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Abortion and Women of Color: The Bigger Picture

By Susan A. Cohen

This much is true: In the United States, the abortion rate for black women is almost five times that for white women. Antiabortion activists, including some African-American pastors, have been waging a campaign around this fact, falsely asserting that the disparity is the result of aggressive marketing by abortion providers to minority communities.

The Issues4Life Foundation, for example, is a faith-based organization that targets and works with African-American leaders toward achieving the goal of "zero African-American lives lost to abortion or biotechnology." In April, Issues4Life wrote to the Congressional Black Caucus to denounce Planned Parenthood Federation of America (PPFA) and its "racist and eugenic goals." The group blamed PPFA and abortion providers in general for the high abortion rate in the African-American community—deeming the situation the "Da[r]fur of America"—and called on Congress to withdraw federal family planning funds from all PPFA affiliates.

These activists are exploiting and distorting the facts to serve their antiabortion agenda. They ignore the fundamental reason women have abortions and the underlying problem of racial and ethnic disparities across an array of health indicators. The truth is that behind virtually every abortion is an unintended pregnancy. This applies to all women—black, white, Hispanic, Asian and Native American alike. Not surprisingly, the variation in abortion rates across racial and ethnic groups relates directly to the variation in the unintended pregnancy rates across those same groups.

Black women are not alone in having disproportionately high unintended pregnancy and abortion rates. The abortion rate among Hispanic women, for example, although not as high as the rate among black women, is double the rate among whites. Hispanics also have a higher level of unintended pregnancy than white women. Black women's unintended pregnancy rates are the highest of all. These higher unintended pregnancy rates reflect the particular difficulties that many women in minority communities face in accessing high-quality contraceptive services and in using their chosen method of birth control consistently and effectively over long periods of time. Moreover, these realities must be seen in a larger context in which significant racial and ethnic disparities persist for a wide range of health outcomes, from diabetes to heart disease to breast and cervical cancer to sexually transmitted infections (STI), including HIV.

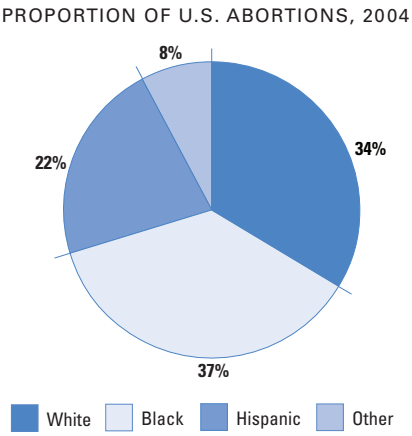
Behind the Numbers

Abortion rates have been declining in the United States for a quarter of a century, from a high of 29.3 per 1,000 women aged 15–44 in 1981 to an historic low (post-*Roe v. Wade*) of 19.4 in 2005. The overall number of abortions has been falling too, dropping to 1.2 million in 2005. Currently, about one-third of all abortions are obtained by white women, and 37% are obtained by black women. Latinas comprise a smaller proportion of the women who have abortions, and the rest are obtained by Asians, Pacific Islanders, Native Americans and women of mixed race (see chart).

The abortion rates among women in minority communities have followed the overall downward trend over the three decades of legal abor-

WHO HAS ABORTIONS

Most abortions in the United States are obtained by minority women.



Notes: "Other" includes Asians, Pacific Islanders, Native Americans and those of mixed race. These numbers add to 101% because of a small overlap among the Hispanic, black and other categories.
Source: Guttmacher Institute, 2008.

tion. At the same time, however, black women consistently have had the highest abortion rates, followed by Hispanic women (see chart). This holds true even when controlling for income: At every income level, black women have higher abortion rates than whites or Hispanics, except for women below the poverty line, where Hispanic women have slightly higher rates than black women.

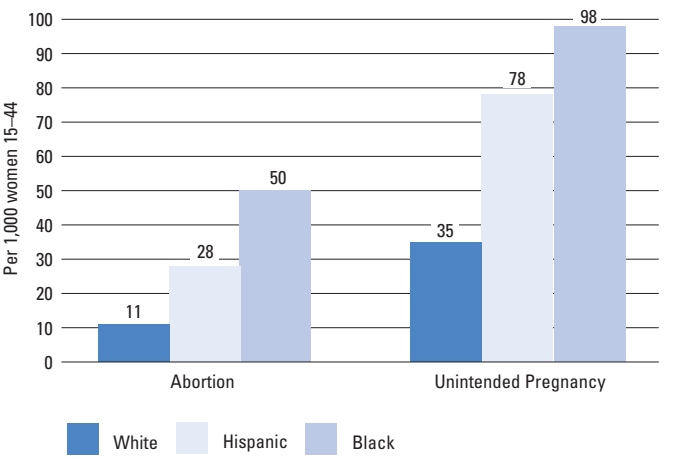
These patterns of abortion rates mirror the levels of unintended pregnancy seen across these same groups. Among the poorest women, Hispanics are the most likely to experience an unintended pregnancy. Overall, however, black women are three times as likely as white women to experience an unintended pregnancy; Hispanic women are twice as likely. Because black women experience so many more unintended pregnancies than any other group—sharply disproportionate to their numbers in the general population—they are more likely to seek out and obtain abortion services than any other group. In addition, because black women as a group want the same number of children as white women, but have so many more unintended pregnancies, they are more likely than white women to terminate an unintended pregnancy by abortion to avoid an unwanted birth.

The disparities in unintended pregnancy rates result mainly from similar disparities in access to and effective use of contraceptives. As of 2002, 15% of black women at risk of unintended pregnancy (i.e., those who are sexually active, fertile and not wanting to be pregnant) were not practicing contraception, compared with 12% and 9% of their Hispanic and white counterparts, respectively. These figures—and the disparities among them—are significant given that, nationally, half of all unintended pregnancies result from the small proportion of women who are at risk but not using contraceptives.

Whether an at-risk woman practices contraception, however, does not in itself tell the whole story. For an individual woman who is attempting to avoid a pregnancy, the particular method she chooses and the way she uses it over time also matter. In fact, all of the major contraceptive methods are extremely effective if used "perfectly." In actual practice, however, there are significant variations in a method's effectiveness in "typical use" (i.e., for the average person who may not always use the method correctly or consistently). The IUD has a very low failure rate because it is long-acting and requires little intervention by the user. Coitus-related methods such as condoms are at the other end of the typical-use effectiveness scale, because they depend on

STARK CONTRASTS

Black and Hispanic women have much higher abortion rates than white women—because they have much higher rates of unintended pregnancy.



Notes: Abortion data, 2004; unintended pregnancy data, 2001. *Sources:* Guttmacher Institute, 2008 and 2006.

proper use at every act of intercourse. The pill, which is not coitus-related but must be taken every day, is usually more effective than the condom, but less effective than an IUD (see table). Factoring together the method choices and the real-life challenges to effective use over long periods of time, women of color as well as those who are young, unmarried or poor have a lower level of contraceptive protection than their counterparts.

Widespread Disparities

Fundamentally, the question at hand is less why women of color have higher abortion rates than white women than it is what can be done to help them have fewer unintended pregnancies. Obviously, facilitating better access to contraceptive services is key. Beyond access, however, dissatisfaction with the quality of services and the methods themselves may be as much or sometimes more of an impediment to effective use of contraceptives.

Studies by Guttmacher Institute researchers, published in *Perspectives on Sexual and Reproductive Health* in 2007 and in *Contraception* in 2008, sought to shed some light on the reasons women at risk of unintended pregnancy do not use contraceptives at all or use them only sporadically. Geographic access to services is a factor for some women; however, for many, it is more a matter of being able to afford the more effective—usually more expensive—prescription methods.

Beyond geographic and financial access, life events such as relationship changes, moving or personal crises can have a direct impact on method continuation. Such events are be more common for low-income and minority women than for others, and may contribute to unstable life situations where consistent use of contraceptives is lower priority than simply getting by. In addition, a woman's frustration with a birth control method can result in her skipping pills or not using condoms every time. Minority women, women who are poor and women with little education are more likely than women overall to report dissatisfaction with either their contraceptive method or provider. Cultural and linguistic barriers also can contribute to difficulties in method continuation.

These themes resonate beyond the domains of contraceptive use, unintended pregnancy and abortion. Indeed, they probably underlie many of the stark racial and ethnic disparities that exist across a broad range of health indicators. For example, the Centers for Disease Control and Prevention presented data in March 2008 indicating that black teens were more than twice as likely as their white or Mexican-American counterparts to have one or more of the four STIs studied (chlamydia, trichomoniasis, genital herpes and human papillomavirus), independent of income and number of sexual partners. Reported cases of syphilis are triple the rate for Hispanics than for whites, according to the American Social Health Association. According to the Department of Health and Human Services Office of Minority Health, the AIDS case rate for African-American men is more than eight times that for whites; the rate for Latinos is more than three times that for whites. Hispanic women are more than twice as likely as whites to be diagnosed with cervical cancer; black women are less likely to be diagnosed with breast cancer than white women, but 30% more likely to die from it.

CONTRACEPTION WORKS

The most commonly used contraceptive methods vary widely in their theoretical and real-world effectiveness, but all are far more effective than not using a method at all.

Method	First year failure rate*	
	Perfect use	Typical use
Oral contraceptives	0.3	8.7
Tubal sterilization	0.5	0.7
Male condom	2.0	17.4
Vasectomy	0.1	0.2
3-month injectable	0.3	6.7
Withdrawal	4.0	18.4
Copper IUD	0.6	1.0
Hormonal IUD	0.1	0.1
Periodic abstinence	†	25.3
Implant	0.05	1.0
Patch	0.3	8.0
No method	85.0	85.0

*Percentage of women experiencing an unintended pregnancy during first year of use. †Failure rate varies by specific method of periodic abstinence, from 9% for calendar method to 1% for post-ovulation.
Source: Guttmacher Institute, 2008.

Beyond sexual and reproductive health, African-Americans and Hispanics bear a greater disease burden than whites across a range of important health indicators. Blacks, for example, are almost twice as likely as whites to have diabetes. New cases of colorectal, pancreatic and lung cancer occur more often in African-American women than in any other group. There is a higher incidence of stomach and liver cancer among Hispanics, male and female, than among whites and a higher mortality rate from these cancers as well.

Access to health care, including financial access, remains a significant issue that particularly affects minority communities; however, there is increasing recognition of the critical importance of quality of care as it affects health-seeking behavior and outcomes. In 2002, the Institute of Medicine (IOM) reported that "minorities are less likely than whites to receive needed services, including clinically necessary procedures." The IOM offered a number of explanations for this finding, including linguistic and cultural barriers that interfere with effective communication between a patient and a provider. The IOM also noted a level of mistrust for the health system in general that exists in minority communities. Mistrust can cause a patient to refuse treatment or comply poorly with medical advice, which in turn can cause providers to become less engaged—leading to a vicious cycle. These obstacles are difficult enough to surmount in cases where a patient is ill and presumably motivated to receive some kind of treatment. In the case of a prevention intervention such as birth control, however, where the need for "treatment" may seem less pressing, the cumulative effect of these obstacles could be daunting.

Ironically, treating all patients the same, regardless of race or ethnicity, may not be the answer to the problem of health disparities. Harvard Medical School professor Thomas Sequist published the results of his research in a June 2008 issue of the *Archives of Internal Medicine* in which he and his colleagues found that a physician's failure to match a treatment regimen with a patient's cultural norms could contribute significantly to the poor compliance and worse health outcomes manifest in minority communities. "It isn't that providers are doing different things for different patients," he explained to the *New York Times.* "It's that we're doing the same thing for every patient and not accounting for individual needs. Our one-size-fits-all approach may leave minority patients with needs that aren't being met."

Speaking for Themselves

Perhaps all that is certain about racial and ethnic health disparities is that there are too many, they are too great and the reasons for and solutions to them are complex. Narrowing the gaps in access, quality and health outcomes is essential and a priority in the public health community. It is also a priority among key members of Congress, led by Rep. Hilda L. Solis (D-CA), chair of the Congressional Hispanic Caucus Task Force on Health and the Environment, along with Del. Donna M. Christensen (D-VI), chair of the Congressional Black Caucus Braintrust, and Del. Madeleine Z. Bordallo (D-GU), chair of the health care task force of the Congressional Asian Pacific American Caucus. Under Solis' leadership, these three caucuses have been advocating for passage of the Health Equity and Accountability Act of 2007, legislation designed to address some of the known impediments to quality health care, including some aspects of reproductive health care, for minority populations.

Perhaps it is because they are more acutely aware of the larger societal issues surrounding health disparities, members of the Black, Hispanic and Asian Pacific American caucuses in Congress, overwhelmingly, are strong and reliable advocates of reproductive heath and rights, including abortion rights. So, too, is an array of organizations representing women of color, including African American Women Evolving (AAWE), the National Asian Pacific American Women's Forum, the National Latina Institute for Reproductive Health and Sistersong, among others.

To be sure, the leaders of these organizations have on occasion voiced their own frustrations with what they consider the "mainstream" reproductive rights movement, contending that the movement has been too narrowly focused on

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The root causes of these disparities are manifold: a long history of discrimination, too few educational and professional opportunities for disadvantaged groups and unequal access to safe, clean neighborhoods, just to name a few. There are no easy solutions to these complex challenges. Innovative strategies—looking at empowering individuals, ongoing cross-cultural education of providers, access to and quality of care, and efforts to reduce entrenched poverty and improve education—will all have to be part of the longer-term approach.

The bottom line is that even as advocates press for targeted initiatives to reduce sexual and reproductive health disparities, they need to give greater attention to the larger forces that drive disparities. Addressing social and economic disparities is critical to reproductive health. At the same time, empowering women and couples to decide if and when to have a child and enabling them to have a healthy pregnancy and baby are critical to achieving social justice. www.guttmacher.org

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protecting and promoting family planning and abortion rights. They argue that these rights, although critical, must be lodged in the broader health, social and economic context of women's lives—especially the lives of poor and low-income women who are disproportionately minority—and interconnected with other critical life needs and aspirations. AAWE's mission, for example, states forthrightly that "a woman's ability to lead [a] reproductive healthy li[fe] is closely connected to her ability to overcome other social and economic barriers." AAWE advocates for reproductive health in a broad way that includes addressing issues surrounding infertility and menopause, reducing infant and maternal mortality, and promoting breast care and prenatal care, as well as promoting access to quality contraceptive services, safe abortion services and services to prevent STIs, including HIV.

The fact that AAWE and other minority-focused groups argue as passionately for alleviating poverty, promoting access to health care more broadly and advancing women's equality more generally as they do for family planning or abortion rights in no way diminishes their commitment to those rights. To the contrary. In stark contrast to the antiabortion pastors who appear intent on trying to protect minority women from themselves, it is these groups and their advocates in Congress who are working to advance the real interest of women of color, by advocating for all women's meaningful access to the range of health information, services and rights they need to live and improve their own lives. www.guttmacher.org

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