Exploring Reproductive Oppression Among Undocumented Immigrants in Texas

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Exploring Reproductive Oppression Among Undocumented Immigrants in Texas

Darci Phillips

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Abstract

Reproductive rights (RR) have been defined as all individuals and couples having the basic right to “decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so” (United Nations Population Division, n.d.). Reproductive justice (RJ) was born from combining reproductive rights with social justice (Ross & Solinger, 2017, p. 9) and goes beyond RR by placing a greater emphasis on access. Access takes other factors into consideration such as the disproportionate number of women of color who cannot afford abortion care or are unable to travel long distances to their nearest clinic (Ross & Solinger, 2017), suggesting choice is irrelevant without access. Additionally, reproductive justice addresses the exceptional systemic challenges women of color often experience in accessing contraception, sexually transmitted infection prevention and treatment, sex education, adequate pregnancy care, alternative birthing options, fair wages, safe homes, domestic violence support, and more (Ross & Solinger, 2017).

The state of Texas was ranked among the lowest states for access to health care and affordability by the Commonwealth Fund (Hasstedt, 2014). Activists in the state are forced to continuously combat restrictive abortion legislation yet maintaining the legal status of abortion is only one step in the pursuit of reproductive justice. Asylum seekers and undocumented women in Texas might be the most vulnerable population regarding reproductive justice as their rights per this movement are gravely and repeatedly violated. State policymakers continuously pass legislation to make abortion care inaccessible, which disproportionately impact immigrant and other marginalized communities.
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Introduction

Texas has higher rates of unintended pregnancies, lower rates of abortion care, as well as higher rates of human immunodeficiency virus (HIV), chlamydia and gonorrhea compared to nationally representative data (Hasstedt, 2014). In terms of meeting the need for public funded contraceptive services, Texas comes in last, tied with Nevada, at only 10% (Hasstedt & Sonfield, 2017). Furthermore, in 2012, researchers from the Texas Policy Evaluation Project (TPEP) found a higher rate of self-induced abortion compared to the national average (Hasstedt, 2014). Their research was conducted before 2013 when new abortion restrictive legislation led to mass clinic closures across the state, suggesting that the rate for self-induced abortion may have drastically increased (Hasstedt, 2014).

Over the last decade, 2010-2020, several state policies have been implemented in Texas which have had devastating outcomes regarding access to family planning services and abortion care. These policies have had disproportionately negative impacts on rural or low-income women in the state. The main reason these women face greater barriers in accessing abortion care is cost; whether it be for procedures, childcare, lodging, transportation, or a lack of paid time off from their work (Jerman, Frohwirth, Kavanaugh, & Blades, 2017). Family planning services can be difficult to access for low-income women in Texas due to lack of health insurance and the insufficient number of available family planning clinics (Hasstedt, 2014).

Undocumented women in Texas are more likely to be low-income, less likely to have health insurance, and must deal with both restrictive abortion legislation at the state level as well as changes in immigration policies at the federal level, which have negatively impacted their lives. This literature review will discuss some of these state and
federal policies in greater depth and examine their heightened negative consequences on undocumented women in Texas. Finally, several recommendations will be made to safeguard undocumented women’s reproductive health.

**Background**

**Immigration Populations and Disparities in Reproductive Services**

According to the Center for Migration Studies (CMS), approximately 10.6 million individuals living in the United States had no lawful immigration status in 2017 (Trovall, 2019). The Migration Policy Institute (MPI) closely analyzed the undocumented population between 2012 and 2016. Key findings from their analysis include 67% were originally from Mexico and Central America; among those age 25 and older, 47% had less than a high school diploma; 62% had lived in the United States for more than 10 years; and 44% were considered to have limited English proficiency (Gelatt & Zong, 2016). In addition, 28% of the undocumented population was living under the federal poverty level compared to only 17% of United States born individuals (Gelatt & Zong, 2016).

Research shows that among all immigrant women in the United States, regardless of their legal status or country of origin, they are less likely to have health insurance or to obtain reproductive healthcare services, including contraceptive counseling; screenings for reproductive cancer and sexually transmitted infections (STI); as well as pre and postnatal care (Desai, Long, & Jones, 2019). According to one recent study, approximately one-half of all immigrant women compared to two-thirds of women born in the United States had received information regarding contraceptives in the year prior (Hasstedt, Desai, & Jones, 2018). Other findings showed that women born in the United
States are more likely to utilize contraceptive methods considered highly effective such as intrauterine devices (IUDs) or implants (Hasstedt et al., 2018). While not fully understood, this trend might be partially driven by individuals’ contraceptive preferences, higher costs, and the requirement of a clinician for placement processes (Hasstedt et al., 2018). The findings regarding contraceptive care indicate that the risk of unintended pregnancy is higher among immigrant women (Hasstedt et al., 2018). In addition, immigrants are less likely to receive Pap tests (cervical cancer screenings), putting them at greater risk of cervical cancer, and less likely to receive hepatitis B vaccinations, which can be a life-threatening infection when passed on to infants (Hasstedt et al., 2018; Hassted, 2013). Finally, women born in the United States are significantly more likely to receive mammograms compared to immigrant women, putting them at a higher risk for delays in care if diagnosed with breast cancer (Hasstedt et al., 2018). There are several reasons for these disparities, which will be discussed in more detail later; however, the primary cause has to do with several policies that exclude immigrants from obtaining affordable healthcare coverage (Hasstedt et al., 2018).

Other research has shown disparities in healthcare services when comparing undocumented immigrants to lawfully present immigrants. For example, one study found that 78% of lawfully present immigrants had one physician visit in the previous year compared to only 60% among undocumented immigrants (Vargas Bustamante et al., 2012). Furthermore, only 52% of undocumented immigrants have a usual source of care compared to 73% of lawfully present immigrants (Vargas Bustamante et al., 2012). In addition, nearly 10% of undocumented women receive no prenatal care, which makes the
risk of delivering a low-birth weight baby four times greater, and results in poorer overall reproductive health outcomes (Gostin, 2019).

**Texas Immigration Populations and Disparities in Reproductive Services**

An estimated 1.8 million undocumented immigrants reside in Texas, meaning the state alone accounts for almost 17% of the total undocumented population nationwide (Trovall, 2019). While the undocumented population has decreased by 9% over the last 7 years in the United States, it has increased by 5% in Texas (Trovall, 2019). Among the total undocumented population in Texas, an estimated 71% are from Mexico, 47% are female, and 47% are at or below 149% of the federal poverty level (FPL) (MPI, 2018). For reference, in 2020, a family of 4 making only $39,000 per year is at 148.85% FPL (My Coverage, 2020). In addition, approximately 64% of undocumented immigrants in Texas are uninsured compared to 18% using state-wide representative data (MPI, 2018; Smith, 2020).

In Texas, undocumented immigrants are ineligible for almost all public health insurance options, including Medicaid (joint federal-state health insurance coverage for low-income individuals), Children’s Medicaid, the Children’s Health Insurance Program (CHIP), and Refugee Medical Assistance (Dunkelberg, 2016). (See Appendix B for a table outlining all options for immigrants in Texas). As such, their only options for public health insurance are CHIP Perinatal and Emergency Medicaid, both of which offer limited coverage for few select services and do not benefit most undocumented adults (Dunkelberg, 2016). Depending on the county in which they reside, they may or may not be eligible for the Indigent Health Care Program (Dunkelberg, 2016) which provides low-income individuals, who are ineligible for Medicaid, access to some health-related
services, and each county determines whether or not immigration status is a criteria for eligibility (Texas Health & Human Services, 2020). In addition, undocumented immigrants, and Deferred Action for Childhood Arrivals (DACA) recipients are ineligible for coverage under the Affordable Care Act (ACA) due to their immigration status (Dunkelberg, 2016). Furthermore, immigrants with or without a lawful immigration status, are more likely than United States born individuals to have low-wage jobs which do not offer employer-sponsored health insurance (National Women’s Law Center, 2017). In Texas, undocumented immigrants rely heavily on community health centers (CHCs), which offer basic medical care using sliding scale fees based on the patient’s income, or emergency rooms for medical treatment (Wiltz, 2018).

Almost half of immigrant women are of reproductive age and having inadequate access to basic care is a threat to their health, economic security, and general well-being. Additionally, it threatens the stability of their family and community (Hasstedt et al., 2018). Regarding the Texas economy, the state’s choice to limit healthcare options for undocumented immigrants has likely had a negative impact (Wiltz, 2018). Researchers have found that many undocumented people forgo primary care, even when it is available (Wiltz, 2018). As a result, they often end up in the emergency room and are unable to pay, which makes their outstanding medical bills considered ‘bad debt’ (Wiltz, 2018). Bad debt is either billed to Federal Emergency Medicaid, which comes from general taxes, or it increases rates for those who have private health insurance (Wiltz, 2018). This vicious cycle puts a strain on the state’s health care system (Wiltz, 2018). Furthermore, there is clear evidence demonstrating how states which initially expanded Medicaid through the Affordable Care Act are experiencing reductions in bad debt and net savings
in their states’ budgets (Cross-Call, 2018). These findings contribute to the argument that expanding public health insurance across the board is economically beneficial.

**State Policies Deteriorating Reproductive Healthcare Access**

In order to thoroughly grasp why Texas fares so poorly in terms of reproductive justice, it is important to learn about a few pieces of legislation: which include changes made in 2011 to the state’s family planning budget; Texas House Bill 2 in 2013; the inception of a state-funded program known as Alternatives to Abortion (A2A) in 2006; and the Women’s Right to Know Act in 2003. The Title X Family Planning Program administers federal funding for clinics that provide reproductive health services for women, men, and teens of low-income and requires services to be provided regardless of immigration status (Sobel, Salganicoff & Frederiksen, 2017). Public Health Departments, CHCs, and independent family planning clinics, which refer to clinics that specialize in contraceptive services such as Planned Parenthood (PP), are eligible for Title X funding (Sobel, Salganicoff & Frederiksen, 2017). Planned Parenthood has over 700 health centers in the United States and is the nation’s leading provider of reproductive health services and sex education (Planned Parenthood, 2020). In addition, PP helps prevent approximately 515,000 unintended pregnancies every year (Planned Parenthood, 2020).

**2011: Family Planning Budget Cut.** Prior to 2011, Texas’s family planning budget was comprised of Title X funding and other federal block grants, including Title V (Maternal and Child Health) and Title XX (Social Services) (White et al., 2012). However, in 2011, the Texas state legislature cut two-thirds of the family planning budget, from $111 million to $37.9 million for a two-year period, by reallocating Title V and Title XX funds towards other efforts (White et al., 2012). The remaining funds (the
$37.9 million) primarily came from Title X, which cannot be reallocated to other efforts. Unfortunately, these remaining funds would now have to be provided through a priority system in which Public Health Departments and CHCs would be given priority over independent family planning clinics (Hasstedt & Sonfield, 2017). As a result, 82 clinics, one-third of which were Planned Parenthood, were forced to close (Novack, 2019). Consequently, 54% fewer patients in the following period were served (White et al., 2012).

Texas relied primarily on Public Health Departments and CHCs to fill the gap for providing family planning services as they were placed in the first tier of the new priority system for receiving funds (Rosenbaum, 2017). While both CHCs and Public Health Departments made great attempts to increase capacity, many patients reported having to wait months to receive services from a CHC or health department in their area (Redden, 2017). The CHCs are an extremely important resource for primary care among low-income, undocumented women. However, absorbing all the patients from Planned Parenthood and other independent family planning clinics that were forced to close is simply too great a challenge (Rosenbaum et al., 2018). After 2011, Medicaid family planning claims decreased by more than 35% and Medicaid births increased by 27% (Rosebaum, 2017). Additionally, TPEP conducted a study following women who depended on Planned Parenthood for Depo Provera, which is an injectable contraceptive, in Midland and Houston (Redden, 2017). Their findings indicated that 25% of women who were planning to stay on Depo Provera missed the next dose and 25% of those women became pregnant (Redden, 2017). Those who did not miss their next dose often
had to pay high out of pocket fees or travel great distances to obtain the shot (Redden, 2017).

In March 2013, when the state’s Title X contract ended, the Women’s Health and Family Planning Association of Texas (WHFPT), now known as Every Body Cares, was awarded the Title X grant instead of the Department of State and Health Services (DSHS) (Smith, 2013). For their first fiscal year, the WHFPT received 13.5 million (Blackman, 2013). Because the organization is not a state agency, Title X funds would no longer be subjected to the priority system in which independent family planning clinics are left with little to no support (Smith, 2013). As a result, WHFPT has been able to help some previously closed clinics reopen and help existing clinics expand capacity (Tuma, 2018). However, there are still fewer Title X-funded clinics now than there were prior to the state’s massive cut to their family planning budget (White et al., 2015).

Studies have shown that a higher proportion of immigrants compared to United States citizens depend on publicly funded clinics for care (Desai, 2019). In addition, undocumented immigrants are ineligible for the state’s fee-for-service family-planning program called Texas Healthy Women, which has successfully barred independent family clinics like Planned Parenthood from providing coverage to enrollees (see Appendix C for more information). As such, there is a high probability that undocumented women in Texas are disproportionately impacted by the massive cuts made to the family planning budget in 2011.

2013: Texas House Bill 2. The Texas House of Representatives voted 96-49 to approve House Bill 2 (HB2) in 2013, and it was passed by the Senate three days later with a 19-11 margin (Aaronson, 2013; Smith, Aaronson, & Luthra, 2013). The bill
included the following provisions: (1) doctors are required to have active admitting
privileges at a hospital no more than 30 miles from the clinic; (2) all abortions must be
performed in ambulatory surgical centers; (3) requires providers to follow outdated U.S.
Food and Drug Administration (FDA) procedures for distributing abortion pills; and (4)
abortions are prohibited at 20 weeks (Smith. et al., 2013). Before HB2 passed, there were
41 clinics in the state that provided abortion care. Shortly after legislation was passed,
there were only eight. From November 2012 to April 2014, the abortion rate in Texas
decreased by 13%. In addition, there was a relative increase in second trimester abortion
during this period, which comes with financial consequences, considering the cost of
abortion increases alongside gestational weeks (Nuestro Texas, 2015). The number of
Texas women of reproductive age who lived more than 200 miles from an abortion-
providing clinic increased from 10,000 women in May of 2013 to 290,000 women by
April 2014 (Nuestro Texas, 2015).

National data has shown Latinas, women of Latin American origin, to be the least
likely of all racial groups to travel over 100 miles for an abortion due to transportation
barriers (Nuestro Texas, 2015). Eighty-six percent of undocumented immigrants in Texas
are of Latin American origin, meaning many undocumented women would have been
included in the finding (MPI, 2018). According to the National Latina Institute for
Reproductive Justice (NLIRJ), many undocumented women in Texas fear leaving their
communities (Nuestro Texas, 2015). They found several reasons to explain this fear,
including internal immigration checkpoints on Texas roads; the pervasive presence of
Immigration & Customs Enforcement (ICE); not having access to obtain a driver's
license; and poor public transportation, which tends to be costly, inefficient and does not exist in some counties (Nuestro Texas, 2015).

Two provisions of HB2, one requiring doctors to have hospital admitting privileges and the other requiring abortions to be performed in ambulatory surgical centers, were struck down by the Supreme Court in the 2016 Whole Woman’s Health V. Hellerstedt case (NARAL Pro Choice Texas, 2020). After the victory, several clinics reopened, and there are currently 25 in Texas (Abortion is Healthcare, 2020). Unfortunately, Texas has not been able to re-open all of the clinics due to complex legislation, an unnecessary amount of mandatory paperwork, and surprise inspections by DSHS, all of which aim to make opening an abortion clinic in the state difficult. (Lopez, 2019).

**2006: Alternatives to Abortion.** The Alternatives to Abortion (A2A) program is a state-funded program founded in 2006. The A2A primarily provides funding to Crisis Pregnancy Centers (CPCs) (Novack, 2019). The CPCs are faith-based pregnancy centers that offer few to no reproductive health services (Novack, 2019). They are known for using deceiving and sometimes coercive tactics to discourage women from having abortions (Novack, 2019). Furthermore, they typically provide medically inaccurate information regarding abortion, contraceptives, and condoms (Bryant & Swartz, 2018). For example, CPCs frequently suggest that serious mental health issues can be caused by abortions (Bryant & Swartz, 2018). They aim to appear as medical clinics that can offer legitimate healthcare services and advice; however, they are exempt from the credentialing oversight and licensures which apply to real healthcare facilities, and most do not have any licensed clinicians on staff (Bryant et al., 2018). From A2A’s inception
to 2018, the program was allocated 93.2 million dollars of state funds (Tuma, 2018). Following the last legislative session, the state’s total investment in A2A will reach 182 million through fiscal year 2021 (Najmabadi & Walters, 2021). According to the Crisis Pregnancy Center’s official map locator, there are currently 203 centers in Texas (Swartzendruber & Lambert, 2020).

**2003 Women’s Right to Know Act.** The 2003 Women’s Right to Know Act requires doctors to provide patients with a booklet containing medically inaccurate information, written by the government, 24 hours prior to any abortion procedure (Pattani, 2016). The booklet claims that abortion care is correlated with an increased risk of death, breast cancer, and infertility, none of which are true according to medical experts (See Appendix D for image) (Pattani, 2016). Also, throughout the entire booklet, the words “your baby” are used instead of the correct medical term, fetus (Pattani, 2016). This suggests that the law’s true objective is to use fear and shame as tactics to discourage women from obtaining abortion care. In addition, abortion providers must give every patient a list of agencies for counseling, most of which are anti-abortion groups such as CPCs (NARAL Pro Choice Texas, 2020). Finally, in 2011, the law was amended to include a sonogram mandate, which requires women to undergo a sonogram (image generated from ultrasound procedure) at least 24 hours before obtaining abortion care (Jones, 2012). Because of the sonogram mandate, a person must make at least two trips to a health center to receive an abortion, and according to NLIRJ, transportation is a common barrier to abortion care for undocumented populations.

According to the MPI, among undocumented immigrants in Texas age 25 and older, 53% had less than a high school diploma and 50% considered to have limited
English proficiency (MPI, 2018). Nationally representative data estimates that approximately 90% of individuals, aged 25 and older in the U.S., have a high school diploma (United States Census Bureau, 2017). These findings suggest that the undocumented population may be more vulnerable to the misleading and medically inaccurate information provided by CPCs and in the government-mandated booklet doctors must provide per the Women’s Right to Know Act. In addition, abortion care is time-sensitive; therefore, delays potentially caused by CPCs or the Women’s Right to Know Act may lead to more expensive treatment and can even prevent the person from being able to receive care in Texas if they are close to the state’s gestational limit of 20 weeks. Because a disproportionate number of undocumented immigrants are low-income and may be less likely to travel, these systemic barriers pose a greater risk to the population.

**Challenges Associated with Immigration Status**

Existing pathways to acquiring legal status include family reunification, employment, or humanitarian protection (AIC, 2019). Each pathway is subject to strict eligibility criteria and numerical limitations (e.g., individuals who have resided in the country for more than one year cannot submit an asylum application), which many undocumented immigrants are unable to meet (AIC, 2019). As a result, most do not qualify for any form of immigration relief regardless of how hard they work and how much they contribute to their communities (AIC, 2019). The evidence in terms of economic security is clear (Lynch & Oakford, 2013), legal status allows undocumented immigrants to earn significantly higher incomes (Lynch & Oakford, 2013). As a result, they consume more and pay more in taxes, which benefits the economy. Such narrow
pathways to acquiring legal status for undocumented immigrants is in clear violation of RJ as it jeopardizes their economic security and makes them chronically ineligible for most public benefits.

Before the Trump Administration (2016-2020), policies surrounding deportation prioritized United States resources (AIC, 2018). For example, single mothers with citizen children would not likely be placed in deportation proceedings because it could require the provision of foster care services once deported. As such, ICE emphasized removing individuals convicted of severe crimes (AIC, 2018). The Trump Administration eliminated such priorities in 2017 when the President issued an executive order, called “Enhancing Public Safety in the Interior of the United States.” The order made all undocumented immigrants an equal target for deportation enforcement (AIC, 2018). As ICE stated in their 2017 year-end report, no exemptions will be made for any category or class of removable noncitizens from enforcement (AIC, 2018). From January 25, 2017, when the executive order was officially signed, to September 30, 2017, ICE arrests increased by 42% compared to the same period in 2016 (AIC, 2018).

The Transactional Records Access Clearinghouse (TRAC) at Syracuse University analyzed ICE records from September 2016 to December 31, 2018, a period primarily coinciding with the Trump administration (Ferriss, 2019). They found that the number of ICE detainees who had been convicted of a serious crime dropped by 17% while the number of detainees who had never been convicted of any crime increased by 39% (Ferriss, 2019). In addition, mass immigration raids, which typically take place at worksites, have increased in terms of both frequency and the number of arrests made under Trump’s Administration, and several of these large-scale raids have occurred in
Texas (National Immigration Law Center, 2020). Finally, the number of 287(g) agreements, which is a partnership between ICE and local law enforcement that requires police officers to enforce immigration laws, have drastically increased in Texas since the Trump Administration took office. Currently, 25 counties in Texas hold 287(g) agreements, which is one third of all agreements nationwide (Palomo Garcia, 2018). In 2018 alone, the 287(g) program led to over 7,000 deportations (ILRC, 2019). Studies have shown that public safety suffers in counties with 287(g) agreements (Muñoz Lopez, 2018). One survey found that among undocumented immigrants who knew that their county held a 287(g) agreement, they were 61% less likely to report witnessing a crime and 43% less likely to report being a crime victim (Muñoz Lopez, 2018).

Research suggests that as deportations increase, the undocumented community becomes more distrustful of public agencies (Potochnick, Chen, & Perreira, 2017). As expected, there has been a recent trend among undocumented immigrants to either avoid or drop out of assistance programs, even though they are eligible to receive the benefit(s) (Perreira & Pedroza, 2017). For example, Women, Infants and Children (WIC), a federal assistance program intended to support low-income pregnant women and children under five years old in gaining access to nutritious food and infant formula does not consider immigration status as a criterion for eligibility (Bottemiller Evich, 2018). However, there is a fear that their participation in the assistance program will eventually lead to their deportation (Perreira & Pedroza, 2017). Furthermore, the non-attendance rate at CHCs all over the country is rising among undocumented populations, which is also likely a result of the recent increase in deportations and mass immigration raids (Kuo, 2017). Many undocumented individuals fear that the clinic could be a target (Kuo, 2017). Forgoing
these services puts immigrant families and their children at undue health risks, both short and long-term (Bottemiller Evich, 2018). For example, one study found that increased immigration enforcement can severely disrupt a child’s life, making them more vulnerable to preventable health issues and food scarcity (Potochnick, Chen, & Perreira, 2017). In addition, mass immigration raids have been found to be associated with lower birth weight babies (Hoffman, 2017). For instance, after a mass immigration raid in Pottsville, Iowa, babies born to Latina immigrants had a 24% increased rate of low birth weight than those born the previous year (Hoffman, 2017). Considering the risk of delivering a low birth weight baby is 4 times greater among individuals who receive no prenatal care, this finding suggests that undocumented individuals might be more likely to defer health treatment due to fear following the occurrence of a nearby mass immigration raid (Hoffman, 2017). Undocumented immigrants’ right to raise their children in a safe environment is violated as the community fears being torn away from their families.

**Addressing the Issue**

There have been several initiatives at the national, state, and local level, addressing reproductive oppression in Texas. This section will detail some of the efforts, which are specifically aimed to improve access to abortion care in the state.

**National Level.** The National Network of Abortion Funds (NNAF) works with member organizations across the United States to alleviate the financial and logistical barriers many low-income women face in accessing abortion (2020). Member organizations are referred to as abortion funds. Abortion funds are nonprofits that provide support with all or some of the following services: financial assistance for the procedure,
transportation, translation, childcare, doula services (person who provides support to individuals obtaining a surgical abortion), and lodging for those having to travel. There are currently 70 NNAF member organizations nationally.

**State Level.** Currently, there are nine abortion funds providing services in Texas (National Network of Abortion Funds, 2020). Due to limited resources, these agencies, regardless of their location, are not able to cover the entire cost of treatment through their financial assistance programs (National Network of Abortion Funds, 2020). According to NNAF, there are more abortion funds in Texas compared to any other state, which is due in part to the state’s strict legislation surrounding abortion (2020). For example, the insufficient number of clinics in Texas causes additional barriers in terms of transportation, childcare, and lodging, which ultimately increases the need for support from abortion funds. Regarding initiatives carried out by these agencies, abortion fund leaders from across the state worked with Rep. Sheryl Cole, D-Austin, to get Rosie’s Law introduced in the Texas legislature in January 2020 (Tuma, 2019). If passed, it would provide abortion coverage for low-income Texas families enrolled in Medicaid (Tuma, 2019). Rosie Jimenez was the inspiration for Rosie’s Law. She was a 27-year-old single mother from Mcallen, Texas, and she was the first woman to die from an unsafe abortion after the Hyde Amendment was passed in 1976, which prohibited the use of federal funds to pay for abortion care (Tuma, 2019). In addition, three abortion funds in the state recently collaborated with five other pro-choice or civil rights organizations in Texas to develop the Texas Abortion Access Network (TAAN). The TAAN is dedicated to expanding health care access, defending abortion rights, educating the public on RR, and building a movement of abortion rights advocates (Wallace, 2020). The TAAN offers an
eight-week advocacy training program, which helps individuals gain the skills necessary for becoming an effective advocate and leader in the reproductive rights movement (Wallace, 2020).

**Local Level.** In 2018, Austin City Council passed Rosie’s Resolution, and as a result, $300,000 is now provided to their local abortion fund, Lilith Fund, on a yearly basis (Lilith Fund, 2019). Lilith Fund covers the city of Austin and several other counties in south Texas (Lilith Fund, 2019). Shortly thereafter, activists in Dallas and Houston started local collaboratives known as Repro Power Dallas and Repro Power Houston (Repro Power Dallas, 2020; Repro Power Houston, 2020). Among other initiatives, both aim to organize residents of their respective counties in calling upon their local governments to pass a similar resolution for abortion coverage (Repro Power Dallas, 2020; Repro Power Houston, 2020).

The research outlined in this literature review provides evidence for the disproportionate experience of reproductive oppression among the undocumented community in Texas. The first findings contribute to the claim that Texas fares poorly in terms of reproductive justice compared to other states. Next, research comparing access to reproductive health care services among immigrants and United States born citizens was presented, and these findings suggested greater access among individuals born in the country. Later, disparities among undocumented immigrants compared to lawfully present immigrants regarding access to care and reproductive health outcomes was discussed. There are several factors contributing to the high level of reproductive oppression experienced by undocumented immigrants. Contributing factors considered for recommendations in this paper include the lack of options for insurance coverage; the
state program A2A, which provides funding to CPCs; the inadequate number of abortion clinics; the insufficient number of family planning clinics; improving access to reliable transportation; and the inability of abortion funds to cover a greater proportion of the cost for their recipients.
Scope of Project

Introduction

This section includes information regarding my fieldwork placement with Texas Equal Access Fund (TEA Fund). First, basic background information, including the agency’s history, funding sources, mission, primary services, and target population, will be discussed. Later, I will describe my role within the agency as well as projects I have worked on during my placement.

Agency Description

TEA Fund, founded in 2005, is one of NNAF’s 70 member organizations and one of nine abortion funds in Texas. According to TEA Fund’s official website, their mission is to provide “funding to low-income people in the northern region of Texas who are seeking abortion and cannot afford it” and to work simultaneously “to end barriers to abortion access through community education and shifting the current culture toward reproductive justice” (TEA Fund, n.d.). TEA Fund is primarily funded through private donations. The board of directors works tirelessly to raise money through hosting private house parties, benefit shows, online giving events as well as meeting with major donors and foundations (TEA Fund, n.d.).

TEA Fund’s primary services include the Funding Helpline, Clinic Escorting, Abortion Doula Support, and the Client Engagement Program, all of which are intended for low-income women considering the termination of their pregnancy. The weekly budget for the funding helpline is $7,000 U.S. dollars; however, some weeks the budget is increased to $9,000 U.S. dollars based on the agency’s capacity to provide additional funding. If the helpline recipient is between 1-11 gestational weeks, $300 is allocated,
between 12-17 weeks, $450 is provided, and $500 is allocated to individuals who are over 18 weeks. Clinic Escorting involves connecting interested helpline recipients with a trained volunteer who will accompany them to their appointment to distract them from the daily crowd of anti-abortion picketers who try and influence a patient’s decision to seek an abortion using aggressive tactics outside clinics. Through the Abortion Doula Support Program, abortion doulas are trained to provide physical and emotional support to interested helpline recipients, who are undergoing a surgical abortion. Finally, through the Client Engagement Program, helpline recipients can participate in reproductive rights movements and develop new initiatives throughout Texas. The TEA Fund’s target population includes low-income women who need financial assistance to cover their abortion.

The TEA fund coverage area includes all North Texas, which was estimated to be 7.4 million people in 2019 (Tompkins, 2019). They provide financial assistance to anyone who is a resident of North Texas, regardless of where they will be obtaining their abortion, and anyone who is traveling to one of the four abortion clinics located in North Texas, regardless of where they live. (See Appendix E for TEA Fund’s coverage map). There are six full time staff members of TEA Fund, each holding distinct jobs: an executive director, a social worker, an advocacy and outreach director, a community organizer, a communications director, and a development director. Other than my preceptor, who is the executive director, the projects I have worked on involve the intake director and the community organizer.
Project Description

My project focused on creating a few different resources for the TEA Fund, which should help them carry out their mission more effectively. First, I created a spreadsheet-database using Airtable, which outlines abortion restrictive legislation in each state (See Appendix F for image of product). The idea for this project was derived from a discussion I had with the executive director after the governor of Texas announced that abortion care would not be considered essential during the outbreak of COVID-19 (Tuma, 2020). Abortion care is time-sensitive, and the delays in care caused by the governor’s ruling likely led to more expensive treatment for many women, and it may have even prevented some from being able to receive care if they were close to the state’s gestational limit of 20 weeks and did not have the resources to travel. The staff at TEA Fund were scrambling to help those that they serve reschedule their appointments in neighboring states, prioritizing those who were close to the gestational limit of 20 weeks in Texas. When the executive director mentioned the need for having quick access to abortion restrictive legislation for each state, the idea for this project was born. Because legislation evolves overtime, the record for each state contains a link for two different websites that consistently update abortion restrictive legislation for that state. In addition, the spreadsheet-database guides the user through how to interpret the legislation.

Second, I developed an education series to be shared with volunteers. A range of social justice issues are covered, including reproductive justice, decolonizing abortion (the re-centering of indigenous perspectives in terms of abortion care access), racial justice, the intersections of reproductive justice and gender justice, immigrant justice,
disability justice, and economic justice. Having more informed volunteers, who work
directly with TEA Fund clients, should help improve the quality of services provided.
For example, volunteers on the helpline with a basic understanding of reproductive
justice might be more inclined to ask the person whether they have reliable
transportation to their appointment and provide necessary referrals if not.

Third, I created a self-care cookbook magazine called, *Recipes for Self-Care: An
Act of Resistance* [link here]. The magazine is a total of 25 pages and features the
favorite recipes and self-care practices among TEA Fund staff, interns, and board
members. Additionally, it discusses the benefits of self-care and why it is necessary for
anyone engaging in advocacy work (See Appendix G for image). Finally, I developed
an electronic survey, which will be used in an attempt to gain a better understanding of
outcomes among individuals who either did not receive financial assistance from TEA
Fund or those who did not attend their appointment, thus, did not utilize the funds
which were committed to them [link here]. As the TEA Fund gathers more information
on the community through the survey, it should help inform operations on the helpline
and improve their methods of outreach.

**Recommendations**

**Lack of insurance coverage options for undocumented people.**

As previously mentioned, undocumented immigrants are ineligible for coverage
under the ACA, and indigent health care coverage of undocumented immigrants varies by
county (Dunkelberg, 2016). An informal query of county hospital policies found that
most of Texas’ largest urban areas do not require proof of immigration status as a
criterion for eligibility (Dunkelberg, 2016). However, most of the smaller population counties do not cover their undocumented residents. (Dunkelberg, 2016)

A coalition should be formed with the goal of expanding health insurance options for undocumented people. At the national level, the coalition will advocate for making the ACA blind to immigration status. At the state and local level, the coalition will advocate for coverage of undocumented immigrants in counties whose indigent healthcare programs exclude undocumented residents from the program.

**Dismantling A2A**

Using state tax dollars to fund programs like A2A, which do nothing for a woman's health, is a gross misuse of the state’s budget, especially when low-income women are struggling to find affordable publicly funded family planning services. State policymakers should advocate to defund A2A followed by proposing all funds originally reserved for A2A are reallocated to CHCs and publicly funded family planning clinics.

**Increase Number & Improve Services of Family Planning Clinics**

Every Body Cares, formerly known as WHFPA, should apply for federal block grants such as Title V and Title XX as these grants were combined with Title X funds for the state’s family planning budget prior to 2011. With a greater budget, they can support the opening of more Title-X funded clinics and improve services at existing ones.

**Ending the 287(g) Agreement in Texas**

According to the American Civil Liberties Union (ACLU), the agreement has led to civil rights violations, racial profiling and makes undocumented people hesitant to report crimes (Palomo Garcia, 2018). In addition, one study found that 287(g) agreement is correlated with a 10% increase in risk of food insecurity (Potochnick, Chen, &
Perreira, 2017). State policymakers should vote to end county governments from signing 287(g) agreements.

**Improve Transportation Access**

The impact of inadequate public transportation is far-reaching. Low-income individuals without access to their own vehicle as well as senior citizens who cannot drive and rely solely on public transportation carry the greatest burden (White, 2015). However, companies, including employers of individuals without a vehicle and other local business owners, experience negative financial consequences due to poor public transportation. (National Express Transit, 2017). Additionally, nonprofits assisting low-income individuals have a vested interest in improving public transportation as it would improve the lives of those they serve. Due to these far-reaching negative consequences, an opportunity is presented for abortion funds to join, develop, or participate in cross sector coalitions that promote better public transportation. In addition to advocating for better public transportation, abortion funds could work with immigrant rights organizations in promoting to overturn legislation which prohibits undocumented immigrants from obtaining a driver’s license in Texas. Allowing undocumented immigrants to obtain drivers’ licenses would help reduce the community’s the fear of being pulled over by local law enforcement and facing legal and financial consequences due to driving illegally (Nuestro Texas, 2015).

**Increase the financial capacity of abortion funds.**

All the Texas abortion fund leaders can approach the Latina Institute Texas, which is a branch of the NLIRJ and ask for their support in organizing the state (NLIRJ, 2020). Their goal will be to find more allies, encourage participation among existing ones as
well as raise awareness and money. With the support that will come from mobilizing the state, they can organize fundraising activities on a much greater scale. Some of the proceeds will go towards hiring a new employee who will utilize a CBPR approach in writing a grant for federal funding from the Title X Family Planning Program. The grant money would be used to cover a higher proportion of abortion care procedures for all the funds’ recipients in Texas. The rest of the proceeds from these fundraising activities will go directly towards this financial assistance program to cover the entire cost of treatment for the recipients. When additional funding has been secured, all the abortion funds can work together in launching a social marketing campaign so that more women in the area are aware of the organization’s services.

Implications

Individual Level

It is well known that individuals without health insurance are less likely to have regular outpatient care and are more likely to postpone or forgo necessary medical services, which often comes with severe health and financial consequences (Tolbert, Orgera, & Damico, 2020). Furthermore, research on the impact of the ACA has shown it to be associated with an increase in preventive care, better self-reported health status, and reductions in emergency room visits as well as out-of-pocket health costs among enrollees (Blumenthal, Collins, & Fowler, 2020). These findings indicate that if undocumented immigrants were eligible for ACA coverage and immigration status was not a criterion for eligibility in more county indigent healthcare programs, the population would experience greater access to care and fewer financial burdens. In terms of abortion
funds increasing their financial capacity, a greater proportion of individuals who call the helpline each week would receive funding, which would prevent delays in abortion care.

**Local Level**

Counties which remove immigration status as a criterion for eligibility for their indigent healthcare programs will experience less debt from high costs associated with emergency room visits. In addition, some evidence suggests that exclusive immigration policies can cause poorer health and employment outcomes (Perreira & Pedroza, 2019). This finding indicates the potential for improved health and employment outcomes among undocumented immigrants in counties which decide to make them eligible for their indigent healthcare programs.

**State Level**

Defunding A2A would work to reduce the harmful role held by CPCs in Texas and save the state millions of dollars. Additionally, prohibiting local governments from signing 287(g) agreements will lead to fewer deportations and should help reduce cases of racial profiling and civil rights violations. Also, public funds across the state will increase as these agreements are known to be expensive.

**Conclusion**

**Summary of Public Health Issue.**

Approximately 17% of the total undocumented population nationwide reside in Texas, which is likely to increase in the coming years (Trovall 2019). Due to exclusive policies at the state and federal level, undocumented immigrants are disproportionately uninsured. In addition, they are more likely to be low-income, less likely to have a clinic they regularly depend on for medical care, and obtain fewer reproductive health services
such as mammograms, prenatal care, and Pap tests. Furthermore, they are less likely to receive information regarding contraceptives and family planning strategies, and research has indicated that they are at higher risk of unintended pregnancy. Inadequate access to reproductive health services threatens the health, overall well-being, and economic security of immigrants as well as their families and communities.

**Highlights of Public Health Issue.**

Recently implemented state policies and state-funded programs such as A2A demonstrate how reproductive rights are continuously undermined in Texas, and this literature review has explained how undocumented immigrants might be bearing the greatest burden. For example, studies have shown that immigrants, regardless of legal status, are more likely to depend on publicly funded clinics, indicating that they were likely disproportionately impacted by the funding cuts made in 2011 to the Title X Family Planning Program. In addition, the passing of HB2 in 2013, significantly increased the number of Texas women of reproductive age who lived more than 200 miles from an abortion-providing clinic. Because undocumented immigrants often fear leaving their communities and cannot obtain a driver’s license in the state of Texas, they face greater barriers in terms of travelling to an abortion clinic. Finally, the disparities in education among undocumented and US born adults suggest that undocumented immigrants are likely more vulnerable to the medically inaccurate information provided at CPCs and by abortion providers per the 2003 Women’s Right to Know Act.

Federal policies, both new and existing, exacerbate the level of reproductive oppression experienced by undocumented immigrants in Texas. First, all existing pathways to acquiring legal status in the United States are subject to strict eligibility
criteria, and most undocumented immigrants do not qualify for any form of immigration relief. As a result, they are chronically ineligible for the vast majority of public benefits in Texas, which puts their economic security in jeopardy. Second, changes in priorities for removal by ICE put all undocumented immigrants at an equal risk of deportation, regardless of how long they have lived in the country or whether they have ever committed a crime. Coupled with the recent increase in mass workplace immigration raids in Texas, many undocumented people are in constant fear of being separated from their families, and as a result, refuse services that could help safeguard their health.

Next steps and implications

The most relevant next steps include improving options for transportation throughout the state, expanding options for public health insurance, dismantling A2A, increasing the number of family planning clinics as well improving services at current ones, ending 287(g) across the state, and increasing the financial capacity of abortion funds.
References


Abortion is health care (2020). Retrieved from https://needabortion.org/clinics/


Budiman, Amy (2020). Key findings about U.S. immigrants. Pew Research Center

Retrieved from https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/


Austin, Texas: Center for Public Policy Priorities. 


Ellmann, N. Immigration detention is dangerous for women’s health and rights. Retrieved from


https://jamanetwork.com/channels/health-forum/fullarticle/2759639


doi:https://doi.org/10.26099/2dcc-mh04

https://www.guttmacher.org/article/2017/07/it-again-texas-continues-undercut-access-reproductive-health-care


Planned Parenthood. (2020). This is who we are [Fact Sheet]. Retrieved from https://www.plannedparenthood.org/files/2313/9611/7298/Planned_Parenthood_Who_We_Are.pdf


## Appendix A.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Competency</th>
<th>Method of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health &amp; Health Care Systems</strong></td>
<td><strong>#5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings.</strong></td>
<td>Support TEA Fund staff in accessing information more feasibly regarding abortion restrictive legislation in neighboring states through developing a spreadsheet-database.</td>
</tr>
<tr>
<td></td>
<td><strong>#6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels.</strong></td>
<td>Help engage volunteers and donors by creating a political education series.</td>
</tr>
<tr>
<td><strong>Planning &amp; Management to Promote Health</strong></td>
<td><strong>#8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs.</strong></td>
<td>Help engage volunteers and donors by creating a political education series.</td>
</tr>
<tr>
<td><strong>Planning &amp; Management to Promote Health</strong></td>
<td><strong>#9. Design a population-based policy, program, project or intervention.</strong></td>
<td>Support TEA Fund staff, volunteers and clients in practicing self-care through creating a cookbook to be shared with staff, volunteers and clients.</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td><strong>#19. Communicate audience-appropriate public health content, both in writing and through oral presentation.</strong></td>
<td>Support TEA Fund staff in accessing information more feasibly regarding abortion restrictive legislation in neighboring states through developing a spreadsheet-database.</td>
</tr>
</tbody>
</table>
## Appendix B.

### Immigrants’ Access to Healthcare in Texas

<table>
<thead>
<tr>
<th>Health Care Program or Service</th>
<th>Lawfully Present Immigrants (visa holder or LPR)</th>
<th>Undocumented Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid-Adults 19 and older</strong></td>
<td>NO: for the majority of immigrants who came to U.S. after 8/22/1996, YES: for immigrants who came to the U.S. before 8/22/1996; humanitarian visa holders; and those who had a humanitarian visa but have since obtained a green card. -- is limited to the same strict eligibility criteria as U.S. citizens (very few parents are eligible, and no adult without dependent children are eligible unless they are pregnant, elderly, or disabled)</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Medicaid-Children under age 19</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Emergency Medicaid</strong> pays providers for emergency care only</td>
<td>YES, but only ER bills for individuals who meet the strict criteria for adult Medicaid (excluding immigration status)</td>
<td></td>
</tr>
<tr>
<td><strong>CHIP-Children under age 19</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>CHIP Perinatal Program</strong>-prenatal, delivery, and postpartum care</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Refugee Medical Assistance Medical</strong> assistance to refugees &amp; asylees for up to 8 months from the individual’s legal date of entry or the day they were granted asylum (those who apply after their legal date of entry month receive less than 8 months of RMA coverage).</td>
<td>YES --&gt; Must have a USCIS verified refugee status or letter proving they have been granted asylum</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Programs using federal health care block grant funds</strong> (run by state, county or city): Examples include: mental health, family planning, immunization, and communicable diseases</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Program</td>
<td>Status 1</td>
<td>Status 2</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Programs providing health services necessary to protect life or safety, includes those using local, state or federal funds. Examples include Emergency food, medical, or shelter; domestic violence services; mental health crisis; disaster relief; and crime victim assistance.</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>County Hospital or Health Districts and Indigent Care Programs</td>
<td>YES</td>
<td>Varies by county</td>
</tr>
<tr>
<td>Marketplace Insurance Coverage, with subsidies</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Marketplace Insurance Coverage, no subsidy</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Healthy Texas Women</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Family Planning Program (there is no information regarding the efficacy of this new program)</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Breast &amp; Cervical Cancer Services (helps pay medical bills for individuals with breast or cervical cancer)</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

(Dunkelberg, 2016)
### Appendix C.

**Timeline:**
Medicaid Waiver: Women’s Health Program --> Texas Healthy Women

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Medicaid waiver</td>
<td>Centers for Medicare and Medicaid Services (CMS) issues a Medicaid waiver to Texas for family planning services as a joint federal-state effort (White et al., 2015). The program is named Women’s Health Program (WHP). Eligibility for WHP is expanded, ensuring many women, who are not eligible for Medicaid, can qualify for WHP (Hasstedt &amp; Sonfield, 2017).</td>
</tr>
</tbody>
</table>
|      | Eligibility criteria for adult Medicaid includes: | - The maximum income limit is based on monthly dollar amounts, meaning the FPL differs slightly depending on the family’s size. It typically varies between 14% and 17% FPL (Medicaid.gov, 2020; KFF, 2020).  
- Must have dependent children. Single adults are not eligible for Medicaid under any circumstances (KFF, 2020).  
- Qualified Immigrants (KFF, 2020). |
|      | Eligibility criteria for WHP included: | - The maximum income limit is 185% FPL  
- Person must be female  
- Between the age of 18 and 44  
- Qualified Immigrants (White et al., 2012). |
| 2007 - 2010 | Planned Parenthood serves | Planned Parenthood serves an estimated 40-50% of women enrolled in WHP (Novack, 2019). |
| 2011 | Texas state legislature imposes new restrictions | The Texas state legislature imposes new restrictions and moves to exclude organizations affiliated with abortion providers from participating in WHP (White et al., 2015). |
| January 2012 | WHP due for renewal | The WHP is due for renewal by the Centers for Medicare and Medicaid Services (CMS) (White et al., 2015). |
|      | The state’s decision to exclude organizations affiliated with abortion providers | The state’s decision to exclude organizations affiliated with abortion providers is in direct conflict with a long-established Medicaid law, which ensures enrollees’ the opportunity to obtain family planning services from any willing and qualified provider. (Hasstedt & Sonfield, 2017). As such, CMS deems Texas as non-compliant and rejects their request to renew WHP (Hasstedt & Sonfield, 2017). |
| 2016 | Texas Health and Human Services Commission (HHSC) launches | The Texas Health and Human Services Commission (HHSC) launches a state run family planning program called Healthy Texas |
Women to replace the WHP. Undocumented immigrants remain ineligible for the program (Novack, 2019).

It is entirely divorced from the joint federal-state effort so the state could continue to exclude safety-net providers like Planned Parenthood (Hasstedt & Sonfield, 2017).

<table>
<thead>
<tr>
<th>2016-2017</th>
<th>For fiscal year 2017, the Heidi Group, an anti-abortion organization which provides support to CPCs, is contracted by the state to find providers and oversee the program (Novack, 2019). They are awarded 1.6 million dollars and pledge to serve 51,000 women for their first year (Novack, 2019).</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of FY2017</td>
<td>The Heidi Group spends $1.3 million to serve only 2,300 people (Novack, 2019). Nearly half of the providers did not treat a single patient through the Texas Healthy Women program (Novack, 2019).</td>
</tr>
<tr>
<td>May 2018</td>
<td>Texas Health and Human Services Commission (THHSC) releases data for the program and did not include the number of patients served (Novack, 2019).</td>
</tr>
<tr>
<td>December 2018</td>
<td>Texas ends their contract with the Heidi Group and begins an investigation into their questionable spending habits.</td>
</tr>
</tbody>
</table>
Appendix D.

Abortion risks

This section describes the risks associated with an abortion. The risks of having an abortion can vary depending on several factors.

Death
You have a greater risk of dying from the abortion procedure and having serious complications the further along you are in your pregnancy. The Centers for Disease Control and Prevention (CDC) recently reported 0.73 legal abortion-related deaths per 100,000 reported legal abortions in the United States from 2008-2011. Studies of other highly developed countries have shown a higher mortality rate from legal abortion.

Physical Risks
Additionally, abortion could result in physical side effects, with different levels of severity. A woman will usually have cramping and vaginal bleeding after any type of abortion procedure. Other symptoms or side effects include nausea (feeling sick to your stomach) or vomiting, diarrhea, warmth or chills, headache, dizziness and fatigue (feeling very tired).

Abortions and miscarriages (also called spontaneous abortions) can result in complications such as injuries to the internal organs, blood clots or serious infections. These will be listed in detail for each type of abortion later in this booklet.

Mental Health Risks
Women report a range of emotions after an abortion. This can include depression or thoughts of suicide. Some women, after their abortion, have also reported feelings of grief, anxiety, lowered self-esteem, regret, sexual dysfunction, avoidance of emotional attachment, flashbacks and substance abuse. For some women, these emotions may appear immediately after an abortion or gradually over a longer period of time.
Appendix E.
This map shows the part of Texas that TEA Fund covers for services.

Appendix F.
Image of Spreadsheet Database, containing abortion restrictive legislation in each state
Appendix G.

Recipes for Self-Care Cover Page
<table>
<thead>
<tr>
<th></th>
<th>Table of Contents</th>
</tr>
</thead>
</table>
| 1 | **SELF-CARE**  
Self-care defined  
An act of resistance |
| 2 | **FAVORITE RECIPES**  
Learn how to make our favorite recipes!  
- TEA Fund staff, volunteers, partners and supporters share their favorite dish.  
- **BONUS:** Read about their favorite ways to practice self-care. |
| 3 | **DIY Self-Care Products**  
Learn how to make a few personal care products, using only natural, nontoxic ingredients. |
What is self-care?

Self-care refers to deliberately engaging in an activity with the intention of caring for one's own physical, emotional, and mental health. While self-care may seem like a simple concept, it is often misunderstood. Some confuse it for self-improvement, which derives from a motivation to 'fix' something about ourselves. Sometimes, people mistake numbing behaviors with self-care. According to one survey, 44% of people believe it is not possible to practice self-care without sufficient time, and 35% believe it is not possible without enough money. Such misconceptions can be detrimental to our health and overall well-being. (1)

The benefits of self-care are long-lasting and can be profound. Self-care is known to improve one's overall mood and reduce anxiety. (1) Some studies have found a relationship between self-care and an increase in productivity, creativity, and empathy as well as an improvement in cognitive functions. Finally, self-care gives individuals a greater capacity to help others. (2) TEA Fund feels that self-care is an act of compassion and must be prioritized.

How is it an act of resistance?

The fight for reproductive justice can be tiring, especially in Texas, where several state policymakers continuously act upon their desire to deny people their right to bodily autonomy. We and other activists in Texas are constantly having to combat restrictive abortion legislation, yet maintaining the legal status of abortion is only one step in the pursuit of reproductive justice. This can be emotionally draining, which is why self-care has become an integral part of our work.

Some of us might feel wrong or even guilty taking the time to rest or seek pleasure. We all have a right to rest and pleasure. Self-care is an act of resistance because it gives you the energy needed to remain committed to the cause.
Pakistani Biryani
A Family Recipe From: Maleeha Aziz | Community Organizer

INGREDIENTS
- 1 cup of cooking oil
- 2 lbs basmati rice
- 3 lbs bone in chicken (cut in pieces)
- 1 large onion
- 1 lb of tomatoes
- 1 tsp ginger paste
- 1 tsp garlic paste
- 1 cup plain yogurt
- 5 whole cardamoms
- 3 pieces of mace
- 7 whole cloves
- ¼ nutmeg chopped finely
- 2 whole aniseed flowers
- 7 whole black peppers
- 1 tsp turmeric
- 1.5 tsp red chilli powder
  - less if you want it less spicy
- Orange food color
- Saffron to taste

DIRECTIONS
Heat up one cup of oil and add the finely sliced onions till they are golden brown. Add the ginger and garlic paste and simmer. When the onion is thoroughly cooked, add 1 lb of finely chopped tomatoes and let it simmer on low heat. Remove from heat when there is a pasty consistency. Add 1 cup of yogurt and mix well. Put the pot back on medium heat and add cardamom, mace, nutmeg, aniseed flowers, black peppers, cloves, turmeric and chilli powder. Add the chicken to this mix and cook it till it is half done. In a separate pot boil rice with ½ tsp of salt and a few drops of oil till half done. Soak in water for 20 mins before boiling to speed up the process. In a flat bottomed pot add a little of the chicken curry gravy, a little oil and half of the rice. Add the chicken curry over the rice and spread it out (layering) and add the rest of the rice on top of it. Mix a pinch of food color in a cup of hot water, add a few flakes of saffron to this and pour it over the rice. Cover the pot with foil and place the lid on top tightly. Put the pot on low heat till you see steam coming out of the sides of the lid. Garnish with cilantro and serve hot. The Biryani is done. Enjoy!
No Bake Peanut Butter Balls
A Recipe from: Nikiya Natale | Advocacy & Outreach Director

INGREDIENTS
• 2 cups of smooth, unsweetened peanut butter (you can use any nut or seed butter)
• 3/4 cup of coconut flour
• 2 tablespoons of maple syrup

DIRECTIONS
Combine and mix all ingredients in a large mixing bowl. If the batter seems too watery, add a bit more coconut flour to firm it up.

Using your hands, roll the dough into balls and place them on a glass dish or on a plate.

Put the balls in the fridge for at least 30 minutes. Yum!
<table>
<thead>
<tr>
<th>Activity 1</th>
<th>Activity 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing with my daughter</td>
<td>Watching Netflix</td>
</tr>
<tr>
<td>Online shopping</td>
<td>Cooking</td>
</tr>
<tr>
<td>Mindfulness meditation</td>
<td>trying out new recipes</td>
</tr>
<tr>
<td>Connecting with my friends and family</td>
<td>in the air fryer</td>
</tr>
<tr>
<td>Chilling on the couch and watching T.V.</td>
<td>I go to counseling</td>
</tr>
<tr>
<td>Coloring</td>
<td>Walking my dog</td>
</tr>
<tr>
<td>Being a plant mom</td>
<td>Essential oils</td>
</tr>
<tr>
<td>I have a self-care buddy to keep me accountable</td>
<td>Painting without an agenda</td>
</tr>
<tr>
<td>Skin-care routine</td>
<td>Virtual Reality &amp; VR Chat</td>
</tr>
<tr>
<td>Limit intake of the news</td>
<td>Walking</td>
</tr>
<tr>
<td></td>
<td>Yoga</td>
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Part 2 continued on next page
Nontoxic Lotion

**INGREDIENTS**
- Coconut Oil
- Shea Butter
- Cocoa Butter (optional)
- Arrowroot Powder
- Essential Oil

**DIRECTIONS**
Use equal parts coconut oil, shea butter and cocoa butter. I usually use about 1/2 cup each. Melt the three ingredients using a double boiler. If you don’t have a double boiler, that’s okay! Just put the coconut oil, shea butter, and cocoa butter into a jar with a lid. I like to use the same jar I’ll be using to store my lotion. Next, put the jar, containing these ingredients into a a bowl (not stainless steel). Pour hot water into the bowl so that the ingredients melt together. I like to put something on top of the jar so that it doesn’t float up (refer to the picture on the previous page for nontoxic deodorant.) If you decide to use cocoa butter, keep in mind that it will take longer to melt so it might be a good idea to keep the lid slightly open to prevent any risk of the glass breaking. After the ingredients have been melted or close to melted, stir thoroughly using a whisk or hand mixer.

Next, put equal parts arrowroot powder and continue to stir. Arrowroot powder will prevent the lotion from being too oily so feel free to use as much or as little as you’d like. Put your melted jar of lotion in the refrigerator for 20 minutes and then add 15–20 drops of your preferred essential oil. If you are using cocoa butter, orange goes best and it will have a lovely orange, chocolatey fragrance. Stir thoroughly and put it back in the refrigerator if it needs more time! Finally, use and enjoy!

*Self-care product from Darci Phillips*