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Developing a Medication Abortion Advocacy Toolkit with Community and Policy Groups: A Special Studies Project

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Abstract

Developing a Medication Abortion Advocacy Toolkit with Community and Policy Groups: A Special Studies Project

By: Priya Chandresh Shah

Background: Medication abortion (MA) is safe and effective. Telemedicine for MA has the potential to increase access to abortion care; however, many state-level restrictions seek to ban telemedicine for abortion, disproportionately affecting marginalized communities. Reproductive Justice (RJ), a framework and social movement started by Black feminists, emphasizes the human rights to have children, not have children, and parent one's children with health and dignity free of coercion.

Purpose: The purpose of this special study project is to 1) participate in community-led research on medication abortion and 2) collaborate with RJ and policy advocacy groups to respond to emergent policy needs. This will support the safety of telemedicine and medication abortion while amplifying the voices and experiences among Black and Latinx women in Atlanta, GA.

Methods: The Georgia Medication Abortion (GAMA) study led by HIV and RJ organization SisterLove seeks to explore MA experiences and perceptions among Black and Latinx women. This special studies project conducted a secondary analysis of GAMA data on abortion stigma. This project expanded to incorporate participant observations at a Georgia Senate hearing on telemedicine for abortion and develop an advocacy toolkit for policymakers informed by RJ leaders.

Results: Findings from GAMA show that abortion stigma among Black and Latinx women in Atlanta, GA is a complex, intersectional phenomenon contextualized by the history and intergenerational trauma of social and racial injustice, reproductive and economic oppression, and sexual exploitation. Participant observations concluded that abortion stigma is evident in the abortion policy-making process and reinforces negative connotations about people who have or support abortion. The advocacy toolkit provided talking points and a comprehensive literature review on the evidence of telemedicine abortion safety and was delivered to all Georgia Senators and Representatives. The proposed bill did not pass.

Discussion: Access to safe abortion is critical more than ever. Despite abundant evidence, stigmatizing and unscientific policies are still being introduced. To achieve RJ and destigmatize abortion, intersectional frameworks that center marginalized communities' lived experiences and perspectives are needed. Public health researchers, local RJ organizations, and other advocacy groups must collaborate to bridge the gap between policy, evidence, and experiential knowledge.

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Chapter 1: Introduction

Introduction and Rationale

The Supreme Court decision of *Roe v. Wade* declared abortion a constitutional right in 1973; however, many states have challenged this legislation by enacting restrictions to further regulate and control access to critical health care. In fact, a recently leaked Supreme Court draft opinion in the Dobbs v. Jackson case (disputing a 15-week gestational age limit in Mississippi) strongly suggests the Supreme Court is posed to overturn Roe v. Wade at any moment (Compton and Greer, 2022). Since enacted, 1,338 state-level abortion restrictions have been put in place to overturn Roe, with almost 44% of them introduced in the past decade alone (Guttmacher, 2022a). These restrictions vary from gestational age limits, mandated counseling designed to dissuade people from having an abortion, unnecessary waiting periods, and burdensome physician and hospital requirements (Guttmacher, 2022c). Evidence suggests that restrictive abortion policies disproportionately affect historically vulnerable groups (including Black and Latinx women, lower-income people, and younger people) and contributes to existing racial and social inequities (Upadhyay, 2018).

According to the Guttmacher Institute, approximately 18% of pregnancies end in abortion, and about one in four (24%) women[1] in the US will have an abortion by the age of 45, making this a quite common procedure (2019). Most recent findings from the Guttmacher Institute show that medication abortion accounted for more than half (54%) of US abortions, making a significant jump from 39% in 2017 (Guttmacher, 2022b). Medication abortion (MA) is an abortion method where two medications, mifepristone (also known as Mifeprex) and

[1] We acknowledge that abortion care is not only for cisgender women, but also includes non-binary, gender non-conforming, and trans people. Throughout this manuscript, we use the terminology of each study cited (i.e., if they only included cisgender women and use the term women, then we use that term when describing their findings).

misoprostol, are taken together to safely end a pregnancy up to 70 days gestation or less (Donnovan, 2018; Guttmacher, 2021). Since the Food and Drug Administration (FDA) approval in 2000, MA has had a significant increase in utilization (Donnovan, 2018). Findings show that abortion patients early enough in their pregnancy (10 weeks or less) chose MA over other traditional methods such as aspiration or dilation and evacuation (D&E) (Guttmacher, 2019).

The distribution and use of mifepristone have been restricted under the FDA's Risk Evaluation and Mitigation Strategy (REMS) Program since 2011 (FDA, 2021). In 2016, the agency approved a new protocol based on extensive clinical research demonstrating the safety; however, it still limited the distribution of Mifeprex to patients only in clinics, hospitals, or medical offices under the supervision of a certified prescriber and could not be sold in retail pharmacies (FDA, 2021). Although data suggests MA has steadily been increasing over time, the COVID-19 pandemic undoubtedly accelerated that trend as it highlighted the need to adopt innovative practices to continue providing comprehensive care while keeping patients safe from exposure (Guttmacher, 2020).

To support the continuum of care during the public health emergency, the Department of Health and Human Services (HHS) took significant action to promote the use of telemedicine. Telemedicine – sometimes called telehealth — lets a doctor provide health care online primarily through a computer, tablet, or smartphone (HHS, 2022). With abortion care, telehealth can be used to provide comprehensive assessment, counseling, and follow-up care for medication abortion with similar rates of safety and effectiveness to in-person care (Anger, Raymond et al., 2021; Grossman and Grindlay, 2017; Kerestes et al., 2021; Thompson et al., 2022). In the spring of 2021, the Biden administration and FDA temporarily lifted the in-person requirement of mifepristone and allowed people to receive abortion pills by mail via telehealth (Belluck, 2021).

Even before the expansion of telehealth during COVID, studies have suggested that patients who received their abortion pills via telemedicine and mail had a complete abortion with little to no adverse outcomes (Anger, Raymond et al., 2021; Grossman et al., 2011; Grossman and Grindlay, 2017).

On December 16, 2021, the FDA determined that the evidence supporting the safety and benefits of removing the in-person dispensing requirements outweighs the risk and permanently allowed abortion pills to be dispensed by mail via telehealth (FDA, 2021). Unfortunately, anti-choice activists and legislators saw this as an opportunity to attack and quickly acted to strip individuals of their right to privacy and access to care.

Problem Statement

Access to safe abortion is declining in the United States, especially in the South (Guttmacher, 2022b). Although constitutionally protected under the Supreme Court decision of *Roe v. Wade*, the fundamental right to abortion is under assault. With the new FDA ruling allowing MA pills to be dispensed via mail, states have proposed legislation to ban the telehealth delivery of MA. In Georgia legislators and anti-choice leaders immediately introduced Senate Bill 456 (SB 456). SB 456 prohibits mailing abortion pills to patients or prescribing them through a pharmacy, requires an in-person exam and ultrasound, requires that the pills be administered in-person at the clinic by a qualified physician, encourages medically inaccurate information, and requires an in-person follow-up visit (Prabhu, 2022). In sum, SB 456 presents many restrictions to care, particularly for communities that already experience barriers to access, including Black, Indigenous, people of color (BIPOC) women, young adults, the lesbian, gay, bisexual, trans, queer, intersex and asexual (LGBTQIA+) community, immigrants, and rural

individuals, making this bill unnecessarily cruel, harmful, and oppressive (Anger, Raymond et al., 2021).

Women of color have historically experienced complex systems of oppression based on their intersecting social identities (race, ability, class, gender, sexuality, age, and immigration status) and the combined influence of white supremacy, patriarchy, and capitalism (Ross, 2017). This intersectional theory is the foundation of Reproductive Justice (RJ), a framework and social movement to examine and dismantle injustices by promoting the universal human rights to have children, to not have children, and to parent one's children with health and dignity free of oppression and coercion from individuals or states (Ross, 2017 & 2021). Although abortion access remains the central focus within reproductive rights groups, RJ provides a wider conceptual lens to better understand the intricacies of systemic inequalities that shape people's decision-making around parenting and childbearing, especially Black and Latinx women. This includes abortion but also resources needed for childbearing and parenting such as infertility care, paid parental leave, and police reform (Ross, 2017). In a partnership with a local HIV/AIDS and RJ community-based organization (CBO), SisterLove, this special study utilizes the RJ framework and community organizing approach to center the voices and experiences of Black and Latinx women to dismantle forms of reproductive oppression that threaten optimal well-being and bodily integrity for all people in Georgia.

Purpose Statement

Founded in 1989, SisterLove is the first women's HIV/AIDS and RJ organization in the southeastern United States dedicated to educating, preventing, and advocating for women at risk for or living with HIV/AIDS. The purpose of this special study project is to create an advocacy

toolkit designed to support the safety of telemedicine and MA and amplify the voices and experiences among Black and Latinx women in Atlanta, GA. The objectives for this project are:

1. To conduct a secondary analysis of the community-led GAMA study data to explore medication abortion stigma among Black and Latinx women in Atlanta, GA
2. To create an advocacy toolkit outlining the evidence of telemedicine abortion safety and efficacy for use by RJ and other policy advocacy groups

Significance Statement

The U.S. Supreme Court is poised to overturn Roe v. Wade at any moment, making access to early abortion via telemedicine more urgent than ever. Moreover, the United States is notorious for its dehumanizing practices of white supremacy that control the female body and reproduction, particularly among Black and Latinx women (Ross, 2021). Historical and contemporary accounts of population control and eugenics (e.g., forced sterilization of low-income and incarcerated people, sexual assault, and control of enslaved women) are inextricably linked to the health outcomes and social inequities we see today and are at the core of RJ activism. Considering the historical reproductive injustices against communities of color, it is critical to employ research and policy advocacy models that center communities and position them to overcome structural power inequalities in comprehensive and transformative practice. This Special Topics Project utilizes community-led research by women of color to protect telemedicine abortion access in Georgia and beyond. Ultimately, access to safe abortion care reduces the risk of maternal mortality from unsafe abortion or pregnancy-related complications and reduces negative health and social outcomes that occur when someone is denied a wanted abortion. These include increased risk of the pregnant person and their children living in poverty,

increased risk of living in a violent relationship, and increased mental health consequences such as anxiety (Foster, 2020).

Definition of Terms and Abbreviations

Community-based Participatory Research: A method that emphasizes the importance of joining with the community as full and equal partners in all phases of the research process and integrating their experiential knowledge to address social and structural inequities (Israel et al., 1998)

Intersectionality: The critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age are not mutually exclusive entities but operate as reciprocal phenomena that shapes complex social inequalities (Collins, 2015).

Knowledge Justice: A framework to decolonize research that centers communities' expertise in navigating and thriving in oppressive systems through the right to research, the right to know, the right to be seen, and the right to be heard (CCC, n.d.).

Medication Abortion: An abortion method where two medications, mifepristone, and misoprostol, are taken together to safely end a pregnancy up to 70 days or less (Donnovan, 2018; Guttmacher, 2021).

Reproductive Justice: A positive approach that links sexuality, health, and the human rights to have children, to not have children, and to parent children with dignity in a safe environment to social justice movements. This approach places abortion and reproductive health issues in the larger context of the well-being and health of women, families, and communities (Ross, 2006).

Structural Violence: A concept framed by Dr. Paul Farmer describes the suffering and harm intrinsically embedded in large social structures that intentionally produce differences of power, wealth, privilege, and health that are unjust and unacceptable (Farmer, 1996).

Telemedicine (or Telehealth): A model of health service delivery where providers and patients can interact in real-time, primarily through a computer, tablet, or smartphone (HHS 2022; WHO, 2022)

Toolkit: A collection of adaptable resources for front-line staff that enables them to learn about an issue and identify approaches for addressing them (American Library Association, n.d.)

Abbreviations

Black, Indigenous, People of Color (BIPOC)

Food and Drug Administration (FDA)

Georgia Medication Abortion Study (GAMA)

Lesbian, Gay, Bisexual, Trans, Queer, Intersex, and Asexual (LGBTQIA+)

Medication Abortion (MA)

Reproductive Justice (RJ)

Senate Bill 456 (SB 456)

Chapter 2: Literature Review

Reproductive Justice

Women of color have advocated for theoretical and social organizing frameworks that encompass the interconnectedness of race, class, gender, and sexuality in order to dismantle social inequalities (ACRJ, 2005; Luna and Luker, 2013). In 1994, twelve Black feminists coined the term "reproductive justice" to recognize the lack of representation in the mainstream (White) feminist movement (that only emphasized reproductive rights to contraception and abortion) (Ross, 2017) and the need to work towards a larger goal of women and community empowerment (ACRJ, 2005). The ongoing fight for reproductive liberation is a response to historical and contemporary accounts of individuals, institutions, and society controlling women's bodies and reproduction through multiple systems of oppression, including racism, heteropatriarchy, and capitalism. BIPOC women have faced compounded institutional disadvantages that have produced "an actual experience of domestic violence, rape, and remedial reform qualitatively different from White women" (Crenshaw, 1994).

Population control, experimentation, and exploitation have had an intergenerational impact on communities of color, and they have evolved into modern systemic practices such as hostile immigration restrictions, disproportionate incarceration, and reproductive coercion by judges and prisons (ACRJ, 2005). Namely, the control of Black women's fertility during slavery and its manifestation of overt harm, negatively upheld social stereotypes of Black motherhood, persistent racial stigmatization, and systemically intentional economic oppression have been forced upon the Black community (Ross, 2017; ACRJ, 2005). Through acts of coerced sterilization, abuse, and colonization, the Indigenous community was imprisoned in a genocidal strategy and unjustly displaced from their land and this country's history (ACRJ, 2005). The

eugenics movement promoted targeted policies to restrict reproduction and achieved population control among the most marginalized communities who were socially deemed "undesirable" or "unfit to parent" (ACRJ, 2005; Luna and Luker, 2013). Dehumanizing practices continued and evolved, particularly among immigrants, where Latina women are still experiencing sterilization involuntarily at higher rates (Fleming and Lebron, 2020). Additionally, potentially dangerous contraceptives were systemically pushed on lower-income young women of color, further perpetuating harm.

Reproductive justice transformed the consciousness and praxis of articulating the demand for holistic reproductive and sexual human rights (ACRJ, 2005; Ross, 2017). Moving beyond the "pro-choice" movement, RJ highlights the unique challenges of BIPOC women and promotes the universal right of reproductive integrity and self-determination (ACRJ, 2005; Luna and Liker, 2013; Ross, 2017). RJ acts as an intersectional framework for community organizing and movement building as well as a social theory of change (Luna and Luker, 2013; Collins, 2015). Intersectionality as an individual framework has gained much attention in academia; however, RJ has limited application focused on understanding marginalized women's experiences, especially experiences of accessing abortion. Findings from a study investigating women's perceptions of cervical cancer screening prevention emphasized the importance and benefit of applying an RJ approach to better understand the intersection of race, class, and gender and how it contributes to existing disparities in treatment (Sundstrom et al., 2019). Furthermore, a study using RJ as a conceptual framework exploring rural health disparities in South Carolina found that racial and cultural norms heavily influenced insufficient access to health care and attitudes towards health (Smith et al., 2019).

Abortion Stigma

Abortion stigma is a complex phenomenon significantly influenced by contextual factors and cultural constructs. Kumar et al. (2009, p. 628) defines abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood." Women seeking and having an abortion are seen as challenging the gendered norms and widely held assumptions that abortion is immoral, murderous, selfish, and dirty, and the desire to be a mother is key to being a "good woman" (Kumar et al., 2009, p. 628).). These beliefs also imply that women should only have sex if they intend to procreate, interpreting sex and pleasure as "illicit" (Norris et al., 2011). Furthermore, abortion stigma is a multi-level and socio-interactional theory, meaning it can be expressed in various forms and affects a range of individuals and groups. Those connected to abortion and may be susceptible to stigma include people who have abortions, abortion care providers and workers, and supporters of women who have abortions (e.g., significant others, advocates, and researchers) (Cockrill and Nack, 2013; Kumar et al., 2009). Marginalized groups such as women of color and low-income women often experience *intersectional* stigma, which goes beyond general abortion stigma, and considers the socio-cultural and historical factors contributing to current attitudes, behaviors, and health outcomes (Earnshaw and Kalichman, 2013; Mosley et al., 2019; Mosley et al., 2020). Intersectional stigma has yet to be comprehensively explored in the context of abortion access.

Cockrill and Nack's (2013) theoretical framework suggests that stigma can be *internalized* when a woman has accepted the negative cultural values of abortion, or it can be *felt* which is a result of assessing others' abortion attitudes or *enacted* which is clear or subtle actions that reveal prejudice (i.e., emotional abuse, discrimination, hate speech). Although stigma is experienced differently across those connected to abortion, it all manifests through the same

veins of public opinion and mass culture, governmental and structural policies, institutional influences, and community and individual factors (Kumar et al., 2009). Women who have abortions are likely to follow the "implicit rule of secrecy," where they are expected to suppress their experiences to manage their reputations and sense of self-worth (Cockrill and Nack, 2013; Norris et al., 2011, p. 4). Providers' exposure to stigma may be continual as their work is closely tied to their identity but can result in professional difficulties with anti-abortion colleagues, fears about disclosing one's work in social settings, and burnout (Norris et al., 2011). Likewise, family and friends may experience a "courtesy stigma" due to their association with someone who had an abortion (Norris et al., 2011, p. 6).

Notably, stigma requires a power imbalance such that there is a stigmatizing group/individual (with relatively more social power) and a stigmatized group/individual (with relatively less social power) (Link and Phelan, 2001; Norris et al., 2011). More specifically, abortion stigma is sustained through inequitable access to power and resources (Kumar et al., 2009). Legal restrictions and policies (i.e., parental consent requirements, gestational limits, waiting periods, and mandated ultrasound viewing) intentionally make it more difficult for people to access abortions and reinforces the idea that abortion is morally wrong (Norris et al., 2011). Research shows that the more severe restrictions are, the more likely unsafe abortions will occur, increasing mortality and morbidity (Singh, Wulf, Hussain, Bankole, & Sedgh, 2009). Additionally, the anti-abortion movement utilizes stigma as a tactic to create barriers to care and influence cultural values, beliefs, and norms so women would be less likely to seek an abortion, regardless of its legal status (Norris et al., 2011).

Hostile and restrictive abortion environments (i.e., policy and social attitudes) perpetuate abortion stigma, which then perpetuates negative policies and harmful social norms. This

happens because policies influence normative behaviors, create negative stereotypes, lead to social judgment, and normalize nondisclosure among women who have abortions (Baum et al., 2016). This is especially true in Southern communities, which are highly religious and racially/ethnically diverse. Smith et al. (2016) discuss the implications of the hostile Southern abortion climate, specifically the influence of Christian religiosity on pregnancy decisions and abortion experiences. For example, while researchers have found that Black and Latina women in Texas were more likely than white women to use abortion pills to manage their abortion, they also faced substantially more barriers due to restrictive policies and hostile abortion attitudes (Baum et al., 2016).

Medication Abortion

Medication abortion is a low-risk, easy-to-follow, noninvasive abortion method where two pills are taken together to safely end a pregnancy up to 70 days gestation. It accounts for more than half of all abortions in the United States (Guttmacher, 2022b) and is a fundamental element of women's health care (Black & Bateson, 2017). A National Academies of Sciences, Engineering, and Medicine committee recently reviewed all available data on abortion methods and clinical circumstances and confirmed that MA is safe and effective (2018). Nonetheless, mifepristone, the only pill approved by the FDA for MA, was heavily restricted under the FDA REMS and hindered access to potential patients. A 2017 expert panel suggested that the REMS was inconsistent with mifepristone's safety record and placed an unfair burden on those seeking MA (Raymond et al., 2021). For example, the World Health Organization recommends that general practice physicians, nurses, and midwives administer MA; however, previously upheld the REMS protocol only allowed certified physicians to provide MA in specified settings (Guttmacher, 2022b). Fortunately, after further conducting an independent review of the REMS

Program for mifepristone, the FDA determined that the data supported protocol modification to reduce the burden on patient access and the health care delivery system and ensure the benefits outweigh the risks. The modifications to the Mifepristone REMS Program removed the requirement to be dispensed in limited specific settings and allowed pharmacies to prescribe MA (FDA, 2021).

Telehealth for Medication Abortion

The recent growth of telemedicine in diverse health care settings has proven that it is an effective and valuable tool for expanding access to care, improving health outcomes, and reducing health care costs. TelAbortion is a prospective trial that began before the COVID-19 pandemic that compared outcomes among patients who received pre-abortion ultrasound and pelvic exam before a MA via direct patient-to-patient telemedicine and mail to those who did not (Anger, Raymond et al., 2021). Their results showed that 95.6% of patients had a complete medication abortion with pills alone, and there was no statistical difference between the groups regarding adverse events or serious outcomes (Anger, Raymond et al., 2021). Thus, this study supported the continued success and safety of providing medication abortion care via telemedicine and mail. Additional studies suggest that the use of telemedicine to deliver MA indicates that the effectiveness and acceptability of telemedicine for medication abortion were similar, with Grossman et al. (2011) reporting a slightly higher success rate for telemedicine vs. clinic patients and Grossman and Grindlay reporting slightly lower rates of adverse events among telemedicine vs. clinic patients (2017).

Research indicates that Black, Latinx, and low-income individuals have higher rates of abortion due to systemic and racialized inequities while simultaneously experiencing lower access to abortion services (Thompson et al., 2021). Reduced access to abortion for these groups

results in disproportionately higher experiences of adverse outcomes such as increased financial insecurity, reduced aspirational life plans, and increased incidence of severe pregnancy and postpartum complications (Thompson et al., 2021). The utilization of telemedicine for MA is an opportunity to not only address existing disparities and alleviate barriers like costs, distance to clinics, and lack of transportation and childcare but also decreases the risk of unsafe self-managed abortion (Thompson et al., 2021; Verma and Shainker, 2020).

Chapter 3: Methodology

The Georgia Medication Abortion (GAMA) Study

The Georgia Medication Abortion (GAMA) study, led by an HIV and RJ organization SisterLove and supported by a team of researchers from local universities in Atlanta, sought to explore Black and Latinx women's perceptions, experiences, barriers to, and facilitators of MA through in-depth interviews and focus group discussions (Mosley et al., 2021). The entire research process applied community-based participatory research (CBPR) and RJ principles from conceptualization to dissemination. CBPR is a method that emphasizes the importance of joining with the community as full and equal partners in all phases of the research process and integrating their experiential knowledge to address social and structural inequities (Israel et al., 1998).GAMA implemented oversight and guidance informed by the Community Advisory Board, which included abortion clinics and advocacy groups, community-based organizations (CBO) serving Black and Latinx communities, faith leaders, researchers, and Black and Latinx women from metro Atlanta (Mosley et al., 2021).

I.1 Study Setting

This GAMA study was conducted in metro Atlanta, where structural and social inequities disproportionately affect Black and Latinx communities. In Georgia, nearly one in five Black and Hispanic people live in poverty, and approximately half of all counties in the state have no obstetrical care or physicians, particularly in rural areas (Center for Reproductive Rights, 2019; Grady Newsource, 2020). These inequities in resources and information manifest in poor maternal and infant outcomes and alarming disparities. For example, Georgia is ranked 49th for maternal mortality rates and labeled "the most dangerous state to be pregnant in" (Grady Newsource, 2020). Black women are 3.3 times more likely to die from pregnancy-related

complications than white women, and Black babies are twice as likely to die compared to their counterparts (Center for Reproductive Rights, 2019; Grady Newsource, 2020; Twagirumukiza, 2019). Latina women also face similar outcomes and experience unique barriers to care due to socio-cultural stigma, immigration enforcement, and language barriers (Mosley, 2021; Center for Reproductive Rights, 2019). Data from 2014 suggests that more than 1.2 million women in Georgia needed contraceptive services, and more than a third of women who gave birth reported that their pregnancies were unwanted or mistimed. Furthermore, Georgia lacks a mandate for comprehensive sexual education and allocates over $2 million annually in the state's budget to fund Crisis Pregnancy Centers and programs that are not evidence-based and ultimately prevent individuals from accessing medically accurate information about their reproductive health options (Center for Reproductive Rights, 2019; Twagirumukiza, 2019). Despite legislative and structural efforts preventing individuals from accessing the essential health care they need, the state has a unique and robust presence of RJ activism and grass-root collaboratives working together to fight for reproductive justice, freedom, and liberty for all (SisterLove, 2019) making this an ideal area to investigate experiences and perspectives of MA.

I.2 Participant Recruitment and Data Collection

Data were collected in two phases over the timeframe of April 2019-December 2020. The first phase conducted semi-structured key-informant interviews with abortion providers and leaders of CBOs serving Black and Latinx communities across the metro-Atlanta area. Key informants were recruited by email from local abortion clinics, partnering CBOs, and members of the Community Advisory Board. The second phase conducted in-depth interviews and focus group discussions with Black and Latinx women recruited through abortion clinics, CBOs, social media, radio advertising, or flyers in the community. To be eligible for the study, participants

had to identify as Black or Latina, be 18 years or older, and live in the metro-Atlanta area. In sum, GAMA conducted 15 in-depth interviews with Black women, 15 in-depth interviews with Latinx women, 3 focus groups with Black women (n= 4, 4, and 5), and 3 focus groups with Latinx women (n= 8, 5, and 4). Interviews and focus groups lasted up to an hour, and all participants received a $30 gift card for participation (Mosley et al., 2021)

3.3 Data Analysis

The GAMA study team used Dedoose, a qualitative and mixed methods research platform, to analyze interview and focus group transcripts using a Sort, Sift, Think, Shift protocol that applies multiple approaches to qualitative analysis (Maietta, 2011) With permission granted to access, analyze, and disseminate results from the data collected through GAMA, this thesis conducted a secondary data analysis by reviewing all de-identified interview transcripts to further familiarize the data and existing analysis. This project applied similar protocols found in the parent study and explored relevant themes to answer the following research questions, using RJ as a conceptual lens:

1. What are Black and Latinx women's perspectives and experiences of medication abortion?
2. How do Black and Latinx women conceptualize abortion stigma and support in their communities?

Following the thematic and narrative analysis procedure, this project developed analytic memos and summaries and identified notable quotes to illustrate the lived experiences and perspectives of MA among Black and Latinx communities in metro Atlanta. Codes further investigated included abortion attitudes and beliefs, abortion stories, abortion stigma and support, and social norms and culture surrounding abortion.

Participant Observation of Health & Human Servies Committee Hearing

In addition to a secondary analysis of the GAMA data on medication abortion stigma, I also conducted participant observation of the Health & Human Services Committee Hearing at the Georgia State Capitol on February 9, 2022. The Committee on Health & Human Services has general authority over health care and social services legislation in the Georgia General Assembly. This committee also addresses healthcare professionals' licensing and regulation (Georgia General Assembly, 2022). In order for the committee to have a bill become a law, it must go through a process that involves **six** steps illustrated below. After the authoring legislator has announced the bill, the bill will be sent to the Office of the Legislative Council, where an attorney will assist with terminology and formatting. Then, if the legislator is a Senator, the bill is filed with the Secretary of the Senate. If the legislator is a Representative, they will file the bill with the Clerk of the House.

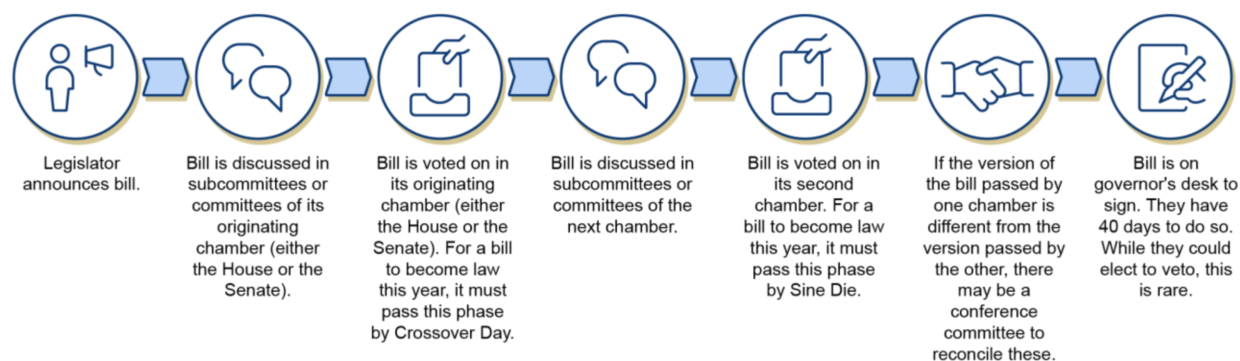

Figure 1. Steps for a Georgia Bill to become Georgia Law

On February 9, 2022, The Committee on Health and Human Services met to discuss the newly proposed SB 456 (see Appendix A), authored by Senator Bruce Thompson. The purpose of this hearing was to introduce and vote on legislation that would further restrict access to abortion by banning telehealth as a mode of delivery. Local RJ policy and advocacy organizations called for volunteers to attend the committee hearing or testify against the

proposed legislation to show collective opposition. Despite the significant amount of support and the proven misinformation rooted in the legislation, the bill passed through the Committee and moved forward for a full vote in the Georgia Senate (where it also passed) and then moved onto the next chamber (where it did not pass).

Developing the Toolkit

Reproductive justice leaders and policy advocates—including SisterLove, Amplify Georgia, Access Reproductive Care-Southeast, and Feminist Women's Health Center—expressed the need to amplify the evidence surrounding the safety and efficacy of MA and telemedicine. Local researchers, volunteers, and community leaders determined that developing a toolkit outlining the data to support MA and telemedicine in Georgia would enable a rapid response to disseminate critical information to volunteers and advocates, and legislators. The materials in the toolkit would intentionally magnify the potential ramifications of outlawing telemedicine for abortion in Georgia and present the existing data in a concise and digestible manner. Developing the toolkit consisted of an iterative process of peer reviewing and adapting information as new tactics were presented by opponents. In sum, this unique special project initiated the development of community-informed materials that would support community priorities and advocacy strategies during the legislative session.

Chapter 4: Results

The original intention of this special studies project was to amplify the voices and experiences of Black and Latinx women[2] accessing MA in Georgia. The goal was to explore the stigma around MA more deeply and understand how stigma is perceived and enacted in Black and Latinx communities. Those results are presented below in Section 4.1. However, in February 2022, SB 546, ironically titled the "Women's Health and Safety Act," was introduced in the Georgia legislature. Thus, this project expanded to include Participant Observation at the hearing (see Section 4.2) and a Toolkit (Fact Sheet and Literature Review) because collecting evidence and delivering that in a digestible way to legislators became a top priority of RJ policy advocacy groups. The Toolkit is presented in Section 4.3 and Appendix B.

4.1 GAMA Study Findings

When exploring data on abortion stigma, four major themes were identified among Black and Latinx participants.

1. *Abortion Stigma is Intersectional*

First, data suggest that individual-level experiences of abortion stigma are intersectional, meaning that experiences vary based on socioeconomic status, racial identity, gender, age, sexuality, and even religious affiliation. One Latinx participant alluded to the influence of their cultural and social background and the risk of being judged by family compared to other members who may not have the same educational and economic background.

> *"It's, you know, if it was me or if it was my situation I think my tías would be like…they wouldn't judge me because compared to my other cousins, they never like went to college, didn't graduate…I think they'd be more forgiving but if it was like one of my cousins who like didn't graduate or still has a part-time job at like a retail, then they'd be*

[2] In this study, we focus on cisgender self-identified "women." We acknowledge that people of all genders access and need abortion care, however the experiences of transgender, non-binary, and gender non-conforming people are outside the scope of this project.

more judgmental, and they'd be like, "Oh, you know, well, she's this type of girl, and what did you expect." I think it depends on the individual how my tías would take it. Yeah, but overall, I think my tías would be disappointed, they'd be like, "Why, why did you do that, like you have this network of people that could have helped you." - 26-year-old Latinx woman

Other stigmas from unintended pregnancy, teenage pregnancy, sexuality, and motherhood influence community perceptions of abortion. One Black woman shared how her community has internalized misogyny and further allowed it to shape their perception of Black sexuality and reproduction.

"I would say one thing that has really shaped it is like I've really seen how stigmatized getting pregnant is because you know in black communities there's the stereotype of the teenage pregnancy, the pregnant you know single mom, that stereotype is so strong, and it's so stigmatized. But it also, but it's always this place of tension for me because like getting pregnant is stigmatized, but also having an abortion is stigmatized. So that's why I kind of just always felt like no matter what, a woman exercising her – exercising any control over her body is something that she's going to see people be upset over. So I kind of felt like based on that like women should be able to – like no matter what you do, misogyny is so strong, and people are in such a belief that they should be able to control your body, that somebody is going to be mad that you're not doing with your body what they want you to do." -24-year-old Black Woman

The same participant described the "criminalization" of Black women and their reproduction and how community expectations and norms further contribute to stigma and attitudes around abortion and sexuality.

"Also, I think it's less about the abortion and the pregnancy and more about this criminalization of folk's sexuality, especially the sexuality of Black women. I feel it has to do more with that fear and that, "Oh, you're not supposed to do this or else, you're that." Just this thing of, "Oh, you shouldn't be having sex in the first place," type of idea that's pushed out. Then that lead into a pregnancy and then leading to an abortion. I think the abortion piece of it has to do less with actually being pregnant and whatnot and more to do with this thing of, "Oh, girls shouldn't have sex, blah, blah, blah. You all should keep your legs closed. You should do this. You should do that. This is what a proper woman does."

All those messages just messes, and it makes it difficult to take care of a pregnancy in the way that we want to take care of pregnancy, whether we want to keep it or get rid of it, or

adopt, or do whatever. It just messes with all that because we're not able to be sexually whole people." -24-year-old Black Woman

Black and Latinx participants also discuss the role of stigma when trying to access services and resources and how difficult it may be, especially for those from communities disadvantaged by multiple systems of oppression, including racism, poverty, and misogynoir.

"I think it would be harder for minorities like Blacks and Latinos, yeah, that's the whole part of this conversation, I think we have to think about like the culture, and there's already like so much stigma about like the welfare queen and all these other things that they would make it so much harder…I mean, we can't even access birth control like easily, so imagine like an abortion pill [laughs]. Especially for Black and Latina women that are predominantly in low-income working-class like they think it's harder, they think it's more expensive, there'd be so much stigma around it if you have access, if you do have access to it, yeah, sadly, I don't know, I'm sad."-26-year-old Latinx Woman

2. ***Abortion Experiences and Attitudes are Contextualized by Historical and Ongoing Racialized Trauma***

In addition to experiencing intersectional stigma and oppression, participants' stories demonstrated the presence of ongoing trauma that has manifested from historical injustices rooted in white supremacy. One participant described how abortion bans and restrictions are products of larger systems of gender, racial, and economic oppression.

"I feel like it's made me more confident in my decision to have a medication abortion. Just seeing the type of people who are pushing these agendas, these anti- legislations throughout the country, it's just like, "This is disgusting. This is another form of white supremacy at work. I'm not going to like fall into this trap. I'm going to advocate for it regardless, and no one can say whatever about it. You do not control my body. Your people have controlled our bodies for way too long. I'm not going to allow your stigmatization and all these scriptures that you bring up that you don't even follow yourself to basically control how I move and what I decide to do with my body."-24-year-old Black Woman

A Latina abortion provider expressed the trauma and fear her community has when it comes to surgeries, where women are scared to be put to sleep and not wake back up and often ask if "cutting" is involved.

"When it comes to the Latina community (pause), it could go both ways depending on the circumstances. I do overall feel like they would prefer medical simply because most

> *Latinas will say I don't want to be put to sleep. They are scared of not waking up. Second is because there are scared, because, when you say surgery…surgical…they always ask is there cutting involved, that is typical common question we get.* – 30-year-old Latinx Woman

One participant expressed the fear of not knowing the long-term effects of what will happen to her body after taking MA and does not trust its safety because of the history of being "experimented" on.

> *"...probably the fear of...this being like... a trial basis, you know, not knowing whether it would be safe. So, if I'm terminating the fetus from medication, what is that doing to my body? Would I eventually have cancer later down the line, would I eventually not be able to conceive again, you know just with these experiments, experiments, experimentation sometimes is the reason, especially all ethnic group, they don't really like those things. So, when you talk about the syphilis case with the Tuskegee experience and things like that, a lot of times we're being used... and then you have issues where they were doing an experiment, and they were leaving women—Black women—sterile."* -35-year-old Black Woman

Participants also shared experiences of being coerced into having a surgical abortion instead of MA because of the doctor's perception of her identity (i.e., implicit bias). One Black participant discussed how the doctor did not provide adequate information about other options of care and ultimately "made the decision" for her.

> *"I guess a couple of years ago, I had an abortion, and they didn't give me too much information about the two types. They just said, 'Okay, well, this is the only option,' and I didn't know that there was another option until much, much later. I actually researched it, and I saw that there was another option, and I would have asked for a medical abortion. So, I guess like doctor's just like, "Oh, this is the only--" They didn't present all the options to me."*-27-year-old Black Woman

3. Personal Beliefs Do Not Necessarily Dictate the Need for Restriction for Others

Participants, particularly Black women, emphasized that their own personal beliefs about abortion should not dictate policies or other people's choices about their pregnancies.

> *"We, it's very mixed, ah, very mixed emotions when it comes to abortions. ... even those that may not have had an abortion because they don't believe in it, they still believe that a woman has a freedom of choice, whether or not, you know, she wants to have an abortion*

> *or not....So...it's a mixture... If I would say the majority... will probably be against having an abortion, but be for, they would be for a woman having a choice if that makes sense."* -49-year-old Black Woman

Black and Latinx participants also acknowledged how religion, particularly Christianity in the South, contributes to abortion stigma. However, some participants also shared that they may be religious or spiritual but do not have negative views on abortion or, at least, do not impose those religious beliefs onto others. One Black focus group participant said,

> *"I'd say for religion, it's a hard one because my upbringing was very Christian, very Southern, Baptist, so that's where a lot of the views about negative views about abortion came from. Now that I've shifted into being more open-minded… there's still that balancing act of I'm still a spiritual person who believes in my faith, but there's still elements that I don't believe in them, one of them being that abortion is wrong, and you're going to be banished to hell and ask for forgiveness, all these negative things about a woman who chooses to abort. Oftentimes, in some church services that I've chosen not to go to that church anymore, they will say, thank God for the woman who chose to have her baby and struggled through it and making it out. Then the woman sitting next to her, who may have chosen to terminate, what are you saying about her? Is her life not worth anything because she didn't choose to go through a struggle, she knew she wasn't able to handle at that time? It's shaped a lot of my mindset, and it's almost made me, I don't want to say resent the church, but there's just so many times I want to shake some people."*

4. Communities Define Appropriate Solutions for Destigmatization

Black and Latinx participants suggested different solutions to destigmatize MA within their communities, such as integrating MA into different clinical settings (i.e., primary care, public health, and community-based clinics).

> *"If they go see their doctor for something, and they feel comfortable talking about it with their doctor so that they don't have to go to a separate clinic... you have that option. I think that would also make it easier as well and less stigmatizing. They're here, they're at their doctor's office for...whatever it may be or something else, and their doctor prescribes them the medication abortion. I'm really just thinking about my family and my network just because you're not being seen at a specific abortion clinic. These are just ways that will just make it seem like it's for something else, like a routine check-up or something*."- 26-year-old Latinx Woman

Participants also expressed that sharing stories in trusted community spaces can help address stigma and the mistrust between Black/Latinx communities and abortion providers. One Black focus group participant shared,

> *"I'm a woman who was glad to come forward to tell my story because, I think those people, they're big and bad enough to protest because they haven't talked to someone like me...or anybody else who's had an abortion or had experience with medication abortion to learn what their specific story was. If you start matching a face and a personality and a life to this instead of just some figment of your imagination, some wanton woman...perhaps, that will end. That's my hope, and that's part of the reason why I want there to be more conversations about this because this is happening to real people...I want people to talk more about it, and I want people to have the license and the courage to come out of the dark. This is not something to be ashamed of."*

Other creative solutions to increase access included amplifying culturally appropriate messages on social media because it has "a bigger reach" (I.e., Facebook, Instagram, Twitter) and providing MA by mail.

> *"They may need to have it like blasted on some type of social media…maybe on the Twitter feed… Instagram, that's very popular for this generation and not Facebook, but maybe Facebook so that people can be aware of it. But I, I just think that…it could be integrated, but it's going to have to be talked about."* -49-year-old Black Woman

> *"There is many good resources because even online, I found a service where you can live anywhere in the world, and they will send you your medication for your medical abortion. That is a super good resource that I think is very important. They set it fairly easy. They have a discreet packaging, et cetera. I think that takes every, some half of it worldwide knowing that that service is there."* -28-year-old Latinx Woman

> *"I would say through the mail. I think through the mail is so convenient. I don't have to talk to anybody. I don't have the big worry about picking it up. It just comes in the mail... I think by mail would be a really amazing way."*—22-year-old Black Woman

4. 2 Participant Observation Results

When participating in the committee hearings, we concluded that stigma is evident in the abortion policy-making process and is largely detached from scientific evidence. Participating in person for the first committee hearing was also notably more emotionally exhausting and taxing than attending the second one virtually. For example, committee members changed the time of

the first hearing as a tactic to demobilize the many policy advocates and volunteers who showed up in solidarity with local RJ organizations. The first hearing started with an intentionally stigmatizing prayer, whereas the virtual hearing (with fewer in-person participants) did not. Audience members of the first hearing were told to act with "great decorum and respect," or they were threatened to be removed and arrested if they expressed any emotion or reaction in opposition to the bill seeking to restrict abortion access for Georgians. This statement felt very tied to the White legislator's perceptions of the audience's various racial and gender identities.

During both committee hearings, audience members had the opportunity to share testimonies to support or oppose the bill. When participating in the first hearing, members and advocates who opposed the bill were not given the same amount of time, respect, and dignity as those who supported the bill. For example, Dr. Mosley—an RJ advocate, researcher, and member of this Special Topics Committee—tried to provide evidence-based science related to MA and telemedicine, but she was not allotted the entire two minutes and was forced off the stand because she "obviously opposed it [SB 456]." Even when she had another opportunity to testify at the second hearing in the Georgia House of Representatives, some committee members did not acknowledge her remarks or credibility as a social scientist and continued to sway the conversation in their favor. Another RJ leader attempted to highlight how the Georgia legislature continues to deny the fundamental right to care and was rudely and condescendingly told to stop speaking and leave the stand. Fortunately, Staci Fox, former President, and CEO of Planned Parenthood Southeast, shared her testimony with no interruptions and stayed below the allotted time limit.

> *"I just want to take my time to just highlight one thing about this bill in case you don't remember. I'd like to take you back to 2019, when the legislature and the governor passed HB 481 and signed a six-week abortion ban into law in the state of Georgia. We*

are also imminently waiting for a decision from the supreme court related to the Jackson Women's v Dobbs case. This bill is nothing but a performative bill in the middle of an election year. Abortion has already been decided by this state, so there is no reason for y'all to be wasting tax dollars and taxpayers' time on debating a bill like this. Thank you." -- Staci Fox, President, and CEO of Planned Parenthood Southeast

Toolkit Product

The "Telemedicine and Medication Abortion in Georgia" toolkit consisted of a fact sheet with Georgia-specific data and a concise literature guide that amplified the most recent and credible evidence around the safety and efficacy of MA and telehealth (see Appendix B). Developing a strategy to disseminate this data was incredibly important during the legislative session's rapid response. SB456 was rooted in misinformation, reinforced outdated data, and stigmatized the abortion procedure by legislators who helped co-author the bill.

Through iterative peer review and adaptation as the policy landscape shifted throughout the session, the community-informed material provided volunteers, advocates, and legislators a summary of high-level talking points to help dispel many misconceptions and misinformation embedded in the bill. These talking points demonstrated how telehealth in Georgia provides safe, comprehensive assessment, counseling, and follow-up care for MA, and restricting telehealth for abortion creates an undue burden with negative health and social effects for the most marginalized communities (Appendix B). The fact sheet also outlined Georgia's maternal mortality disparities and obstetric shortage, which can worsen with restricted abortion access. The supplementary literature guide summarized the most important and relevant studies that provided recent, and up-to-date evidence legislators needed to know about MA. This included evidence from the Contraception Special Issue on Medication Abortion, which was used to change the FDA REMS regulations (Appendix B).

The community-led partnership with researchers and advocates was a unique experience and positively impacted the outcome of this harmful bill. The toolkit was utilized as an instrument for volunteers and advocates to engage with their representatives during rapid-response lobbying sessions. Most importantly, a legislator used the materials from the toolkit to combat arguments made during the second committee hearing among his colleagues who favored the bill. The Senate was poised to vote yes on SB 456 late at night on Sine Die, but it did not pass. This was likely due to both our advocacy efforts and other political factors. For example, Governor Kemp personally went to the Senate Floor demanding that an anti-trans bill be passed that prevents trans kids from playing sports with a team matching their gender identity. Ultimately, Republican legislators prioritized that bill and did not push SB456 forward.

Chapter 5: Discussion

Medication abortion by telemedicine is safe and effective (Donnovan, 2018; Guttmacher, 2021; FDA, 2021). Most recent data suggest that MA accounts for the majority of all US abortions, noting a substantial increase in utilization since 2017 (Guttmacher, 2022b). Simultaneously, the most amount of damaging state-level abortion bans of all types have been enacted within the last decade alone (Guttmacher, 2022a). With the rise of telehealth utilization coupled with federal efforts to increase access to MA by removing restrictions on mifepristone, state-level opponents are enacting burdensome and medically unnecessary requirements to further restrict access to abortion care, including MA, and disproportionately affecting the most marginalized communities (Guttmacher, 2022a; Mosley et al., 2021; Upadhyay, 2018).

Abortion restrictions and policies not only further restrict patients from receiving the care they desire and deserve, but it also reinforces negative connotations of abortion and those who are seeking (or supporting) one (Kumar et al., 2009; Norris et al., 2011). Abortion restrictions

have also been shown to further exacerbate racial and socioeconomic inequities in maternal health (Redd et al., 2021). Being denied an abortion can have devastating effects on women financially. Studies found that people who want an abortion and are denied an abortion are more likely to be living in poverty 7 years later, experience negative mental health outcomes, and remain in violent relationships (Greene Foster, 2020). MA by telemedicine can be particularly useful in hostile climates like Georgia, allowing women to end their pregnancy privately and safely outside the typical medical care setting (Guttmacher, 2022b).

The GAMA study led by SisterLove is unique as it is a community-led study examining and exploring MA attitudes and experiences among Black and Latinx women using reproductive justice as a conceptual lens (Mosley et al., 2021). The GAMA project heavily engaged and worked with the study's Community Advisory Board and community partners. The entire engagement and research process applied participatory and RJ principles from conceptualization of the study to disseminating results and identifying future research endeavors.

Findings from GAMA suggest that MA provides Black and Latinx women a safe, effective, private, and accessible option to have an abortion in the comfort and privacy of their own home. However, many multi-level barriers impede access to care, such as negative socio-cultural norms, restrictive policies, demedicalized and decentered systems of care, as well as individual and community marginalization. Abortion stigma was a salient topic that deserved deeper exploration, and this project concluded that abortion stigma for Black and Latinx women in Atlanta is a complex, intersectional phenomenon significantly contextualized by the history and generational trauma of social and racial injustice, reproductive and economic oppression, and sexual exploitation.

On May 2, 2022, a draft document was leaked from the Supreme Court of the United States (SCOTUS) voting to strike down *Roe v Wade*, and the nation was shaken with the painful idea of a world without the protected right to abortion. Before *Roe,* illegal abortions made up one-sixth of all pregnancy-related deaths, and doctors estimate that number to be higher (Guttmacher, 2003). Data shows us that attempting to prohibit abortion results in dangerous practices and disproportionately affects low-income women. For example, a survey conducted in the 1960s found that among women with low incomes in New York City who had an abortion, eight in 10 attempted a dangerous, self-induced procedure (Guttmacher, 2003).

Although the leak was just a draft document, communities across the nation mobilized and immediately fought back with nationwide rallies, protests, and marches. RJ organizations and leaders have been preparing for this moment as reproductive rights have always been on the brink of being stripped due to hostile state legislatures and policies. Namely, almost immediately in response to the SCOTUS document leak, Oklahoma passed the nation's strictest and most outrageous abortion ban yet, banning abortion from the moment of fertilization and relying on private citizens to enforce the law through private lawsuits (Zernike, Smith, and Ploeg, 2022). If Roe v. Wade is overturned, at least 26 states are expected to ban abortion completely, and over 36 million people who can become pregnant are at risk of losing abortion access in their state (Planned Parenthood, 2021).

Access to safe abortion has never been more critical. The need to amplify MA by telemedicine as a safe method during a time of structural assault and uncertainty led to the creation of the materials found within the toolkit. The factsheet and the concise literature guide outlined the importance and evidence supporting the safety and efficacy of telemedicine for abortion as well as the benefits of utilizing another mode of health care delivery. Telemedicine

for MA can alleviate many barriers such as transportation, lack of childcare, and economic constraints (Thompson et al., 2021) and must be accessible for all. A qualitative analysis of Black and Latinx women's perceptions and experiences of accessing MA within their community was conducted to further amplify and center the experiential knowledge and insight communities have in determining their liberation. Although experiencing intersectional forms of stigma and oppression, these communities identified practical solutions rooted in resilience, respect, and equity.

The community-researcher-policy advocacy partnership embodied the determination, courage, and power needed to get one step closer to reproductive justice. Listening and learning from community leaders was a key component of the policy advocacy strategy and significantly informed the team's response to enhance and strengthen our mobilization efforts as advocates. The experience included many instances of structural violence from legislators and anti-abortion advocates, as well as institutional barriers such as employers prohibiting and fear-mongering involvement in such topics and advocacies. Nonetheless, the community's strength was stronger than the fear and harm presented. Researchers who want to do similar work must be prepared for the risks that may arise, especially in hostile and volatile environments. Working inside the capitol walls is another challenge to emotionally prepare for, where not only the most underserved and underrepresented voices are constantly suppressed, but the credibility of social scientists and science as a whole is ignored and overlooked for political and personal gain. Researchers must be willing to unlearn and detach from traditional expectations and approaches

to public health academia and apply their work in new mediums to speak up for the communities their work ultimately serves to profoundly move the needle in the desired direction.

Strengths and Limitations

This special studies project has many strengths and some limitations. First, the GAMA qualitative analysis relied on secondary data. This means this project did not initially collect the data analyzed, was not involved in developing research instruments, and had to develop a research question based on what was feasible and already available. Additionally, the data collected and presented from GAMA is non-representative. This means the qualitative data findings are not generalizable to the entire state, region, or the entire Black and Latinx community. GAMA data specifically illustrates the experiences of Black and Latinx folks who live in metro Atlanta, GA, which can significantly help inform stakeholders and leaders working in this area serving these specific communities. Furthermore, the infographics may not have all the available data to support telemedicine and MA; however, it is a strategy to help rapidly deliver high-level information due to emerging policy landscapes.

Nonetheless, this project presented high-value results and materials that were easily understandable, inclusive, nonjudgmental, and utilized by the intended audience. This project made an intentional pivot in its methods in order to better respond to community needs and translate research to support evidence-based policy advocacy. By triangulating resources, summarizing peer-reviewed articles, and amplifying experiential learning resources, knowledge justice was emphasized, and communities had access to deliverables that could immediately use to support their work within the legislative session and beyond to further promote telemedicine and MA.

Lastly, as a woman of color, community organizer, public health student, and storyteller,

this special studies project was a unique and impactful experience as I seek to embed RJ in all aspects of my work. My perspectives and lived experiences prompted me to focus my entire academic career on sexual and reproductive health and provided me with a special lens and understanding while navigating the stories and experiences that were collected through GAMA and participating in community calls and rapid response efforts. Merging my personal identity with my academic pursuits was a significantly meaningful strength and produced a project centered on local organizations' needs to better serve the many communities in Atlanta to achieve justice and equity for all.

Public Health Implications and Recommendations

Abortion-related deaths are more frequent in countries with more restrictive abortion laws (Haddad and Nour, 2009). Abortion restrictions exacerbate maternal and infant health inequities (Redd et al., 2021) and disproportionately affect communities of color (Mosley et al., 2021). Access to MA could make a significant difference in health outcomes such as maternal mortality and morbidity and can continue to keep abortion safe even in restrictive environments. Fortunately, the new legislation around telemedicine and MA has resulted in an unintended increase in public discourse around MA. Public discourse is also a form of public health evidence that calls for new and innovative research strategies to further understand its impact, especially during monumental moments of the policy change and social movements.

Findings from GAMA call for a reconceptualization of abortion stigma. There is a need to further explore how abortion stigma intersects with other forms of stigma, oppressions, and various social identities within all communities (i.e., race, class, gender, religion, socioeconomic status, sexuality). Understanding abortion stigma and the diverse ways it is perceived and experienced can contribute to more effective and culturally responsive solutions to destigmatize

abortion. This includes but is not limited to integrating MA in different systems of care, creating material that is community-informed and representative of the community being served, and engaging in storytelling in trusted spaces. Furthermore, participating in policy advocacy and developing the toolkit emphasizes the need for medically accurate and evidence-based policies and that effective deliverables can come in a variety of mediums which must be accessible to non-academic settings.

There is a need for public health researchers and institutions to cultivate meaningful relationships with local RJ organizations rooted in mutual trust and respect in order to amplify community perspectives and scientific evidence in the policy-making process. With knowledge and reproductive justice as a foundation, these partnerships could happen anywhere. At the heart of public health is application, and Emory University provides fertile ground for applied projects and partnerships as such. Through the Global Elimination of Maternal Mortality from Unsafe Abortion (GEMMA) endowed fund and the Emory Reproductive Health Association (ERHA), students have the unique opportunity to conduct research and initiatives in a field that is often underfunded and underrepresented while creating a meaningful community with peers, partners, and stakeholders around the world.

Conclusion

Despite the abundance of peer-reviewed and evidence-based research to support the safety and effectiveness of medication abortion by telemedicine, stigmatizing and unscientific policies are passed, and systems of inequity are upheld. In order to truly achieve reproductive justice, intersectional and holistic frameworks that center on the lived experiences and perspectives of the community are required to address the unique dimensionality of abortion stigma and abortion access in the south. Public health researchers, local RJ organizations, and

other advocacy organizations must collaborate to bridge the gap between policy, evidence, and experiential knowledge. Researchers must also be willing to shift the paradigm of traditional academia expectations of publications and authorship and transform evidence into applied practice. This includes responding to rapidly evolving social and political systems and landscapes and practicing reflexivity, self-care, and cultural humility. Embodying these principles cultivates a synergistic praxis and allows us to create environments of reproductive and knowledge justice within the communities we are serving and standing in solidarity for.

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Appendices

Appendix A: SB 456

22 LC 33 8983

Senate Bill 456

By: Senators Thompson of the 14th, Kirkpatrick of the 32nd, Miller of the 49th, Gooch of the 51st, Hatchett of the 50th and others

A BILL TO BE ENTITLED
AN ACT

1 To amend Title 31 of the Official Code of Georgia Annotated, relating to health, so as to
2 provide requirements relating to the use of abortion-inducing drugs; to provide for
3 definitions; to prohibit abortion-inducing drugs in school facilities or on state property; to
4 provide for related matters; to repeal conflicting laws; and for other purposes.

5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

6 SECTION 1.

7 Title 31 of the Official Code of Georgia Annotated, relating health, is amended by adding
8 a new chapter to read as follows:

9 "CHAPTER 9C

10 31-9C-1.

11 As used in this chapter, the term:

12 (1) 'Abortion' means the act of using, prescribing, or administering any instrument,
13 substance, device, or other means with the purpose of terminating a pregnancy with
14 knowledge that termination will, with reasonable likelihood, cause the death of an unborn

Appendix B: The Telemedicine and Medication Abortion in Georgia: Fact Sheet and Literature Review

Telemedicine and Medication Abortion in Georgia: Fact Sheet

Authors: Elizabeth Mosley, PhD MPH*; Priya Shah, MPH Candidate; Sara Redd, PhD MSPH; Subasri Narasimhan, PhD MPH
*Contact at elizabeth.mosley@gmail.com

Telehealth provides comprehensive assessment, counseling, and follow-up care for medication abortion, which is a safe and effective abortion method where two medications, mifepristone, and misoprostol, are taken to terminate a pregnancy.[1-4]

Last updated: March 15, 2022

Key Facts

1. **Medication abortion by telemedicine is safe and effective to use in Georgia.** Georgia studies show patients can accurately estimate their gestational age using pregnancy tests at home and do not need to have an ultrasound before or after the medication abortion.[5,6] After an extensive scientific review of the safety of medication abortion, the Food and Drug Administration (FDA) removed the in-person dispensing requirement for Mifepristone and now allows certified pharmacies, in addition to certified providers, to dispense the pills via mail and other modes of telehealth.[4]

2. **Restricting telemedicine for abortion creates undue burden with negative health and social effects.** For example, recent research conducted by Emory showed that restrictive abortion policies are associated with higher rates of low birthweight babies and preterm birth at the population level.[7,8] The Turnaway Study followed people over time who received or could not access abortions in Georgia and elsewhere. They showed that people who want an abortion and are denied an abortion are more likely to be living in poverty 7 years later, experience negative mental health outcomes, and remain in violent relationships.[9]

3. **Georgia already has an obstetric provider shortage and high maternal mortality rates, which can worsen with restricted abortion access.** Georgia has one of the highest maternal mortality rates (26 per 100,000 live births) in the country.[10] A major contributing factor is Georgia's OBGYN shortage. In fact, 43 of the 82 Georgia perinatal care service areas outside of the Atlanta-Metro area (52%) have either a complete absence of obstetric providers or an overburdened obstetric workforce.[11] When abortion access is restricted, maternal mortality rates increase due to potentially unsafe and ineffective methods of self-managed abortion.[12]

Telemedicine for medication abortion is an opportunity to provide safe, effective abortion services to patients outside the clinic. Without access to safe abortion care through telemedicine, the risk of unsafe self-managed abortion increases.[1-3,12]

4. **Restricting telemedicine for abortion inequitably affects people of color, low-income people, and people in rural parts of Georgia**[1,7,8] These groups already face extra barriers to abortion care. Telemedicine for abortion can alleviate barriers like costs, distance to clinics, and lack of transportation and childcare. This is particularly important for Black people in Georgia, who are 3 times more likely to die during pregnancy and childbirth than white people.[10] Restricting telemedicine for medication abortion will further contribute to maternal mortality rates, particularly among Black, low-income, and rural communities.

Telemedicine and Medication Abortion in Georgia: Literature Guide

1. **Addressing structural inequities, a necessary step towards ensuring equitable access to telehealth for medication abortion care during and post COVID-19** (Thompson, Northcraft, & Carrion, 2022)

   Black and Latinx individuals have higher rates of abortion (in large part due to racialized poverty), while simultaneously experiencing lower access to abortion services. Reduced access to abortion for these groups results in disproportionately higher experiences of adverse outcomes such as increased financial insecurity, reduced aspirational life plans, and increased incidence of severe pregnancy and postpartum complications. Telehealth has been successfully used to provide abortion care to Black, Latinx, and rural communities.

2. **Safety of medical abortion provided through telemedicine compared with in person** (Grossman and Grindlay, 2017)
3. **Effectiveness and acceptability of medical abortion provided through telemedicine** (Grossman et al., 2011)

   These studies examining the use of telemedicine to deliver medication abortion indicate that effectiveness and acceptability of telemedicine for medication abortion were similar, with Grossman et al. reporting a slightly higher success rate for telemedicine vs. clinic patients and Grossman and Grindlay reporting slightly lower rates of adverse events among telemedicine vs. clinic patients

4. **Questions and Answers on Mifeprex** (U.S. Food and Drug Administration, 2021)

   "After conducting a review of the single, shared system Risk Evaluation and Mitigation Strategy (REMS) for mifepristone, known as the Mifepristone REMS Program, FDA determined that the data support modification of the REMS to reduce burden on patient access and the health care delivery system and to ensure the benefits of the product outweigh the risks. The modifications to the Mifepristone REMS Program will consist of:
   - Removing the requirement that mifepristone be dispensed only in certain healthcare settings, specifically clinics, medical offices, and hospitals (referred to as the "in-person dispensing requirement")
   - Adding a requirement that pharmacies that dispense the drug be certified"

5. **Clinical and service delivery implications of omitting ultrasound before medication abortion provided via direct-to-patient telemedicine and mail in the U.S.** (Anger, Raymond et al. 2021)

   TelAbortion is a prospective trial that compared outcomes among patients who received pre-abortion ultrasound and pelvic exam before a medication abortion via direct patient-to-patient telemedicine and mail to those who did not. Their results showed that 95.6% of patients had a complete medication abortion with pills alone, and there was no statistical difference between the groups regarding adverse events or serious outcomes. Thus, this study supports the continued success and safety of providing medication abortion care via telemedicine and mail.

Telemedicine and Medication Abortion in Georgia: Literature Guide

6. **Provision of medication abortion in Hawai'i during COVID-19: Practical experience with multiple care delivery models** (Kerestes et al., 2021)

   This study aimed to demonstrate the effectiveness of medication abortion implemented via telemedicine in response to the COVID-19 pandemic. Patients had the option of choosing traditional clinic care or telemedicine with either in-clinic pickup or mailing of medications. Results from this study found that the overall rate of complete medication abortion without surgical intervention was 95.8%, with a success rate of 97.1% for patients who opted for the mail delivery option. Findings from this study continue to support the effectiveness and low rates of adverse effects of delivering medication abortion through multiple modes of delivery.

7. **Racial/ethnic and educational inequities in restrictive abortion policy variation and adverse birth outcomes in the United States** (Redd et al., 2021)

   This study examined racial/ethnic and educational inequities in the relationship between state-level restrictive abortion policies and adverse birth outcomes including preterm birth and low birthweight. Data analyzed from the National Center for Health Statistics between 2005-2015 showed that Black individuals with increased exposure to restrictive abortion policies experienced a 3% increase in probability of preterm birth. Additionally, those with less than a college degree with increased exposure to restrictive policies experienced a 2-5% increase in probability of low birthweight than college graduates. In sum, this study suggests that restrictive abortion policies contribute to increases in preterm birth and low birthweight for Black people and those with fewer years of education, potentially exacerbating racial and socioeconomic inequities in infant and maternal health. These findings urge policymakers to prioritize enacting policies that address structural inequities in order to combat the devaluation of Black and lower educated communities seeking sexual and reproductive health care.

8. **Racial and Ethnic Abortion Disparities Following Georgia's 22-Week Gestational Age Limit** (Mosley et al., 2021)

   This study aimed to explore variations in abortion numbers and ratios in Georgia by race after HB954 went into effect, a bill that prohibits abortions after 22 weeks from the last menstrual period. The Georgia Department of Public Health requires all entities that provide abortions to report each Induced Termination of Pregnancy (ITOP) event. ITOP data collected from 2007 through 2017 were analyzed and found that 98% of abortions in Georgia occurred less than 22 weeks, and there was a dramatic decrease in abortion after 22 weeks; however, Black and Latinx individuals experienced a higher rate of abortion at less than 22 weeks compared to white individuals. These findings suggest abortion restrictions as such disproportionately affect our communities of color, and decrease access to safe and needed health services. Policymakers are encouraged to recognize underlying conditions that increase the need for abortion and apply a public health approach to sexual and reproductive care by supporting equitable access to abortion, high-quality contraceptives, and anti-poverty measures that improve social services and resources.

Telemedicine and Medication Abortion in Georgia: Literature Guide

9. **The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—Or Being Denied—An Abortion** (Greene Foster, 2020)

   Nearly 1,000 women seeking an abortion from 30 facilities nationally participated. Using rigorous prospective longitudinal study designs, researchers found that abortion does not harm a women's mental health nor does it increase a women's use of alcohol or drugs. Being denied an abortion reduces women's and children's financial security and safety: they had almost 4 times greater odds of having a household income below the federal poverty level and 3 times greater odds of being unemployed. There was also an increased likelihood that women did not have enough money to pay for basic family necessities after being denied and abortion. Additionally, women unable to terminate unwanted pregnancies were more likely to stay in contact with violent partners.

10. **Georgia Maternal Mortality Report 2019** (Georgia Dept of Public Health, 2019)

    "There were 64 maternal deaths for every 100,000 live births. Of the 250 maternal deaths reviewed, 101 were determined to be pregnancy-related deaths, 60% of the pregnancy-related deaths were preventable. There were 26 pregnancy-related deaths for every 100,000 births.... Between 2012-2014, Black non-Hispanic women were about 3.3 times more likely to die due to pregnancy-related complications than White, non-Hispanic women."

11. **Georgia's Obstetric Care Shortage** (Zertuche and Spelke, 2013)

    Full presentation to the Georgia General Assembly Joint Study Committee on Medicaid Reform in 2013, including figures and tables, can be found at: https://www.house.ga.gov/Documents/CommitteeDocuments/2013/MedicaidReform/GMIHRG_ObGyn_Shortage_MedicaidReform_Nov18_2013_Final.pdf

12. **Maternal mortality, abortion access, and optimizing care in an increasingly restrictive United States: A review of the current climate** (Verma and Shainker, 2020)

    "Over the past few years, the U.S. has witnessed a rapid increase in abortion restrictions.... counseling mandates and waiting periods, ultrasound requirements, targeted regulation of abortion providers, gestational age limits, personhood laws, and insurance coverage limitations...One recent study...found that after 2009 restrictive states had a significantly higher MMR than protective states. For example, in 2017, restrictive states had an average MMR of 28.5 compared to 16.1 in protective states. A particularly disparate burden was noted on Black and Native American women in restrictive states, with the MMR increasing from 28.2 to 47.2 and 13.4 to 37.9, respectfully. Another recent study... found that reducing the proportion of Planned Parenthood clinics by 20% from the state-year mean increased the maternal mortality rate by 8%, an association that was found across multiple states. In addition, the researchers reported an association between restricted abortion access based on gestational age and increased maternal mortality rates (on average, six additional maternal deaths per 100,000 live births)...the current data does support the connection between restricting abortion access and the rising maternal mortality rates in the U.S."