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"Post-*Roe*" Abortion Policy Context Heightens the Imperative for Multilevel, Comprehensive, Integrated Health Education

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Abstract

The exceptionalism of abortion in public health education, due to social stigma, politicization, and lack of training, contributes to misinformation, policies unjustified by rigorous science, lack of access to person-centered health care, and systemic pregnancy-related inequities. Now that abortion access has vanished for large portions of the United States, following the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* (*JWHO*), health educators must work to eliminate abortion-related silos, destigmatize abortion education, and bring comprehensive sexual and reproductive health information and evidence to the many audiences that will require it. We discuss consequences of abortion exceptionalism in health education for the public, health care providers, pregnant people, and health professionals in training—and opportunities to better and more accessibly provide sexual and reproductive health education to these audiences.

Keywords

pregnancy, family planning, comprehensive health education, health care disparities, stigma, evidence-based practice

The U.S. Supreme Court decision, *Dobbs v. Jackson Women's Health Organization* (*JWHO*; 2022), reversed decades of precedent set in *Roe v. Wade* (1973) and removed federal protection of abortion rights, further burdening a U.S. public health system already grappling with inequities in access to primary and obstetric and gynecologic care (U.S. Department of Health and Human Services et al., 2021), and maternal and infant mortality and morbidity (Howell, 2018). Now, abortion care is further out of reach for many (Guttmacher Institute, 2022b). It is imperative that public health educators, scholars, and advocates lead in the provision of comprehensive public health education around a full spectrum of sexual and reproductive health (SRH), in public, clinical, and professional spaces.

Health education and promotion are critical determinants of SRH well-being and equity (Holt et al., 2020). Yet, as Drs. Lieberman, Goldfarb, and other scholars discuss, health education around abortion is exceptionalized due to social stigma and politicization (Kolbe, 2022; Lieberman & Goldfarb, forthcoming). This exceptionalism breeds silence and treats abortion care as taboo, often leading to misinformation and policies ungrounded in scientific evidence. The role of health educators in the "post-*Roe*" context is to eliminate silos between abortion and other related public health contexts (e.g., maternal and child health, health policy, health services research), destigmatize abortion, and bring health education and evidence to the many audiences that will require it. With more severely limited abortion access, individual-level health education will not be sufficient to prevent poor health outcomes. Instead, health educators must respond more broadly and deliberately, providing abortion-related information to the public, people who become pregnant, their partners and family, health professionals, and schools of medicine, nursing, and public health, among others. In the following sections, we discuss consequences of abortion exceptionalism in health education for these audiences—and opportunities to improve and more accessibly provide SRH education to them.

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Comprehensive and Integrated Health Education

More than four decades of extensive research has underscored the crucial role and efficacy of comprehensive SRH education in sexual health promotion and pregnancy prevention (Hall et al., 2016). Yet, psychosocial and sociopolitical barriers undermine implementation nationally, particularly in school settings (Hall et al., 2016; Lieberman & Goldfarb, forthcoming). Although more than 50% of U.S. states mandate some youth SRH education as a part of the K-12 curriculum, only a handful require comprehensive, age-appropriate, or medically accurate education (Guttmacher Institute, 2022c). Many states require or center abstinence content, ignoring the resulting counterproductive outcomes (increased pregnancy and sexually transmitted infection rates, and decreased contraceptive use; Atkins & Bradford, 2021; Hogben et al., 2010; Stanger-Hall & Hall, 2011). Comprehensive SRH education for adults is often concentrated in clinical settings or after transformative health events (e.g., pregnancy). States that have and are likely to ban abortion post-*Roe* also limit or restrict access to comprehensive SRH education—the combined implications of which have far-reaching consequences for health and well-being, including the potential to increase the likelihood of unwanted or mistimed pregnancies and of negative outcomes from forced pregnancies such as greater economic insecurity (Foster et al., 2018), life-threatening birth complications (Gerdts et al., 2016), pregnancy-related death (Stevenson, 2021), and preterm birth (Redd et al., 2022). The current moment requires health educators to fully implement comprehensive SRH education—including by recognizing the intersections between SRH and other relevant public health education topics (i.e., adverse childhood experiences such as sexual abuse, sexual and gender-based violence, healthy relationships), and responding to the need for informed and equitable clinical care.

Informed Clinical Care

Surgical and medication abortions are safe and common procedures—and routine treatments for many pregnancy conditions (e.g., miscarriages, ectopic pregnancy, placental abruptions, and premature labor). Yet in many states, their use is now limited to gestational ages often predating pregnancy detection and to urgently life-threatening instances. New ethical and legal complexities around patient counseling are emerging, particularly in states limiting or eliminating abortion access, due to more extreme abortion restrictions. Clinicians in such contexts may be forced to adhere to legal requirements of states which run counter to well-being and desires of patients, violating the medical principles of beneficence and respect for patient autonomy (Brief for American College of Obstetricians and Gynecologists et al. as Amicus Curiae Supporting Respondents, 2022).

Even prior to *Dobbs v. JWHO*, some state laws required that counseling around abortion care include medically inaccurate information (e.g., medication abortion reversal, ability of a fetus to feel pain, risks to future fertility, and risk of breast cancer; Guttmacher Institute, 2022a). On the contrary, anti-abortion biased clinical counseling requirements codified through multiple state laws allow the omission of pregnancy-related medical information that could inform abortion decision-making (e.g., results of prenatal testing for genetic and chromosomal conditions; Guttmacher Institute, 2022d). Taken together, policy restricting abortion access and delivery contributes to medical provider fear of breaking the law while providing health care (Harris et al., 2011), undue avoidance of medical interventions (Kulczycki, forthcoming), concern that these policies worsen women's health care, worry about interference in the doctor–patient relationship (Higgins et al., 2021), and impedes ability to provide supportive, nonjudgmental abortion care (Britton et al., 2017). With no federal protection of abortion rights, states where abortion care is restricted are able to enact similarly or more egregious policies that interfere with patient informed consent.

It is critical to note that abortion information inaccessibility affects equity, and in turn, care delivery will not be experienced equally. Young and lower income people, and Black, Indigenous, and other people of color, may be more likely to lack timely access to accurate, critical care information and resulting health opportunities as suggested by countless historical and present-day reproductive injustices and abuse in which marginalized groups were given treatments or interventions without their informed consent (Kathawa & Arora, 2020; Roberts, 1997). Evaluations of contraceptive and pregnancy options counseling also reflect racial, income, and age biases (Dehlendorf et al., 2010; Higgins et al., 2016; Mann et al., 2022; Nobel et al., 2022). Such systemic discrimination is tied to inequities in pregnancy and childbirth outcomes to include disproportionately high rates of Black infant and maternal morbidity and mortality (Hardeman et al., 2020). Furthermore, Black people experiencing pregnancy complications in restrictive settings may be less likely to receive or experience delays in receiving surgical or medication abortion in life-threatening instances, potentially exacerbating racial inequities in maternal morbidity and mortality. Education for public health professionals is an important support to ameliorate these biases, particularly in a post-*Roe* world.

Public Health Professional Education

Despite its importance, abortion education has generally and historically been left out of graduate-level SRH training, namely for public health, medical, nursing, and other health professionals, and is most consistently provided within clinical education. Yet, even there, abortion is often siloed, covered as an elective, and not as an integrated part of SRH service provision (Veazey et al., 2015). In fact, only 32% of medical schools surveyed by the American College of Obstetricians and Gynecologists offered an abortion-related lecture ("ACOG Committee Opinion No. 612: Abortion Training and Education," 2014). Only half of obstetrics and

gynecology residents separately surveyed received routine abortion training in their program (Turk et al., 2014). Such omissions in training and isolation within clinical care also lead to isolation of abortion providers, which further stigmatizes abortion care (Chowdhary et al., 2022; Harris et al., 2013; Smith et al., 2018). Post-*Roe*, this isolation is likely to become worse. Support for clinical education around abortion already varied geographically (Steinauer et al., 2018), with regional abortion training gaps, namely, the South—where abortion access is severely restricted. New laws like those passed in Texas and Oklahoma that allow private citizens to take civil action against anyone who "aids and abets" abortions have far-reaching implications for clinical providers (Editors, 2022), further reducing the available and future skilled SRH workforce (Vinekar et al., 2022).

In and beyond clinical education, there are a dearth of health professional training opportunities on abortion as a public health, societal, and policy issue, despite the implications of lack of abortion access for SRH. The health workforce must understand the implications of lack of access to abortion on the health, well-being, and life course of people who can become pregnant and their families. Further development of egalitarian models of academic and nonacademic abortion training that increase accessibility, and taking education beyond academic and clinical settings are essential to destigmatize abortion. Foundational, evidence-based public health and social science abortion education is greatly needed in broader fora.

At our own institution, the Global Elimination of Maternal Mortality From Abortion (GEMMA) Seminar was developed in response to lack of abortion-specific training and funding. Taken by hundreds of students to date, GEMMA seminar is a graduate public health seminar that explores public health, medical, legal, ethical, human rights, and religious perspectives on abortion. Beyond didactic content, students engage in values clarification exercises and debates, write policy briefs, present elevator speeches, propose surveillance or research projects, and are financially supported to do applied practice experiences (Lathrop & Rochat, 2013). The seminar is led by health educators in partnership with reproductive justice activists and clinicians—all with abortion and SRH expertise, harnessing their collective knowledge to expand abortion education. In 2021, we extended the course to an interactive community workshop for students, community members, and SRH professionals across the Southeast and outside of Emory University. After the workshop, attendees were more comfortable having conversations and advocating about abortion in their personal and professional lives. The GEMMA seminar has been replicated at other academic institutions and these models may be further expanded to other settings where similar knowledge and resources exist.

These strategies are examples of integration of abortion training in graduate and community education and opportunities to bring together interdisciplinary perspectives, to further destigmatize abortion. In addition, courses across the various subdisciplines of public health (i.e., health policy, behavioral sciences, epidemiology) may also integrate abortion as a module or throughout their teaching. Supporting the integration of evidence-based abortion curriculum will also require support from academic leadership. Leaders in universities, professional societies, and credentialing and certification bodies must also vocally and fully support the inclusion of such training as part of core curriculum. For example, the Deans of the School of Medicine, School of Nursing, and School of Public Health at our own institution released a statement, including the assertion that "laws that restrict access to abortion will adversely impact our ability to provide students, residents, fellows and trainees with direct patient care and training in abortion care. Let us be clear—comprehensive reproductive health education includes abortion" (Fallin et al., 2022). Institutions and their leadership have far-reaching influence on abortion stigma, the available clinical workforce, and on those with skills to track and measure the influence of access to abortion on reproductive well-being. It is time for institutions and leaders within them to mainstream and destigmatize abortion across their curricula to address structural barriers to abortion-related information and education.

Strategies for Moving Forward

A common public health adage is that information is necessary but not sufficient; this is especially true in the case of health education related to abortion care. Since well before *Dobbs*, health education related to sex, sexuality, and pregnancy has been limited—especially for adolescents—and the topic of abortion stigmatized. As we have argued, health educators must integrate abortion into public health education. Failure to do so endangers the lives of people who are or may become pregnant and their families. We must also expand existing notions of health education such that discussion of abortion is normalized within and across health education topics, settings, and audiences.

No matter how successful and widespread these efforts are, access to abortion care will still be necessary, even if comprehensive SRH education and contraceptives are universally available. Contrary to the goal of anti-abortion proponents, an "abortion-free America" is not possible. Some pregnant people—those experiencing pregnancy complications, medical emergencies, miscarriages, and survivor of rape and incest—will need abortion care, and the conditions under which pregnancy- and abortion-related health care is available to them must not be dependent on their geographic, financial, or information accessibility. The complexities around providing and obtaining clinical care will translate directly to clinical scenarios, including counseling related to pregnancy prevention, pregnancy options, and other pregnancy-related conditions and complications. As Dr. Kulczycki writes and other experts have long documented and foreboded, people experiencing pregnancy loss and seeking termination are subject to criminalization in this policy environment (Kulczycki,

forthcoming). Although most states do not ban clinicians from providing abortion counseling or referrals, the *Dobbs* decision creates additional chaos around the ability of clinicians in restrictive settings to counsel, treat, and refer patients to early, out-of-state, or self-managed abortion care.

To the extent they are willing and able, clinicians in restrictive settings can incorporate additional information into pregnancy prevention and options counseling, including education around options for accessing various contraceptive methods; recommendations for monitoring for pregnancy as early as possible (i.e., testing at the first sign of a missed menstrual cycle); providing resources and guidance around miscarriage management, self-managed abortion, health information privacy, security, and rights; and providing referrals for early and/or out-of-state abortion care. For patients with limited financial resources, clinicians can provide referrals to free or low-cost pregnancy testing and to their local abortion funds, which provide logistical, financial, and emotional support to people seeking abortion care. Publicly accessible, online information and decision-making tools, such as ineedana.com, have eased some of the provider burden in directing to care and resources across pregnancy-related and socioeconomic circumstances. These activities reduce barriers and strengthen community-level support for self-advocacy (i.e., insurance coverage and employment coverage for abortion-related travel) and the exercise of reproductive autonomy among pregnant people.

To complement health education at the individual, interpersonal, and community levels, institutions training health professionals—including schools of medicine, nursing, and public health—must maximize information accessibility. Direct examples beyond the provision of training through academic courses include massive open online courses (Evans et al., 2017) and public workshops. Additional strategies include the evidence-based use of social media and engagement with public discourse alongside traditional academic publishing.

Conclusion

Health education is more effective when comprehensive and inclusive of abortion. Yet abortion has been siloed from other interrelated components of SRH education, clinical care, and health professional training, with dire consequences for policies and pregnancy-related health inequities. In the post-*Roe* abortion policy climate, these ramifications are exacerbated. Abortion is an essential part of the reproductive life course and public health education. Health educators must work toward integrated abortion education across public health education curricula, normalizing abortion-related conversation across health education settings (classroom, clinical, public, etc.), and engage the support of institutional and professional leaders. Doing so is critical to achieving reproductive justice, which encompasses the following human rights: to healthy sexuality, disassociated from reproduction; to decide if and when to become pregnant and the conditions for birth; to decide not to become pregnant or not to continue pregnancy, and the conditions for doing so; and to parent with dignity and support, in a safe, healthy environment (Scott et al., 2020; Sistersong Women of Color Reproductive Justice Collective, 2019).

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