League of Women Voters of Nashville
Position Paper on Access to Comprehensive Reproductive Services

August 23, 2022, updated October 31, 2022

Since 1993, the League of Women Voters has actively supported health policy solutions to contain costs and ensure quality, affordable health care for all, including comprehensive reproductive health services.[1] The League supports the right of all citizens to make their own reproductive choices, and believes that reproductive choice is not only a critical issue affecting the rights of women and all who may become pregnant, but one of racial and economic justice.[2] Overturning reproductive rights will disproportionately harm Black, Brown, and low-income people who are most impacted by systemic inequalities.[3]

On June 24, 2022, the U.S. Supreme Court voted to overturn *Roe v. Wade,* a landmark decision in place for nearly 50 years that balanced the reproductive rights of women with the right of a viable fetus to be born. The Court's decision in *Dobbs v. Jackson Women's Health Organization* disregarded what most constitutional scholars had considered settled law and ruled that reproductive choices in early stages of pregnancy no longer belong to women living in the U.S. but are now the purview of state legislatures.

The LWV of Nashville (LWVN) stands with the national League in calling for the federal government to ensure restrictions on reproductive rights are reversed and that government programs and policies advance reproductive justice. However, we are gravely concerned that this will not happen in time to avert serious consequences for thousands of Tennessee women and their families. Due to state legislation passed between 2019 and 2021 and triggered by *Dobbs*, as of August 25, 2022 all abortions performed in Tennessee—even those considered medically necessary or sought in cases of child abuse, rape or incest, or severe fetal abnormality—are now considered criminal acts. Our state law no longer recognizes the mental health of pregnant women as a valid medical concern. Providers of obstetrical, gynecological and emergency medicine who intervene in a pregnancy at any point following conception are subject to felony prosecution unless they can prove in court that they acted to prevent the death or irreversible impairment of a bodily function of the mother.

The LWVN calls on our Governor and the General Assembly to repeal the state's total abortion ban. This ill-conceived legislation unnecessarily deters and delays needed healthcare for thousands of women, children, and families across our state. Tennessee currently ranks 46th lowest among the 50 states in quality, cost, and access to women's health care,[3] 11th worst in maternal and fetal mortality rates,[4] and 8th worst in childhood poverty.[5] Black women in our state are 2.5 times more likely to die from pregnancy-related causes than White women, and pregnant persons with disabling health conditions face the highest mortality disparities.[6,7] Women living in rural communities often have no or limited access to obstetrical care.[8] Tens of thousands of Tennesseans of reproductive age who are living below the poverty level are currently denied access to preconception and contraceptive healthcare due to our state's refusal to expand Medicaid. Policy makers need to focus on making it possible for every family to raise children safely, healthfully, and not in poverty. This includes not only expanding access to health care but also guaranteeing affordable childcare and housing, a living wage, safe schools, and supportive social environments for families.

Until a national right to reproductive choice is codified in law, the LWVN will work to repeal Tennessee's total abortion ban and oppose any abortion law which criminalizes medical interventions or denies exceptions for protecting the life, bodily function, and mental health of pregnant persons, or in cases of child sexual abuse, rape, incest or severe fetal abnormalities.

Legal Background and Implications

<u>Tennessee Abortions Rights Prior to *Dobbs*</u>

In 2019, the most recent year for which statistics are available, there were about 9,700 induced terminations of pregnancy in Tennessee. Surgical abortions accounted for 49% and medication abortions for the remaining 51%. Abortions were allowed up to 20 weeks of pregnancy, although 89% were in the first trimester (before 12 weeks gestation). Approximately half of those having an abortion (surgical or medication) were Black. Nine percent (9%) were 19 years of age or younger, 60% in their 20's, and 28% in their 30's. Nearly 67% had never had a previous abortion and 14% were married.[9]

Prior to *Dobbs*, Tennessee law mandated a 48-hour waiting period after consulting an abortion provider, in-person counseling, and an ultrasound before termination could be completed. Tennessee also required the physical presence of a physician when providing a medication abortion. Medicaid (TennCare) could cover abortions in cases of rape, incest, or life endangerment for low-income women. There were six facilities providing abortion services in Tennessee.

<u>The *Dobbs* SCOTUS Decision</u>

On June 24, 2022, in the *Dobbs v. Jackson Women's Health Organization* case,[10] the U.S. Supreme Court rejected its 1973 ruling in *Roe v. Wade* which established that women have a constitutional right to seek abortion care before the point of viability of a fetus. The *Dobbs v. Jackson* ruling leaves the regulation of reproductive rights to the states. The new ruling says: "The Constitution does not confer a right to abortion; *Roe* and *Casey* are overruled; and the authority to regulate abortion is returned to the people and their elected representatives." The Court's majority reasoning in the 6-3 decision includes the following: "*Roe* held that the abortion right is part of a right to privacy that springs from the First, Fourth, Fifth, Ninth, and Fourteenth Amendments...The Court finds that the right to abortion is not deeply rooted in the Nation's history and tradition...Guided by the history and tradition that map the essential components of the Nation's concept of ordered liberty, the Court finds the Fourteenth Amendment clearly does not protect the right to an abortion...Attempts to justify abortion through appeals to a broader right to autonomy and to define one's 'concept of existence' prove too much."

<u>Current Tennessee Abortion Ban</u>

In 2020, the Tennessee legislature passed a fetal cardiac activity law which bans abortions past 8 weeks gestational age or, if cardiac activity can be detected, at any point after 6 weeks gestational age. Its implementation had been blocked until the *Dobbs* ruling but became effective by a decision of the 6th U.S. Circuit Court of Appeals in late June 2022. This 2020 "Heart-beat Bill" (TCA 39-15-1207)[11] makes it a felony for a medical provider to terminate any pregnancy but offers an "affirmative defense" (described below) in cases of preserving the life and bodily function of a pregnant woman. Tennessee law also criminalizes pregnancy termination at any point if the termination is sought for reasons of gender, race or presence of the genetic chromosomal abnormality that results in Downs Syndrome.

However, as a result of *Dobbs*, an even more restrictive 2019 law, the "Tennessee Human Life Protection Act" (T.C.A. 39-15-213)[12] superseded the "Heart-beat Bill" on August 25, 2022. Enacted to be triggered 30 days following the date on which *Roe v. Wade* was overruled (hence the name "Trigger Law"), it totally bans abortion *from the moment of fertilization*. All pregnancy terminations are criminalized leaving an affirmative defense available to physicians who end a pregnancy "to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function." The Trigger Law specifies that protecting a pregnant person's mental health does *not* qualify as a reason to terminate a pregnancy. There are also *no* exceptions for rape or incest, even for victims of child sexual abuse, nor are there any exceptions for fatal fetal abnormalities.

Post-*Dobbs*, current Tennessee law could lead to criminal felony charges for anyone involved in abortion care. Performing an abortion could subject a provider to a minimum of 3 and up to 15 years in prison if convicted.

Post-*Roe/*Pre-*Dobbs* abortion laws uniformly contained exceptions to the definition of abortion for rape, incest and the life and health of the mother. By carving out these exceptions to the definition of "abortion," a criminal abortion would not be considered to have occurred if any of the exceptions applied. The burden of proving that an abortion was a criminal act Post-*Roe* and Pre-*Dobbs* was on the State.

Post-*Dobbs,* under the Tennessee Trigger Law, the burden of proving that a needed medical procedure is *not* an abortion has been shifted to accused medical providers. To be clear, medical providers acting consistent with their training and Hippocratic Oaths to protect their pregnant patients' health can now be charged with a felony unless they can establish their innocence only by proving an "affirmative defense" before a jury in an abortion prosecution.

An affirmative defense is a concept in criminal law which allows a person who has committed a criminal offense to escape conviction if he/she can prove facts which constitute the affirmative defense. For example, in a murder prosecution, a defendant can raise the affirmative defense of insanity. To assert the defense of insanity the defendant must admit that he or she committed the offense by unlawfully killing another. With that admission, the defendant can then assert that he or she is not responsible for the act because of mental illness. The burden of proving mental illness is on the defendant.

According to the Trigger Law, the affirmative defense applies only to abortions performed by a physician. The affirmative defense has three components, all of which must be proven by a preponderance of the evidence:

- First, in the good faith medical judgment of the physician, the abortion was necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman. (The phrases "death of the pregnant woman" and "serious risk of substantial and irreversible impairment of a major bodily function" are not defined and will have to be developed by case law).
- Second, the physician acted in such a way to provide the best opportunity for the unborn child to survive, unless in the physician's good faith medical judgment, termination of the pregnancy in that manner would pose a greater risk of the death of the pregnant woman or substantial and irreversible impairment of a major bodily function. (Again, the phrases "greater risk of the death of the pregnant woman" and "irreversible impairment of a major bodily function" are not clearly defined and will have to be developed by case law).
- Third, in either case, the action of the physician cannot be based on a claim or diagnosis that the woman will engage in conduct that would result in her death or substantial and irreversible impairment of a major bodily function or for any reason relating to her mental health. In other words, the mental health of the pregnant woman or her threatened suicide is not justification for an abortion.

Each of these elements has to be proven by a preponderance of the evidence, which means that the evidence is more likely than not true or, put in another way, the evidence is at least 50.1% in favor of supporting the affirmative defense. The State would counter the proof offered in support of the affirmative defense through cross examination and by offering its own expert opinion disputing the assertion of an affirmative defense by a physician.

Medically necessary terminations of pregnancy to preserve the life of the mother or prevent serious impairment may require the assistance of medical professionals other than or in addition to physicians. The Tennessee Trigger Law is silent about the legal liability of ancillary personnel under such circumstances. We are concerned that nurses, physician assistants, or other medical professionals supporting a physician in pregnancy terminations to

preserve the life of a mother could also be criminally charged but would have no legal defense available to them. The LWVN questions the constitutionality of any law which assumes that medical providers are guilty until they can prove their innocence.

Tennessee law also directly conflicts with a federal requirement to provide medical care when a pregnant person's life is at stake. Tennessee's law creates an untenable situation for both medical providers and women needing emergency care for pregnancy complications. Fear of legal liability and confusion created by ambiguities in the statutory language could force medical providers to delay standard interventions until a pregnant person's life is imminently threatened, or require families to travel longer distances to find available care in other states, if they can afford to do so.

Reproductive Health, Health Care Access, and Health Education Impacts

Reproductive Health

As explained in the previous section, following the *Dobbs* decision, Tennessee's restrictive 2020 "Heart-beat Bill" was quickly superseded by the 2019 Human Life Protection Act which imposed a total ban on abortion effective August 25, 2022. Doctors providing reproductive health care in our state are now faced with the legal-ethical quandary of risking a Class C felony conviction for intervening to protect the health of their patients.

Abortion bans imposed by Tennessee and a number of other states place women experiencing miscarriages, ectopic pregnancies, co-occurring cancer, and other medical conditions that prevent them from carrying pregnancy to term at higher risk of maternal death and morbidity. Health policy researchers have predicted that banning abortion in the U.S. would lead to a 21% increase in the number of pregnancy-related deaths overall and a 33% increase among Black women, simply because staying pregnant is more dangerous than having an abortion.[13] Criminalizing abortion is expected to lead to increased deaths due to unsafe abortions or attempted abortions and suicides.[14]

It is difficult to list all circumstances for which an abortion may be medically necessary given individual differences. However, several complications of pregnancy are presented as examples of dire unintended consequences of extreme abortion bans:

- *Conditions threatening the life of a fetus*, such as Potter's Syndrome (absence of kidneys in the fetus), trisomy 13 and trisomy 19 are incompatible with a viable fetus. Anencephaly, an undeveloped brain and skull, is incompatible with life beyond a few days after birth. Fetal abnormalities likely to result in stillbirth or death within hours of days of delivery are extremely traumatic events for pregnant women and their families, but there are no exceptions for termination of non-viable pregnancies in Tennessee's current law. While genetic diagnostic techniques are continually improving, most current methods do not detect chromosomal abnormalities until between 10 to 18 weeks of gestation. Screenings for other severe anomalies are currently done between week 15-20 of gestation. *The LWV believes that exceptions for non-viable pregnancies should be allowed whenever a serious abnormality is confirmed, and such exceptions should not be subject to arbitrary timeframes.*
- *A pregnancy with premature rupture of the membranes* (amniotic sac) at 16-18 weeks has only a 10% chance of progressing and is usually fatal to the fetus. The lungs of the fetus do not develop, and the fetus dies. The most likely result of premature rupture of the membranes is that the pregnant woman becomes septic with significant risk of death notwithstanding antibiotics. There is a narrow unpredictable margin when the pregnant woman who appears well then becomes severely ill and dies in spite of antibiotics.
- *An ectopic pregnancy* which occurs in up to 2% of all pregnancies,[15] may have a heartbeat, but the fetus

is nonviable in any situation. It cannot be transplanted to a uterus. The pregnant woman is at serious risk of rupture and bleeding if ectopic pregnancies are not treated promptly.

- *Spontaneous miscarriages* occur in 12-15% of recognized pregnancies, and in certain groups of women the risk is higher.[16] Miscarriages often require a surgical intervention (dilation and curettage or D & C) to remove all placental and fetal tissue to avoid serious infections. We have grave concerns that women experiencing spontaneous miscarriages will not be able to get appropriate medication or surgical treatment in an environment where physicians responding to a tragic but natural fetal death will be considered guilty of performing an abortion procedure.

- *Cancers* that are diagnosed in the first or second trimester of pregnancy present another serious situation. *Breast cancer* tends to be more aggressive in younger women of child-bearing age, and potent chemotherapy is often needed to arrest it but cannot be given to pregnant women. Under these circumstances, a pregnant woman would need an abortion to receive appropriate breast cancer therapy.

- *Pregnancy-related maternal mortality associated with mental illness* is deliberately disregarded as a concern by Tennessee's Trigger Law, which specifies that protecting a pregnant person's mental health does *not* qualify as a legitimate reason to terminate a pregnancy. Yet according to the Tennessee Department of Health, 27% of pregnancy-related deaths and an additional 23% of maternal deaths in the first year postpartum are caused by mental illness.[7] *The LWVTN believes that a pregnant person's mental health must be factored into medical decisions about a patient's risk of death or disability.*

- *Sexual abuse of a child resulting in pregnancy.* While relatively rare, pregnancy among the very young is traumatic, with high rates of morbidity and mortality. Young maternal age is associated with low birth weight, pre-term birth, increased risk of birth trauma due to small pelvis size, maternal anemia, infection, eclampsia and pre-eclampsia, emergency cesarean delivery, and postpartum depression. Globally, complications relating to pregnancy and childbirth are the leading cause of death for girls aged 15-19, according to the World Health Organization.[17]

  These complications are worse in even younger children ages 10-14. The nation was horrified by news that a 10-year-old child impregnated by a rapist in Ohio was denied the option to terminate that pregnancy, just days after the overturning of *Roe v. Wade* triggered abortion restrictions in that state. The same restriction now applies in Tennessee where, in 2018 alone, 87 girls ages 10-14 were impregnated (39 White, 43 Black).[18]

  All children are legally innocent. A pre-teen girl is not able to give consent. She is the victim of a crime and should never be forced to carry a pregnancy to term to the detriment of her own health. No child is ready to face the complications of pregnancy, childbirth, and motherhood. Abortion can be lifesaving in these circumstances. *The LWVN believes that exceptions to Tennessee's abortion law should be allowed for sexual abuse of a child resulting in pregnancy.*

- *Pregnancies resulting from rape or incest at any age* can trigger fear, shame, and confusion that may delay reporting of such crimes within the brief window when emergency contraception might be effective. According to the Tennessee Department of Health's 2021 report on *Sexual Violence -- Tennessee, 2019,*[19] the consequences of sexual assault are physical, psychological, and life changing. Victims can experience long-term effects such as post-traumatic stress disorder or recurring reproductive, gastrointestinal, cardiovascular, and sexual health problems. In addition, sexual violence is linked to nicotine, alcohol, and other drug use disorders and to engaging in risky sexual activity. For the state to add the emotional, physical, and economic burden of being forced to carry a resulting pregnancy to term is cruel and unnecessary punishment for rape victims. *The LWVN believes that exceptions should be allowed for pregnancies resulting from rape and incest at any age.*

Even the health of people who are not pregnant can be negatively affected by Tennessee's abortion law. For

example:

- Autoimmune diseases are frequently treated with methotrexate, an extraordinarily effective anti-inflammatory medication taken by nearly 60% of all rheumatoid arthritis patients. This medication can make the difference between living a normal life and being bed-bound due to chronic pain. However, it can cause birth defects (in 10% of pregnancies) and miscarriages (in 40% of pregnancies). While rheumatologists would not prescribe to patients planning pregnancy, in response to criminalization of abortions, some pharmacies have stopped dispensing this medication altogether. This jeopardizes the medical treatment of patients who have no intention of becoming pregnant and who have had good control of their condition with this medication.[20]
- Isotretinoin, a commonly prescribed dermatological medication for severely scarring acne, has a 20%-35% risk of causing serious malformations in a fetus. Females of childbearing age taking isotretinoin are counseled to use regular birth control and are required to take monthly pregnancy tests. Since no form of birth control is 100% effective except complete abstinence, pregnancies do occur and termination is recommended. If dermatologists stop prescribing isotretinoin to patients of childbearing age, it takes away their autonomy and may leave them with lifelong scars. Other acne treatments are not as effective, have side-effects, and may not be covered by insurance.[21]

The LWVN believes that, at a minimum, the following changes to Tennessee abortion law are needed:

- **The provision of medically necessary pregnancy terminations must be decriminalized.**
- **The medical necessity of intervention in a pregnancy should be determined by a pregnant person and their medical provider, not the legislature or the courts.**
- **The mental health of the pregnant person must be considered in assessing the risk of death and permanent damage to a person's functioning.**
- **Exceptions for rape, incest, child sexual abuse, and severe fetal abnormalities must be reinstated.**
- **TennCare and private health insurance should continue to cover pregnancy terminations to protect the life and health of pregnant women and in cases of rape and incest.**

Health care access

Investments in comprehensive health services, coupled with improved economic conditions and increased access to health insurance, have been found to contribute more to decreases in abortion rates than restrictive abortion laws.[22, 23]

Over half of all births in our state are now covered by TennCare, which has an income eligibility level for pregnant women at 195% of the federal poverty level. The LWVN welcomes the extension of maternal health coverage to a full year post-partum under the TennCare III program and is hopeful that TennCare support for doula services and community health worker support to new mothers will be approved quickly and generously. Expansion of the duration of coverage[24] and inclusion of support services are demonstrated to lower maternal death rates, improve pregnancy outcomes, and promote child development.[25]

Preconception health care is also critical. However, many low-income Tennesseans are missing out on comprehensive health care that would improve the likelihood of healthy pregnancies. Currently low-income Tennesseans are only eligible for TennCare if they are disabled or caretakers of minor children and live in a household earning below 100% of the federal poverty level or *after* they are confirmed to be pregnant. According to the Tennessee Department of Health's Maternal Mortality Report to the legislature this year, 46% of maternal deaths between 2017-2020 were related to cardiovascular disease, obesity, substance use disorders

and mental health disorders—all conditions that *could have been prevented or managed by preconception health care*.[7]

While Tennessee has a relatively robust primary care safety net program for uninsured and underinsured individuals, many communities still lack access to specialty care, mental and behavioral health services, obstetrical care, and the full range of reproductive health services. County and regional health departments need additional state support to maintain and expand their current services:

- Birth control information and supplies
- Preconception counseling
- Complete physical examinations for men and women
- Emergency contraception
- Pregnancy testing and counseling
- Basic infertility services
- Reproductive life planning
- Screening for sexually transmitted infections including HIV
- Referral to other health and social services

Access to the full range of contraception options must continue to be guaranteed in our state through TennCare and private insurance. Affordable Care Act Plans on the federal Healthcare Marketplace offer contraceptive coverage. Any teen or adult, no matter their insurance status, race, sex, sexual orientation, gender identity, income, or residency status can currently go to a County Health Department family planning clinic or Federally Qualified Community or Rural Health Center for contraceptive care. The LWVN will work to ensure these services continue to be adequately funded, along with extended hours for working people and students, transportation services to those who need them, and the full range of contraceptive options, including emergency contraception (pregnancy testing and Plan B) and long-acting reversible contraception (LARCs) such as IUDs and implants. Non-profit organizations, which provides LARCs, contraceptive education and health care navigation services, also need to be supported through public and private partnerships.

It is also necessary for our state to address the lack of access to specialized obstetrical maternity care in our state. In its 2020 Report: *Nowhere to Go: Maternity Care Deserts Across the United States*[8] the March of Dimes identified one-third of Tennessee counties as maternity care deserts, with no access to a board-certified obstetrician or nurse midwifery services. Another 35% of Tennessee counties had only limited access to maternity care. This lack of access to maternity care is further threatened by the criminalization of obstetricians who intervene to save the lives of their patients when medically necessary.

The LWV will continue advocacy to:

- **Expand TennCare to cover 300,000-400,000 low-income uninsured Tennesseans excluded from care by our state legislature.**
- **Increase State planning and investment in equitable access to health care, including support of rural hospitals and recruitment of primary care, behavioral health, and obstetric care providers to underserved areas.**
- **Provide ongoing support for county and regional health departments to maintain and expand current reproductive services.**
- **Provide TennCare reimbursement of doula and community health outreach workers services to support maternal health and child development.**

Health Education

All methods of contraception work by preventing pregnancy, not terminating it. In the aftermath of the *Dobbs* decision, it is more important than ever that all Tennesseans of child-bearing age have access to accurate information about contraception.[26] Tennessee's 2020 Family Life Education law currently requires "abstinence only" reproductive education in public schools. While complete abstinence from sexual intercourse does prevent pregnancy, Tenn. Code Ann. § 49-6-1304 states that a family life curriculum shall "emphatically promote *only* [emphasis added] sexual risk avoidance through abstinence, regardless of a student's current or prior sexual experience." There are other restrictive requirements within the law such as a focus on sexual activity *only* in the context of marriage, and lack of acknowledgement of same sex relationships.

Health educators should be permitted to discuss comprehensive sex education and family planning with teens before relationships result in pregnancy, which they are prevented from discussing by current law. Health researchers report that there is no demonstrated effectiveness of abstinence-only curricula. To date, these programs have not resulted in less risky sexual behavior or delays in sexual intercourse. Moreover, abstinence only curricula withhold health information needed to make informed decisions about pregnancy and prevention of sexually transmitted infections. Many of these programs also foster gender stereotyping and marginalize LGBTQ youth.[27]

There are other options that should be available to schools. The CDC Division of Adolescent and School Health has established an evidence-based approach referred to as "quality sexual health education" that is a systematic, effective way schools can provide adolescents with health information and critical skills needed to decrease sexual risk behaviors. Youth who participate in these programs are more likely to delay initiation of sexual intercourse, have fewer sex partners, have fewer experiences of unprotected sex, increase their use of protection (specifically condoms), and improve their academic performance.[28]

The Youth Risk Behavior Surveillance System (YRBSS)[29] is a biennial national survey developed by the Centers for Disease Control and administered by the Tennessee Department of Education. The survey monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection. However, there are no current statewide data about sexual behaviors among Tennessee youth because our state has excluded sexual behavior questions on the YRBSS survey since 2017. Without these data, there is no way for parents, public health departments and school systems to evaluate the effectiveness of reproductive health and education programs, trends in risk behaviors, or how best to target prevention programs.

The LWVN will advocate for the following educational initiatives:

- **Return choice of family life curriculum to local school boards.**
- **Make Quality Sexual Health Education as described by the Centers for Disease Control Division of Adolescent Health (CDC DASH) an optional curriculum framework.**
- **Develop certification programs for teachers, school nurses, and other school staff who teach health. This could be a collaborative effort among universities and departments of health and education**
- **Ensure the TN Department of Education's health education and Lifetime Wellness standards are met in all grades. This will provide a foundation for lifelong health. TDOE has completed a health education crosswalk with other courses to help schools with the issue of time needed to teach all the courses required for grade progression and graduation.**
- **Improve understanding and trends of health-related risks among TN youth by resuming the inclusion of sexual health questions on the Youth Risk Behavior Surveillance System.**

Support for Programs that Improve Social Determinants of Health

As noted above, half of all births in Tennessee are currently covered by Medicaid, and 1 in 5 infants and children live below the federal poverty level. These bleak realities will persist and possibly intensify post *Dobbs* unless our state invests more wisely in programs that provide social and economic supports to women and their families.[30]

According to a study conducted by the Institute for Women's Policy Research, children born to women with abortion access had lower rates of poverty, were more likely to graduate college, and were less likely to receive public assistance as adults. Conversely, the financial consequences of abortion denial can be severe. Individuals denied abortions who eventually gave birth were four times more likely to have household incomes below the federal poverty level and were more likely to report being unable to afford basic necessities.[31]

Rearing a child anywhere can be complex and depends on many factors, but adequate financial support is certainly one of them. According to the Brookings Institute, it now costs $310,605 to raise a child through high school graduation in the United States.[32] Tennessee does not fare well in addressing socioeconomic factors that can determine health outcomes. Tennessee is among states directly providing the lowest amounts of financial assistance to needy families. For every 100 families in Tennessee with children living in poverty, only 11-20 families receive Temporary Assistance for Needy Families (TANF) benefits.[33]

Other determinants of health include access to nutritious food, safe and affordable housing, healthy working conditions, a living wage, reliable transportation, education, health care, and supportive social relationships. Public policy shapes the social environment in which families struggle or thrive impacting health, productivity, and longevity.

Evidence-based social policies and programs that would minimize health disparities and build healthier families across the state include the following:

- **Increase access to TANF/ Families First program benefits, including Teen Child Care Assistance for young mothers.**
- **Expand and extend supplemental food assistance and school nutrition programs.**
- **Support affordable housing initiatives to increase housing stock for low-income families.**
- **Enact a state minimum wage increase from $7.25/hour to a living wage.**
- **Improve methods of collecting child support so hiring an attorney is not required to enforce court-ordered child support; and provide state subsidies to bring single-parent families above the poverty level.**
- **Expand access to early childhood and PreK programs, including transportation access**
- **Enact family leave policies that include provisions for parents to care for sick dependents.**

Summary of LWVN Recommendations to Protect and Improve the Reproductive Health of Tennesseans

Restore Reproductive Health Access:

- **Decriminalize provision of medically necessary pregnancy terminations**
- **Allow the medical necessity of intervention in a pregnancy to be determined by a pregnant person and their medical provider, not by the legislature or the courts**
- **Consider the mental health of the pregnant person in assessing the risk of death and permanent damage to a person's functioning**
- **Reinstate exceptions for rape, incest, child sexual abuse, and severe fetal abnormalities**
- **Continue to require TennCare and private health insurance to cover pregnancy terminations to protect the life and health of pregnant women and in cases of rape and incest**

Expand Access to Comprehensive Health Services:

- **Expand Medicaid/TennCare to cover 300,000-400,000 low-income uninsured Tennesseans excluded from care by our state legislature**
- **Plan and increase state investment in equitable access to comprehensive health care, including support of rural hospitals and recruitment of primary care, behavioral health, and obstetric care providers to underserved areas**
- **Provide ongoing support for county and regional health departments to maintain and expand current reproductive services**
- **Provide TennCare reimbursement of doula and community health outreach workers services to support maternal health and child development**

Enhance Health Education:

- **Return choice of family life curriculum to local school boards**
- **Make *Quality Sexual Health Education* as described by the Centers for Disease Control Division of Adolescent Health (CDC DASH) an optional curriculum framework**
- **Develop certification programs for teachers, school nurses, and other school staff who teach health as a collaborative effort among universities and departments of health and education**
- **Ensure the TN Department of Education's health education and *Lifetime Wellness* standards are met in all grades**
- **Improve understanding and trends of health-related risks among TN youth by resuming inclusion of sexual health questions on the Youth Risk Behavior Surveillance Study**

Support Programs that Improve Social Determinants of Health:

- **Increase access to TANF/ Families First program benefits, including Teen Child Care Assistance for young mothers**
- **Expand and extend supplemental food assistance and school nutrition programs**
- **Increase state support of affordable housing initiatives to increase housing stock for low-income families**
- **Enacting a state minimum wage increase from $7.25/hour to a living wage**
- **Improve methods of collecting child support so hiring an attorney is not required to enforce court-ordered child support; and provide state subsidies to bring single-parent families above the poverty level**
- **Expand access to early childhood and PreK programs, including transportation access**
- **Enact family leave policies that include provisions for parents to care for sick dependents**

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