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NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

Written Testimony of Center for Reproductive Rights, National Latina Institute for Reproductive Health, and National Asian Pacific American Women's Forum to the Ways and Means Committee on Concerns Regarding Wide Racial and Ethnic Disparities in Reproductive Health

The Center for Reproductive Rights (the Center), National Asian Pacific American Women's Forum (NAPAWF), and National Latina Institute for Reproductive Health (NLIRH) urge the Committee to act quickly to eliminate disparities in reproductive and sexual health among women of color in the United States. The Center is a New York-based organization that uses the law to advance reproductive freedom as a fundamental human right. NAPAWF is a membership based, multi-issue women's advocacy organization working to advance human rights for Asian and Pacific Islander (API) women and girls. NLIRH is the only reproductive justice organization that works to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization and policy advocacy.

I. Key Racial Disparities in Reproductive and Sexual Health

Many barriers exist for women of color in accessing essential preventative services such as contraception and prenatal care. A disproportionate number of women of color lack health insurance and are confronted with multiple obstacles in accessing publicly funded health programs, such as linguistic and cultural barriers to care. Consequently, preventable reproductive health disparities continue to be prevalent in communities of color as a whole, and specifically in women of color. These structural barriers will be discussed further in Section III, but first we highlight the most prominent disparities in sexual and reproductive health.

Despite the highest per capita expenditure on health care in the world, the U.S. has significantly poorer sexual and reproductive health indicators than other western developed countries. The U.S. maternal mortality rate ranks 35th in the world, far below most other western developed countries.¹ Racial disparities help to explain why these rates are so high. For the past five decades, African American women have been dying four times as often in childbirth than white women.² Government agencies and expert international bodies recognize that access to timely prenatal care is critical to reducing the risk of maternal mortality,³ and studies show that African American women, American Indian/Alaskan Native, and Latinas are far less likely than non-Hispanic white women to access timely prenatal care.⁴

There are also significant racial disparities in sexually transmitted infections, or STIs. African American women are 23 times more likely to be infected with HIV/AIDS than their white counterparts⁵ and 14 times more likely to die of the disease than white women.⁶ Together, African American women and Latinas account for 82% of reported female HIV/AIDS diagnoses, even though they represent only 24% of the U.S. female population.⁷ The Chlamydia infection rate for American Indian/Alaskan Natives is five times that of white women.⁸ Disparities continue to grow; the syphilis rate increased among all women between 2005 and 2006, but it jumped 18.2% among Asian/Pacific Islander women compared to 5.6% among non-Hispanic white women.⁹ Finally, the STI human papillomavirus (HPV), which is believed to be responsible for 90-95% of cervical cancers,¹⁰ is more prevalent among people of color.¹¹

¹ World Health Organization (WHO), *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UFPFA*, Appendix 1 (2007), available at http://www.who.int/whosis/mme_2005.pdf (last viewed June 19, 2008) (showing the U.S. ranked below every country in Western Europe except Luxembourg when comparing countries that use a similar method of data collection for maternal deaths).

² Nat'l Ctr. for Health Stat., *Maternal Mortality and Related Concepts*, 3 VITAL HEALTH STAT. No.33, 8-9 (Feb. 2007); Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*, 97 AM. J. PUB. HEALTH 247-51, 247 (2007).

³ Ctrs. for Disease Control, *Births: Final Data for 2004*, 55 NAT'L VITAL STAT. REP. No. 1, 16 (Sept. 29, 2006); NAT'L CTR. FOR HEALTH STAT. (NCHS), HEALTH, UNITED STATES, 2006 160 (2007), available at <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm> (last viewed Dec. 14, 2007) [hereinafter 2006 NAT'L HEALTHCARE DISPARITIES REP.] (“recommend[ing] that women begin receiving prenatal care in the first trimester of pregnancy”); Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health* (20th Sess. 1999), ¶ 31, U.N. Doc. A/54/38 at 5 (1999) (calling on states to “reduce maternal mortality rates through safe motherhood services and prenatal assistance”).

⁴ 2006 NAT'L HEALTHCARE DISPARITIES REP., *supra* note 3, at 160.

⁵ Ctrs. for Disease Control, *HIV/AIDS among African Americans 2* (June 2007), available at <http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm> (last viewed Dec. 14, 2007).

⁶ 2006 NAT'L HEALTHCARE DISPARITIES REP., *supra* note 3, at 221.

⁷ Ctrs. for Disease Control, *HIV/AIDS among Women 2* (June 2007), available at <http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm> (last viewed Dec. 14, 2007); Dept. Health & Human Servs., *African-Americans and HIV/AIDS in the United States* (June 2006), available at <http://hab.hrsa.gov/history/AfricanAmericans> (last viewed Dec. 14, 2007).

⁸ Dep't of Health & Human Servs., *Sexually Transmitted Disease Surveillance 2006* 8-9 (Nov. 2007), available at <http://www.cdc.gov/std/stats/toc2006.htm> (last viewed Dec. 14, 2007) [hereinafter *STD Surveillance Report 2006*].

⁹ *Id.* at 34.

¹⁰ Harold Freeman & B.K. Wingrove, *Excess Cervical Cancer Mortality: A Marker for Low Access to Health Care in Poor Communities* 13 (Nat'l Cancer Inst., 2005).

Despite recent trends of declining cervical cancer incidence and mortality among women overall, women of color, especially Latinas and African Americans, are significantly more likely than white women to develop cervical cancer and to die from it.¹² Presently, a pap smear costs approximately \$50-200—a prohibitive cost for many women of color who are uninsured and employed in low paying jobs. Cervical cancer is one of the most curable diseases *if detected early*. Therefore, high death rates among women of color are linked to their low rates of screening and follow-up care.¹³ For example, Vietnamese-American women, who have the highest incidence rate of cervical cancer of any racial or ethnic population (and three times higher than the next group, Latinas), are among the least likely to be screened for the disease or understand the purpose of a pap test.¹⁴

Unintended pregnancy is another area of reproductive health where women of color face significant disparities. The rate among Latinas is 75% higher than among non-Hispanics,¹⁵ and Latinas are three to four times more likely than white women to use no method of contraception.¹⁶ In addition, while overall rates of contraception use increased in the 1990s, since 2002 rates have started to decline due to rising nonuse among low-income women of color.¹⁷ In 2006, the teen pregnancy rate rose for the first time since 1991, and the racial group with the largest increase was young African American women.¹⁸ Almost half of unintended pregnancies in the United States end in abortion.¹⁹

Abortion rates increase when contraception is less accessible to low-income women.²⁰ Women of color, who have less access to contraception and more unintended pregnancies than white women, choose to terminate their pregnancies more often. Since 1991, the abortion rate for African American women has remained three times higher

¹¹ Elizabeth I.O. Garner, *Cervical Cancer: Disparities in Screening, Testing, and Survival*, 12 *CANCER EPIDEMIOLOGY BIOMARKERS & PREVENTION* 242S-247S, at 3 (March 2003).

¹² U.S. Cancer Stat. Working Group, *United States Cancer Statistics: 2003 Incidence and Mortality* (2007); *WOMEN'S HEALTH DATA BOOK: A PROFILE OF WOMEN'S HEALTH IN THE UNITED STATES*, 76-77, 81 (D. Misra ed., 2001) available at <http://www.kff.org/womenshealth/6004-index.cfm> (last viewed Dec. 14, 2007); NAT'L INST. OF HEALTH, *WOMEN OF COLOR HEALTH DATA BOOK: ADOLESCENTS TO SENIORS* 119 (2006), available at <http://orwh.od.nih.gov/pubs/WomenofColor2006.pdf> (last viewed Dec. 14, 2007) [hereinafter NIH, *WOMEN OF COLOR HEALTH DATA BOOK*].

¹³ Dep't. of Health & Human Servs., *Minority Women's Health: Cervical Cancer*, <http://www.womenshealth.gov/minority/hispanicamerican/cc.cfm> (last visited June 20, 2008) (estimating that improved rates of pap testing would prevent 80% of deaths from cervical cancer).

¹⁴ Nat'l Asian Women's Health Org., *A Profile: Cervical Cancer and Asian American Women* (2000), at 1-2, <http://www.nawho.org/pubs/NAWHOCC.pdf> (last visited June 20, 2008).

¹⁵ HEATHER D. BOONSTRA ET AL., *ABORTION IN WOMEN'S LIVES* 28 (Guttmacher Inst., May 2008).

¹⁶ Nat'l Ctr. for Health Stat., *Fertility, Family Planning and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth*, 23 *VITAL & HEALTH STAT.* No. 25, at 101 (2005).

¹⁷ BOONSTRA, *ABORTION IN WOMEN'S LIVES*, *supra* note 15, at 25-26.

¹⁸ Ctrs. for Disease Control, *Births: Preliminary Data for 2006*, 56 *NAT'L VITAL STATISTICS REP.* No. 7, 1-2 (2007).

¹⁹ Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 *PERSP. ON SEXUAL & REPRODUCTIVE HEALTH* 90-96, 90 (2006).

²⁰ Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 *PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH* 231 (2002).

than that for white women.²¹ However, low-income women, a disproportionate number of whom are women of color, often delay seeking an abortion because of cost—both for the initial health care visit to confirm a pregnancy and for the procedure itself.²² Because the cost of an abortion increases with a more advanced gestational age, low-income women are trapped in the cycle of delaying the procedure to raise money, then having to pay even more for a procedure later in the pregnancy.²³ As a result, low-income women obtain an abortion on average three weeks later in their pregnancy than higher income women,²⁴ even though 67% of these women report they would have preferred to get an abortion earlier.²⁵ Moreover, some low-income women are unable to obtain an abortion at all, as evidenced by the fact that low-income women are five times more likely to have an unintended birth than women in the highest income category.²⁶ This burden disproportionately falls on women of color.²⁷

II. Human Rights Concerns Raised by Racial Disparities in Sexual and Reproductive Health

Racial disparities in sexual and reproductive health pose grave public health and human rights concerns. The U.S. is a party to the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), which obligates ratifying countries to take positive steps to address and eliminate racial disparities including disparities in health care.²⁸ The CERD committee, which monitors countries' implementation of CERD, raised persistent disparities in reproductive and sexual health in its review of U.S. in February 2008. The Committee expressed concern that

wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans, high incidence of unintended pregnancies and greater abortion rates affecting African

²¹ Ctrs. for Disease Control, *Abortion Surveillance—United States, 2003*, 55 MORBIDITY & MORTALITY WEEKLY REP. SS-11 6-7 (2006).

²² Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL'Y REV. No. 1, 14-15 (Winter 2007).

²³ *Id.* at 15-16.

²⁴ *Id.* at 14.

²⁵ *Id.*

²⁶ Finer & Henshaw, *Disparities in Unintended Pregnancy*, *supra* note 19, at 94.

²⁷ Ctrs. for Disease Control, *Abortion Surveillance—United States, 2003*, 55 MORBIDITY & MORTALITY WEEKLY REP. SS-11 30 (2006) (showing African American women are less likely than white women to obtain an abortion at less than eight weeks gestation); BOONSTRA, *ABORTION IN WOMEN'S LIVES*, *supra* note 15, at 5 (explaining that the population most likely to obtain an abortion later in pregnancy is women who are young, poor, unmarried, and African American); Suzanne Ryan et al., *Research Brief: Hispanic Teen Pregnancy and Birth Rates: Looking Behind the Numbers* (Child Trends Feb. 2005), <http://www.childtrends.org> (showing that in 2003, Hispanic teens had the highest teen birth rate with 82 births per 1,000 females aged 15 to 19).

²⁸ International Convention on the Elimination of All Forms of Racial Discrimination, arts. 2, 5(e), G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969 [hereinafter ICERD].

American women, and growing disparities in HIV infection rates for minority women.²⁹

The Committee then recommended that the U.S. take affirmative steps to improve access to contraception, preventative services such as family planning and prenatal care, and comprehensive sexuality education.³⁰

U.S. policies leading to racial disparities in sexual and reproductive health also raise other human rights concerns. The human right to the highest attainable standard of health requires that individuals have access to accurate information, including information related to sexual and reproductive health. The right of all people to “seek, receive and impart information and ideas of all kinds,” is protected by the International Covenant on Civil and Political Rights (ICCPR), which was ratified by the U.S. in 1992. The Human Rights Committee, the UN treaty body which oversees compliance with the ICCPR, also has linked the obligation to provide accurate and objective sexuality education to the treaty’s right to life provision.³¹ In addition, the U.S. has signed, but not ratified, human rights treaties which discuss the importance of access to accurate information and education necessary to protect sexual and reproductive health,³² and the necessity of providing low-cost contraceptives for women who cannot afford supplies.³³ By signing these treaties, the U.S. has an obligation to refrain from actions that would defeat the treaties’ object and purpose.³⁴

²⁹ *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America*, 03/05/2008, U.N. Doc. CERD/C/USA/CO/6, ¶ 33.

³⁰ *Id.*

³¹ *Concluding Observations of the Human Rights Committee: Poland*, U.N. Doc. CCPR/CO/82/POL, ¶ 9 (Feb. 12, 2004).

³² Convention on the Elimination of All Forms of Discrimination Against Women, art. 12, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981); Committee on the Elimination of Discrimination Against Women, *General Recommendation 24: Women and Health*, 20th Sess., ¶ 23, U.N. Doc. HRI/GEN/1/Rev.5 (2001); International Covenant on Economic, Social and Cultural Rights, arts. 12, 13, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976); Committee on Economic, Social, and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22d Sess., U.N. Doc. HRI/GEN/1/Rev.5 (2001); Convention on the Rights of the Child, art. 24(2)(e), *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990); Committee on the Rights of the Child, *General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, 33d Sess., ¶¶ 26, 28 U.N. Doc. CRC/GC/2003/4 (2003); Committee on the Rights of the Child, *General Comment 3: HIV/AIDS and the Rights of the Child*, 32nd Sess., ¶ 16, U.N. Doc. HRI/GEN/1/Rev.6 (2003).

³³ *Concluding Observations of the CEDAW Committee: Armenia*, ¶ 50, U.N. Doc. A/52/38/Rev.1, Part II (Aug. 12, 1997); *Concluding Observations of the CEDAW Committee: Hungary*, ¶ 254, U.N. Doc. A/51/38, (May 9, 1996); *Concluding Observations of the CEDAW Committee: Iceland*, ¶ 84, U.N. Doc. A/51/38 (May 9, 1996).

³⁴ Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, arts. 10, 18 (*entered into force* Jan. 27, 1980).

III. Policy Recommendations to Eliminate Reproductive Health Disparities

Instead of developing policies to ensure access to reproductive health for women of color, current government policies inhibit or obstruct their access to maternal health care, contraceptives and family planning, preventative services such as pap tests and STI screening, and abortion. We call on Congress to implement the following policy changes in order to eliminate disparities in reproductive and sexual health.

1. Ensure Health Care for All

In the U.S., where access to health care depends on insurance coverage, lack of health insurance is the primary barrier to receiving reproductive health care. Overall, the number of people enrolled in public health insurance programs is decreasing, even while private insurance coverage continues to shrink.³⁵ Hence, a greater number of low-income people lack insurance of any kind because they do not have employer-based coverage and do not qualify for public insurance. Women of color, who disproportionately work in low-wage jobs that do not offer benefits,³⁶ have lower rates of insurance coverage: 39% of Latinas, 19% of API women, and 18% of African-American women are without affordable health care compared to only 10% of white women.³⁷

Disparities in access to insurance indicate a clear need for a universal system of health coverage for all, regardless of race, ethnicity, gender, or immigration status. In the meantime, the federal government must promote equal access to health insurance by expanding government health insurance programs to cover the rising number of low-income people who do not receive employer-based coverage.³⁸

2. Reduce Eligibility Barriers for Medicaid

Two restrictions on Medicaid eligibility serve as significant barriers for low-income women of color to receive both preventative and primary reproductive health care. Because women of color disproportionately rely on Medicaid for their reproductive health care,³⁹ restrictions to that program have a disproportionate impact on them. First,

³⁵ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* 18-19 (Aug. 2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf> (last viewed June 16, 2008) (showing a decrease from 27.3 million people covered in 2005 to 27.0 covered in 2006).

³⁶ Kaiser Family Found., *Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey 2* (Mar. 2004), available at <http://www.KaiserFamilyFound.org/womenshealth/7018.cfm>. White women (70%) are more likely to have employer provided health coverage than African American women (59%) or Latinas (39%). NAT'L INST. OF HEALTH, WOMEN OF COLOR HEALTH DATA BOOK: ADOLESCENTS TO SENIORS 107 (2006), available at <http://orwh.od.nih.gov/pubs/WomenofColor2006.pdf> (last viewed June 20, 2008) [hereinafter NIH, WOMEN OF COLOR HEALTH DATA BOOK].

³⁷ NIH, WOMEN OF COLOR HEALTH DATA BOOK, *supra* note 36, at 107; Women's Health Policy Fact Sheet: Women's Health Insurance Coverage 2 (Kaiser Family Found., Dec. 2007).

³⁸ U.S. Census Bureau, *supra* note 35, at 18 (showing the number of uninsured increased from 44.8 million to 47.0 million from 2005 to 2006).

³⁹ Latinas are twice as likely (12%) and African American women are nearly three times as likely (18%) to be on Medicaid as white women (6%). Kaiser Family Found., *supra* note 36, at 2.

the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) barred the use of federally funded Medicaid for resident immigrants who have resided in the U.S. for less than five years. Medicaid coverage has declined by half among all immigrant women during the years that this policy has been in effect,⁴⁰ even among long-time resident immigrant women who should not have been affected by the change.⁴¹ This policy deters immigrant women's access to vital preventative and primary reproductive health services such as pre-natal care. Many states have elected to provide pre-natal coverage to all women using state-only Medicaid funds. However, as state budget shortfalls are projected, strong federal policies are needed to guarantee that all women receive timely pre-natal care in order to reduce health disparities in maternal mortality. We support legislation such as the Legal Immigrant Children's Health Improvement Act (H.R. 1308) and the Health Equity and Accountability Act (H.R. 3014), which seek to give states the option to use federal funds to restore SCHIP eligibility for immigrant children and pregnant women.

The second restriction on Medicaid eligibility was imposed as part of the 2005 Deficit Reduction Act and requires documentation of citizenship for women seeking to enroll in Medicaid or renew their beneficiary status. This requirement delays low-income women from getting Medicaid coverage when they need time-sensitive services such as pre-natal care. It has also had a disproportionate impact on women of color. Low-income African American citizens have been dropped significantly from Medicaid enrollment because they are less likely to possess documentation of citizenship than poor whites.⁴² The law has also decreased enrollment for long-time resident immigrants, who are deterred from enrolling because they believe they must produce proof of citizenship instead of only proof of legal status to qualify.⁴³

In order to address these problems, the CERD Committee has suggested that Congress "improv[e] access to maternal health care, family planning, pre-and post-natal care and emergency obstetric services, *inter alia* through the reduction of eligibility barriers to Medicaid."⁴⁴ The repeal of the five-year bar on Medicaid services and the elimination of the DRA citizenship documentation requirements would help reduce barriers to reproductive and health care, thereby reducing disparities.

⁴⁰ Rachel Benson Gold, *Immigrants and Medicaid after Welfare Reform*, 6 GUTTMACHER REP. ON PUB. POL'Y 6-9, 7 (May 2003), available at <http://www.guttmacher.org/pubs/tgr/06/2/gr060206.html> (last viewed June 17, 2008).

⁴¹ *Id.*

⁴² Donna Cohen Ross, *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show* 3-6 (Ctr. on Budget & Pol'y Priorities, July 2007), available at <http://www.cbpp.org/7-10-07health.htm> (last viewed June 20, 2008).

⁴³ Leighton Ku, *Why Immigrants Lack Access to Health Care and Health Insurance* (Ctr. on Budget & Pol'y Priorities, 2006), available at <http://www.migrationinformation.org/Feature/display.cfm?id=417> (last viewed June 20, 2008).

⁴⁴ *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America*, 03/05/2008, U.N. Doc. CERD/C/USA/CO/6, ¶ 33.

3. Increase Funding for Title X

In order to reduce disparities in unintended pregnancy, STIs, and reproductive system cancers, Congress should increase appropriations for the Title X program. This program provides funding to reproductive health clinics across the country that provide contraceptive services and supplies, STI testing and treatment, and preventative screenings to 6.6 million low-income women, 40% of whom are women of color.⁴⁵ For many years, however, Congress has failed to fund the Title X program at the level necessary to meet the reproductive health needs of its target population. Funding for Title X is now at 60% of what it was in 1980.⁴⁶ Meanwhile, the need for services has steadily increased, especially among immigrant populations who are now ineligible for Medicaid.⁴⁷ One impact of reduced funding is that two-thirds of Title X-supported clinics are unable to offer a full range of contraceptives or otherwise meet the family planning needs of low-income women.⁴⁸ The lack of funding of Title X has a greater impact on women of color, who are in greater need of publicly funded family planning services than white women. Between 2000-2006, the number of Latinas and African American women in need increased by 24% and 11% respectively, in contrast to a 1% increase in need among white women.⁴⁹

The CERD Committee recommended that Congress reduce disparities in sexual and reproductive health by “facilitating access to adequate contraceptive use and family planning methods.” We urge Congress to do so by doubling the funding of Title X over the next five years to \$600 million by FY 2013.

4. Repeal the Hyde Amendment

Congress should repeal the Hyde Amendment, the federal policy that bans federal funding for abortions except in cases of life endangerment, rape, and incest. Abortions that are medically necessary for the woman’s health are excluded under Medicaid, even though the Medicaid program funds all other “medically necessary” services.⁵⁰ The majority of states (32) fail to extend coverage beyond the limits of what is covered by

⁴⁵ Title X and the U.S. Family Planning Effort 3 (Alan Guttmacher Inst., 1997), available at <http://www.guttmacher.org/pubs/ib16.html> (last viewed June 20, 2008).

⁴⁶ Rachel Benson Gold, *Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort*, 10 GUTTMACHER POL’Y REV. 13-18, 15 (Spring 2007), available at <http://www.guttmacher.org/pubs/gpr/10/2/gpr100213.html> (last viewed June 20, 2008).

⁴⁷ Adam Sonfield et al., *Cost Pressures on Title X Family Planning Grantees, FY 2001–2004* 4 (Alan Guttmacher Inst., 2006) (explaining that Title X funded clinics reported an average cost increase of 58% from 2001–2004 for language assistance services to serve non-native English speakers), available at <http://www.guttmacher.org/pubs/2006/08/01/CPTX.pdf> (last viewed June 20, 2008).

⁴⁸ Jennifer J. Frost et al., *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*, 33 GUTTMACHER INST. OCCASIONAL REP. NO. 9, at 11-12 (Nov. 2006), available at <http://www.guttmacher.org/pubs/2006/11/16/or33.pdf> (last viewed June 20, 2008).

⁴⁹ Women in Need of Contraceptive Services and Supplies, 2006 (Alan Guttmacher Inst., 2008), <http://www.guttmacher.org/pubs/win/WIN2006.pdf> (last viewed June 20, 2008).

⁵⁰ 42 U.S.C. § 1396(a) (2000).

federal Medicaid.⁵¹ As a result, the majority of women who rely on publicly funded health care programs have no access to abortions unless they are able to cover the entire cost of the procedure out-of-pocket. Between 18-35% of Medicaid-eligible women who want an abortion are forced to continue their pregnancies due to the unavailability of public funding.⁵² The Hyde Amendment and other bans on federal funding for medically necessary abortions disproportionately harm low-income women of color because they are more likely than white women to rely on federally-funded programs for their reproductive health care.

5. Eliminate Funding for Abstinence-Only-Until-Marriage Programs

Federal funding for abstinence-only-until-marriage programs exacerbate disparities in unintended pregnancy and STIs by failing to provide young people the information they need to practice safe sex. Since 1996, the federal government has spent over \$1.5 billion to fund abstinence-only programs. Federal guidelines prohibit abstinence-only programs from teaching about contraceptive use, therefore only permitting the discussion of contraceptive methods in the context of failure rates.⁵³ Many of these programs exaggerate contraceptive failure rates and provide false or misleading information about the effectiveness of contraception in preventing STI infection, including HIV.⁵⁴ Research shows abstinence-only programs do not deter premarital sex or diminish the rate of STI infection,⁵⁵ and some programs deter condom use among sexually active teens.⁵⁶ By failing to teach adolescents about the risks of unprotected sex, including STI infection, adolescents who become infected lack information about testing

⁵¹ State Policies in Brief: An Overview of Abortion Laws (Guttmacher Inst., 2007), http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf (last viewed June 17, 2008).

⁵² Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States*, 2001, 35 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 16-24, 23 (2003).

⁵³ 42 U.S.C. § 710(b)(2) (2007) (requiring that any program receiving federal funding promote abstinence outside of marriage as its “exclusive purpose”); Heather D. Boonstra, *The Case for a New Approach to Sex Education Mounts: Will Policymakers Heed the Message?*, 10 GUTTMACHER POL’Y REV. 2 (Spring 2007), available at <http://www.guttmacher.org/pubs/gpr/10/2/gpr100202.html> (last viewed June 20, 2008) (showing how the “exclusive purpose” definition of abstinence education bars programs from “providing any information that could be construed as promoting or advocating contraceptive use”).

⁵⁴ H.R. Rep., Committee on Government Reform, *The Content of Federally Funded Abstinence-Only Education Programs* 8 (Dec. 2004) [hereinafter Waxman Report], available at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf> (last viewed June 20, 2008).

⁵⁵ Mathematica Policy Research, Inc., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report* 59 (April 2007), available at <http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf> (last viewed June 20, 2008) (finding that the surveyed abstinence programs had “no overall impact on teen sexual activity [and] no differences in rates of unprotected sex” among those who completed the programs); Society for Adolescent Medicine, *Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine*, 38 J. ADOLESCENT HEALTH 83-87, 84 (2006).

⁵⁶ Waxman Report, *supra* note 54, at 4 (showing that students who took a “virginity pledge” as part of an abstinence-only curricula did not have lower rates of STIs than non-pledgers but were less likely to use contraception when they had sex).

and treatment.⁵⁷ Research also indicates that adolescents who complete abstinence-only programs are 50% more likely to have an unintended pregnancy than those who receive comprehensive sexuality education.⁵⁸

Research shows that young women of color are disproportionately affected by abstinence-only programs. Young African Americans and Latinas receive abstinence-only instruction in greater numbers than young white women.⁵⁹ One study showed that fewer than half of sexually experienced young African American women had received instruction about contraception prior to their first sexual encounter, compared to two-thirds of their white peers.⁶⁰ In addition, abstinence-only programs have been criticized for promoting gender stereotypes because they portray “women as socially and sexually submissive and strip them of ownership of their own ambitions and desires.”⁶¹ The programs by their terms also discriminate against lesbian, gay, bisexual, and transgender youth, both by teaching that heterosexual marriage is the only appropriate context for sex and that sex outside of marriage is both psychologically and physically harmful.

Accurate and objective sexual education is critical to advancing public health and promoting human rights. This fact is widely accepted within the international community and is supported by the provisions of fundamental human rights instruments. The CERD Committee observed that disparities in sexual health could be corrected by “providing adequate sexual education aimed at the prevention of unintended pregnancies and sexually-transmitted infections.”⁶² To that end, Congress should redirect monies spent on abstinence-only programs towards comprehensive sexuality education, which has proven to be effective in promoting positive behaviors, including delaying initiation of sex and increasing condom and contraceptive use.

6. Improve Systems for Data Collection and Analysis

The federal government should standardize health data reporting, collection and analysis systems that better reflect the diversity of the U.S. population and identify health trends in a given population so that more targeted health interventions can be utilized to ameliorate health problems. Data collection should also include immigrant communities with a special recognition of primary language, cultural differences, special health needs,

⁵⁷ Boonstra, *The Case for a New Approach to Sex Education Mounts*, *supra* note 53, at 5; Waxman Report, *supra* note 54, at 4; John Santelli et al., *Abstinence and abstinence-only education: A review of U.S. Policies and programs*, 38 J. ADOLESCENT HEALTH 72-81, 76 (2006).

⁵⁸ Pamela Kohler et al., *Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy*, 42 J. ADOLESCENT HEALTH 344-51 (2008).

⁵⁹ Laura Duberstein Lindberg et al., *Changes in Formal Sex Education: 1995-2002*, 38 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH No. 4, 182-88, 185-86 (Dec. 2006) (discussing the results of a study conducted from 1995 to 2000—years which marked an exponential growth in abstinence-only instruction—revealing that by 2000 the number of young black and Hispanic women receiving abstinence-only instruction in lieu of other forms of sexuality education had significantly increased and was higher than young white women).

⁶⁰ *Id.* at 186.

⁶¹ Julie F. Kay, *Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls* 21 (Legal Momentum, New York, NY, 2008), available at

http://www.legalmomentum.org/site/PageServer?pagename=sfr_26 (last viewed Apr. 28, 2008).

⁶² CERD, Concluding Observations, ¶ 33.

and financial concerns. The federal government should ensure that both public and private health systems monitor health disparities on the basis of, *inter alia*, race, ethnicity and national origin, gender, age, primary language, immigration status, sexual orientation, disability and income.⁶³

Current systems of data collection inadequately measure existing health disparities because they fail to take into account profound disparities within ethnic groups. For example, few studies specifically document the reproductive and sexual health trends of API women and girls, and even fewer disaggregate the data by ethnic subpopulation.⁶⁴ The lack of research makes it difficult to identify gaps in services and emerging areas of need for API women and any disparities that exist among the over 30 ethnic subgroups within the API population. For this reason, we support the provision in H.R. 3014 that requires the Social Security Administration to collect data based on the race, ethnic, gender and primary language of all social security applicants.

The federal government should also support efforts to provide federal and state level spending on research specific to communities of color through community health clinics, hospitals, and *promotora* community health workers. In addition, research grants issued by government agencies in the reproductive health, rights and justice community should tie funding to research through a Community Based Participatory Research (CBPR) model, where research partnerships include persons of color and their families as equal partners in all phases of research.

7. Improve Providers' Cultural and Linguistic Competency

Reproductive health disparities are also caused by physicians' failure to understand cultural and linguistic differences among the populations they serve.⁶⁵ Almost 20% of the U.S. population, or approximately 54.9 million people, speak a language other than English at home.⁶⁶ Studies have shown that "Latino patients with language discordant doctors are more likely to omit medication, miss office appointments⁶⁷ and rely on the emergency room for care, which often leads to poorer health outcomes."⁶⁸ In addition, women who are limited English proficient (LEP) receive fewer preventative services including mammograms, pap smears and other important screenings.⁶⁹

⁶³ See *id.* ¶ 32.

⁶⁴ National Asian Pacific American Women's Forum, *Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women* 10 (2005).

⁶⁵ Kevin Sack, *Doctors Miss Cultural Needs, Study Says*, N.Y. TIMES, June 10, 2008.

⁶⁶ Sharon Barrett, *Language Access: Understanding the Barriers and Settings in Primary Care Settings*, at 2 (2008).

⁶⁷ Cindy Brach & Irene Fraser (Agency for Healthcare Research & Quality), *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 MEDICAL CARE RESEARCH & REV. 181-217, 190 (Nov. 2000) at http://mcr.sagepub.com/cgi/reprint/57/suppl_1/181.pdf.

⁶⁸ Good Intentions Are Not Enough! Latino Health Disparities and Barriers to Health Care Access, Latino Health Advocates Founders Summit, *available at* <http://www.latinoaids.org/misc/goodintentions.pdf> (last viewed June 20, 2008).

⁶⁹ NAPAWF, *Reclaiming Choice*, *supra* note 64, at 12.

The Culturally and Linguistically Appropriate Services (CLAS) standards should be adopted and implemented in all health care institutions.⁷⁰ Culturally competent care includes taking into consideration, recognizing, and responding to the different values, preferences, beliefs, and needs of an individual patient. Health care providers can do this by creating an environment in which patients from diverse cultural backgrounds feel comfortable discussing their specific health beliefs, practices, and needs. The provision of culturally competent health care can dramatically improve health outcomes, increase levels of patient satisfaction and improve cost efficiency. The Health Resources and Services Administration notes that culturally competent practices enable providers to: 1) obtain more specific and complete information to make a diagnosis; 2) facilitate the development of treatment plans that are more likely to be adhered to by the patient and supported by the family; and 3) enhance overall communication and interaction between patient and provider.⁷¹

Existing racial health disparities for women of color will only become more severe if health care providers are not able to respond to their diverse language and cultural needs. The need for increased language assistance services, coupled with the mandate under Title VI of the Civil Rights Act that federal funding recipients must ensure meaningful access to services for LEP individuals, demands increased resources and funding towards language access programs. Specifically, the federal government should provide funding and legislation that support training and assistance for medical interpreters, clinicians and health care providers⁷² *specific to reproductive health* in order to protect such private and confidential matters such as contraception, sterilization, and abortion. In addition, funding for Medicaid and the State Children Health Insurance Program should be increased in order to provide linguistically and culturally adequate standards health service for providing to low-income and/or uninsured persons of color.

⁷⁰ Office of Minority Health, National Standards for Culturally & Linguistically Appropriate Services (CLAS) in Health Care *available at* <http://www.hhs.state.ne.us/minorityhealth/docs/CLASBrochure.pdf> (last viewed June 20, 2008). Some of the CLAS standards are mandates, others are guidelines, and still others are recommendations. All are issued by the U.S. DHHS Office of Minority Health. They are intended to inform, guide, and facilitate required and recommended practices related to cultural and linguistically appropriate health services. They were designed to contribute to the elimination of health disparities by addressing the linguistic and cultural needs of individuals in an appropriate manner.

⁷¹ See Health Resources and Services Administration Study On Measuring Cultural Competence in Health Care Delivery Settings, Sect. II, <http://www.hrsa.gov/culturalcompetence/measures/sectionii.htm>.

⁷² This includes doulas, midwives, obstetricians and gynecologists. The word “doula” refers to a person who provides continuous physical, emotional, and informational support to a woman before, during and just after childbirth. See DONA International, *What is a doula?*, <http://www.dona.org/mothers/index.php> (June 20, 2008).