NUESTRO TEXAS: A REPRODUCTIVE JUSTICE AGENDA FOR LATINAS
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In November 2013, the National Latina Institute for Reproductive Health and the Center for Reproductive Rights released a fact-finding report called *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley.* The report describes, through personal narratives, widespread violations of Latinas’ human rights to life and health, non-discrimination and equality, autonomy and privacy in reproductive decision-making, and freedom from ill treatment. And it shows how Latinas in the Valley are organizing to educate one another and build their political power, mobilizing for a better future.

Fourteen months later, and on the eve the 84th Texas Legislature, we present a policy roadmap for Texas Latinas. This document updates and elaborates upon the recommendations in the *Nuestro Texas* report, offering a context for the current state of Latinas’ health and health care access in Texas as well as policy recommendations that respect and fulfill the human rights of Latinas and their families across the state. It provides a vision for a better Texas that includes concrete steps for restoring access to reproductive health services for the Latinas in rural and underserved areas. Other recommendations call for longer-term commitments to address structural barriers to health care: expanding coverage for the uninsured, eliminating transportation barriers, strengthening public health infrastructure, and ensuring reproductive health services are available to all regardless of immigration status.

This agenda centers the needs, voices, and leadership of Texans who have been historically marginalized, including women of color, low-income people, LGBTQ people, young parents, and immigrants. Latinas in the Lower Rio Grande Valley and throughout Texas remain resilient in the face of the violations to their human rights as outlined in the *Nuestro Texas* report. Through the Texas Latina Advocacy Network (Texas LAN), women in the four counties of the Valley work collectively to advance reproductive health and human rights for all women. Their strategic campaigns have addressed some of the systemic barriers to health care, such as improvements in transportation access for the rural communities known as colonias. After the legislative funding cuts of 2011, which shuttered nearly a third of the region’s clinics, the Texas LAN redoubled their efforts to organize, educate, and mobilize for policy change.

By organizing those most impacted by detrimental policy decisions, the Texas LAN leaders and activists are building a culture of resilience, where women not only learn about reproductive health but also how to claim their human rights. Leveraging the *Nuestro Texas* report and utilizing the human rights framework to build a more inclusive movement, the Texas LAN is mobilizing a multi-generational activist base to hold government actors accountable to their human rights obligations.
A PROFILE OF TEXAS LATINAS

STATEWIDE DEMOGRAPHICS
Texas has the second highest population of Latinos in the country. At 10 million people, Latinos comprise nearly 40% of the state’s population. And as of 2012, Texas has 4.3 million immigrants—the third highest population of any state after California and New York. But Texas is tied with California as the state with the largest absolute growth in immigrant population between 2000 and 2012. In 2012, the foreign-born population from Mexico accounted for 59% of the immigrant population in Texas.

Latinos have the highest rate of poverty of any major racial or ethnic group in Texas, and are over three times as likely to live in poverty as whites. In the most recent five-year American Community Survey (2008-2012), women in the Lower Rio Grande Valley had among the highest rates of poverty in Texas; in Starr and Willacy counties the rate topped 41%, or twice the state average. More than one in eight women of reproductive age living in poverty in Texas lived in the four counties of the Lower Rio Grande Valley and El Paso County.

Latinas are the highest population of women of childbearing age (15-44) in Texas (approximately 2.5 million out of 5.7 million). The percentage of Texas women of reproductive age living in poverty—20.8%—is 10% higher than the national average. Although the fertility rate among Latinas has declined the fastest of all major racial and ethnic groups from 2003-2012, Latinas continue to have the state’s highest fertility rate at 79 live births per 1,000 women of childbearing age.

Latinas are the most likely of Texas women to lack a personal doctor and the least likely to have seen a doctor in the past year due to cost. They are more likely than non-Hispanic white women in Texas to report being in fair or poor health. They also report a higher rate of general health problems, including diabetes, cardiovascular disease, obesity, and cancer mortality, than Latinas nationally.

LATINOS LIVING IN TEXAS BORDER COMMUNITIES
The border areas of Texas are home to a population that is overwhelmingly Latino—the population of South Texas, for example, is 81% Latino—and growing faster than the state average. Many Latinas in border areas live in one of the state’s 1,400 colonias, or unincorporated border communities that often lack basic infrastructure such as plumbing, electricity, sewage systems, and paved roads. The poverty rate in border colonias is 2.5 times higher than that of the rest of Texas, and over 60% of the residents of border colonias live in poverty or near poverty.

ACCESS TO HEALTH CARE
As of 2013, Texas has the highest uninsured population of any state in the nation at 22% of the population. Latinas are more than twice as likely as whites to be uninsured in Texas, and foreign-born Latinos in Texas are more than twice as likely to be uninsured as U.S.-born Latinos. Latinos living in border counties are significantly more likely than those from other racial or ethnic groups to be uninsured and living without health insurance for over a year. Hidalgo County in the Valley, for example, has the highest rate of uninsured people among all metropolitan counties in the nation. The percentage of residents of colonias who lack insurance is even higher, ranging from 50-80%.

Eight out of the ten counties with the highest uninsured rates for women in the state—over 33.5%—are in South and West Texas on the border with Mexico. Can also be designated health professional shortage areas (HPSAs) for specific types of providers. Statewide, Texas averages 157 doctors per 100,000 residents, far below the national average of 220 doctors per 100,000 people. When narrowed to primary care physicians, the state average is 69.5 per 100,000 people. Many border regions in Texas are especially underserved. In the Rio Grande Valley, Starr and Willacy Counties have whole county designations as primary care HPSAs, while Cameron has been designated a partial county HPSA. The Valley’s ratio of primary care physicians per 100,000 residents is 20% lower than the state average and approximately half the national average, ranging from 24.7 primary care physicians per 100,000 residents in Starr County to 57.6 in Cameron County.

TRANSPORTATION CHALLENGES
The lack of access to private or public transportation throughout Texas, especially in rural regions like the Rio Grande Valley, is a major barrier that keeps women from accessing health services. Few border counties have less access to women’s health care than the general population; for example, they are less likely to have an OB/GYN visit in the past year. Over half of adult women of reproductive age in the Lower Rio Grande Valley lack health insurance.

Two hundred and thirty-one Texas counties are designated as partial or fully medically underserved areas by the federal government, meaning the population has a shortage of health services and providers while facing elevated health risks and numerous socioeconomic barriers to health access, such as poverty and lack of health insurance. Counties can also be designated health professional shortage areas (HPSAs) for specific types of providers. Statewide, Texas averages 157 doctors per 100,000 residents, far below the national average of 220 doctors per 100,000 people. When narrowed to primary care physicians, the state average is 69.5 per 100,000 people. Many border regions in Texas are especially underserved. In the Rio Grande Valley, Starr and Willacy Counties have whole county designations as primary care HPSAs, while Cameron has been designated a partial county HPSA. The Valley’s ratio of primary care physicians per 100,000 residents is 20% lower than the state average and approximately half the national average, ranging from 24.7 primary care physicians per 100,000 residents in Starr County to 57.6 in Cameron County.

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A REPRODUCTIVE JUSTICE AGENDA FOR LATINAS

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from accessing essential reproductive health care. Private transportation is costly and difficult to arrange and public transportation is limited mainly to major cities. In the Valley, with its population of 1.3 million people, for example, only the two biggest cities have city bus systems. Many times, these bus systems do not run regularly and their routes do not reach rural regions or colonias.

IMMIGRATION CONCERNS

Those without authorized immigration status in the United States experience difficulties in accessing reproductive health care for many reasons, often aggravated by transportation barriers and cost. In Texas, undocumented women fear traveling outside their communities due to the ubiquitous presence of border patrol agents and internal immigration checkpoints on Texas roads. Others remain close to their communities because they lack a driver’s license or valid vehicle registration, and public transportation is both inefficient and costly.

Many immigrants without lawful status in the United States guard their immigration status carefully, even with health care providers, and may avoid seeking care for fear of disclosure.

If they reach a provider, non-citizens also experience difficulties at the point of care. In addition, they are often unable to produce the required documentation to qualify for reduced-rate health services, such as proof-of-income or legal residency in Texas, because they do not hold pay stubs, rental documents, state identification, or utility bills in their own name.

CIVIC PARTICIPATION

Latinas throughout Texas continue to organize within their communities to address health disparities and the systemic barriers to the health care they need. Since 2007, the National Latina Institute for Reproductive Health (NLIRH) has been organizing Latinas in the Valley through the Texas LAN to claim their fundamental human right to reproductive health care. By highlighting a reproductive justice framework and drawing on human rights strategies, the Texas LAN effectively blends strategies of community organizing and civic engagement to counter the dominant narrative, demand human rights, and shift the political landscape.

In Texas alone, the Latino/a electorate is gaining ground. By the 2016 Presidential election, over 58% of new eligible voters in the entire state will be Latino/a. Utilizing various voter engagement strategies, the Texas LAN is engaging this electorate in the reproductive justice movement and mobilizing them to take action. The political power of the Latino/a community in the Valley will only continue to grow. As they raise their voices for reproductive health and human rights, the Texas LAN will continue to organize and mobilize voters and non-voters alike to demand that the recommendations outlined in this report are fully realized.

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Source: Kyle Janek et al., Presentation to Senate Committee on Health and Human Services (2014)

Texas Women of Childbearing Age (15-44) by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latinas</td>
<td>2.5 million</td>
</tr>
<tr>
<td>Black women</td>
<td>0.7 million</td>
</tr>
<tr>
<td>White women</td>
<td>2.1 million</td>
</tr>
<tr>
<td>Women of other races</td>
<td>0.4 million</td>
</tr>
</tbody>
</table>


Pregnancy-Related Health Outcomes for Texas Women in Border and Non-Border Counties

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Border Counties</th>
<th>Non-Border Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late entry into prenatal care</td>
<td>31.5%</td>
<td>22.4%</td>
</tr>
<tr>
<td>Births via Caesarean section</td>
<td>33.4%</td>
<td>23.7%</td>
</tr>
<tr>
<td>No maternal postpartum checkup</td>
<td>23.4%</td>
<td>15.4%</td>
</tr>
<tr>
<td>No contraceptive method postpartum</td>
<td>40.9%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

Source: Texas DSHS, 2010 Texas PRAMS data

Texas Abortion Clinics and Immigration Checkpoints

<table>
<thead>
<tr>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>EL PASO</td>
</tr>
<tr>
<td>FT. WORTH</td>
</tr>
<tr>
<td>AUSTIN</td>
</tr>
<tr>
<td>SAN ANTONIO</td>
</tr>
<tr>
<td>DALLAS</td>
</tr>
</tbody>
</table>

Photo © Jennifer Whitney, jennwhitney.com
Reproductive Justices Concerns for Texas Latinas

Access to Contraception

Barriers to affordable contraception put Texas women at higher risk of unintended pregnancy. The state’s rate of unintended pregnancy (58 per 1,000 women) is higher than the national average (50 per 1,000 women). Latinas in Texas are almost 20% less likely, as compared to white Texas women, to report a pregnancy as intended and over 25% more likely to report a pregnancy as mistimed.49

For women who are low-income and lack insurance, cost is a major barrier to access to contraception. Without subsidized rates, a monthly supply of birth control pills can start at $40.40 The cost of long-acting reversible contraceptives—the preferred method for many low-income women who struggle to access clinics on a regular basis—is generally far higher.41 Low-income Latinas in the Rio Grande Valley interviewed for the Nuestra Texas report explained that the high cost forced them to choose between paying for contraception and feeding their families.44

With respect to voluntary sterilization, research has shown that even though it is a strongly preferred method of contraception in the Texas Latina community, it is not easily attainable. A 2012 study by the Texas Policy Evaluation Project found that of the Latinas in El Paso who were sampled and wanted no more children, 72% wanted sterilization but had not been able to obtain the procedure due to cost.42 Subsequent interviews with women in the Valley confirm that sterilization is preferred to other forms of contraception—including pills and long-acting, reversible contraceptives—but the cost of the procedure is too high for those without insurance.46

Reproductive System Cancers

While cervical cancer has been on the decline for U.S.-born women, research shows that the disease—which can be prevented through routine gynecological care and is highly treatable when caught early—is becoming more prevalent among certain racial and ethnic groups with high immigrant populations, especially Latinas.43 In Texas, the incidence of cervical cancer is 17% higher than the national average, and Texas Latinas have a higher incidence rate of cervical cancer than their white or black peers.45 The death rate from cervical cancer is also higher in Texas than it is nationally.46

Racial and ethnic disparities in cervical cancer are especially wide in counties that border Mexico. Women living in counties bordering the Texas-Mexico border are 31% more likely to die of cervical cancer compared to women living in non-border counties.47 For the last decade in which data is available, the incidence rate of invasive cervical cancer in Hidalgo County for Latinas was higher than both the statewide rate for Latinas and the state-wide rate for non-Hispanic white women. Additionally, the incidence rate for Latinas in Hidalgo County was more than double the rate for the county’s non-Hispanic white women.48

Most cervical cancer in the United States develops in women who have never been screened or have not been screened for five years.49 Texas Latinas ages 21-64 are less likely than Latinas nationally and less likely than white or black women in Texas to have received a Pap test within the last three years.49 Barriers to screenings are particularly high for some individuals, including lesbian and bisexual women, as well as transgender men, due to homophobia and transphobia within the health care profession and lack of training on the health needs of the LGBT population.49

Wide disparities exist in screenings for other types of reproductive system cancers, including breast cancer. As of 2012, Texas Latinas ages 40 and older were less likely than white or black Texas women and less likely than Latinas nationally to report having a mammogram in the past two years.62 Although the overall incidence and death rates of breast cancer are lower in Texas than they are nationally,63 Latinas in Texas have higher incidence and death rates than do Latinas nationally.64

Intimate Partner Violence

Intimate partner violence (IPV) is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another to dominate and gain, maintain, or retain power and control in a relationship. It is an epidemic affecting individuals in every community, regardless of age, economic status, race, religion, nationality, or educational background.65 Intimate partner violence can result in physical, mental, sexual, and reproductive health problems, and may increase vulnerability to HIV infection.66 Reproductive and sexual coercion can take many forms, including impregnating a partner against her will, coercing a partner to have unprotected sex, or interfering with or sabotaging contraceptive methods.67 A Texas study revealed that 22% of the women reporting IPV in their lifetime became pregnant as a result of abuse and 25% contracted a sexually transmitted infection.44

A 2013 statewide survey by the Texas Council on Family Violence shows that one-third of Texas counties lack a physical access point for family violence survivors to access necessary services.68 The need for such services is higher in counties that are rural, located, situated on the Texas-Mexico border, have a higher female population aged 20-24, and have a high population of college graduates.69 Populations of survivors identified as particularly underserved in Texas include those with limited English language proficiency, especially those living in the colonies, and residents of rural areas, youth, and LGBTQ populations.69 In the Rio Grande Valley, for example, there are few medical resources to respond to an array of health complications resulting from IPV—increased risk of...
unintended pregnancy, sexually transmitted infections, and poorer birth outcomes for both mothers and babies—and a lack of health care providers who are trained to detect and prevent IPV.

As most women visit health care providers during their childbearing years for contraception, prenatal visits, or pediatric services, these visits provide a window of opportunity to address violence and to empower patients with information. One study found that women who talked to their health care providers about the abuse were four times more likely to use an intervention, and then 2.6 times more likely to exit the abusive relationship. Clearly, taking advantage of these points of contact presented in the health sector can provide women access to key resources to improve their health and well-being during and after pregnancy and can connect them to support systems in their community, a critical protective factor against domestic violence. For Latinas in the Valley, building the capacity of community health outreach workers, or promotoras, to understand the dynamics of violence can assist in early intervention in young families before violence escalates, particularly given challenges—including access, cost, transportation, and immigration status—faced by so many Texas women.

MATERNAL HEALTH CARE

The percentage of women who access prenatal care within the first trimester is lower in Texas than it is in any other state. Texas Latinas are less likely than white women to begin prenatal care within their first trimester and almost twice as likely to begin prenatal care late or not at all. Texas women residing in border counties also have higher rates of late entry into prenatal care, while Texas Latinas have the lowest rates of multivitamin/prenatal vitamin use among all major racial and ethnic groups. While rates of low-risk Cesarean deliveries have gone down across the country over the last several years, they have decreased in Texas at only half the rate of the national level of decline. Low-risk Cesarean deliveries have decreased at much higher rates for non-Hispanic white women than they have for Hispanic women, and in Texas, women in border counties have higher rates of births via Cesarean section as compared to women residing in non-border counties.

Texas Latinas are approximately twice as likely as white Texas women to not receive a maternal postpartum checkup. Similarly, when compared to women in non-border counties, Texas women residing in border counties are less likely to receive a maternal postpartum checkup or use any contraceptive method postpartum.

ABORTION ACCESS

Latinas face many cultural and linguistic barriers in seeking abortion care, which has become less and less accessible across the United States. Since 2010, state legislatures have enacted over 170 restrictive abortion laws designed to make it harder or impossible for women to access abortion services in their communities. Due to legal restrictions passed in Texas in 2013, the number of clinics providing abortions in Texas dropped by half between May 2013 and July 2014. The number of Texas women of reproductive age who live more than 20 miles away from an abortion provider has increased from about 4,000 women in May 2013 to over 10,000 women by April 2014. For Latinas in the Valley, this means the distance to the nearest abortion clinic increased from 10,000 women in May of 2013 to 290,000 women by April 2014. Among Latinas in the Valley, especially transportation and poverty, reflect the significant barriers to abortion access for women. The cost of an abortion procedure compounds these barriers. Texas is one of 34 states across the country that refuse to provide public coverage for abortion in cases that are deemed medically necessary, a policy that effectively denies low-income women abortion access when their health is in danger.

The recent abortion restrictions in Texas have made abortion more difficult to obtain for women in underserved areas such as the Lower Rio Grande Valley, causing some to delay or forego abortion care altogether. From November 2012 through April 2014, the abortion rate in the area decreased by 20%, compared to a state average decline of 13% period during that same period. The Texas Policy Evaluation Project also found a relative increase in second trimester abortion in the same time period, showing that the restrictions forced women to delay the procedure and consequently face higher costs and risks of complications associated with later abortion.

SEXUALITY EDUCATION

Sexuality education is not mandated in Texas, but if taught, it must stress abstinence. Texas high schools teach prevention of HIV, sexually transmitted infections, and pregnancy as part of the national average for grades 9-12, but Texas
schools are less likely to teach students how to access the information, goods, and services they need to practice safe sex. LGBT youth in Texas face additional access barriers due to stigma of non-heterosexual sexual activity or identity and are often overlooked, if not purposely ignored, in sex education courses. In fact, Texas mandates the inclusion of only negative information regarding sexual orientation—one of just three states to do so. Latina women are less likely than white women to receive any formal instruction on methods of birth control before age 18, and they are also less likely than white or black women the same age to receive any formal instruction before age 18 on how to say no to sex. Additionally, as of 2010, publicly funded clinics in Texas were only meeting 22% of the contraceptive needs of youth clients.

Not surprisingly, Texas youth face additional barriers to attaining sexual and reproductive health and making their own decisions about pregnancy and parenthood. In 2010, Texas youth experienced among the highest rates of unintended pregnancy in the country and the highest prevalence of repeat births to teen mothers. Although reported sexual activity of Latina youth is not significantly different than that of their white counterparts, Latina youth have significantly lower rates of contraceptive use and higher pregnancy rates than their white counterparts. Latina youth in Texas are also more likely than white Texas women to have a repeat birth.

Pregnancy among youth is higher in border regions and medically underserved areas with high Latino populations. For example, Health Service Region 11 (South Texas, including the Rio Grande Valley) had the highest teen pregnancy rate in the state in 2011, at 59% higher than the state average. This region also had the largest percentage of births to mothers aged 17 or younger.

Texas youth, especially Latina/o youth, also lack the information and tools to protect against sexually transmitted infections. As of 2012, Texas had the highest number of reported gonorrhea and syphilis cases in women of any state in the country and was second only to California in the number of reported chlamydia cases. These rates are far higher for Latinas than for white women. In 2011, Texas Latinas 15 and older had a rate of gonorrhea 2.4 times higher than that of white Texans and twice as high as Latinas nationally. Texas Latinas 15 and older had a 2.5 times higher rate of syphilis than white Texans—twice as high as Latinas nationally. They were also nearly three times as likely as white Texans of the same age group to contract chlamydia.
The successive 82nd and 83rd Texas Legislatures rolled back reproductive rights, leaving Texas’ women without access to affordable contraception and other preventive health care while also severely limiting their access to abortion services. Some groups of women—including the state’s sizeable population of low-income and uninsured Latinas—were left entirely without sources of family planning and abortion care as a result of these policies. This section explains the need for a reversal of the regressive policies that have manufactured this women’s health crisis and that drive the need for a new policy framework grounded in human rights and reproductive justice.

**DISMANTLING THE REPRODUCTIVE HEALTH SAFETY NET**

The need for family planning services in Texas has always been greater than the supply, but for the past several decades the state had been taking concrete steps to address this gap. Beginning in the 1970s, Texas had steadily built a network of specialized providers serving women in all regions of the state, implemented a Medicaid family planning expansion program that served a substantial number of uninsured low-income women with federal matching funds, and distributed state funding efficiently through diverse funding streams that met the needs of different populations. Despite these gains, in 2011 Texas embarked on a radical experiment to drastically alter its system of distribution of family planning goods and services, first by severely cutting funding for women’s health, and second by disrupting the network of providers that have served low-income women for decades.

Until 2011, state funding for women’s preventive health services was directed through two sources: family planning programs administered by the Department of State Health Services (DSHS), and the Women’s Health Program, a Medicaid family planning expansion program administered through the Health and Human Services Commission (HHSC). Through a combination of grants and fees for services, these state funds supported a network of specialized family planning clinics that offer high quality, low-cost, and culturally competent services, making them a trusted source of care for Latinas statewide. DSHS family planning clinics in Texas have historically served a population that is 76% Latina and low-income—75% of clients served are at or below 100% FPL.105

Notwithstanding the benefits to women’s health and the state’s six-to-one cost savings by investing in preventive women’s health care, the 82nd Texas Legislature made significant changes to the funding levels and distribution scheme of state family planning funding. It slashed the DSHS family planning program by two thirds, from $111 million to $37.9 million for the 2011-2013 biennium. It then put in place a priority funding scheme that ensured all of the remaining funding would be first distributed to health departments and community health centers. This left no funds for specialized family planning clinics. Following these changes, the state of Texas lost its federal Title X grant, denying the state $32.2 million in federal funding to support family planning clinics.106 The disruption of services and the dismantling of the provider network caused profound and long-lasting damage to the state’s reproductive health safety net. Importantly, this service interruption punctuated a decade of gradual decline in providers of family planning services even as demand rose; in 2010, there were fewer providers than nine years prior, and they served 20% fewer women.108 In 2012, the state served 63% fewer women than it had the previous year at a cost of 15% more per client.109 DSHS projects that family planning matching funds for the Medicaid family planning expansion program, stripping Texas of $71.3 million. On January 1, 2013, Texas dissolved the Women’s Health Program and created in its place the fully state-funded Texas Women’s Health Program (TWHP). This action permitted the continued exclusion of Planned Parenthood as a family planning provider.

The disruption of services and the dismantling of the provider network caused profound and long-lasting damage to the state’s reproductive health safety net. Importantly, this service interruption punctuated a decade of gradual decline in providers of family planning services even as demand rose; in 2010, there were fewer providers than nine years prior, and they served 20% fewer women.108 In 2012, the state served 63% fewer women than it had the previous year at a cost of 15% more per client.109 DSHS projects that family planning matching funds for the Medicaid family planning expansion program, stripping Texas of $71.3 million. On January 1, 2013, Texas dissolved the Women’s Health Program and created in its place the fully state-funded Texas Women’s Health Program (TWHP). This action permitted the continued exclusion of Planned Parenthood as a family planning provider.

The same Legislature also made changes to provider qualifications for the Women’s Health Program. It directed the HHSC to begin enforcing a regulation called the “affiliate rule” designed to preclude Planned Parenthood health clinics from receiving state funding for family planning because of their brand affiliation with clinics that perform abortion services.102 As a result of excluding a federally recognized provider, the U.S. government refused to renew federal

**Photos:** (bottom) © Alex H. Gomez
LIMITING ACCESS TO ABORTION

On July 18, 2013, Texas Governor Rick Perry signed into law House Bill 2 (HB2), the most extreme package of abortion restrictions in the country.10 The sweeping legislation included several unconstitutional and medically unnecessary measures regulating abortion services in Texas: a ban on abortion after 20 weeks, a restriction on the provision of medication abortion, a requirement that doctors have admitting privileges at a local hospital, and a requirement that all abortion be performed in hospital-like facilities. At the time of publication, HB2 had already forced the closure of approximately half of Texas’ abortion clinics and raised the prospect that the majority of the remaining clinics will close once the law is fully implemented.

Perhaps the most harmful provision of HB2 is the requirement that all abortion clinics meet the same building requirements as hospital-style surgery centers, called ambulatory surgical centers (ASCs).11 (Since 2003, Texas had required clinics performing abortions at or after 16 weeks to conform to ASC requirements.)12 Texas lawmakers argued that ASC requirements for abortion facilities were necessary to protect women’s health and safety, even though abortion is one of the safest medical procedures,13 and no evidence existed that abortion facilities in Texas jeopardized women’s health. Existing abortion clinics are not exempt from compliance with this legislation; to remain operational, they must spend millions to update their facilities to comply with medically unnecessary regulations.14 If the courts allow this provision of the law to go into effect, dozens of abortion providers across the state will be forced to close, and the number of women living more than 200 miles from an abortion clinic will rise from 290,000 to 752,000.117

Another harmful provision of HB2 requires doctors who perform abortions to secure admitting privileges at a local hospital within 30 miles of the clinic.115 Admitting privileges are not necessary to the provision of abortion care because so few abortion clinics are not exempt from compliance with this legislation; to remain operational, they must spend millions to update their facilities to comply with medically unnecessary regulations. The second challenge to HB2, filed in September 2014, challenged the admitting privileges requirement as it applies to all clinics as well as the restrictions on medication abortion. Although a trial judge held these provisions unconstitutional and enjoined their enforcement,15 a panel of the Fifth Circuit Court of Appeals ultimately allowed them to go into effect in October 2013.134 This led to the closure of about 20 of the state’s more than 30 abortion clinics. In October 2014, the Fifth Circuit denied the plaintiffs’ request to rehear the case before a full panel of judges.

Women in the United States have been safely and legally using medication abortion for over a decade, with one in three women who make the decision to end a pregnancy in the first nine weeks choosing this method.125 Nevertheless, HB2 restricts the provision of medication abortion by requiring physicians to use an outdated and less effective FDA-approved protocol, rather than an updated regime based on new scientific research.126 This new protocol is just as effective as the old method but results in fewer side effects and requires fewer doctors’ visits. HB2 also requires women to visit the doctor in person for each dosage of the pill, thereby negating the benefits of medication abortion for rural women.

Legal challenges to HB2 continue. The first legal challenge to HB2, filed in September 2013 by more than a dozen women’s health care providers across the state, challenged the admitting privileges requirement as it applies to all clinics as well as the restrictions on medication abortion. Although a trial judge held these provisions unconstitutional and enjoined their enforcement,125 a panel of the Fifth Circuit Court of Appeals ultimately allowed them to go into effect in October 2013.134 This led to the closure of about 20 of the state’s more than 30 abortion clinics. In October 2014, the Fifth Circuit denied the plaintiffs’ request to rehear the case before a full panel of judges.

The second challenge to HB2, filed in September 2014, challenged the law’s ASC requirement and the admitting privileges requirement in two of the state’s hardest hit areas—the Valley and El Paso. On October 14, 2014, the U.S. Supreme Court reinstated an injunction blocking the two provisions from taking effect. This ruling countermanded a Fifth Circuit Court of Appeals decision two weeks earlier allowing the state to fully enforce HB2,127 which in turn had stayed an injunction against the law by a federal district judge.127 Following the Fifth Circuit’s decision, 13 more clinics had closed overnight, leaving an 80% reduction in the number of clinics statewide and no clinics at all west and south of San Antonio. The Supreme Court’s October ruling allows these 13 clinics to reopen while the case proceeds, but they will be forced to close again if the courts ultimately allow Texas to fully implement the law.

The need for rights-affirming policy solutions can be found in political will and actions that affirm their human right to reproductive health care. These include policies that:

- Support women’s health care providers across the state, challenged the
- Allow the state to fully enforce HB2,127 which in turn had stayed an injunction against the law by a federal district judge.
- The second challenge to HB2, filed in September 2014, challenged the law’s ASC requirement and the admitting privileges requirement in two of the state’s hardest hit areas.
- The U.S. Supreme Court reinstated an injunction blocking the two provisions from taking effect.

Texas Latinas are ready for policies that affirm their human right to reproductive health care.

In 2013, recognizing the fiscal consequences of eliminating preventive care, the 83rd Texas Legislature attempted to fix the crisis in women’s preventive health. It restored state spending on women’s health services to pre-2011 funding levels ($32.1 million to DSHS to replace the lost Title X funding; $71.3 million to the TWHP to compensate for lost federal funding; and $100 million to a new program under DSHS—Expanded Primary Health Care (EPHC)—with 60% of the new funding earmarked for family planning services). Although the increase in funding levels was a positive move, as of late 2014 the disruptions to the reproductive health safety net have yet to be fixed, particularly in areas most affected by the loss of services.

More changes to women’s health programs are on the horizon. In October 2014, the Texas Sunset Advisory Commission, which reviews the performance of state agencies and makes recommendations to change agencies’ missions and operations as needed, released its review of the Health and Human Services Commission. Concluding that “administration of multiple women’s health programs wastes resources and is unnecessarily complicated for providers and clients,” the Commission recommended consolidation of the three existing women’s health programs (DSHS family planning, EPHC, and TWHP). Rather than review the particulars of that report and speculate about legislative action in the 84th session, this policy blueprint seeks to identify the guiding principles and key components of a women’s health care model that will affirm the health and human rights of Texas Latinas.
Texas can and must do better when it comes to passing policies that respect and fulfill the human rights of Latinas and their families across the state. The policy recommendations that follow represent a bold vision for a better Texas.
This vision calls for **full access** to reproductive health services in rural and underserved areas; access to safe, legal, and affordable **abortion for all** Texas women; **expanded health care coverage** to improve the health and well-being of all Texans; and **protection for non-citizens’** basic human rights, including the right to health.

**Ensure that preventive sexual and reproductive health services meet the needs of all Texans**

**PARTICIPATION OF IMPACTED COMMUNITIES**

The right of people to participate in decision-making about the protection of their human rights is core to the promotion of human rights and democracy. Government has the responsibility to engage and support civil society participation, and especially to ensure meaningful consultation with communities who are most impacted by policies that impact human rights.

Ensure a significant, meaningful, and ongoing stakeholder involvement process for any redesign of state-funded women’s health programs in Texas

As the 84th Legislature contemplates whether to follow the Sunset Advisory Commission’s recommendation to consolidate Texas’ three women’s health and family planning funding streams—DSHS, EPHC, and TWHC—into one, every effort should be made to ensure there is a process for community members and service providers alike to influence the outcome. The Sunset staff report for HHSC notes that “changes in policy and funding over the past four years have significantly altered the landscape of state-funded women’s health services in Texas” and that providers “have grown weary of change.” It is imperative that any redesign of the reproductive health safety net, including the consolidation of existing programs, include significant, meaningful, and ongoing stakeholder involvement. To this end, providers and constituents most affected by recent disruptions to the reproductive health safety net (Latinas, rural women, young people, and LGBTQ individuals) should be included in all stages of planning, implementation, and evaluation of proposed changes to state women’s health services.

The Commission recommends that HHSC consolidate the programs and roll out the new program by January 1, 2017. Though the pressures to quickly improve the women’s health care safety net are great, Texas should not be guided solely by an inflexible transition deadline that tracks the legislative timelines. Instead, Texas should create a transition plan that includes an ongoing assessment of whether changes to the current system are truly enhancing the quality and efficiency of services for Texas providers and consumers. Texas should avoid rapid, large-scale, and inadequately informed changes to its women’s health programs, or risk wreaking more turmoil on a system that has already undergone significant changes in the last four years.

**Strengthen community support structures to ensure that women in highly impacted communities have adequate information and access to services**

Community health workers (CHWs), or promotoras/es, provide crucial health-related information and promote health in their own communities. In the Latina/o community, they are trusted leaders who use their deep knowledge of the language, socio-cultural norms, and life experiences of community members to provide health services and information and to serve as liaisons to providers. They educate women about their reproductive health, demystify the health care system through information, provide informal counseling, build capacity in health decision-making, and connect women to health care providers and other safety net services.
The number of promotoras in Texas increased more than fourfold from 2007 to 2013, now totaling 2,687 statewide. Despite the rise in demand and growth in training, the ability of promotoras to do their work effectively is hampered by a lack of structural support, visibility and appreciation for their role, and funding. The Texas Legislature should promote the role of promotoras by increasing access to high-quality certification training and by supporting professional development, especially for promotoras in border areas and other underserved communities. It should also encourage the recruitment of promotoras trained in reproductive health and ensure that comprehensive reproductive health care is included in the core competencies for training of all community health workers.

Developing sustainable employment opportunities is key to strengthening the promotora network. While promotoras may serve as employees or volunteers, paid positions require certification. In order to become certified, one must complete a training of at least 160 hours or verify the completion of 1,000 hours of community health service work in the most recent six years. Although the border areas such as the Valley and El Paso have a relatively high number of promotoras, they are more likely to be unpaid volunteers than promotoras in other counties of Texas, in part because of the expense involved in certification courses or volunteer hours.

As identified by both DSHS and HHSC, the lack of stable funding is a key barrier to the sustainability of promotoras programs. In 2011, the 82nd Legislature charged the state of Texas to undertake a study of the desirability and feasibility of employing promotoras and to develop recommendations to sustain employment and expand funding and reimbursement for their services. In January 2013, DSHS and HHSC submitted the “Texas Community Health Worker Study” to the Texas Legislature with their recommendations. While much has been achieved in recent years to increase education and professional development of CHWs (for example, the number of trained CHWs grew from 500 in 2007 to 2,150 in 2013), Texas can do more to ensure employment opportunities and sustainable funding for promotoras.

Currently, the Texas Department of State Health Services has incorporated CHWs in the EPHC contracts, allowing reimbursement for their services. Of 55 new EPHC contractors, approximately 40 indicated that they were utilizing or planned to utilize CHWs to provide outreach and to direct women to services such as cancer screenings, dental services, and family planning services. Moving forward with any changes to the women’s health programs, Texas should enhance such contract opportunities to ensure critical women’s health services information reaches those who need it most. Allowing reimbursement for promotora services increases the likelihood that providers will rely on promotoras to educate hard-to-reach communities.

An amended Centers for Medicare and Medicaid Services (CMS) rule (42 CFR §440.130(c)) was promulgated in January 2014, allowing preventive services recommended by physicians or other licensed providers to be offered, at state option, by practitioners other than physicians or other licensed practitioners. To qualify for reimbursement under the Medicaid state plan, services must involve direct patient care and be for the express purpose of diagnosing, treating or preventing illness, injury, or other impairments to an individual’s physical or mental health. Texas should clearly identify which promotora functions meet the federal definition of preventive services and submit a state plan amendment to cover these practitioners.

Affordability of Women’s Health Services

One of the key standards underlying the human right to health is accessibility of health goods, services, and information for all on an equitable basis. Accessibility has several dimensions, including financial accessibility (affordability), physical accessibility, and information accessibility. Human rights standards require governments to ensure equitable distribution of health resources so that the ability to pay does not become a barrier to health care, and the poor are not disproportionately burdened with health care expenses.

Substantially increase family planning funding to match the growing demand for publicly supported family planning services and supplies

Texas has more women in need of publicly subsidized contraception than any other state, except California, and it ranks last in the percentage of women whose need is met by the state’s publicly funded clinics. The rate of women in need has increased by 34% over the past decade, reaching 1.75 million in 2012. And this need is not evenly distributed: the number of Texas Latinas in need of publicly funded contraception is 1.6 times that of non-Hispanic whites and 3.2 times that of blacks. This tracks a national trend showing Latinas to have the largest increase in the need for contraceptive services of any major racial or ethnic group in the last 10 years.

Any women’s health and family planning programming, either under the current system or the proposed consolidation, needs a substantial increase in funding to match the growing demand for publicly supported family planning services and supplies. In 2012, the first full year following the devastating cuts to family planning funding, Texas met only 13% of the need for publicly funded contraception—half what it had satisfied just two years earlier. Investments by the 83rd Legislature included more than $215 million in women’s health and family planning programs for fiscal years 2014 and 2015 (representing a 17% increase from the 2010 to 2011 biennium, before budget cuts in 2012 and 2013). However, it is estimated that to fully meet the demand for women’s preventive care and wellness services, Texas will need to invest $265 million per year.
A REPRODUCTIVE JUSTICE AGENDA FOR LATINAS

AVAILABILITY OF WOMEN’S HEALTH SERVICES
A person’s ability to exercise her right to health depends on health care being available in sufficient quantity in all geographic areas and communities. Consequently, governments have an obligation to ensure an adequate health care infrastructure with facilities for different types of services including sexual and reproductive health, trained health care professionals, and an adequate supply of drugs and medical equipment necessary to offer high quality care. Availability of health care goods and services also depends on satisfaction of the underlying determinants of health, such as safe food and drinking water, basic sanitation, adequate housing, and living conditions.

Boost provider capacity in family planning service provision, especially in underserved areas
The dismantling of the frontline planning provider network as a result of the 2011 funding cuts and affiliate rule severely diminished provider capacity. By the end of 2012, 76 family planning clinics statewide were forced to close (most of these were not Planned Parenthood health centers), while dozens more were forced to reduce their staff and hours of service and raise their fees. Texas continues to face difficulties recruiting providers to fill the gap left by Planned Parenthood, which served 45% of the WHP clients in 2010. In the Valley, for example, the four providers that served the highest volume of clients were Planned Parenthood health centers, and all four closed as a result of the cuts. (One has since reopened with support from a Title X grant.) Concerns remain that the state will be unable to recruit enough providers to replace specialized family planning clinics, especially in rural areas.

Family planning clinics are typically located in or close to low-income communities and have decades of expertise in identifying their particular health needs. The loss of funding for these frontline providers has particularly affected sub-populations of the state such as Latinas, non-English speakers, and immigrants, who trusted them to provide affordable, culturally competent, high quality, and confidential care—to underserved populations who face significant difficulties in accessing health programs is essential for serving low-income populations who face significant difficulties in accessing clinics. Clinics need the capacity to determine a patient’s eligibility when a patient arrives, in order to provide efficient and effective care. Many Texas women face significant challenges to making a second trip to the clinic after eligibility is determined, particularly in large swaths of the Valley where transportation infrastructure is almost nonexistent.

Ensure adequate training of primary care providers in family planning counseling and service provision
Community Health Centers (CHCs) have a longstanding history of providing quality care—including culturally and linguistically competent care—to underserved communities in the United States. Nationwide, one of every three patients at a health center is Latina. In Texas specifically, 60% of the patients served in CHCs are Latinas. CHCs play a critical role in the delivery of sexual and reproductive health care in the public sector and are well positioned to receive the increase in women’s preventive health care funding via primary care. However, CHCs have historically served less than 20% of the number of patients served by family planning clinics and would benefit from targeted support to increase their capacity to provide specialized women’s health care.

Research shows that primary care providers in low-income and rural areas face greater challenges in meeting demands for family planning due to the strain of addressing their patients’ competing health needs. CHCs are not immune to these challenges. Consequently, Texas should dedicate funds towards training primary care providers in family planning counseling and service provision. Linguistic and cultural competency should also be included in order to improve the quality of services for the state’s substantial, and growing, population of Latinas and immigrants.

In April 2014, the United States Department of Health and Human Services released a report titled “Providing Quality Family Planning Services,” which contains guidelines intended to apply to health care providers who specialize in the provision of family planning services, as well as to “private and public providers of more comprehensive primary care.” As Texas works to dedicate funds towards training primary care providers in family planning counseling and service provision, close adherence to these guidelines will help ensure all providers can effectively provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and testing for sexually transmitted infections.

Ensure that eligibility determination procedures do not deter clients, delay or interfere with services, or burden providers
Same-day eligibility determination for reproductive health programs is essential for serving low-income populations who face significant difficulties in accessing clinics. Clinics need the capacity to determine a patient’s eligibility when a patient arrives, in order to provide efficient and effective care. Many Texas women face significant challenges to making a second trip to the clinic after eligibility is determined, particularly in large swaths of the Valley where transportation infrastructure is almost nonexistent.

In order to facilitate care and reduce the burden on providers, the state should adopt a model that presumes eligibility until proven otherwise. Specifically, Texas should avoid creating any eligibility determination model where the provider carries all of the financial risk of treating a patient before eligibility has been confirmed. Such a model would likely create a disincentive for providers to see and treat women often in need of care.

Ensure access to all FDA-approved contraceptive methods
Our documentation in the Valley and additional research by the Texas Policy Evaluation Project has shown a strong preference in the Latina community for long-acting reversible contraceptive (LARCs) methods,
such as IUDs. The 2011 cuts to family planning forced clinics to make difficult choices about allocating funds, and many were forced to stop stocking LARCs. Moreover, unlike Title X clinics, providers contracted through the current EPHC system are not required to stock all FDA-approved contraceptive methods. This necessitates that women take another trip to fill their prescriptions at a pharmacy, an extra step that burdens low-income women who already face significant transportation barriers.

Texas should encourage HHSC to develop guidelines that require all providers in the proposed women’s health and family planning program to offer a full range of FDA-approved contraceptives, including LARCs available onsite, in addition to comprehensive options counseling and referrals. It is critical that Texas support the ability for Latinas to have access and information to health centers and programs.

EQUITABLE DISTRIBUTION OF HEALTH RESOURCES

The human rights principle of equity calls for health resources, goods, and services to be distributed and accessed according to need rather than one’s ability to pay. Equity—a core obligation of governments to satisfy the right to health—ensures that those least able to afford health care are able to enjoy their human right to health. The failure to address inequality in distribution of health resources is considered a violation of the right to health.

Promote and invest in mobile health clinics to serve rural and low-income communities

The Texas Legislature should explore creative solutions to address transportation barriers for women in rural and underserved areas, including the use of cost-effective mobile health clinics. Such clinics are in high demand in areas like the Valley, where knowledge of the health care system is low and transportation barriers deter women from traveling outside their communities to seek services. Mobile reproductive health clinics, women who are low-income can receive free or low-cost contraceptive counseling and supplies, as well as Pap tests and breast exams, without negotiating the costs and burdens of transportation to a clinic far from their communities. Another advantage is that mobile clinics can also tailor their services to particularly hard-to-reach communities by providing linguistically and culturally appropriate care.

These clinics are a cost-efficient means of providing quality, low-cost care to underserved populations with poor health status living in isolated and medically underserved communities. For example, reproductive health mobile clinics operated by the University Medical Center of El Paso served an important public health service to women in El Paso. The Texas Legislature should promote partnerships between mobile health clinics and urban health centers and programs.

FREEDOM FROM DISCRIMINATION IN ACCESS TO HEALTH SERVICES

Health care must be accessible to all people, free from discrimination based on gender, race, ethnicity, age, health status (e.g. HIV), sexual orientation, disability, language, religion, national origin, and income or immigration status. Freedom from discrimination is the exercise of the right to health, as with other human rights, includes protection from policies that have the effect of discrimination in addition to purposeful discrimination. The right to access health care free from discrimination applies especially to the most vulnerable or marginalized sectors of the population.

Ensure access to affordable and high quality sexual and reproductive health services for all Texans free from age discrimination

As Texas contemplates a major reform of its current health care system, the Legislature should ensure that those least able to afford health care are able to enjoy their human right to health. The failure to address inequality in distribution of health resources is considered a violation of the right to health.

Ensure access to affordable and high quality sexual and reproductive health services for all Texans free from income discrimination

Ensure access to affordable and high quality sexual and reproductive health services for all Texans free from gender identity discrimination

Transgender and gender non-conforming Latino/as face myriad barriers in accessing reproductive health care. The National Transgender Discrimination Survey (NTDS) found that 28% of Latino transgender individuals live in poverty. Additionally, discrimination and prejudice in medical facilities negatively impact the health outcomes of Latinas. In fact, the NTDS found that 23% of Latino/a transgender respondents had been refused

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Such exclusions are not just a problem for young women; they have devastating consequences for older women as well. For example, women over age 44 who are not yet menopausal, as is the case in the DSHS Family Planning program, may be denied access to needed services free from age-based discrimination. For this reason, the Texas Legislature should support the Sunset Commission’s recommendation of extending eligibility to include women over 44 years of age who are not yet menopausal, as well as women who have been sterilized. Many Latinas who cannot access affordable and consistent contraception will pull together limited resources to pay for sterilization. However, as the Nuestro Texas report showed, many women who chose to be sterilized reported an unexpected dilemma: while they felt relief at no longer having to pay for contraception, now they do not qualify for reduced rates for breast exams and Pap tests. Whether or not they retain reproductive capacity, all women continue to need preventive care such as breast and cervical cancer screenings, as well as sexually transmitted infection screening and treatment.

Photo © Jennifer Whitney, jennwhitney.com

Ensure access to affordable and high quality sexual and reproductive health services for all Texans free from discrimination based on sexual orientation or gender identity

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medical care due to bias, and 36% reported having postponed care when they were sick or injured due to fear of discrimination.157

Texas should dedicate funds towards training primary care providers in family planning counseling and service provision, with a special focus on the unique health care needs for transgender and gender non-conforming Latinas. For example, research indicates that lesbian women may be less likely to receive annual or routine Pap smears and are more likely to perceive bias among providers than heterosexual women.158 Additionally, transgender persons who have not surgically removed breasts, uterus, ovaries, or testicles are at risk for cancer in these organs and must undergo screenings recommended for these cancers.159 By investing in comprehensive training for providers, Texas can help ensure that necessary preventive screenings such as Pap smears and prostate exams are accessible to all Texans without fear of humiliation and discrimination, and that Texas doesn’t leave transgender and gender non-conforming Latinas at the margins of care.

ACCOUNTABILITY AND TRANSPARENCY IN REPRODUCTIVE HEALTH POLICY
A policy framework should be based on the principles of accountability and transparency in order to realize the right to health.160 Accountability requires monitoring of the public and private entities involved in the delivery of health goods and services in order to ensure compliance with laws, regulations, and ethical standards. Where compliance falls short, mechanisms should also be developed to ensure these entities are held accountable for their failure to meet human rights standards. The principle of transparency requires that information and decision-making processes regarding implementation of the right to health be easily accessible for everyone to understand and act on to protect their health.

Ensure that any future changes to women’s health programming include a reporting mechanism and periodic evaluation
Accurate reporting and independent evaluations of programming on women’s health are necessary to determine whether a change of course is warranted. The Sunset Commission report on HHSC notes that under the current women’s health care delivery system—where EPHC and family planning programs are administered by DSHS, and THWP is administered by HHSC—agencies are unable to determine the scope and impacts of the current program limitations. Other key data sets like the number of providers for all programs are also not available, further limiting the ability to assess program effectiveness and efficiency.161

Moving forward, periodic monitoring and evaluation of the current distribution scheme for family planning will allow the Texas Legislature to prevent future harm to the safety net. The Texas Legislature should rigorously monitor provider recruitment, client enrollment, and service utilization for any women’s health care and family planning program. If service delivery falls short of targets, the Legislature should take corrective actions without delay.

Ensure access to comprehensive information about sexuality and reproduction

The right to information and education about sexual and reproductive health is rooted in the rights to health, life, education, and non-discrimination.162 It is based on the principle of reproductive autonomy—that in order for individuals to make informed decisions about their sexuality and reproduction, they must have comprehensive, accurate, and unbiased information. Accordingly, the realization of women’s right to health requires removal of all barriers interfering with access to health services, education, and information, especially in the area of sexual and reproductive health.163

Require schools that teach sex education to use age-appropriate, evidence-based information
Current Texas law gives public schools discretion on whether to provide sex education instruction and requires that if schools elect to provide that instruction, it must be abstinence-based.164 There is no requirement that the instruction, if provided, be rooted in medically accurate information. As a result, students may be subjected to false or misleading sex education.165

Texas must move away from abstinence-only programs and toward sex education that includes medically accurate information about contraception—a change that would bring state policy in line with the beliefs of a strong majority of Texans. It is important to note that individual communities and school districts have increasingly elected to make improvements to existing abstinence programs.166 However, in order to ensure statewide improvement are made, Texas should pass legislation requiring schools that elect to teach sex education to teach age-appropriate, evidence-based information.

Remove the requirement that women be informed about an association between abortion and a risk of breast cancer as part of the consent process
Informed consent for a medical procedure requires that each patient have access to medically accurate and relevant information at the right time—abortion care should be no exception. Since 2003, the state-mandated “Woman’s Right to Know” booklet has included misinformation on an association between breast cancer and abortion.167 This misinformation persists despite the fact that in 2003 and again in 2010, the National Cancer Institute concluded that “induced abortion is not associated with an increase in breast cancer risk.”168 Furthermore, in 2009, the Committee on Gynecologic Practice of the American College of Obstetricians and Gynecologists concluded that “more rigorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk.”169

To ensure women receive scientifically accurate information when considering an abortion, the Texas legislature should remove the risk of breast cancer as part of the informed consent for this procedure.

Remove waiting periods and biased counseling laws that interfere with women’s right to information and autonomous decision-making about their reproductive health
A 2003 Texas law requires that a woman wait 24-hours for an abortion following instruction by her doctor regarding 1) the gestational age of the fetus, 2) the medical risks associated with abortion, and 3) the medical risks of carrying the pregnancy to term.170 The doctor must also conduct a sonogram and...
Ensure access to safe, legal, and affordable abortion for all Texas women

Where governments have recognized the right to abortion, human rights standards require that governments ensure that this right can be meaningfully exercised. As mentioned above, two key components of the right to health are availability and affordability of health care goods, services and information. In the context of abortion services, the right to health requires that there be enough abortion clinics within the state’s borders to serve the population's needs. Affordability looks beyond whether a service is available and requires that the service also be economically accessible.

Under the U.S. Constitution, every state has a constitutional duty to ensure its residents can meaningfully exercise their federal constitutional rights. In recent years, however, states have attempted to restrict a woman’s right to abortion by passing laws that interfere with women’s decision-making and access, or that over-regulate facilities and physicians with the intent of making abortion too expensive or burdensome to provide. Texas has led the charge in attacking abortion rights, threatening the health and human rights of its 5.8 million women of reproductive age. Because of the particular challenges that many of the state’s Latinas face in accessing safe, legal, and affordable abortion care, Texas must repeal its harmful restrictions and ensure full access to abortion rights as an integral part of women’s reproductive rights.

For intervals between October 2013 and October 2014, during the time the admitting privileges provision and the ASC provision of HB2 were briefly in effect, women in the South and West of Texas temporarily lost access to safe abortion services as the last clinics in their areas were forced to close. Women in the Valley were forced to make a 500-mile round trip to San Antonio to access care before a federal court intervened to allow the clinic in McAllen to reopen. The combined effect of the clinic closures and geographic distribution of the remaining clinics functions, in the words of a federal judge, “just as drastically as a complete ban on abortion.”

If HB2 is fully implemented, all of the remaining clinics will be located in Texas’ four largest metropolitan cities. For the women of the Valley, this will require a 500-mile round trip, costing at least $150 in gas—the equivalent of wages earned by working more than half the week at a minimum wage job in Texas. This does not include the cost of a hotel or the fee for the procedure itself, which can range from $300-950 depending on the clinic and stage of pregnancy. Logistical barriers, including arranging for childcare, taking time off from work, and passing through internal immigration checkpoints, are so onerous that many Latinas living in South Texas are unable to make the trip and must forgo care even when offered some financial assistance.

Medically unnecessary requirements on facilities and providers of abortion care are creating a severe shortage of safe abortion access in Texas that disproportionately impacts women in rural areas, including millions of Latinas. The number of clinics providing abortions in Texas dropped by half between May 2013, before the passage of HB2, and July 2014, after it had begun to be implemented. In this time period, the number of Texas women of reproductive age who live more than 100 miles from an abortion clinic more than doubled to over one million women.

To provide the woman with an image and explanation of the sonogram. Additionally, the woman must receive state-mandated information from her doctor including that 1) medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, 2) the father is liable for child support even where he has offered to pay for the abortion, and 3) she has the right to review state-printed materials listing abortion-alternative services and agencies.

Taken together, these laws undermine a woman’s right to receive timely reproductive health care free of biased, medically inaccurate information designed with the purpose of dissuading a woman from having an abortion. Moreover, waiting periods for abortion disproportionately impact low-income and rural women for whom it is a significant challenge to make an additional visit to an abortion clinic.

Texas’ reproductive health policy should be informed by the principles of the human right to health, including: equity, non-discrimination, participation by impacted communities, transparency, and accountability.

Repeal HB2 and refrain from passing laws targeting abortion facilities and providers that make safe abortion harder to obtain.

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Some women unable to obtain a legal abortion will take desperate measures to end their pregnancies, including crossing the border into Mexico or finding other ways to purchase miscarriage-inducing drugs on the black market. Self-induced abortion is more common in the border areas of Texas. A 2012 survey by the Texas Policy Evaluation Project found that 12% of women living in McAllen and El Paso reported attempting to self-induce, compared to 7% of women statewide.124

Repeal laws that place unnecessary and costly burdens on obtaining abortion, including the 24-hour waiting period and restrictions on provision of medication abortion

For women living in poverty, the cost of an abortion—including transportation, accommodation, lost wages for time off work, and childcare costs—can be prohibitive. Some private funds exist to support low-income women who cannot afford the cost of the procedure or travel-related expenses, but these funds are insufficient to meet the demands of all low-income women in Texas. In addition to repealing HB2, Texas should repeal restrictions on abortion that increase the cost burdens and disproportionately impact low-income women. For example, Latinas often prefer medication to surgical abortion. But the waiting period and sonogram requirements force those seeking an abortion to make up to four trips to a clinic; one for a mandatory ultrasound in accordance with the 24-hour waiting period law, and one follow-up visit 14 days after receiving mifepristone. The multi-trip requirement functions as an effective ban for women who lack the funds and other resources to travel outside their communities.

Expand health insurance coverage

The principle of universality—that human rights must be afforded to everyone, without exception—is fundamental to the promise of human rights. As stated in the Universal Declaration of Human Rights, “All human beings are born free and equal in dignity and rights.”125 Public welfare laws that carve out exceptions for non-citizens or that fail to cover the maximum extent of those in need, run contrary to the principle of universality.

Nationwide, the number of Americans with health care coverage has already grown substantially under the Affordable Care Act (ACA). Recent findings, however, show yet another reason why states like Texas must expand Medicaid: while the uninsured rate among working-age Latina/o adults dropped by about half—from 35% to 17%—in states that expanded Medicaid, the uninsured rate in states that did not expand Medicaid, including Texas and Florida, was statistically unchanged.126

Texas can and must do better to ensure affordable health insurance coverage reaches those hard-working Texans who need it most. Specifically, Texas must close the “coverage gap” to maximize coverage for its uninsured population and take proactive steps to ensure Texans have access to culturally competent health information and resources when seeking coverage through the federally operated health insurance marketplace.

Improve the health and well-being of Texans by ensuring access to affordable health care coverage

Texas should expand coverage to ensure that low-income Texans have access to affordable health care coverage. One of the major ways the ACA sought to increase health insurance coverage to the uninsured was through an expansion of Medicaid to adults with incomes at or below 133% of the federal poverty level (FPL). While this provision of the law was designed to be implemented nationwide, in 2011 the Supreme Court struck down the provision requiring states to participate in Medicaid expansion.127 As of November 2014, Texas is one of 21 states that has not yet elected to expand Medicaid to cover its uninsured population.128

Currently there are over one million Texans in a “coverage gap.” These are people who earn too much to qualify under the state’s extremely restrictive Medicaid eligibility standards—to qualify, parents of dependent children must earn less than 20 percent of the FPL, or $3,958 for a family of three—but earn too little to afford private insurance on the marketplace exchanges even with federal tax subsidies.129

Latina/o/as are disproportionately represented among those in the coverage gap. Currently, of the more than one million Texans who are in the coverage gap, approximately 600,000 are Latinas.130 Also in this category are veterans and their spouses, Texans living with a mental illness or disability, as well as those working retail, construction, child care, hospitality, health care, and food service.131 Because of the coverage gap, an estimated 9,000 Texans are expected to die prematurely each year.132 In addition, more employers will pay a federal penalty for failure to provide insurance to their employees, which could reach $399 million per year.133

The coverage gap can be closed by expanding Medicaid or by creating an alternative “Texas solution.” If the latter, the program must be carefully crafted in order to ensure access to affordable health care for the entire population that falls in the coverage gap and strengthen the strong network of safety-net providers statewide.134 In either model, the federal government will pay 90% or more of the cost. Closing the coverage gap would bring nearly 600,000 Latina/o/as closer to getting the care they need, while also creating 200,000-300,000 new jobs over the
next the next 10 years, and lowering insurance premiums for businesses and taxpayers.190

Ensure that all Texans have ready access to the robust information, application/enrollment systems, and culturally competent consumer assistance they need to gain, use and maintain quality health insurance

Despite Texas’ refusal to expand Medicaid, Texas still saw a higher-than-average rate of Latina/o participation in the first open enrollment period of the ACA.191 Research indicates that Texas Latina/os are eager to gain health care coverage, in part because they faced more obstacles than other ethnic groups to attaining coverage prior to the ACA.192 Accordingly, Texas Latina/os remain optimistic about the ACA.193 It is incumbent upon state and federal policymakers to ensure that all Texans can access coverage that is right for them and their families when they need it most.

Providing in-person assistance to apply for and enroll in health insurance will be critical to reaching Latina/os. Lawmakers should affirm the important role assisters play in the state’s health insurance system and ensure that all assisters receive the support they need to perform their work. Additionally, lawmakers must acknowledge that getting covered is a first step, as ongoing health insurance literacy will be a cornerstone to a successful enrollment program. Since Latina/os make up a large portion of the newly insured, many would benefit from extra support—delivered in their language and by trusted members of their communities—that allows them to select and use their health insurance effectively.

To this end, the state of Texas can promote the safety and well-being of its future citizens by 1) refusing to authorize the Texas Department of Public Safety (DPS) to establish road checkpoints within the hundred-mile zone; 2) Texas Department of Public Safety (DPS) to establish road checkpoints within 25 miles of the border and clarify legal limits, for example, on initiating stops, referring vehicles to secondary inspection areas at interior checkpoints, and conducting searches. The 25-mile authority will facilitate travel to reproductive health clinics now located further from women’s communities.

Update state identification requirements to ensure all Texans have access to a validly issued ID

To date, ten states plus the District of Columbia have passed laws allowing undocumented immigrants to get driver’s licenses.195 As of 2011, Texas law requires that driver’s licenses are granted only to residents showing proof of legal status,196 putting safe and legal transportation and identification options out of reach for thousands of Texans. Expanding access to driver’s licenses for all—regardless of one’s immigration status—promotes safer driving and enables undocumented families to participate more fully in society.

In order to ensure greater access to the health care that women need, Texas should not permit the DPS to authorize the establishment of additional road checkpoints within the hundred-mile zone. Instead, Texas should limit DPS’ interior enforcement operations to areas within 25 miles of the border and clarify legal limits, for example, on initiating stops, referring vehicles to secondary inspection areas at interior checkpoints, and conducting searches. The 25-mile authority is consistent with the proposed changes at the northern border under the Border Security, Economic Opportunity, and Immigration Modernization Act of 2013 (S744).197,198 This 25-mile authority will facilitate travel to reproductive health clinics now located further from women’s communities.

Refuse to authorize the Department of Public Safety to establish road checkpoints within 100 miles of the border inside Texas

With respect to the rights of immigrants in particular, the principles of universality, indivisibility, interdependence, and non-discrimination ensure that everyone within a nation’s territory is able to exercise all fundamental human rights, regardless of citizenship status.

The principle of indivisibility recognizes that human rights have no hierarchy and must be equally enforced. A violation of one kind of right will implicate another. For example, the interference of a civil and political right such as the right of freedom of movement will implicate an economic and social right such as the right to health. This principle is closely related to the concept of interdependence of rights, which recognizes that the fulfillment of one right such as the right to health may depend on the fulfillment of another right such as the right to information. The interdependence of rights requires governments to ensure the protection of all human rights, not a selective grouping.

Regulations establishing a hundred-mile border zone inside Texas were adopted by the U.S. Department of Justice in 1933, reportedly without any public input or debate. At the time, there were fewer than 1,100 Border Patrol agents nationwide, compared to over 21,000 today.199 With the recent closure of reproductive health clinics in the Rio Grande Valley and other Texas border areas, many Latina/os seeking reproductive health services are forced to travel great distances to get the care they need. Women who lack papers do not travel outside their communities for fear of being stopped by the police for traffic violations or by immigration authorities at checkpoints.200

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A REPRODUCTIVE JUSTICE AGENDA FOR LATINAS

without the constant fear of being stopped by the police. Consequently, many Latino/as are not provided coverage to the woman herself. Consequently, pregnant women suffering from health issues unrelated to the pregnancy, such as a broken arm, are unable to obtain coverage for treatment. The rule also denies medication to control pain during childbirth, and costs to cover post-delivery hospital stays or treatment for the woman following birth regardless of her medical condition. While the CHIP program does provide a vehicle for women to get vital prenatal care they would not otherwise be able to access, it does so using problematic language that fails to meet the full healthcare needs of immigrant women.

The federal government has since offered states the option to remedy the problems caused by this rule with respect to maternity coverage for lawfully present immigrant women. The 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) authorizes states to waive the five-year waiting period for lawfully present pregnant women to allow for this more comprehensive maternal health coverage. Accordingly, states can elect to cover all the maternal health needs of women—not just their fetuses—who would otherwise lack coverage due to the five-year bar. Coverage under the CHIPRA option includes prenatal, delivery and post-partum care. Texas has declined this option to cover pregnant women rather than the fetus. Texas should ensure that all immigrant women authorized to live and work in the U.S. who meet income eligibility for Medicaid are able to receive the comprehensive maternal health care they need for safe and healthy pregnancies.

Provide health coverage for immigrants to the maximum extent possible under state law

Immigrant women in Texas—including undocumented as well as many immigrants authorized to work in the U.S.—face numerous barriers to coverage based on their immigration status. To ensure all immigrant families are covered to the maximum extent possible under state law, Texas should a) accept the federal option to allow lawfully present immigrant adults to enroll in comprehensive Medicaid, and b) accept the provision in the 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) to extend health coverage to lawfully present pregnant women without a five-year delay.

Allow authorized immigrants to enroll in comprehensive Medicaid if they meet federal eligibility requirements

Federal legislation imposes certain restrictions on immigrants’ eligibility for means-tested public benefits. Notably, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act for the first time excluded many non-citizens from means-tested federal benefits programs, including public health insurance coverage. The 1996 law imposed new restrictions on eligibility for lawfully present immigrants, requiring those who arrived after 1996 to wait five years before they become eligible for Medicaid or Children’s Health Insurance Program (CHIP) regardless of their income. However, Texas is one of a handful of states that refuses to extend coverage to those lawfully present in the U.S. who arrived after 1996 even after they complete the federal five-year bar. Consequently, many Latinos are unfairly prevented from receiving the comprehensive medical care they need, even though they are paying taxes to support these programs and meet income eligibility requirements. Texas should accept the option to allow lawfully present immigrants to enroll in comprehensive Medicaid if they reside in Texas, arrived post-1996, have fulfilled the five-year waiting period, and meet income eligibility requirements.

Accept the federal option in the 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) to extend full health benefits to pregnant lawfully present women

Although most lawfully present immigrants are excluded from eligibility for comprehensive Medicaid, limited coverage is available for pregnant women in Texas. Emergency Medicaid covers pregnancy-related services including prenatal, delivery, and postpartum family planning services for up to 60 days after birth. Texas has elected to extend Emergency Medicaid to cover uninsured women with incomes up to 185 percent of the federal poverty level, thus providing necessary maternal health care to immigrants regardless of their status. Texas also allows lawfully present pregnant women who are not eligible for Medicaid to access prenatal care. A 2002 rule issued by the U.S. Department of Health and Human Services under the Bush administration grants states to use federal funds to extend CHIP to pregnant immigrant women, regardless of immigration status, for the purpose of prenatal care. This federal option covers care for the woman’s pregnancy, but does not provide coverage to the woman herself. Consequently,
ACKNOWLEDGEMENTS

The Center and NLIRH extend special thanks to those who reviewed our draft recommendations and shared research and information about the broader context of reproductive health care in Texas. We greatly appreciate the help of Amanda Stevenson and Kristine Hopkins of the Texas Policy Evaluation Project at the University of Texas at Austin; Cathy Miller and John Valentine of the Texas Freedom Network; Yvonne Gutierrez of Planned Parenthood Texas Votes; Susan Hays and Heather Busby of Texas NARAL; and Laurie Glaze of One Voice Texas. We are also grateful to Krista Del Gallo of the Texas Council on Family Violence and Stacey Pogue and Anne Dunkelberg at the Center for Public Policy Priorities for their contributions to the sections on domestic violence, health care access and immigration.

ENDNOTES

16 Their contributions to the sections on domestic violence and shared research and information about the broader context of reproductive health care in Texas. We greatly appreciate the help of Amada Stevenson and Kristine Hopkins of the Texas Policy Evaluation Project at the University of Texas at Austin; Cathy Miller and John Valentine of the Texas Freedom Network; Yvonne Gutierrez of Planned Parenthood Texas Votes; Susan Hays and Heather Busby of Texas NARAL; and Laurie Glaze of One Voice Texas. We are also grateful to Krista Del Gallo of the Texas Council on Family Violence and Stacey Pogue and Anne Dunkelberg at the Center for Public Policy Priorities for their contributions to the sections on domestic violence, health care access and immigration.

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Nuestro Texas

Frustrated demand for supra, note 1, at 24-28.

Cost-Sharing of Contraceptive Services and Supplies Without the new and in the columns as the show results that “incidences and frequencies by race” (showing 2.5 percent of white women do not access prenatal care at all, as compared to 5.0 percent of Latinas).

Nuestro Texas, supra note 1, at 31.

Kost, supra note 41, at 31.

The Hyde Amendment, a federal policy first implemented in 1976, prohibits the use of federal funds for abortion except in cases of life endangerment, rape, or incest. All states must abide by these minimum exceptions, but some go further as federal funds are used for Medicaid payments. The procedure is medically necessary or in order to prevent grave damage to a woman’s health. For a review of state laws on Medicaid funding of abortion, see Guttmacher Inst., State Policies in Brief: State Funding of Abortion Under Medicaid (last updated Dec. 1, 2014), http://www.guttmacher.org/pubs/statepolicy/briefs/STABF.pdf.


Direct Testimony of Daniel Gonsier, M.D., para. 27.


Teen Pregnancy Prevention: What Worked and What Did Not Work? (2012), http://www.guttmacher.org/pubs/report/prr1214.pdf (showing 19 percent decrease in abortion rates in Texas from 2000-2010). The study also demonstrated that 86 percent of pregnancies were among female teenagers, of which 70 percent were among 15-19 year olds. In the same period, an 8 percent decrease in cesarean births compared to 1 percent decline nationally. 93 percent of Texas teens did not have an abortion clinic by 2013; however, in 2016, there were 113 abortion clinics in 2016 (hereinafter Jones & Jerman, Abortion Incidence).


Reproductive and Sexual Coercion in the State of Sexual and Reproductive Health, supra note 40, at 18.


Kosinski, supra note 33, at 24-28.

Our Texas, supra note 40, at 11, 228-229 (2013).

116 Direct Testimony of Anne Layne-Farrar, Ph.D., Susan Dudley & Beth Kruse, DSHS, Council Agenda Memo for State Health Safety of Abortion of ambulatory surgical centers, and that abortion

25 adopted by HHSC upon direction of the 2011 Texas legislature. 25

112 §§ 171.0031, 245.010(a) (West Supp. 2012 www.dshs.state.tx.us/council/agendas/ supra note 112, §§ 171.063(a)(1)-(2),

37 adopted in

120 Brief of Petitioner-Plaintiff at 8-14, Whole Woman’s Health et al., v. David Lakey et al. (5th Cir.) (Dec. 19, 2013),


14. §§ 171.012(a)(i)-(D) tex. HealtH & safety Code aNN.

177 Olga Khazan, The Cost of Being a Woman

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ENDNOTES


195 Nolan Hicks, CPPP, The Texas Health Care Primer 1, 43 (2013), http://library.cppp.org/files/TxHlthPrimer_1111_1_Side_Unit_Side.pdf; and see also NILC, Medical Assistance Programs for Immigrants in Various States 1, 4 (last updated Feb. 1, 2014), www.nilc.org/document.html?id=159.

196 The 25-mile zone is also consistent with the recommendations of dozens of border and national organizations representing faith, labor, immigrants' rights, and human and civil rights groups. See Letter to Gil Kerlikowske, Commissioner, U.S. Customs and Border Enforcement, Re: Recommendations to CBP Re: Promote Humane Border Enforcement Policy and Practice (May 27, 2014), available at http://library.cppp.org/files/2014/05/Kerlikowske-CBP-reforms-sign-on-IMDs.pdf.


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