportion of abortions were performed before nine weeks and an increasing proportion of abortions were performed between 9-12 weeks and 13-19 weeks. This suggests that even though fewer people were having

![Figure 1: Method of Termination (Surgical vs Non-Surgical) 2010-2017](image-url)
abortions, they had to wait longer to get abortion care. However, since 2015 the proportion of abortions occurring under nine weeks has steadily increased; the proportion occurring within 9–12 weeks has fluctuated within a 2.5% margin but overall decreased; and the proportion occurring within 13–18 weeks has decreased. These trends indicate that individuals seeking abortion care have been able to access it earlier in pregnancy, when both cost and risk of complications are lowest.

3. METHOD OF TERMINATION

There are several safe methods of terminating a pregnancy. These methods are classified as surgical or nonsurgical methods of abortion. Surgical methods reported in Ohio include dilation and curettage suction (D&C), dilation and extraction (D&X), dilation and evacuation (D&E), hysterotomy, hysterectomy, and other unspecified surgical methods. In 2017, D&C was used in 58% of abortion procedures, making it the most commonly used surgical method for that year. The use of D&C has decreased since 2014, when 83% of surgical abortions were performed using this method.

Nonsurgical methods reported in Ohio include mifepristone, methotrexate, misoprostol, and other unspecified methods. Nonsurgical methods are commonly referred to as medication abortion and are restricted to use through the first 70 days of gestation. These methods accounted for 25.5% of all abortions provided in Ohio.

On March 30, 2016 the U.S. Food and Drug Administration (FDA) changed their protocol for mifepristone, also known as RU-486. New regulations allowed use of medication abortions through 70 days of gestation (instead of the previous 49 day limit), allowed fewer clinic visits, and recommended a significantly lower dose of mifepristone, 200 mg instead of 600 mg. These changes in FDA policy made medication abortions much more accessible by lowering cost, travel time, and side effects, and by permitting use longer in pregnancy. Use of mifepristone increased by 48% from 2016 to 2017. The increase of mifepristone use may account for the increase in the proportion of abortions performed before nine weeks of pregnancy, but without further data this cannot be definitively proven.

4. COMPLICATION RATES

Abortion is one of the safest medical procedures. For context, the national pregnancy-related mortality ratio in 2015 was 18 deaths per 100,000 live births; in that same year there were six deaths related to complications from over 600,000 legally induced abortions. Ohio’s pregnancy-associated mortality review bifurcates data into (1) pregnancy-related deaths as the
death of a woman while pregnant or within one year of pregnancy from any cause related to or aggravated by the pregnancy or management, excluding accidental or incidental causes; and (2) pregnancy-associated deaths as the death of a woman while pregnant or within one year of pregnancy due to a cause unrelated to pregnancy. Ohio’s pregnancy-related mortality ratio in 2015 was 15.8 deaths per 100,000 live births; in that same year there were no deaths related to legal abortion, as was the case in 2016 and 2017.²,⁶

Ohio’s Department of Health utilizes two forms to record abortion complications: the Confidential Abortion Report which is completed at the time the abortion is performed, and the Post-Abortion Care Report Complications which is completed by the medical professional who treated the complication. Data on complications can vary between these two sources. Given the fact that some complications do not occur immediately following the procedure, the Post-Abortion Care Report shows that in 2015, 0.19% of abortions resulted in one or more complications, compared to the Confidential Abortion Report, which documented a complication rate of 0.12%.²

5. ACCESSING ABORTION: MONEY & TIME

Federal law forbids the use of federal funds such as Medicaid payments to cover abortion. Ohio’s House Bill 79, passed in 2011, went even further and banned insurance coverage of elective abortion in all Affordable Care Act exchange plans. Ohio law also forbids abortion coverage in the insurance plans of state and local government employees, although there is an exemption for home rule cities and counties. The base cost for a medication abortion ranges from $400 to $800 depending on the clinic. For other methods of abortion, costs are approximately $400 to $500 through 12 weeks gestation; $500 to almost $700 through 14 weeks; $450 to $800 through 16 weeks; and around $800 through 18 weeks. Any abortion past 19 weeks’ gestation is likely to cost $1,000 or more.

In addition to the costs of the procedure itself, patients must also cover additional costs for travel to and from their abortion provider, time missed from work and/or school, childcare and lodging. These added expenses may delay or make care totally inaccessible, especially because the majority of women who have abortions have annual incomes at or near poverty levels. Nationwide, 49% of women who had abortions in 2014 had annual incomes lower than 100% of the federal poverty level.⁷ Finding $400 for an unexpected expense such as abortion is not feasible.
**Figure 2: Induced Abortion by Age (Raw Numbers) 2013-2017**

- **Under 18 Years**
- **18-19 Years**
- **20-24 Years**
- **25-55 Years**
- **Outside of Fertility Range**

**Figure 2: Induced Abortion by Age (Percentage) 2013-2017**

- **Under 18 Years**
- **18-19 Years**
- **20-24 Years**
- **25-55 Years**
- **Outside of Fertility Range**
for people living in poverty. Abortion funds are organizations that exist to alleviate some of the financial burden and make abortion more accessible for patients by providing financial and/or logistical assistance to patients in need of help. Women Have Options, an Ohio abortion fund, allocated $129,255 for 533 patients in 2018. Given the high rates of poverty among women who seek abortion care, this is a small fraction of Ohioans who were likely to need help paying for abortion.
6. AGE OF THE PATIENT

The majority (97.1%) of abortion patients in Ohio are legal adults, age 18 and over. Patients from age 25–55 account for the largest demographic. Along with a decrease in teen pregnancy rates, the percentage of teenagers accessing abortion care has steadily declined, despite the fact that Ohio has bare minimum guidelines for sex education. Comprehensive sex education programs facilitated by Beech Brook, Planned Parenthood and Restoring Our Own Through Transformation (ROOTT) are filling in the gap to educate Ohio’s youth about their contraceptive and pregnancy outcome options. While this is not an exhaustive list of available programming, programs like these contribute to the declining teen abortion and birth rates in Ohio by educating teens and increasing their likelihood to utilize effective forms of birth control, condoms, and teaching teens overall reproductive life planning.

7. RACE & ETHNICITY OF THE PATIENT

Ninety-four percent of abortion patients in 2017 were Ohio residents. Of those residents for whom race was reported, 49% were white, 44% were Black/African-American, 5% were Hispanic, 4% were Asian/Pacific Islander, 4% identified as more than one race, and less than 1% were American Indian. For context, the Ohio population is 82% white, 13% Black/African-American, 4% Hispanic, 4% Asian/Pacific Islander, 2% multiracial, and 0.3% American Indian. This demographic data highlights the enormity of Ohio’s current reproductive health disparity crisis. These differences are especially stark in places like Cuyahoga County, Ohio’s second-most populated county and home to two abortion clinics. Residents of Cuyahoga County accounted for 24% of Ohio’s abortion patients, and of those, 64% were Black. For comparison, 30.5% of Cuyahoga County’s overall population is Black.

Further research clarifying the relationship between social determinants of health and Black Ohioans over-representation in abortion data is needed. However it is clear that inequitable access to comprehensive sexual education, contraception, and other health services are barriers for women of color in Ohio and contribute to disparities in abortion rates.

8. EDUCATIONAL LEVEL

Although the Ohio Abortion Report does not track economic indicators, education level is often indicative of an individual’s socioeconomic status and income level. Twenty-one percent of abortion patients in 2017 had obtained degrees, ranging from the associate to doctorate/professional level. The largest demographic (36%) of abortion patients had either a high school diploma or
GED, closely followed by patients who had some college credit but had not yet completed their degree. These education levels are also indicative of the life experience many abortion patients have, experiences which may inform their decision to choose abortion. Contrary to anti-choice rhetoric/popular belief the majority of people who get an abortion are young adults with lived experiences who are more than capable of choosing what is best for themselves.

9. STATE RESIDENCY

Of the 20,893 abortions performed in Ohio in 2017, 94% were obtained by Ohio residents, a percentage that has remained steady since 2010. Taking a closer look at localized data highlights the impact of clinic closures that have happened in the state. In July, 2013, one of the two abortion clinics in Toledo was forced to close because of burdensome and medically unnecessary licensing requirements. The effects were immediate and stark. The percentage of abortions performed in Lucas County dropped from 7.7% in 2012 to 6.5% in 2013 — accounting for the clinic’s closure halfway through the year — to 3.5% in 2014. Beginning in 2017, the percentage of abortions performed in Lucas County rebounded to 6.3% as the remaining clinic increased capacity. Data from Michigan abortion providers suggests that people living in Lucas County may have traveled to Michigan for abortion services. Clinics
in Michigan, which are close to Lucas County, reported a corresponding increase in abortion as the number of abortions in Lucas County decreased. Michigan clinics saw an increase of out-of-state residents receiving abortion care from 531 in 2012, to 708 in 2013, to 1,308 in 2014. In 2017, the numbers for out-of-state abortions in Michigan declined to 837, corresponding to the increase of abortions in Lucas County. Out-of-state abortion figures at Michigan clinics continue to be higher than pre-2013 figures.

10. MARRIAGE AND FAMILY STATUS

The Ohio Abortion Report does not capture data on patients involved in non-traditional partnerships or any form of committed relationships aside from marriage. In 2017, 80.1% of patients receiving abortion care had never been married, 11.8% were married, 2.5% were separated, 5.3% divorced, and 0.3% were widowed. A prevailing stereotype about abortion patients is that they do not understand or value the responsibilities of parenthood. Yet, 62.5% of people who accessed abortion care in Ohio had already given birth to at least one living child, indicating that in fact, people who have abortions are fully knowledgeable about their own parenting capacities and the complexities of expanding a family.

FIGURE 6: LUCAS COUNTY AND ABORTIONS PERFORMED IN MICHIGAN TO OUT OF STATE RESIDENTS 2012-2017

THE STATE OF CHOICE IN OHIO | 2019
11. CONTRACEPTIVE USE

In 2017, almost all abortion patients received contraception information and recommendations from a medical provider during the pre-procedure counseling session held on the first day of appointments.² Male condoms were the most recommended form of birth control, followed by oral contraception.² In a three-year span, recommendations for hormone implants increased significantly, from 730 recommendations in 2014 to 1,356 in 2017.²,¹² In the same time span, recommendations for the hormone patch more than doubled, from 364 in 2014 to 1,160 in 2017.²,¹¹ Meanwhile, recommendations for oral contraception decreased, accounting for 8,207 recommendations in 2014 versus 5,577 in 2017.²,¹² Although very low, the number of recommendations for abstinence and rhythm method in 2014 versus 2017 increased from 42 to 174, and 0 to 13 respectively.²,¹² Also in 2017, 21% of abortion patients reported that they were using contraception at conception. Forty percent of these patients reported a history of oral contraceptive use; 34% reported a history of male condom use; and 16% reported use of other forms of hormonal birth control, such as the hormone patch, Depo Provera, or vaginal ring.²
CHAPTER II: THE STATE OF PREGNANCY AND DELIVERY

1. PRENATAL AND POSTPARTUM CARE

Health outcomes of mothers and infants are key indicators used to evaluate the general public’s health. Pregnancy and early childhood are vulnerable stages of life, during which individuals experience an increased susceptibility to the numerous external and environmental factors that impact health. Ensuring that all Ohioans have access to adequate prenatal and postpartum care is critical to ensuring that reproductive choice is a reality.

The majority of Ohioans receive prenatal care during pregnancy. In 2017, 66.5% of pregnant persons entered prenatal care during the first trimester of pregnancy. Sixty-nine percent of white pregnant persons and 68.5% Black pregnant persons began prenatal care in their first trimester. Approximately 20% of pregnant Ohioans began prenatal care in the second trimester, and 5% began later during the third trimester.

Prenatal care is one of the first and most important contributors to healthy pregnancy. Receiving prenatal care early in pregnancy reduces the risks of complications for mother and baby and promotes fetal health and development. However, the quality of prenatal care varies and is dependent on multiple factors. The kind of health insurance payer people use is associated with differences in the quality of care they receive. Health insurance payer is also a direct indicator of socioeconomic status and a major determinant of health. In 2016, Medicaid was the healthcare payer at time of delivery for 51.8% of all births in the state. When subdivided by maternal race 64% of white patients, 29% of Black patients, and 7% of other/unknown patients had their baby’s birth covered by Medicaid.

Fair Health Consumer is an independent, national nonprofit organization that partners with health insurers to collect and report data on health care costs by procedure and state. They estimate that in Ohio, an uncomplicated vaginal birth with insurance costs $5,705.76 and $10,609.60 without insurance; while an uncomplicated cesarean with insurance costs $8,090.67 and $13,820.24 without insurance. In Ohio, becoming pregnant does not qualify as an eligible life event outside of the ACA open enrollment period. This means that if someone is uninsured and becomes pregnant, they may not able to purchase health insurance through the ACA marketplace. Although the ACA offers tax credits and competitive plans that make health insurance more affordable being unable to get insurance through the ACA may prevent people from going to prenatal
visits and accessing other health care that promote healthy pregnancies. For individuals below 200% of the poverty line, enrollment for Medicaid and CHIP may occur at any time of the year.

In addition to routine testing, prenatal care providers discuss a range of issues to promote healthy pregnancies, such as the effects of alcohol and smoking on the fetus, breastfeeding intentions, and drug use. According to the Ohio Pregnancy Assessment Survey, a representative survey of Ohio women who were pregnant or gave birth between August 2016 and May 2017, Medicaid status did not seem to influence prenatal care providers coverage of topics except for discussion of depression and postpartum birth control plans. Nearly 87% of Medicaid patients discussed postpartum birth control plans with their providers, in contrast to 74% of patients not on Medicaid.\textsuperscript{16}

Medical care providers asked 88% of Medicaid patients' about feelings of depression, in contrast to 70% of patients not on Medicaid.\textsuperscript{16} The higher rates of pre-pregnancy depression and anxiety reported by Medicaid patients may be partially explained by the higher rates at which they are asked about depression and anxiety by care providers.\textsuperscript{16}

Postpartum care is just as important as prenatal care, given the many changes and adjustments that mothers and infants experience in the first few weeks after birth. Data collected from 2009–2016 shows that although more than 85% of all patients receive a postpartum visit, Medicaid patients are less likely to receive this care than patients with other or no insurance.\textsuperscript{16}

\textbf{FIGURE 7: PRETERM BIRTH BY RACE/ETHNICITY 2010–2017}

<table>
<thead>
<tr>
<th>Year</th>
<th>ALL RACES (UNDER 37 WEEKS GESTATION)</th>
<th>WHITE NON-HISPANIC (UNDER 37 WEEKS GESTATION)</th>
<th>BLACK NON-HISPANIC (UNDER 37 WEEKS GESTATION)</th>
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2. UNINTENDED PREGNANCY RATES

The definition of unintended pregnancy is a pregnancy that is not wanted or wanted at another time in the future. Ohio’s 2014 unintended pregnancy rate was 38 per 1,000 women between the ages 15–44. Fifty-nine percent of unintended pregnancies resulted in birth, 27% in abortion, and 14% in fetal loss. This data points to a real need for comprehensive sex education standards, improved contraception access, and better understanding of cultural norms pertaining to conception, pregnancy and birth to reduce unintended pregnancy.

3. LOW–BIRTH WEIGHT/ PRETERM BIRTHS

“Preterm birth” refers to babies born with a gestational age of less than 37 weeks and accounted for 10% of total births in Ohio in 2017. Since 2014, this percentage has remained consistent but there are disparities in the rate of preterm births by race. In Ohio, just 9% of white, non–Hispanic babies are born preterm, while 11% of Hispanic babies and 14.5% of Black babies are born preterm. Racial and ethnic differences are also present in national–level data.

Low birth weight, defined as a baby born weighing less than 5.5 pounds, accounted for 8.7% of total births in Ohio in 2017. Although babies with a low birth weight may be born healthy, there
is an increased likelihood that they may experience developmental problems, short — and long — term disabilities, and are at greater risk for infant mortality (defined as infant death within the first year of life). Very low birth weight, babies born weighing less than 3.4 pounds, accounted for 1.5% of total births and 3.2% of Black, non-Hispanic births in Ohio in 2017. Nationally, in 2015, low birth weight accounted for 8.1% of total births, 7.3% of white births, 13.7% of Black births, 7.7% of Hispanic births, 8.4% of Asian or Pacific Islander births, and 9.1% of American Indian births.

The March of Dimes identifies several risk factors for preterm birth and low birth weight, including: various chronic health conditions and the medications used to treat them; certain infections, such as sexually transmitted infections, chickenpox and rubella; not gaining enough weight during pregnancy, being pregnant with multiples; use of tobacco products; alcohol, prescription or other drug abuse; exposure to lead and/or air pollution; and domestic violence. Some of these risks may be mitigated by behavioral change or medical intervention. Others can be ascribed to inequitable living conditions experienced by communities of color due to biased medical care, negligent health policy, and unequal health coverage.

4. MATERNAL MORBIDITY AND MORTALITY

While maternal mortality, which is the death of a person due to pregnancy or childbirth, is declining globally, the United States is one of the only developed countries in which it is increasing. Ohio’s Pregnancy-Associated Mortality Review tracks pregnancy-associated death, defined as the death of a woman while pregnant or anytime within one year of pregnancy, regardless of cause. Pregnancy-associated mortality is categorized by three definitions: (1) pregnancy-related death, defined as death of a woman while pregnant or within one year of pregnancy from any cause related to or aggravated by the pregnancy or the management of pregnancy, and excludes accidental or incidental causes; (2) pregnancy-associated, but not pregnancy-related, death, defined as the death of a woman while pregnant or within one year of pregnancy, due to a cause unrelated to pregnancy; and (3) could not determine, defined as the death of a woman while pregnant or within one year of pregnancy, due to a cause that could not be determined to be pregnancy-related or not pregnancy-related. There were 408 pregnancy-associated deaths in Ohio from 2008 through 2014, 74% of these occurred in the postpartum period, defined as up to one year after pregnancy, and 39% occurred within the first six weeks of pregnancy. Of those deaths, 38% were determined to be pregnancy-related and within this
category, cardiovascular conditions were the most common cause, accounting for 23% of deaths.\(^{21}\) Fifty-three percent were determined to be pregnancy-associated but not pregnancy-related and within this category, injury was the cause of 66% of deaths.\(^{21}\) Nationally, pregnancy-related deaths per 100,000 live births has steadily increased from 7.2 deaths in 1987 to 18.0 deaths in 2014 and 17.2 deaths in 2015.\(^{22}\) There are racial disparities in pregnancy-associated mortality rates. From 2011 through 2015, pregnancy-associated mortality was highest for Black women, who had a mortality rate of 42.8 deaths per 100,000 live births, followed by 32.5 deaths per 100,000 live births for American Indian/Alaskan Native women, and 14.2 deaths per 100,000 live births for Asian/Pacific Islander women. White and Latinx women have the lowest rates of pregnancy-associated mortality, with 13.0 deaths per 100,000 live births for white non-Latinx women, and 11.4 deaths per 100,000 live births for Latinx women.\(^{22}\)

Researchers have not reached consensus on the reasons for the rise in maternal mortality, but many studies show that an increasing number of women with chronic health conditions such as hypertension, diabetes and chronic heart disease are becoming pregnant. Such health conditions have been found to exacerbate the risk of medical emergencies during pregnancy. Additional reported causes of pregnancy-related deaths in the United States include non-cardiovascular disease (14.3%), infection or sepsis (12.4%), hemorrhage (11.2%), cardiomyopathy (10.8%), thrombotic pulmonary embolism (9.2%), cerebrovascular accidents (7.6%), hypertensive disorders of pregnancy (6.8%), amniotic fluid embolism (5.5%), and anesthesia complications (0.3%).\(^{22}\) Knowledge of an increase in high-risk pregnant patients is useful for the development of preventative measures and treatment plans, but does not fully address the striking racial differences in
maternal mortality rates. More research and action is needed to solve the issue of Black and American Indian/Alaskan Native women dying at such high rates during pregnancy and childbirth.

Severe maternal morbidity is closely related to maternal mortality. Maternal morbidity is defined by the World Health Organization as any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s well-being. The Ohio Department of Health tracks severe maternal morbidity (SMM) by identifying women with at least one SMM indicator of 25 medical conditions while hospitalized for delivery. In 2013, the SMM rate across all insurance categories was 143 per 10,000 deliveries. From 2008–2013 the SMM rate was highest for patients covered by Medicaid, with a rate of 165 per 10,000 deliveries; uninsured patients had the second highest rate of SMM, with 144 SMM for 10,000 deliveries, and privately insured patients had the lowest rates of SMM at 123 per 10,000 deliveries. There are racial and ethnic disparities in maternal morbidity rates. From 2012 through 2013 the SMM rate was lowest for non-Latinx white women, with a rate of 124 per 10,000 deliveries. During this same period, non-Latinx Black women had an SMM of 210 per 10,000 deliveries, Latinx women had an SMM of 215 per 10,000, and women from all other racial groups had an SMM of 143 per 10,000 deliveries. Risk factors for SMM include increased maternal age, a delivery covered by Medicaid insurance, access to care, preconception health status, obesity and other comorbidities. Blood transfusion, disseminated intravascular coagulation and heart failure during procedure or surgery were the three most common maternal morbidities reported during delivery.

The Ohio Department of Health stopped reporting maternal morbidity rates in 2014.

5. MATERNAL MENTAL HEALTH

Mental health during pregnancy is as important as physical health. The postpartum period is not the only time “baby blues” or depression may flare. Fluctuating hormone levels paired with rapid changes to the body and lifestyle most certainly impact mental well-being, both positively and negatively. Health care providers utilize the Edinburgh depression scale during prenatal visits to assess depression and depending on the results, refer patients to additional care. Of Ohio women surveyed by the Ohio Pregnancy Assessment Survey in 2016, 16.4% reported having pre-pregnancy depression, and 22.4% reported having pre-pregnancy anxiety. For women with pre-existing mental illness, pregnancy may complicate their routine care, since some drug treatments are not safe during pregnancy. Higher socioeconomic status may be a protective factor against pre-pregnancy depression and anxiety. Compared to patients with Medicaid
coverage, non–Medicaid patients, which include patients with private insurance, other insurance, or no insurance for their prenatal care, reported lower rates of pre–pregnancy depression and anxiety.\textsuperscript{15} Nearly one out of four (24.9%) Medicaid patients reported pre–pregnancy depression, compared to only 10.5% of patients not insured by Medicaid. Similarly, 32.7% of Medicaid patients reported feelings of anxiety, compared to only 15.4% of non–Medicaid patients.\textsuperscript{15} Differences in prenatal care discussions about depression with providers was significant. Among all women who received prenatal care, 78% were asked by a health care provider about depression, including 70.6% of non–Medicaid patients and 88.3% of Medicaid patients.\textsuperscript{15} Although they were less likely to have a postpartum visit, Medicaid patients were more likely to report feeling depressed after delivery.\textsuperscript{15} Given the fact that Medicaid patients reported that they did not receive prenatal care as early as they desired, there is a clear need for improved prenatal mental health surveillance and treatment. More research is needed to understand the role of mental illness and mental health indicators’ impact on prenatal and postpartum health outcomes.

6. TEEN PREGNANCY

The teenage pregnancy rate captures pregnancies that result in abortion, live birth and miscarriage. In Ohio, the teenage pregnancy rate, reported by the state as the number of pregnancies per 1,000 girls and young women between the ages of 10–19, has steadily declined since 2010.\textsuperscript{24} In 2016, the Ohio teen pregnancy rate for ages 10–14 was 0.6, representing 233 pregnancies in comparison to a rate of 1.1 in 2010, totaling 410 pregnancies.\textsuperscript{24} For teens between the ages of 15–17, the 2016 pregnancy rate was 19.5, representing 4,410 pregnancies in comparison to a rate of 29.6 in 2010, totaling 6,997 pregnancies.\textsuperscript{24} Teens between 18–19 years old had the highest pregnancy rate (67.4) amongst adolescents in Ohio, representing 10,004 pregnancies in 2016 in comparison to a rate of 94.3, totaling 15,526 pregnancies within this age group in 2010.\textsuperscript{24} The Department of Health and Human Services reports that the national teen pregnancy rate for ages 15–19 has steadily declined over the last 25 years, dropping from 117.6 per 1,000 teens in 1990 to 43.4 per 1,000 teens in 2013.\textsuperscript{25} National data is not yet available past 2013. The majority (77%) of teen pregnancies are unplanned (meaning that these are pregnancies that either occurred too soon or were not wanted at all) and result in a live birth (61%).\textsuperscript{25} The 2017 teen birth rate, defined as the number of live births per 1,000 females aged 15–19, was 20.8 for Ohio and 18.8 for the nation.\textsuperscript{26} There are variations in teen pregnancy rates by socioeconomic class. Though there is no data about the household income of teenagers who experience pregnancy, there are limited data
linking other socioeconomic indicators with teen births. Teenagers living in wealthy neighborhoods are less likely to have a baby than those who live in lower income neighborhoods. Teens with older mothers or mothers who have attended some college are less likely to give birth than teens who have mothers who gave birth as teens and/or have only a high school degree. These data indicate that teens belonging to families with higher socioeconomic status may have greater access to reproductive health services such as contraception and abortion.

7. INFANT MORTALITY

Infant mortality refers to the death of an infant before their first birthday. Similar to maternal health, infant health is an indicator of the overall health of a population. In 2017, Ohio’s infant mortality rate, defined as the number of infant deaths per 1,000 live births, was 7.2 deaths per 1,000 live births. This is higher than the national rate, which was 5.8 deaths per 1,000 live births in 2017. Ohio ranks 8th highest nationally in infant mortality rates and is one of the 10 states that had infant mortality rates above 7.1 in 2017. When comparing actual number of deaths, Ohio ranked 5th highest in 2017.

From 2016 to 2017, Ohio’s overall infant mortality rate declined but gaps between racial groups widened. The infant mortality rate for white and Latinx babies declined as the mortality rate for Black babies increased. From 2016 to 2017, the number of white infants who died decreased by 60. Although infant mortality rates went down for Latinx babies, the actual number of Latinx infants who died before their first birthday remained the same. From 2016 to 2017, the total number of Black infants who died increased by 15, the number of Asian/Pacific Islander increased by two, and there were no reported deaths of American Indian infants.

Data shows that young maternal age is associated with higher infant mortality rates. The mortality rate for infants born to teens between the ages 15–17 is 13.4 per 1,000 live births; for ages 18–19 it is 9.8; and for ages 20–24 it is 8.8. Rates significantly decrease during women’s young adult years, approaching the national target of 6.0 deaths per 1,000 births between ages 25–34 and remaining low through age 39. As maternal ages reach 40–44, infant mortality rates begin to mirror those of younger age groups, climbing to 8.4 per 1,000 live births. In every age category, Black infant mortality rates were significantly higher than the overall population rates.

Racial disparities in neonatal death in Ohio, cases in which the infant dies within the first 27 days of life, parallel the racial disparities seen in infant mortality rates. From 2016 to 2017, neonatal death decreased overall, but gaps between racial groups widened. The neonatal death rate, calculated as
the number of neonatal deaths per 1,000 live births, was 5.0 overall, 11.2 for Black babies, and 3.6 for white babies. Rates for other racial and ethnic groups were not reported.

As of 2017, the top causes of infant deaths in Ohio, categorized as death during the first year of life, were prematurity related (32%), congenital anomalies (18.2%), other unspecified causes (16%), obstetric conditions (9.2%), external injury (8.0%), and Sudden Infant Death Syndrome (6.8%).

These disparities in maternal and infant health clearly show that Ohio lacks an adequate public health infrastructure that equitably protects, sustains and nourishes the lives of Ohioans of all racial and ethnic backgrounds.

8. CRISIS PREGNANCY CENTERS/FAKE CLINICS

Crisis Pregnancy Centers (CPCs), also known as “pregnancy resource centers,” are unregulated anti-choice facilities that are promoted as providing unbiased assistance to pregnant women and girls. In reality, the primary purpose of CPCs is to counsel and coerce women away from abortion. CPCs often represent themselves as medical clinics and purport to provide impartial counseling, information, and free ultrasounds, although they are not licensed and often do not have any medically trained staff.

These fake clinics 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 well-being and safety of women and girls in Ohio.

There are nine abortion clinics in Ohio; six are ambulatory surgical centers providing surgical abortions and three provide only medication abortion services. In contrast, there are hundreds of crisis pregnancy centers, many of which receive public subsidies through state funding. The Ohio Parenting and Pregnancy Program subsidizes CPCs and other non-profit organizations whose primary purpose is “to promote childbirth, rather than abortion, through counseling and other services.” The Ohio Parenting and Pregnancy Program is a grant program created by the Ohio Legislature to funnel money into 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 through the Temporary Assistance for Needy Families (TANF) block grant. TANF is a federal grant program that is supposed to provide crucial financial assistance to families in need. Since 2013, Ohio lawmakers have reallocated a significant portion of TANF funds to subsidize crisis pregnancy centers through the Parenting and Pregnancy Support Program. In the 2018–2019 state
budget, the Parenting and Pregnancy Support Program funded Elizabeth’s New Life Center, Heartbeat of Toledo, Pregnancy Decision Health Centers, Columbus, Coleman Professional Services Inc., Catholic Social Services, Inc. and Highland County Community Action Organization. The allocation for this program was $500,000 a year 2014–2019, and for 2020 was increased by 7.5 times, to $3.75 million.

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. As of March 31, 2019, Ohio’s “Choose Life” license plates generated over $585,000. These funds are distributed to crisis pregnancy centers, maternity homes, and adoption programs across the state.
CHAPTER III: THE STATE OF CONTRACEPTION

The concept of choice is meaningless without access to contraception. Starting in 2012, the Affordable Care Act (ACA) required health insurance plans to cover FDA–approved contraception with no out-of-pocket expense, improving access to and use of birth control. The ACA requires that at least one method from each of the 18 different categories of birth control be covered with no cost sharing. However, there is a limit to the brands of birth control covered, and this limit differs by insurance policy. The ACA permits exemptions to nonprofit organizations, small businesses and individuals that have religious and/or moral objections to providing health insurance that covers contraception. This exemption was expanded to include privately held for-profit corporations by the 2014 Supreme Court decision in Burwell v. Hobby Lobby. The ACA allows plans in existence before March 2010 to be grandfathered into the ACA and exempts them from providing contraceptive coverage with no cost–sharing, although the number of these grandfathered plans and the individuals covered by them shrink every year. While the Affordable Care Act sought to reduce financial burdens on individuals when seeking birth control, there are still many people of reproductive age who are insured yet barred from full access because of their employer’s beliefs.

The Guttmacher Institute reported that 55% of Ohio women ages 13–44 needed contraceptive services and supplies in 2014. Women are considered in need if they are sexually active and able to conceive, but are not intentionally pregnant nor trying to get pregnant. Nationally, a little over half (56%) of those women were in need of publicly–supported contraceptive services and supplies, meaning they were either under the age of 20 or had income below 250% of the federal poverty line. Of women between the ages of 20–44, 19% had incomes

"So, while the Affordable Care Act sought to reduce financial burdens on individuals when seeking birth control, there are still many people of reproductive age who are insured yet barred from full access because of their employer’s beliefs."
within 0–137% of the federal poverty line and 15% had incomes within 138–249% of the federal poverty line. Of those needing public support for contraceptive services and supplies, 70% were non-Latinx white women, 19% were non-Latinx Black women, and 4.7% were Latinx women. Adolescent women, or those younger than 20, accounted for 27% of those in need of contraceptive supplies and services who were uninsured and needed publicly-funded services. Public funding sources include Medicaid, state appropriations, maternal and child health block grants, and Temporary Assistance for Needy Families. While there are multiple streams of funding services, only 39% of those in need of publicly-funded providers and services had their needs met in 2014. These numbers are especially concerning given that 23% of all those in need of publicly-funded contraceptive services and supplies were uninsured, and 10% of those women are age 20 and younger.

There are racial and ethnic disparities in uninsured people who are in need of publicly-funded contraceptive services and supplies. In Ohio, 35% of Latinx women, 17% of Black women, and 17% of white women were uninsured and in need of publicly-funded contraceptive services. While these numbers are bleak, there is a slight silver lining, as Medicaid expansion under the ACA in 2014 led to a 27% decrease in the number of women who were uninsured and in need of publicly-funded contraceptive services and supplies.

Despite the clear need for publicly-funded contraceptive services and supplies, publicly-funded providers were only able to meet 39% of these needs in 2014, compared to 49% in 2001. There was a 33% decrease from 2010 to 2014 in the number of women who received services at publicly-funded clinics in Ohio. Although nationally the amount of private doctors serving Medicaid enrollees increased by 14% from 2010–2014, this increase did not correlate to an
overall increase of needs met within this population.\textsuperscript{34} The gap in service provision may be due to a 13\% decrease between 2010 and 2014 in the number of other publicly–supported providers such as family planning clinics.\textsuperscript{34}

The only federal program specifically devoted to family planning is Title X, which provides grant funding to local public health departments, family planning clinics, and nonprofits so these entities can offer reproductive health services such as STI testing, Pap smears, breast and cervical cancer screenings, and a broad range of family planning services including contraception. Title X is a part of the United States Public Services Act, which was enacted in the 1970s. In 2014 a total of 65,220 women in Ohio received Title X–supported contraceptive services, a 33\% decrease from 2010.\textsuperscript{34} Title X funded clinics only met 9\% of publicly–funded contraceptive services and supply needs in 2014, down almost 50\% from 2001, and down 5\% since 2010.\textsuperscript{34} However, despite the paucity of needs met, publicly–supported providers — primarily Title X–funded providers — helped patients avoid 25,500 unintended pregnancies, 12,400 unplanned births and 9,200 abortions in Ohio in 2014 alone.\textsuperscript{34}

Publicly–funded clinics are especially important to meeting adolescents’ reproductive health care needs. In Ohio, 21,460 teens were served at publicly–funded clinics in 2014, which resulted in 11\% of teens need for services met and the aversion of 5,200 pregnancies, 12,400 unplanned births and 1,700 abortions.\textsuperscript{34} In 2014, the number of teens served at Ohio Title X–funded clinics was 13,330, resulting in 7\% of teens need for services being met by these clinics and the aversion of 3,200 pregnancies, 1,600 births and 1,000 abortions.\textsuperscript{34} This demonstrates that within populations served by publicly–funded clinics, Title X funding is responsible for the majority of averted unintended pregnancies, births, and abortions.

With limited funding, publicly–funded providers and clinics are only able to meet a small percentage of the needs of those who are low–income and/or uninsured. Estimates from the 2017 Behavioral Risk Factor Surveillance System indicate that 71\% of women at risk of unintended pregnancy in Ohio are using some method of contraception.\textsuperscript{35} While some women choose not to use contraception, this number suggests that there is still a significant portion of the population at risk for unintended pregnancy for whom contraception is either inaccessible or unaffordable. There is not much data available about the outcomes of unmet contraceptive needs in Ohio, but what can be inferred is that unintended pregnancies and overall reproductive wellness ranging from poor to mediocre are the results of those unmet needs — particularly among rural communities, low–income communities, and communities of color. More funds and resources are required to meet the need for publicly–funded reproductive services in Ohio, so that more Ohioans have access to a broad range of reproductive health care and the opportunity to make decisions best for their bodies and their futures.
CHAPTER IV: THE STATE OF SEXUAL EDUCATION

Sexual education that is comprehensive, medically accurate and unbiased is a critical component of reproductive choice. An understanding of biology, reproductive health, healthy relationships and sexuality, gender, sexual orientation, contraception, conception and pregnancy are all components of a comprehensive curriculum that can equip young learners with the tools they need to lead healthy and happy lives. Without comprehensive and accurate information, reproductive choice is not a reality, because people are left uninformed about their bodies and options. Unfortunately, sexual education programs taught in Ohio schools are required to stress abstinence before marriage and do not educate students about safe sex practices. The biased language used to outline these standards is alarming. The Ohio Revised Code (ORC), O.R.C. 3313.6011 section titled “Instruction in venereal disease education emphasizing abstinence” includes language requiring that sexual education stress the “potential physical, psychological, emotional, and social side effects of participating in sexual activity outside of marriage; teach that conceiving children out of wedlock is likely to have harmful consequences for the child, the child’s parents, and society; and to emphasize adoption as an option for unintended pregnancies.” While it is widely-accepted that abstinence is the most effective method to avoid unwanted pregnancy and STIs, it is also well-known that stigmatizing sex and sexuality is an especially ineffective method of accomplishing these goals. The ORC sets only the minimum standards for sexual education courses, leaving local school districts, administrators and classroom teachers to decide what — if anything — more to include in the curriculum. As a result, the breadth and quality of sexual education classes varies widely across Ohio, and many students receive only the state-mandated minimum. Avoiding important sexual health topics not only leaves young people at greater risk of unintended pregnancy or contracting an STI, but also makes them more vulnerable to misinformation spread by peers, social media, and mainstream media. Furthermore, if young children are not provided age-appropriate education about their bodies, it becomes more difficult for them to develop a language to express themselves, develop healthy boundaries, and respect the boundaries of others. This leads to more risky behavior and adverse health outcomes. In 2016, Ohio had the 9th highest rate of reported chlamydia cases among people ages 15–19, the 6th highest rate of reported cases of gonorrhea, and the 23rd highest rate of reported cases of primary and secondary syphilis in the nation. Data collected in Ohio high schools during...
the 2013 Youth Risk Behavior Survey (YRBS) found 53.7% of female students and 44% of male students reported not using a condom during their last sexual intercourse; 12.8% of female students and 11% of male students reported not using any method to prevent pregnancy during their last sexual intercourse; 11.2% of female students and 4.3% of male students reported being physically forced to have sexual intercourse; and 13.4% of female students and 6.1% of male high school students reported experiencing sexual dating violence in the previous year.36

The CDC identifies 19 critical sexual education topics as crucial to young people's sexual health and necessary for sexual education curricula. These are used as metrics within the CDC’s School Health Profiles, state-specific reports that measure health policies, practices and topics taught in schools nationwide. Data is collected from self-administered questionnaires completed by schools’ principals and lead health education teachers. The following are key findings from the Ohio School Health Profile as reported for the 2015–2016 school year and as found in the SIECUS State Profiles Report for Fiscal Year 2018:36

**Reported teaching critical sexual health education and topics**

- 10.8% of Ohio secondary schools taught students all 19 critical sexual education topics in a required course in any of grades 6, 7 or 8
- 35.6% of Ohio secondary schools taught students all 19 critical sexual health education topics in a required course in any of grades 9, 10, 11 or 12
- 57.4% of Ohio secondary schools taught students about the benefits of being sexually abstinent in a required course in any of grades 6, 7 or 8
• 94.5% of Ohio secondary schools taught students about the benefits of being sexually abstinent in a required course in any of grades 9, 10, 11 or 12

**Reported teaching how to access valid and reliable information, products and services related to HIV, other STDs or pregnancy**

• 48.4% of Ohio secondary schools taught students how to access valid and reliable information, products and services related to HIV, other STDs, and pregnancy in a required course in any of grades 6, 7 or 8

• 90.5% of Ohio secondary schools taught students how to access valid and reliable information, products, and services related to HIV, other STDs and pregnancy in a required course in any of grades 9, 10, 11 or 12

**Reported teaching how to create and sustain healthy and respectful relationships**

• 59.9% of Ohio secondary schools taught how to create and sustain healthy and respectful relationships in a required course in any of grades 6, 7 or 8

• 93% of Ohio secondary schools taught students how to create and sustain healthy and respectful relationships in a required course in any of grades 9, 10, 11 or 12

**Reported teaching about sexual orientation, gender roles, gender identity or gender expression**

• 28.2% of Ohio secondary schools taught students about sexual orientation in a required course in any of grades 6, 7 or 8

• 54.8% of Ohio secondary schools taught students about sexual orientation in a required course in any of grades 9, 10, 11 or 12

**Reported teaching how to maintain reproductive and sexual health, condoms and contraception**

• 44% of Ohio secondary schools taught students about preventive care that is necessary to maintain reproductive and sexual health in a required course in any of grades 6, 7 or 8

• 86.5% of Ohio secondary schools taught students about preventive care that is necessary to maintain reproductive and sexual health in a required course in any of grades 9, 10, 11 or 12

• 17.2% of Ohio secondary schools taught students how to correctly use a condom in a required course in any of grades 6, 7 or 8

• 48.7% of Ohio secondary schools taught students how to correctly use a condom in a required course in any of grades 9, 10, 11 or 12

• 30.8% of Ohio secondary schools taught students about methods of contraception other than condoms in a required course in any of grades 6, 7 or 8

• 76.7% of Ohio secondary schools taught students about methods of contraception other than condoms in a required course in any of grades 9, 10, 11 or 12

**Reported teaching about reproductive and sexual health in general**

40
taught students about gender roles, gender identity, or gender expression in a required course in any of grades 6, 7 or 8

• 54.2% of Ohio secondary schools taught students about gender roles, gender identity, or gender expression in a required course in any of grades 9, 10, 11 or 12

• 39% of Ohio secondary schools provided students with curricula or supplementary materials that included HIV, STD, or pregnancy prevention information relevant to LGBTQ youth

Funding

The federal and state funding landscape for abstinence-only education is complex, with a variety of grant programs that have come and gone over the years. Federal grants and state funds 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 (Title V AOUM) — a federal grant that required that Ohio state funds match $3 for every federal $4 (SIECUS). In 2008, $6,376,091 in grant funds were allocated towards abstinence-only education and given to community-based organizations; many of these grants extended through 2011, 2012 and 2013. The recipients of these grants included: 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 that also gets state funding through the Parenting and Pregnancy Program); 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

"Without comprehensive and accurate information, reproductive choice is not a reality, because people are left uniformed about their bodies and options. Unfortunately, sexual education programs taught in Ohio are required to stress abstinence-only before marriage."
Community Pregnancy Centers of Northwest Ohio. Additionally, The RIDGE Project, Inc. collaborates with the Ohio Department of Health and in fiscal year 2017 received $2,558,222 through Title V funding.

The federal Title V Abstinence–Only Until Marriage funding is now titled the Title V Sexual Risk Avoidance Education Grant Program (Title V SRAE) and was authorized $75 million for 2018. Title V SRAE is administered by the Federal Youth Service Bureau (FYSB) within the Administration for Children and Families (ACF) division of Health & Human Services (HHS). Despite the rebranding, Title V SRAE is still abstinence-based education that aims to send a “message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity.” The previous requirement that state recipients match $3 to every $4 federal dollars is no longer in place. Federal transparency about Title V SRAE grantees has dissipated, and there are now limited details available about state grantees. In 2018, the Ohio Department of Health received $2,197,074 in federal Title V SRAE funding.

The Sexual Risk Avoidance Education (SRAE) program provides funding for programming that teaches “young people to voluntarily refrain from non-marital sexual activity and prevent other youth risk behaviors.” These funds are allocated to both public and private organizations. Three Ohio grantees received a total of $1,157,134 SRAE funding in 2018:

• Healthy Visions, which “works to educate and equip youth, ages 12–18, with the critical thinking skills and knowledge needed to make healthier behavioral choices and to develop stronger relationships” received $300,000. Healthy Visions uses curriculum Choosing the Best to serve Black and Appalachian young people ages 12–16 located at school, community based, and juvenile justice facilities in the Greater Cincinnati metro area.

• Elizabeth’s New Life Center, which “empowers individuals to choose life by showing them the compassion and love of Christ” received $442,019 to implement their curriculum Go for the Gold, which serves Black and LGBTQ youth age 13–17 in community-based and juvenile justice settings in southwest Ohio.

• Operation Keepsake received $415,114 to implement their Represent curriculum in the Greater Cleveland and Youngstown areas within school- and community-based settings, targeting middle- and high school-aged youth.

Funding for comprehensive sexual education is more limited than the funds allocated for abstinence-based education. Through its Division of Adolescent and School Health (DASH), the Center for Disease Control (CDC) provides funding and technical assistance to state and local education agencies seeking to improve student health by offering sexual health education, increasing access to sexual health.
services, and establishing safe and supportive environments within school systems for both students and staff. In fiscal year 2018, the Cleveland Municipal School District (CMSD) received $338,194 through DASH, a slight decrease from the $378,636 received in 2017. DASH also grants funding for policy and program improvements; in fiscal year 2018 CMSD was awarded $59,966, and the Ohio Department of Health was awarded $100,000, both increases from the $58,636 and $65,000 received respectively in fiscal year 2017. These funds are primarily used to collect and report Youth Risk Behavior Survey and School Health Profile data.

The Office of Adolescent Health (OAH) administers the Teen Pregnancy Prevention Program (TPPP), which in fiscal year 2018 had $101 million in funding. TPPP funding opportunity announcements are released by tiers. Tier 1 is reserved for replicating programs that are “evidence-based, medically accurate, and age-appropriate programs to reduce teen pregnancy.” Tier 2 is reserved for new and innovative strategies to reduce teen pregnancy that are evidence-informed, medically-accurate and age-appropriate. In fiscal year 2017, the YWCA of Hamilton County received Tier 1 funding. While there were no Tier 1 grantees in Ohio in 2018, there was one Tier 2 grantee: Healthy Visions, which received $375,000 to implement its abstinence-based Weekly Youth Engagement (WYE) Program in five Cincinnati middle and high schools, primarily targeting Black students in 6th to 12th grade.

The federal Personal Responsibility Education Program (PREP), also administered within the ACF division of HHS, supports “evidence-based programs that provide young people with medically accurate and age-appropriate information for the prevention of unintended pregnancy, HIV, and other STDS” and targets young people who are experiencing homelessness, are in foster care, are living in rural areas or areas with high rates of adolescent births, and are from minority groups. PREIS supports “research and demonstration projects that implement innovative strategies to prevent pregnancy.” The Ohio Department of Health received $1,737,571 from PREP funds in 2017, $1,751,490 in 2014 and $1,788,594 in 2013. PREP funding data is unavailable for 2015, 2016 and 2018. PREP also funds the state grant program Personal Responsibility Education Innovation Strategies (PREIS). The Ohio Health Research and Innovation Institute received $800,721 of PREIS funding in 2017. PREIS funding data for 2015, 2016 and 2018 is unavailable.
V. THE STATE OF SCREENING & TREATMENT

ACCESS TO CARE

Like any part of the human body, reproductive organs are susceptible to infection and disease. Routine screening and prompt, effective treatment of ailments affecting the reproductive system are important aspects of choice. In the absence of medical care, reproductive health issues may lead to infertility and/or spread to other parts of the body. Undiagnosed or improperly treated incidents of sexually transmitted infection can rapidly and unnecessarily become a public health concern.

Access to screening and treatment is often limited by financial barriers and inadequate health insurance coverage. In 2017, 63% of Ohio women ages 19–64 were insured through their employer; 7% were insured through a non-group plan; 21% were insured through Medicaid, 2% through some other public program; and 7% were uninsured (percentages do not sum to 100% due to rounding). Women ages 19–64 made up 56% of Medicaid enrollees in 2016. Fifteen percent of all women ages 18 and older did not have a personal doctor or health care provider from 2016–2018, and there were significant differences between racial groups. Twenty-six percent of Latinx women, 21% of Black women, and 13% of white women over age 18 did not have a doctor or provider. During the same time period, 11% of all women over age 18 reported that they did not see a doctor in the prior 12 months due to cost. Twenty-six percent of Latinx women who did not see a doctor reported that it was due to cost, compared to 9% of Black women and 11% of white women who did not see a doctor in the prior 12 months.

Pap smears and mammograms are key aspects of routine gynecological care. In 2016, 77.9% of Ohio women ages 18–64 reported having had a Pap smear within the past three years, the recommended time frame for women ages 21–65. Pap smears check cervical health and are used to detect abnormal cells that may be indicators of Human Papilloma Virus (HPV) or cervical cancer. There was not much discrepancy in Pap testing between racial and ethnic groups, but there was a noticeable decline in testing among all groups from 2014. In 2014, 90% of Black women reported having had a Pap smear within the past three years, whereas only 74% reported having had one in 2016. Similarly, in 2014, 90% of Latinx women reported having had a Pap smear within the past three years, whereas only 79% reported having had one in 2016. The percentage change for white women was minimal, and declined from 82% in 2014 to 81% in 2016. 2016 data was not available for American Indian, Alaskan Native, Asian and Native Hawaiian or Pacific Islander women. Mammograms, which use low-dose X-ray images to detect abnormal changes
in breast tissue, are recommended every two years for women ages 50–74 and as needed based on personal and family medical history for women younger than 50. In 2016, 80.8% of all women in Ohio reported having had a mammogram within the past two years. During the years 2014–2016, breast cancer screening rates were similar between racial and ethnic groups; 80% of Latinx women, 75% of Black women, and 81% of white women reported having had a mammogram within two years.

Health statistics data, health insurance policies and coverage rarely account for transgender women and men; because of the lack of inclusion of transgender people in health metrics, there is very limited data on transgender reproductive health access and outcomes. Health policies are often so oriented towards normatively-gendered or “cisgendered” individuals that they frequently fail to identify and describe the disparities in health care access between cisgender and transgender individuals. For example, many health care providers assign care coverage based on gender identification, meaning the identity that a person publicly claims. Because of this, transmen with female reproductive organs may not have adequate coverage for necessary gynecological and obstetric care, such as Pap smears. The National Center for Transgender Equality commissioned a survey in 2015 which found that 25% of respondents experienced a problem in the past year with their insurance related to being transgender; 55% of those who sought coverage for transition-related surgery in the past year were denied; 33% of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender; 23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person; and 33% did not see a doctor when needed to because they could not afford it.

Bodily autonomy is the foundation of reproductive choice, including access to appropriate, affirming and necessary health care for transgender people. We were unable to find updated information on health care for transpeople, so the following is directly from the previous State of Choice Report:

Currently, only five states have expanded Medicaid coverage to transition-related health services, and Ohio is not one. 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. 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 the appealing the decision. Private insurance policies vary; however coverage is often denied because many providers classify these surgeries as “cosmetic”, “experimental” or not medically necessary. Many transgender people also experience difficulty obtaining insurance coverage for hormone treatments and other prescription drugs to facilitate their transition. 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

Although the previous State of Choice report included details on Ohio’s cancer screening rates by region, updated data is not available.

SEXUALLY TRANSMITTED INFECTION RATES

Sexually Transmitted Infections (STIs) are a good measure of a population’s access to health care; attitudes and behavior about sex; and knowledge and usage of preventative practices. STIs are extremely common, yet often stigmatized due to societal associations with promiscuity. STI incidence and prevalence give insight to Ohio’s entire landscape of reproductive choice. It should be noted that data discussed in this report is limited to cases reported to the Ohio Department of Health (ODH), and is not a conclusive snapshot of all new and/or current infections.

Chlamydia and gonorrhea are two of the most common STIs, nationally and in Ohio. The number of people with chlamydia has steadily increased since 2014, and there were 63,350 chlamydia cases reported to ODH in 2018. Of these, 42,759 were reported by women, and 20,591 were reported by men. These data imply that women are more likely than men to contract the infection, but some of this disparity may also be attributed to women having more opportunities for testing as a part of their routine gynecological exams, and thus more opportunities for detection and reporting infections. Additionally, the warm and moist environment of the vagina is ideal for bacterial growth so anatomy is also a contributing factor to higher chlamydia rates among women. The bulk of chlamydia cases were reported by adolescents and young adults, with 18,899 cases among people ages 15–19, 23,559 cases from ages 20–24, and 11,233 cases from ages 25–29. Incidence rates among racial and ethnic populations were: Black (24,494), followed by white (20,686), Latinx (1,797), Asian/Pacific Islander (364) and American Indian/Alaskan Native (98).
In 2018, there were 25,219 reported cases of gonorrhea. This number has steadily increased each year since 2014, when there were 16,043 reported cases; to 16,622 in 2015; to 20,537 in 2016; and 23,989 in 2017. Like chlamydia, reported cases of gonorrhea were primarily concentrated in adolescent and young adult populations. In 2018, people age 20–24 accounted for 7,161 cases, age 25–29 had 5,439 cases, and age 15–19 had 4,647 cases. Among racial and ethnic groups, incidence rates were: Black (13,002), white (6,701), Latinx (556), Asian/Pacific Islander (100), and American Indian/Alaskan Native (22). There were 1,912 syphilis cases reported in 2018, the vast majority (1,539) of them by men. People between the ages of 25–29 reported the most cases (420), followed by ages 20–24 (337), ages 30–34 (308), and ages 45–54 (240). Incidence rates for racial and ethnic groups were: Black (869), white (813), Hispanic (109), Asian/Pacific Islander (18), and American Indian/Alaskan Native (2). Since 2010, cases of syphilis have increased within the white population, and the disparity between reported cases among white
and Black Ohioans is closing. In 2018, there were 989 newly diagnosed cases of HIV infection in Ohio, representing a rate of 8.5 per 100,000 people. These cases of HIV infection include “persons with a diagnosis of HIV (not AIDS), an initial diagnosis of HIV and an AIDS diagnosis within 12 months (HIV & later AIDS), and concurrent diagnoses of HIV and AIDS, who were residents of Ohio at the time of initial diagnosis.” Of the 989 total HIV cases, there were 741 newly diagnosed cases of HIV (not AIDS), 202 newly diagnosed cases of HIV & later AIDS, and 46 newly diagnosed cases of AIDS in Ohio. Antiretroviral therapy, known as ART, is a drug treatment that prevents HIV from progressing to AIDS. Because of ART, most people diagnosed with HIV are now able to live long, full lives, and there is not much discrepancy between the life spans of those who are HIV negative and positive.

HIV infection rates, the number of individuals with a reported diagnosis of HIV infection per 100,000 people, illuminate stark differences between gender and race categories as well as age. Respectively, Black and white men accounted for 39% and 35% of HIV diagnoses in 2018. Yet the diagnosis rate for Black men was 55.2 cases per 100,000 people and the diagnosis rate for white men was 7.6 cases per 100,000 people. Similarly, Black women accounted for 8% of 2018 diagnoses with a diagnosis rate of 10.3 cases per 100,000 people, while white women accounted for 9% of the 2018 diagnoses with a diagnosis rate of 1.8 cases per 100,000. Latinx men had the second-highest diagnosis rate at 21.5 cases per 100,000, accounting for 5% of diagnoses made in 2018. Men who identified as multi-racial had the third-highest diagnosis rate at 18.7 per 100,000, accounting for 2% of diagnoses made in 2018. Asian/Pacific Islander made up 1% of HIV infection diagnoses in 2018, cases were too low to calculate a rate for women but men had a rate of 5.0 per 100,000. Latinx women accounted for less than 1% of reported cases, with too few cases to calculate a diagnosis rate. Women who identified as multi-racial had an infection rate of 4.0 per 100,000 people, making up 1% of total diagnoses. There were no reported cases among American Indian/Alaska Native people. As with other STIs, young adults accounted for the bulk of newly diagnosed HIV cases in 2018. People between the ages of 25–29 had the highest rate at 24.7 per 100,000, accounting for 20% of new cases, followed by ages 20–24 which had a rate of 23.2 per 100,000 accounting for 18% of new cases, and ages 30–34 which had a rate of 20.7 per 100,000, accounting for 15% of new cases. Adults between ages 35–39 were most likely (16%) to be concurrently diagnosed with HIV & AIDS at the time of initial diagnosis. Men accounted for 82% of the HIV diagnoses made in 2018, and women have much lower rates and total numbers of HIV diagnoses than men in their same racial or ethnic group. For adult and adolescent cases, male-to-male sexual contact accounted for
63% of newly diagnosed infections.\textsuperscript{50} It should be noted that transgender women are included in the male-to-male sexual contact transmission category if assigned male sex at birth and their risk factor history indicates sex with males. Sexual contact (heterosexual) was also the transmission mode in the majority (66%) of cases reported by women, followed by injection drug use (28%).\textsuperscript{50} Injection drug use accounted for just 8% of HIV diagnoses in men; interestingly, the second-highest transmission mode for men was categorized as other/unknown (21%).\textsuperscript{50} HIV/AIDS that is transmitted sexually is largely preventable, so the fact that it remains the most frequent transmission mode in Ohio is telling; it is indicative of the problems with the public health prevention and education methods we currently have in place.
CHAPTER VI: 
THE STATE OF 
DOMESTIC 
VIOLENCE AND 
SEXUAL ASSAULT

The link between violence and reproductive health has been well documented in research publications, so it is important to consider statewide rates of domestic violence and sexual assault in an analysis of choice. Violence, abuse and coercion surrounding sexual relationships may manifest in several different forms. Reproductive coercion is a relatively new term that refers to “behavior intended to maintain power and control in a relationship related to reproductive health by someone who is, was or wished to be involved in an intimate dating relationship with an adult or adolescent.” Examples of reproductive coercion include being forced to terminate or continue a pregnancy and birth control sabotage, such as destroying a partner’s birth control pills. While reproductive coercion is a very specific term linking abuse with reproductive health outcomes, it is neither the only type of abuse linked to reproductive health, nor is it a form of abuse easily captured by widely used datasets.

At the state level, domestic violence is the most commonly captured form of the various types of abuse. In 2017, there were 76,416 total domestic dispute calls made to Ohio law enforcement agencies, yet 46% of those calls resulted in no charges. The actual rates of domestic violence are probably much higher than these numbers suggest, given the societal tendency to dismiss accusations, and various factors that discourage many victims from reporting, such as financial dependency on, or an intimate relationship with, their abuser. While a compilation of annual data regarding domestic violence services is not available, on September 13, 2018 all 66 identified domestic violence programs in Ohio participated in the National Census of Domestic Violence Services. Within the surveyed 24-hour period in 2018, these programs served 2,302 victims. Domestic violence programs provided 1,392 victims with either emergency shelter or transitional housing, and the remaining 910 victims received non-residential assistance such as counseling, legal advocacy, and support groups for their children. Additionally, on the date for which survey data were collected, there were 804 hotline calls answered and 216 unmet requests for services. The majority of unmet requests were for housing. According to the Ohio Domestic Violence Network, programs across the state were forced to eliminate 34 staff positions in 2017, mostly direct service providers. Ohio historically underfunds domestic violence programs, spending just $2.04 per person, compared to the national average of $5.82 per person. The FY 2020-2021 state budget (which
runs from July 1, 2019–June 30, 2021) includes a 123% increase in funding for domestic violence programs, providing $1 million in funding over the two–year budget period (133rd Ohio General Assembly, House Bill 166). Hopefully, this dedicated funding stream will allow domestic violence programs to retain more staff and provide services in their communities.

Sexual assault in Ohio is captured by the Ohio Incident–Based Report System (OIBRS), a voluntary crime reporting program used by Ohio law enforcement agencies to submit crime statistics. Sexual assault is an umbrella term for a number of criminal acts including rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, and sexual imposition as defined by the Ohio Revised Code. In 2015, the most recent year for which data is available, agencies reported 7,815 incidents of sexual assault, at a rate of 86.9 per 100,000 people. The majority (70%) of reported incidents occurred within a residential structure, mostly in single–family homes. Although there were 7,815 reported incidents, there was a total of 8,447 victims in 2015 because 6% of assault incidents involved more than one victim. The average age of victims was 18.9 and the average age of suspects for whom demographic information is known was 31.9. Victims were overwhelmingly female (83%) and white (70%). Suspects were overwhelming male (93%) and the majority were white (58%). Eighty–three percent of victims reported that their assailant was a known non–family member such as an acquaintance (56%), friend (9%), neighbor (3%), or otherwise known person (26%). Twenty–five percent of victims reported that their assailant was a family member, such as a parent (22%), sibling (18%) or other family member (39).

In addition to the dearth of available data, the absence of detailed reporting makes it difficult to draw complete conclusions about the prevalence of sexual assault in Ohio. What can be noted is that sexual assault impacts reproductive choices, because it is a form of abuse that can result in an unintended pregnancy or sexually transmitted infection, and have a lasting effect on a person’s relationship to their own body, autonomy and sexuality. These troubling statistics, combined with Ohio’s inadequate sexual health education standards, a legislature that is laser– focused on restricting reproductive choice, and proliferation of crisis pregnancy centers, depict an alarming scenario in which choice exists only in theory. It is especially alarming that there are only 31 rape crisis centers to serve all 88 counties in Ohio. Due to state funding mandates, rape crisis programs are restricted in what kind of information they can give about abortion in the counseling offered to clients at risk of pregnancy following a sexual assault or in the educational outreach activities done in the community to combat rape culture.
CHAPTER VII: THE STATE OF ADOPTION AND FOSTER CARE

Eighty-five public children’s service agencies are responsible for addressing the adoption and foster care needs of Ohio’s 88 counties. Ohio is unique in that it is one of nine states with a state-supervised, county-administered child protection system. Ohio ranks last in the nation for the amount of state revenues spent on child protection funding. The state of Ohio contributes 10 cents of every dollar spent on child welfare services in the state; in comparison, other state governments contribute an average of 42 cents of every dollar spent on child welfare in their states. In 2018, public children services spending totaled $1,112,741,635, a slight increase from 2013 spending covered in the previous State of Choice report. Local funding covers the largest share of child welfare spending. In 2018, local dollars accounted for $534,979,579 (or 48.1%); federal dollars accounted for $461,807,374 (or 41.5%); and state dollars accounted for $115,954,682 (or 10.4%). A little over half of Ohio’s counties used a children’s services levy to bring in local tax dollars that cover critical services and programming and keep children safe.

The foster care system in Ohio serves children of varied backgrounds, ethnicities and ages. Data collected on July 1, 2018 shows that 39% of children in Ohio’s foster care system are newborn to age 5, 26% are ages 6-11, 31% are ages 12-17, and 3% are 18 or older. The majority (56%) of children in foster care are white, followed by Black (30%) and multi-racial (12%) children. In 2018, the system placement rate — or the number of children who entered the foster care system — was 10.5 per every 1,000 children. While the total number of children peaked at 15,928 on July 1, 2018, on any given day there were at least 3,000 children in the system. In 2018, 26,737 children were placed out of the home with either a relative or in a foster care arrangement — a slight increase from the 23,553 children placed out of the home in 2016. 2018 placement costs totaled $384,268,466, and are expected to increase 12% by 2020. Placements in a licensed foster home were responsible for the majority of 2018 spending, followed by placement in group/residential care and independent living placement/other. Although efforts are made to place children with an approved relative/kinship home, this makes up just 26% of placements; 55% are placed in a licensed foster home; 12% are placed in group/residential care; 3% received an adoptive placement; and 2% were in an independent living situation or elsewhere.

Data collected on July 1, 2018 showed that the majority of children spend less than two years in the foster care system, although this varies based on the situation, location and desired
permanency outcome. In 2018, a large percentage of children gained a permanent placement through either the Kinship Permanency Incentive Program, reunification, or custody to a relative.\textsuperscript{58} A smaller percentage gained permanency through adoption, which is corroborated by 2016 data showing that 29% of children in foster care spent 12–23 months in the system before being adopted, 27% spent 24–35 months, 23% spent 3–4 years, 14% spent 5 or more years, and just 7% spent less than a year in foster care.\textsuperscript{58,60}

Adoption is often lauded as an alternative to abortion by anti-choice activists. While the state government constantly restricts reproductive freedoms to project a “pro-life” ethos, Ohio consistently ranks at the bottom for state-level expenditures on our child welfare system. In light of the opioid epidemic causing more children to
be placed in care, Ohio officials have made efforts to increase the amount of state and federal funding allocated towards the foster and adoption care system. However, it is still not enough to subsidize a system that has been chronically underfunded, understaffed and overburdened. A survey sample of Ohio’s children’s services caseworkers conducted in 2018 found that 53% had stress levels high enough to be categorized as Post–Traumatic Stress Disorder. During 2016 and 2017, one in seven caseworkers left their positions with no performance concerns by their supervisor. Burnout from an understaffed and overburdened system leads many workers to look for less stressful, better–paying jobs. This pattern of turnover results in children being in foster care longer than necessary, and additional time and money spent by the agency to replace employees. Ohio’s children and families deserve an adoption and foster care system that is capable of providing a healthy, safe environment for those it’s meant to serve, as well as for its employees. For adoption to be a feasible choice as a pregnancy outcome, we must have a child welfare system that is well-funded, well-staffed, and well-functioning.

Statistics and data from the private adoption system are too limited to evaluate the state of private adoption in Ohio.
CHAPTER VIII: THE STATE OF FAMILY LEAVE

Adequate time off from work following the birth and/or arrival of a new addition to the family is necessary for parents to rest and recover, adjust to their new roles, and bond with their child. The United States is the only affluent country that does not offer paid parental leave; however, a handful of states and local governments have taken initiative and enacted paid family and medical leave policies. As of 2018, six Ohio municipalities enacted local ordinances requiring paid family and medical leave, and Columbus is a national leader in taking such action. Legislation for paid family leave has been introduced in both the Ohio House and Senate, but has not yet gained significant traction.

As was the case in the last State of Choice report, there is a limited amount of Ohio-specific data on family leave, making it difficult to thoroughly evaluate the state of choice on this topic. What is known is that unpaid leave, as provided under the Family and Medical Leave Act (FMLA), is inaccessible to 62% of Ohio’s employees, either because they are not protected by the law or because they are unable to afford time off without pay. This statistic is particularly alarming when paired with the fact that in 73% of Ohio households with children, both parents have paying jobs. Almost two-thirds of Ohio’s households are dependent on a woman’s income; 85% of Black mothers, 62% of Latina mothers and 53% of white mothers are essential earners or primary breadwinners for their families. And although Ohio’s gender wage gap narrowed from 1979 to 2016, it is due to the combination of men earning $2.45 less in inflation adjusted dollars since 1979, and women earning $2.66 more. For individuals, especially women, to have a legitimate choice regarding the decision to have a child, they must have adequate income and job security and know that they can smoothly transition back to their jobs after becoming a parent.

Paid family leave does not only benefit parents. Americans are increasingly living longer, leaving a significant number of adults in what is called the “sandwich generation” – responsible for the care of both their children and their aging parents. Paid leave allows employees to attend to family obligations without the additional financial and mental strains that often accompany unpaid leave. The fight for paid family and medical leave is particularly imperative in Ohio. Our state economy is encumbered with low wages for physically demanding jobs (that are also the state’s most common sources of employment), racial wealth gaps, and few employment benefits, creating a hostile environment in which families must decide between fleeting financial security and health. For many individuals and families, choice is an intangible concept without job security, which is why paid family and medical leave is an essential component of reproductive choice.
CHAPTER IX: THE STATE OF CHOICE FOR INCARCERATED OHIOANS

Ohio has the fourth largest population of incarcerated women in the nation. In 2018, the state incarcerated women at a rate of 144 per 100,000 female Ohio residents, outpacing the national rate of 133 per 100,000 female citizens. Prisoners are secluded away from society, and data on their health outcomes are even more obscured than the incarcerated individuals themselves. A complete void exists in reporting of transgender and non-binary incarcerated individuals, and very little is known about inmates’ access to appropriate menstrual supplies, gynecological services, gender affirming treatments, surgeries, contraception, or abortion care for those who live within the confines of the prison and jail systems.

The Pregnancy in Prison Statistics study was successful in collecting data on pregnancy outcomes from state and federal prisons during 2016–2017. This study was the first of its kind to commission the collection of prospective data on pregnant inmates, and resulted in a snapshot that included 53% of all women in state prisons. Ohio was one of several prison systems that participated in the study. Selected pregnancy outcomes for those incarcerated at the study’s start and end dates showed that 92% of pregnancies among Ohio’s incarcerated population resulted in live birth and 6% resulted in miscarriage. Sixteen percent of live births were preterm and 22% were delivered via cesarean section. State-level abortion data was not included in the report. Nationwide, of the 1,396 pregnant women admitted to the state and federal prisons that participated in the study, there were 753 live births, 46 miscarriages, 11 abortions, four stillbirths among preterm deliveries, and two ectopic pregnancies. Although there were no maternal deaths, there were three newborn deaths.

Legally, inmates have the same right to terminate a pregnancy as anyone else, but access is even more out of reach to women behind bars. Prisoners who continue their pregnancy out of personal choice — or for lack of other choices — are faced with the potential of being shackled whenever they are transported within or outside the facility, as well as during labor and delivery. Shackling refers to the use of restraints on the body, most commonly on the wrists, waist, and/or legs as well as the use of restraints to confine an inmate to an object, such as a hospital bed. Many states have very few or no restrictions on shackling pregnant inmates throughout pregnancy, labor and delivery. The American Medical Association censures the use of shackles during birth,
describing it as “a barbaric practice that needlessly inflicts excruciating pain and humiliation.”66 According to the American Congress of Obstetricians and Gynecologists, “shackling interferes with the ability of physicians to safely practice medicine and is ‘demeaning and unnecessary.’”67

Updated information on the Ohio Department of Rehabilitation and Corrections’ shackling policy regarding pregnant inmates was not found, but the following reflects their policy as reported in the previous State of Choice Report.

The Ohio Department of Rehabilitation and Corrections’ 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. During the actual delivery the policy mandates that “no restraints shall be applied to the pregnant inmate.” 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. 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 ODRC’s policy is followed exactly, pregnant inmates are shackled through labor until the active delivery phase and then immediately restrained post-delivery.

The Ohio Department of Rehabilitation and Corrections continues to shackle pregnant women despite criticism against this practice by leading medical organizations.

The state has implemented one positive program, a nursery program for children of incarcerated women to maintain custody and physically stay with their children. The Achieving Baby Care Success Nursery (ABC’s) is a program offered by the Ohio Reformatory for Women which provides parenting instruction such as lactation consultation, postpartum counseling, pediatric care and Head Start. Acceptance and participation qualifications are very strict, but it is the only program like it in the state and one of about ten similar programs nationwide.68 As of June 2019, the Ohio Department of Rehabilitation and Correction reported five babies in the ABC nursery, down by two from the previous month.68,69 The average number of total pregnant inmates in Ohio prisons between January to June 2019 was 27.68,69,70,71,72,73,74
CHAPTER X: THE STATE OF HEALTH DISPARITIES IN REPRODUCTIVE HEALTH

The Centers for Disease Control and Prevention (CDC) describe health disparities as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations... health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.” Health disparities are shown to be fueled by racial, gender and economic injustice throughout this report. But health disparities do not impact all racial groups equally. Overall among racial groups, white and Asian American women do better than their Black, Latina, and Native American counterparts. This section will highlight differences between groups.

Public health outcomes are tied to public spending, and Ohio’s health disparities paint a picture of an oppressive reproductive infrastructure. Increased abortion restrictions, inadequate funding of the state’s child welfare system, and funding cuts to Title X family planning programs, along with increased funding for fake clinics (a.k.a. Crisis Pregnancy Centers) and abstinence-only programs combine to limit choice and further marginalize populations that already face significant barriers to comprehensive, dignified health care. Health disparities are indicative of the state’s funding priorities, which are often misaligned with the funding priorities set by those in the public health and advocacy fields. Attributing racial differences in health outcomes to individuals rather than to systemic racism exacerbates health disparities. This section highlights some particularly problematic statistics.

"Public health outcomes are tied to public spending, and Ohio’s health disparities paint a picture of an oppressive reproductive infrastructure."
that demonstrate a real emergency in health inequities.

I. BLACK WOMEN

Opponents of abortion rights often cite racial differences in rates of abortion as proof of racism and coercion among those who support the right to choose. While it is true that Black people exist in a society founded on and fueled by racism, the anti-choice movement’s narrative implies that Black women are unknowing victims of a national conspiracy. The historical reality contradicts this narrative; in her seminal work Killing the Black Body, Dorothy E. Roberts demonstrates that Black women in America have sought ways to control their reproductive outcomes – and understood the effects of doing so – since the days of chattel slavery. It is both condescending and harmful to rely on concocted narratives to explain the racial differences in abortion rates. However, it is important to take a closer look at the socioeconomic conditions in which reproductive decisions are made and understand how these conditions affect health disparities.

The majority of data available to write this report paints an alarming picture in which Black Ohioans suffer worse health outcomes than Ohioans in other racial and ethnic groups. This pattern of inequitable racial distribution is seen in rates of abortion, preterm births, low birth weight, prenatal care, infant mortality, STIs and teen pregnancy. Nationwide, Black women are three to four times more likely than white women to experience a pregnancy-related death, have higher rates of unintended pregnancies than any other racial group – partially due to inequitable access to contraceptive care and counseling – and bear the burden of abortion restrictions, which increase time and money needed to access care.
Additionally, the majority (75%) of Black women give birth at hospitals that serve majority Black populations. These hospitals have higher rates of maternal complications and worse performance outcomes as it relates to elective deliveries, non–elective cesarean sections and maternal mortality.  

The rates of non–elective cesarean births and maternal mortality are indicative of socioeconomic factors that drive health inequities for Black women in America. “Allostatic load” is a scientific term which describes physical “weathering” of the body that accelerates physical aging in response to chronic stress, such as that resulting from “socioeconomic disadvantage and discrimination over the life course.” This weathering of the body makes achieving healthy reproductive outcomes particularly difficult for Black women.  

Income and educational attainment, which are associated with better health outcomes for white women, are not protective factors for Black women and femmes wishing to continue a pregnancy, achieve a healthy delivery, and witness a healthy first year of baby’s life.  

Nonetheless, it is important to examine the economic situation of Black Ohioans because income and occupation influence people’s quality of life. Nearly four out of ten of Ohio’s Black residents live in the cities of Cincinnati, Cleveland or Columbus, with about 25% residing in the five–county Cleveland metro area. For all Ohioans, the median household income is $54,000, but the median household income for Black Ohioans is just 59% of that, at $32,163. Insufficient opportunities for full–time employment are partially responsible for this income gap. Of those Black Ohioans who are age 16 and older, fewer than 37% worked full–time, in comparison to 42% of all Ohioans. The median earnings for Black Ohioans working part–time is less than $9,000 in comparison to the $35,000 earned by Black Ohioans working full–time all year. Black Ohioans represent a large portion of service employees; 27% are employed in service occupations such as food service and health care support. Production, transportation, and material moving occupations also account for a large portion of Black workers, employing 20% of Black Ohioans. The overall unemployment rate for Black Ohioans is 10.2%, and 14.3% for Black Ohioans aged 20–24. In comparison, the overall unemployment rate for all Ohioans age 20–24 is 8.0%.  

Income disparities are important to note since income is closely linked to health outcomes for a multitude of reasons such as quality of life and quality of health care, both of which have a positive correlation to income. These income figures are not included to suggest that individuals who live in or near poverty are responsible for their own poor health outcomes. Rather, income differences highlight how individuals who live in poverty have additional barriers to accessing quality health care, housing,
and employment that offers health insurance and benefits like paid family leave. Nationwide, just 30% of Black mothers are both eligible for and able to afford unpaid leave offered through FMLA.\textsuperscript{77} Also nationwide, nearly 30% of pregnancy discrimination charges in the workplace filed from 2011–2015 were filed by Black women.\textsuperscript{77} Stable employment that pays a living wage is necessary to live and express reproductive autonomy in regards to the decision to have a child, not have a child, and to raise children with dignity in neighborhoods that are safe and sustainable.\textsuperscript{80}

Beyond income inequality, historical policies such as redlining have a direct impact on present day health disparities. Maps of neighborhoods in Cuyahoga County that were redlined in the 1930s overlap with maps of neighborhoods that have high rates of infant mortality today.\textsuperscript{81} Economic inequalities engender health disparities, and historically discriminatory policies such as redlining have set the foundation for ongoing racial disparities in health. Reproductive health disparities such as infant mortality, maternal mortality, preterm birth, and low birth weight disproportionately impact Black Ohioans. These negative health outcomes are driven by the same social determinants of health that are responsible for higher rates of chronic conditions, such as diabetes, found in Black communities. Since it is evident that Black Americans are navigating a system designed to oppress them, more effort needs to be made to understand the circumstances in which they are making reproductive choices. More effort must also be made to enact policies that protect Black women from receiving discriminatory health care, invest in quality improvement initiatives, and address the social determinants of health.
"Regarding abortion, the choice to continue or terminate a pregnancy for many people is a choice shaped by a financial reality where funds to sustain a household are already severely constrained."

II. LATINX / HISPANIC WOMEN

Ohio’s Latinx community comprises 3.7% of the total population. In this report, we use the term Latinx instead of Hispanic because of criticism of the term Hispanic from within the community. Critics argue that the term Hispanic centers Spain and its colonial domination of Latin America, and excludes Portuguese speaking communities. Advocates prefer Latinx because it refers to people with historical ties to Latin America and is a gender-neutral term that advances non-binary representations of gender. The US census now uses the term Latinx/Hispanic, whereas some health survey data which we discuss continue to collect data using the category Hispanic. People of Latinx/Hispanic ethnicity may identify their heritage as Latinx, Spanish, or Hispanic and may be of any race or identify as multi-race.

Latinx/Hispanic is an ethnicity, which refers to people with heritage from predominantly Spanish-speaking countries such as Spain, Central America, South America, and the Dominican Republic.

The majority of Latinx Ohioans reside in the north and northwestern regions of the state, and about 30% of Latinx Ohioans live in Cleveland, Columbus, Lorain or Toledo. Although the median household income for Latinx Ohioans is $40,921, 25% of Ohio’s Latinx families households live in poverty, and 44% of Latinx families living in poverty have children younger than five years old. Similar to Black Ohioans, Latinx Ohioans are predominantly employed in low-paying occupations such as food preparation and service. As discussed previously in this report, low-paying jobs tend to offer inadequate health insurance and employee benefits, which in turn impact families’ quality of life.
Reproductive health outcomes for Latinx Ohioans are mixed; they fare better than other Ohioans in some outcomes and worse in other outcomes. Two highlights are that STI rates are fairly low in the Latinx community, and the majority of Latinx women report getting routine mammograms. However there are maternal health outcomes that cause alarm and deserve more attention, research, and funding to determine the root cause. Specifically, 11% of all Latinx babies born in Ohio were preterm births, in comparison to 9% of white babies and 14.5% of Black babies. The infant mortality rate for Latinx babies decreased from 2016 to 2017; however, the percentage of Latinx babies who died before their first birthday remained the same from 2016 to 2017. Most alarming is that Latinx Ohioans had the highest rate of severe maternal morbidity, with 215 cases per 10,000 deliveries. This statistic is even more alarming in light of the fact that 28% of Latinx Ohioans reported having no personal health care provider, and nationwide, Latinx people have the highest uninsured rates of any racial or ethnic group. Factors such as lack of access to preventive care, lack of health insurance, and cultural/language barriers heavily influence health outcomes within the Latinx population. Xenophobia and racism play a significant role in shaping the social environment Latinx Ohioans must navigate to get reproductive health care. Since 2016, Trump’s campaign and presidency has intensified public discourse around immigration reform and furthered narratives that paint Latinx immigrants in a negative light. This sort of public discourse harms the Latinx community as a whole, regardless of immigration history and/or citizenship status, because it treats Latinx people as “outsiders” who do not belong in the US and does not honor the rich legacy and contributions of Latinx people living in America.

III. ASIAN, PACIFIC ISLANDER WOMEN AND FEMMES

It is difficult to fully ascertain the state of health disparities for Asian and Pacific Islander women who reside in Ohio, because the state does not collect as much data on this population’s health outcomes as it does for other ethnic groups. Ohio’s Asian American community, which includes people with origins from East Asia, Southeast Asia and the Indian subcontinent, accounts for 2.8% of the state’s total population. The majority of Ohio’s Asian American community resides in counties that house or are adjacent to the state’s major metropolitan areas: Franklin, Cuyahoga, Hamilton, Summit, Montgomery, Butler and Delaware. This population’s median household income is $71,820, 33% higher than the median income for all Ohio households. Fourteen percent of Ohio’s Asian Americans live below the poverty line, and just 10% of family
households live in poverty, of which 66% have children in the home. The state’s overall unemployment rate is 5.2% but unemployment in the Asian American community is at 4%. A little under half of Ohio’s Asian American workforce is employed in professional occupations such as computer/engineering/science, management, health care, and education.

Compared to other ethnic minority groups, Asian Americans’ economic advantages may correlate to the generally good reproductive health outcomes seen in this population. Asian Americans accounted for 4% of abortions in 2017. The 2015 teen birth rate in Ohio for Asian and Pacific Islanders was seven per 1,000 females age 15–19, far below the state’s rate of 23 per 1,000, and the lowest of all five racial groups reported. Although the past nine years have shown a slight increase in reported cases of chlamydia, gonorrhea and syphilis among Asian Americans in Ohio, the prevalence of STIs is still relatively low among Asian Americans compared to other Ohioans. About 8% of Asian and Pacific Islander babies born in Ohio in 2015 had a low birth weight, which was comparable to the statewide total of 8.5%, and perhaps the only health indicator in which Asian Americans fare close to the overall population.
Although a few external resources provide state level data on the Asian American community in Ohio, there should be a concerted effort for state agencies to collect and report data on this population in order to fully analyze how their reproductive health outcomes compare to other racial and ethnic groups.

IV. AMERICAN INDIAN WOMEN AND FEMMES

Even more so than Ohio’s Asian American community, information about Ohio’s American Indian community is severely limited. It is difficult to determine the state of health disparities for American Indian women who reside in Ohio because the state collects limited data on this population’s health outcomes. This may be due, in part, to the fact the American Indian community accounts for just 0.2% of Ohio’s total population. American Indians accounted for 0.3% of abortions in 2017. In 2015, 9.1% of American Indian babies born in Ohio had a low birth weight, the second highest percentage after African Americans and more than the statewide percentage of 8.5%. In 2015, this population’s teen birth rate was 16 per 1,000 females age 15–19, slightly higher than the overall rate of 23 per 1,000, but the fourth lowest of all five racial/ethnic categories reported. Nationally, the teen birth rate for American Indians was 32.9 per 1,000 women ages 15–19, the highest out of all races and ethnicities. American Indians are the only racial group with no reported infant deaths in 2014 and 2017, and two reported deaths in 2015 and 2016. This group also had the lowest reports of syphilis, chlamydia, and gonorrhea.

Although American Indians represent a small portion of the state’s population, data on their health outcomes is still important to analyze the overall state of choice. State agencies should make a concerted effort to collect and report reproductive health data for this group.

V. HEALTH DISPARITIES

CONCLUSION

Three conclusions can be drawn after assessing the reproductive health disparities rampant in Ohio. First, both the gender and racial wage gaps play key roles in compounding barriers to quality health care and diminishing choice, especially for women who are also racial or ethnic minorities. Regarding abortion, the choice to continue or terminate a pregnancy for many people is a choice shaped by a financial reality where funds to sustain a household are already severely constrained. Across the nation, in every racial and ethnic group, women are paid less than men of their same race or ethnicity, and women from every group are paid less than white men. Of women working full-time in 2018, Black
women made 65.3% of white men’s weekly median earnings and 89% of Black men’s weekly median earnings. Latinx women made 61.6% of white men’s weekly median earnings and 85.7% of Latinx men’s weekly median earnings. Asian women made 93.5% of white men’s weekly median earnings and 75.5% of Asian men’s weekly earnings (Asian men out-earned white men in 2018).

For Ohio to achieve a society in which everyone really has a choice when it comes to their health and having children, there must be job opportunities that pay a living wage so people can afford the childcare, housing and other costs associated with supporting a family. Eleven of the thirteen most common jobs in Ohio pay less than $34,000 a year. For a family of three, that income is more than 200% below the federal poverty line, the standard marker of a low-income household. It is important to contextualize parenting within the economic landscape of Ohio, considering the fact that in 2017, 37.1% of people who had abortions already had two or more children and 25.4% already had one child.

Ohio ranks among the bottom seven states for income eligibility limits for childcare assistance, meaning that in Ohio families must be deeply impoverished before they qualify for benefits. This is particularly concerning for women-led households because women must balance their childcare responsibilities with their employment. Employment that offers comprehensive health insurance, adequate paid time off to recover from illness or childbirth, and care for a new baby or other family member is essential for working Ohioans to achieve and maintain good reproductive health outcomes.

Second, a significant investment in Ohio’s public health infrastructure must be made to increase access to critical preventative measures such as routine women’s wellness visits, STI testing and treatment, prenatal and maternity care, and gender-affirming treatment and therapy. Everyone deserves quality reproductive health care, but as the data in this report illustrate, not everyone has equal access to care. Income, place of residence, and insurance status should not be the determinants of health outcomes. Yet for many racial minorities, these factors are structural barriers that make it nearly impossible for people to access the care they need. The current state of health disparities in Ohio are the result of underfunding and disinvestment of the services and programs that impact the social determinants of health. Within the public health sphere, infant health is a prime indicator of a society’s well-being. Ohio’s exceptionally high rates of Black infant death are indicative of a state which fails Black parents well before conception and throughout their lives.
Lastly, health inequity can be attributed to the racism and discrimination present in the medical care system. This report describes the problem in Ohio, but research shows that racial bias in medical care provision is a problem all across America. There is a large body of scholarly research that details widespread problems with minority patients not being offered preventive care and receiving lower quality care than their white counterparts. There are also countless first-person narratives of women of color not being heard, taken seriously, or treated with respect while accessing reproductive health care. Health care in general, and reproductive health care more specifically, has a sordid history of maltreatment of and testing on Black and Brown bodies, so it is not surprising that health disparities in medical care persist. In order for disparities to become an issue of the past there must be a serious effort to address structural racism in the health care system and in society as a whole. Changes can be implemented to improve treatment of patients in exam and delivery rooms, but until the structures holding up racist practices in health care are eliminated, health disparities will persist in our society.
CONCLUSION

The state of choice in Ohio is bleak, but not hopeless. There are policymakers, researchers and advocates working tirelessly to advance the much-needed structural changes and help realize an Ohio where an individual’s reproductive health is cared for, centered and protected. This report is meant to be a comprehensive resource of reproductive health outcomes in Ohio. It is our hope that this report will be used not only by those in the realm of reproductive health, but also by those seeking to amplify the connection of reproductive health with other socioeconomic and health indicators in Ohio. We hope that this report sparks discussion and innovative solutions for change.

Based on the findings in this report, we offer the following recommendations for improving the state of choice.

The state of Ohio must adopt a data-driven approach to state reproductive health care policies. Ohio has positioned itself as a national frontrunner for passing restrictive abortion policies, having abominable infant mortality rates, woefully inadequate funding for the child welfare system, and incarcerating women at a rate higher than the national average. Since 2012, Ohio has funded crisis pregnancy centers through the parenting and pregnancy program, and recently increased such funding from $500,000 to $3.25 million per year. Based on existing research, there is absolutely no proof that increasing funding for these centers will reduce the number of people facing unintended pregnancies and seeking abortion care, adoption services, accessible prenatal care and paid parental leave; in fact, existing data suggests that the opposite is more likely to be true. Instead of basing policy decisions on data and research, Ohio legislators use policy to placate their political base. Data-driven policy would be a step in creating an Ohio in which reproductive health disparities are addressed and eradicated, policy is transparent and comprehensive, and state funding is used responsibly towards solving problems and creating real-time solutions.

The state of Ohio must conduct research to clarify the relationship between dollars spent and changes in health outcomes in the state. It is difficult to measure the true impact of reproductive health policy without adequate data collection procedures in place. For several topics, data was not collected for every race and ethnicity, or data was voluntarily submitted, or datasets were completely restructured from year to year, which makes comparing and drawing conclusions extremely difficult, if not totally impossible. Because public health outcomes are so closely tied to public spending, there must be in-depth research conducted on the relationship between dollars spent and changes in health outcomes in
the state. This is necessary to better understand how government funding has both contributed to the current state of choice, and is also necessary to forge funding streams that improve reproductive health outcomes for all Ohioans.

Finally, **The state of Ohio must honor the reproductive autonomy of every Ohioan.** Restrictive anti-choice legislation that closes clinics, censors medical providers and incites abortion stigma creates a climate in which accessing abortion is unnecessarily difficult, costly and stressful. Everybody deserves the right to medical treatment they deem best for their body. Medical decisions should be informed by the recipient and their chosen provider, not by policymakers far removed from the lived reality of their constituents. Ohioans deserve to live in a state that honors their reproductive autonomy.

Although the content of this report uncovers many alarming statistics and reveals a severe dearth of current data at the state level, we hope it inspires readers to create and implement change. It will take a dedicated group of researchers, advocates, constituents and policymakers to reverse the current state of choice, but the work can and must be done. We hope that this report serves as a comprehensive guide to the current state of affairs, provides a baseline to track issues, and is useful in the identification of necessary policy changes. In publishing this report we hope to contribute to a conversation about changing the state of choice for the better, and creating a reality in which reproductive health outcomes are greatly improved and Ohioans have full access to the full range of reproductive health care they want, need and deserve.
WORKS CITED


31. NARAL Pro-CHOice Ohio Foundation, 2013


NARAL PRO CHOICE OHIO FOUNDATION
IS A PROUD MEMBER OF: