

Racial and Socioeconomic Disparities Related to Abortion Care in a Post-Dobbs United States: A Narrative Review

by

Jordan Michelle Smith

Bachelor of Science, University of Michigan, 2021

Submitted to the Graduate Faculty of the
Department of Health Policy & Management
School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2023

UNIVERSITY OF PITTSBURGH

SCHOOL OF PUBLIC HEALTH

This essay is submitted

by

Jordan Michelle Smith

on

April 19, 2023

and approved by

Essay Advisor: Lindsay M. Sabik, PhD, Associate Professor and Vice Chair for Research,
Health Policy and Management, School of Public Health, University of Pittsburgh

Essay Reader: Sara E. Baumann, PhD, MPH, Assistant Professor, Behavioral and Community
Health Sciences, School of Public Health, University of Pittsburgh

Copyright © by Jordan Michelle Smith

2023

Racial and Socioeconomic Disparities Related to Abortion Care in a Post-Dobbs United States: A Narrative Review

Jordan Michelle Smith, MPH

University of Pittsburgh, 2023

Abstract

The purpose of this narrative review is to examine existing racial and socioeconomic disparities related to abortion care access and the way in which these disparities will worsen from lack of abortion care access in the United States. The United States Supreme Court decision of *Dobbs v. Jackson Women's Health Organization* repealed the previously established constitutional right to abortion in every state. This essay reviews existing research to identify the negative externalities of not being able to receive a safe and legal abortion. Findings suggest that populations consisting of racial minorities and lower socioeconomic status will face a greater impact on both access and outcomes due to the changes in legislation, as restricting access will only further existing disparities in health and economic outcomes. Future considerations discussed include the inevitable dangers of at-home abortions, disparities in persecution for illegal abortions, and further attempts to cut off access to care.

Table of Contents

Overview	vii
1.0 Introduction.....	1
1.1 Abortion Care	1
1.2 History of Abortion in the United States	3
1.3 Public Health Significance and Theory	7
2.0 Methods.....	11
3.0 Findings.....	17
3.1 Barriers to Accessing Safe Abortion.....	17
3.2 Health Problems Without Abortion Access	21
3.3 Increase in Health Disparities	24
3.4 Non-Medical Consequences	28
4.0 Discussion.....	32
4.1 Future State Predictions and Considerations	32
4.2 Addressing Disparities	35
4.3 Conclusion	37
Bibliography	38

List of Figures

Figure 1. Essay Framework for Pregnancy and Abortion Decision and Outcome Flow	2
Figure 2. Social-Ecological Model on Abortion Access	9

Overview

The purpose of this paper is to provide a narrative review of abortion care access in the United States reviewed through current literature with specific focus on racial and socioeconomic disparities and framing the results of *Dobbs v. Jackson Women's Health Organization* as a public health issue.

The scope of this paper is a narrow focus on the impacts of racial and socioeconomic disparities. While there is wide-ranging research into racial and socioeconomic factors associated with birth outcomes and abortion access, the research is disjointed. This narrative review will synthesize existing research to create a complete report of what is known about these disparities and how they are fragments of overarching systemic issues. There are non-medical impacts from lack of abortion access for those able to give birth that will be reflected. This paper will touch on issues such as intimate partner violence, inequalities in salaries and job opportunities, and postpartum impacts like postpartum depression, extensive recovery, and economic hardship and their impact on overall quality of life, as they are all tied to the outcome of not being able to receive abortions as desired. The purpose in focusing on the racial and socioeconomic disparities is to highlight distinct changes in health equity in the United States under eras in which abortions were legal for the entire country and eras in which abortions were not guaranteed. The two key United States Supreme Court cases referenced throughout this paper will be *Roe v. Wade* and *Dobbs v. Jackson Women's Health Organization*, also referred to as *Dobbs v. Jackson*.

1.0 Introduction

This section will be focusing the implications of legislative change on the right to abortion, the foundation of current state of abortion access, as well as the historical context for how abortion rights have been built and destroyed in the United States. These introductory sections will introduce terminology, areas of focus relating to abortion access and policy, establishing the framework of abortion health care, and building background knowledge. The Social-Ecological Framework will be used to describe how issues such as spatial access to abortion, maternal health outcomes, and cost barriers to care relate to difficulties and disparities appearing at the individual, interpersonal, communal, organizational, and societal levels to ideally create a better understanding of the public health significance of the *Dobbs v. Jackson Women's Health Organization* decision.

1.1 Abortion Care

In regards to the terminology and phrasing surrounding pregnancies and abortion, there are key definitions and distinctions to be made. In the medical sense, there are two types of abortions: spontaneous abortion, which is also known as miscarriage, and is a sudden loss of pregnancy that occurs prior to 20 weeks of pregnancy without medical induction; medical abortion, which includes some type of medical intervention to induce the termination of a pregnancy (Gyn Choices of Central Jersey, 2022). While a miscarriage is not triggered by intentional intervention, it may require medical intervention, especially past the first trimester of pregnancy. As for types of

abortion, self-managed abortion is one that is conducted by an individual outside of a health care setting; medication abortion includes taking pills, either vaginally or orally, and surgical abortion comes from a dilation and curettage or dilation and evacuation (Center for Reproductive Rights, 2022). Dilation and curettage or evacuation are both procedures in which a provider has to manually remove fetal tissues from the uterus (Center for Reproductive Rights, 2022).

The relationship between abortion and health inequities is complex. It is impacted both by ability to access care and outcomes from not receiving safe and legal care. Below is Figure 1, describing the pathway that the issues and factors discussed in the paper relate to and lead into one other:

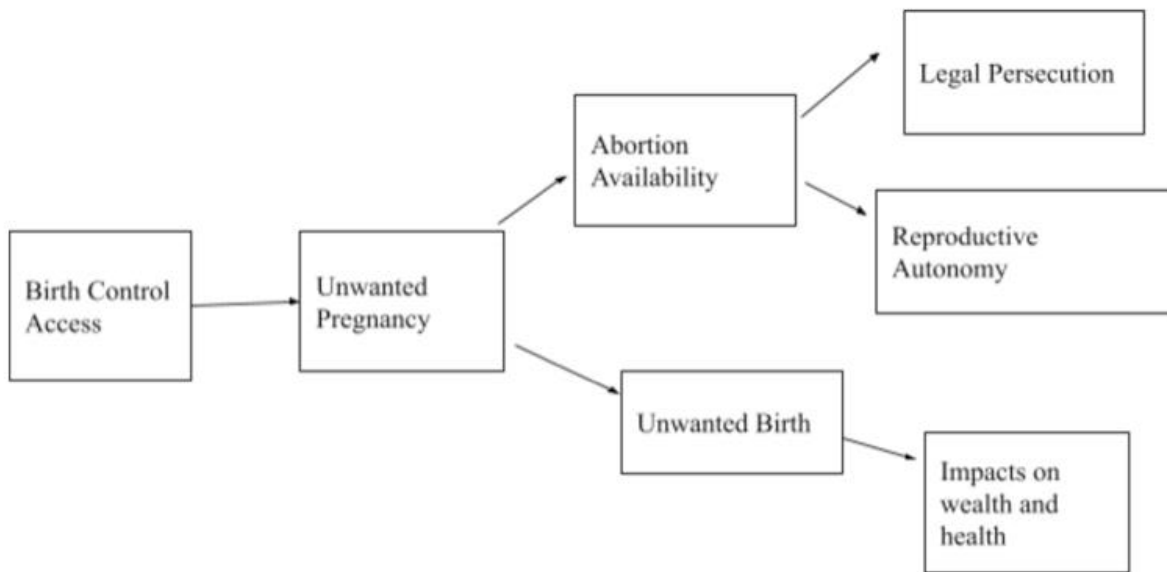


Figure 1. Essay Framework for Pregnancy and Abortion Decision and Outcome Flow

Figure 1 displays the topics that will be discussed throughout this paper as a way to illustrate the different domains in which race, socioeconomic, and their intersection can impact outcomes of unwanted pregnancies. At all steps on the path from an unwanted pregnancy to final outcomes of either giving birth or having an abortion, racial and socioeconomic disparities are interacting with these options and outcomes, changing the outcomes for racial minorities or low-income populations. The display of these factors represents how they will be discussed, and will be useful to maintain as a frame of reference throughout. As shown, access to birth control options can be determined by economic factors, which then determines the ability to avoid unwanted pregnancies. There are two outcomes of an unwanted pregnancy: abortion or an unwanted birth, each with resulting impacts. However, people of color will face heightened risk of legal persecution or poorer outcomes from giving birth compared to White counterparts; low-income populations experience decreased ability to access abortion and also face poorer health outcomes. All of the outcomes listed: legal persecution for receiving an abortion, safe practice of reproductive autonomy, and impacts on wealth and health from giving birth will be discussed through the lens of socioeconomic and racial disparities and where harm to racial minority and low socioeconomic status populations is being done.

1.2 History of Abortion in the United States

Abortion has existed in some form or another for centuries throughout multiple cultures. According to Planned Parenthood, abortion in the United States was regularly practiced between the 1600s and 1900s until legislators started passing legislation in the 1860s banning and regulating abortions. Prior to the mid-19th century, abortions were legal under common law in the early stages

of pregnancy, at least until a woman could feel movements of the fetus in-utero, known as “quickening” (Reagan, 2022). This line came from perspectives of the earlier eras, where they viewed the creation of life as an ongoing process, rather than a singular moment in time (Reagan, 2022). Abortions were documented as an ongoing practice in Native Americans for centuries, using beatings to the womb or herbs and medicines, such as red cedar (Acevedo, 1979). These practices were considered safe, but as English colonization occurred in America, questions of legality arose, but the right still remained prior to the quickening stage of pregnancy (Acevedo, 1979). In the years to come, abortion remained available to all in America until complications arose from the laws of the home countries of colonists; the diversion of attention due to the Revolutionary War, and eventually, in the 1820s the first anti-abortion laws started passing across individual states (Acevedo, 1979). Acevedo in their paper, *Abortion in Early America*, notes the reinvigorated stirrings against legalized abortions came in 1803 with an overhaul of British criminal laws. According to Winny, the American Medical Association (AMA) can be noted for their claims that life started at conception in an attempt to medicalize women’s health (Winny, 2022).

While approximately 40 states banned abortions in the 1800s, women who were wealthy were able to go forward to court to be able to request an exemption (Winny, 2022). Since the requests were due to life-threatening conditions for the mother, those who could not afford to go to court were doomed to carryout pregnancies likely to seriously harm or kill them (Winny, 2022). When *Roe v. Wade* came up on the Supreme Court docket in 1972, there were key cases that set precedence using several parts of the constitutional rights for those living in America. *Griswold v. Connecticut* was a case decided in 1965 that stated married couples had the right to privacy in their own home to be prescribed and use birth control, if they so wished (Planned Parenthood, n.d.).

Specifically, the right to privacy came from the First, Third, Fifth, and Ninth Amendments of the U.S. Constitution for *Griswold v. Connecticut* and stated this privacy was a right between a married couple and their provider to make their own care decisions, as it did not harm others (Haydel, 2009). Building off of that, *Roe v. Wade* used the same amendments in *Griswold v. Connecticut* to establish that the right to access abortion care existed under the right to privacy in the home and between a provider and patient to select appropriate care (Center for Reproductive Rights, 2022). So, in 1973, *Roe v. Wade* established the constitutional right to abortion in the United States (Winny, 2022). Only a few years later, the Hyde Amendment was passed, which prohibited Medicaid coverage of abortion services, effectively creating a barrier to abortion for those least capable of affording the services themselves (Planned Parenthood, n.d.). Following these events, the U.S. Supreme Court handled the 1992 case of *Planned Parenthood of Southeastern Pennsylvania v. Casey* (Oyez, n.d.). This case dictated that someone seeking an abortion must wait 24 hours after their initial exam and undergo counseling, outlining options other than abortion, in order to receive an abortion (Oyez, n.d.). This concession, along with allowing states to ban abortion after fetal viability, which is a timeline that is heavily debated, made the case of *Casey* a serious hit to abortion rights (Winny, 2022).

Abortion access was attacked from many different sides in the decades following *Roe v. Wade* as a way to chip down the right to abortion care bit by bit. One significant piece of legislation was the Texas SB8 law, also known as the Texas Heartbeat Act, which allowed private citizens to sue other private citizens for receiving or helping someone receive an abortion after a heartbeat was detected for a fetus (LegiScan, 2021). Following the requirements on waiting periods and restrictions based on viability, the universal right to abortion care in the United States came to a halt on June 24th, 2022 with the *Dobbs v. Jackson Women's Health Organization*, also known as

Dobbs v. Jackson. This case eliminated what *Roe v. Wade* had established: the constitutional right to abortion, and instead allowed states to make individual laws, including trigger bans that became effective with the removal of *Roe v. Wade* (Center for Reproductive Rights, 2022). With the *Dobbs* decision, a dissent from Supreme Court Justice Elena Kagan stated, “Above all others, women lacking financial resources will suffer from today’s decision,” which highlights the inevitable health disparities in abortion access and outcomes associated with socioeconomic factors.

The table below summarizes the key legislation or legal standards surrounding abortion rights in America from the 1600s to 2022:

Table 1. Key Legislation Summarization

Legislation:	Impact:	Year:
Abortion permitted until “quickening”	At-home remedies and practices used	1600s-1860s
40 states ban abortion	Abortions only permitted for the wealthy whose lives were at risk	1860s-1972
<i>Griswold v. Connecticut</i>	Right to privacy in the home that permitted married couples to receive birth control from their providers	1965
<i>Roe v. Wade</i>	Constitutional right to abortion, making all states provide abortion care	1973

Hyde Amendment	Medicaid insurance cannot pay for any abortion care	1979
<i>Planned Parenthood of Southeastern Pennsylvania v. Casey</i>	Required consultation discussing all option for pregnancy and a 24-hour waiting period before receiving an abortion	1992
<i>Dobbs v. Jackson Women’s Health Organization</i>	Removed the constitutional right to abortion that was established in <i>Roe v. Wade</i>	2022

1.3 Public Health Significance and Theory

In regards to lack of abortion access as a public health issue, the disparities caused for racial minorities and low socioeconomic status populations highlight its relevance to public health. The Social-Ecological Model, as adapted from Urie Bronfenbrenner’s Ecological Systems Theory on childhood development created in the 1970s, can be used to consider how abortion access and outcome issues can impact society on multiple levels: individual, interpersonal, community, organizational, and societal (Poux, 2017). For an issue like abortion, it can be considered to impact all of the aforementioned areas of life. As an individual, not having access to abortion can contribute to poor health outcomes from complications in prenatal and postpartum conditions (Declercq & Zephyrin, 2021). Being denied a legal abortion can result in a pregnant person seeking out illegal, unsafe abortion practices (Harris & Grossman). In interpersonal relationships, those

forced to carry a pregnancy can be faced with intimate partner violence, potentially because of increased stress or jealousy from a partner over a child (Roberts et al., 2014). Rising to the community level, a community that is unable to reach abortion care will be faced with a greater burden on social services for prenatal services and the resulting children born that will be raised in these areas that may be living in poverty and require more community services (Monea & Thomas, 2011). At the organizational level, parents being forced to give birth can face bias in the workplace and face fewer growth opportunities (Cheung, et al., 2022). For the societal level, the restriction to access creates a divide in which some are able to access certain rights where others cannot, and will have significant impacts on overall potential for societal health and wellbeing (Rader, et al., 2022). In all of the examples given for abortion access and unwanted pregnancy outcomes, racial and socioeconomic disparities are actively working with these factors, which is resulting in different outcomes for different populations, indicating inequities. For example, at the societal level, if conditions were equitable then those with low socioeconomic status would not face greater difficulty in being able to access abortion or peripartum care throughout their pregnancies compared to those with higher socioeconomic statuses (Kaiser Family Foundation, 2023). Intersectionality of racial and socioeconomic factors refers to the interconnectedness of the two social identities and how they interfere with existing conditions in a society (Center for Intersectional Justice, n.d.). Racial and socioeconomic disparities can intersect to create issues in care, such as when a low-income, racial minority individual has a harder time not only affording care during pregnancy, but is also more likely to see a worse health outcome from pregnancy and

giving birth (Daw et al., 2020). The graphic below displays these examples and how the hierarchy of the Social-Ecological Model is constructed:

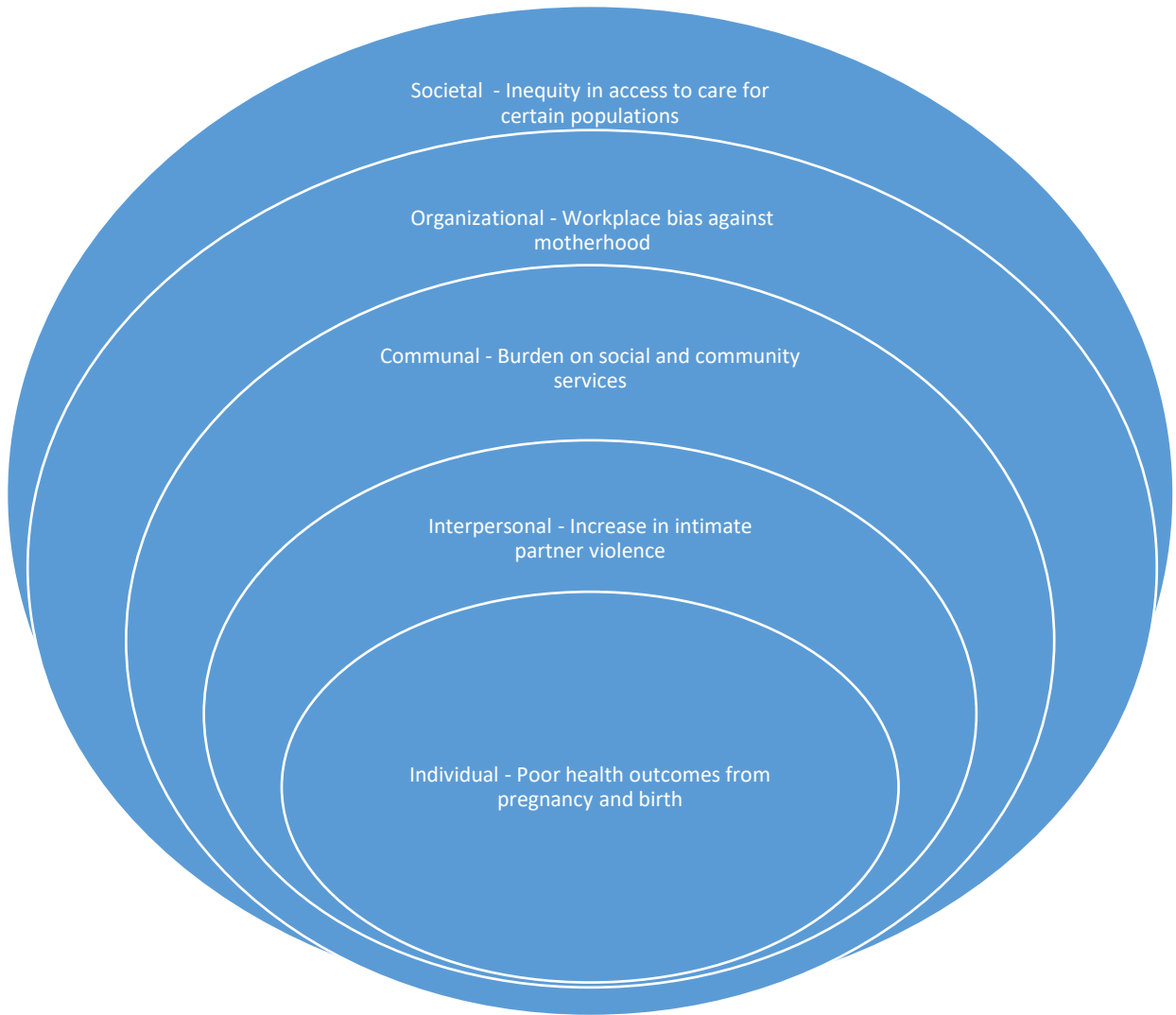


Figure 2. Social-Ecological Model on Abortion Access

All the examples given can be tied back to being worsened by racial and socioeconomic factors, or these disparities can become more prevalent as a result of these conditions. Considering the issues with existing disparities in access to quality care and outcomes for disadvantaged populations, these concerns will only be exacerbated with current policies. Documenting the racial

and socioeconomic disparities that exist in abortion care today will inform how changes in policy will continue to worsen conditions for racial minority or socioeconomically disadvantaged populations without properly addressing these complicated interactions throughout all levels of society. Harm done to these groups will worsen and understanding the full impact of these changes is necessary so the field of public health can begin to address these issues. This paper will endeavor to further dissect this complex web.

2.0 Methods

This is a narrative review of literature pertaining to socioeconomic and racial impacts of lack of abortion access in the United States in order to understand resulting disparities. This paper will examine the policy changes that established racial and wealth disparities in abortion care in the United States. Peer-reviewed articles will be the main source of support for establishing lack of abortion access as a public health issue due to its relationship to racial and socioeconomic disparities. Other sources, such as non-profit groups providing surveillance data, will be used to develop insight into the impact of *Dobbs v. Jackson*. The end target of this paper is to bring attention to health disparities for economically disadvantaged and racial minority populations going forward under *Dobbs*. Sources were identified through online databases including Google Scholar, PubMed Central, University of Michigan Digital Library, and University of Pittsburgh Health Sciences Library, with relevant stakeholders, such as non-profit policy analysis institutes, as well as peer-reviewed journals and articles. The search process of identifying sources included the following keywords to narrow down specific aspects of policy changes and their impacts that were relevant to this paper:

Table 2. Search Terms Overview:

Keywords:	Secondary Keywords:	Reference Point:
Racial Disparities		Post-Dobbs
Socioeconomic Disparities		Post-Dobbs

Racial Disparities	Maternal Mortality	Abortion Access
Racial Disparities	Insurance Coverage	During Pregnancy
Socioeconomic Disparities	Insurance Coverage	During Pregnancy
Socioeconomic Disparities		Abortion Access
Racial Disparities		Abortion Access
Racial Disparities	Maternal Morbidity	During Pregnancy
Racial Disparities	Postpartum Depression	Postpartum
Socioeconomic Disparities	Postpartum Depression	Postpartum
Socioeconomic Disparities	Workplace Bias	Postpartum
Racial Disparities	Incarceration	Post-Dobbs
Race or Racial	Disparities	Abortion Access
Low-Income or Economic	Disparities	Abortion Access
Race or Racial	Disparities	Pregnancy or Giving Birth
Low-Income or Economic	Disparities	Pregnancy or Giving Birth

Sources were considered from multiple outlets including relevant non-profit organizations involved in policy work in pregnancy and abortion access, reputable news outlets; and published government reports. The search results from the databases and other listed sources were manually stored and sorted in Microsoft Excel with all citation material to sort by topic and if the source met inclusion criteria. In peer reviewed articles, initial abstracts were screened and deemed appropriate for the scope of this paper if it was published within the last 15 years. Exceptions to include papers published longer than 15 years ago were made if their topics were on historical context with unchanging facts regarding the topic. Specific criteria for inclusion were that articles discussed

incidence or prevalence rates of poor health outcomes, costs and barriers to care access, or health disparities linked to race or socioeconomic status relating to abortion care. Most papers were sorted through to only include multi-state populations, but if these studies were not available, Canada and other developed countries were considered acceptable proxies based on similarities in size, proximity, and population demographics. Single-state studies were included if multi-state population studies were not available on a specific topic point of the paper. Papers were also included if they accounted for the previously mentioned factors (e.g., lack of access to abortion care, postpartum health outcomes, etc.) through a lens of racial or socioeconomic disparities, or both. While expert opinions can be relevant materials, opinion pieces were not included in the resources for this paper, as the objective was to present a relevant and objective overview focused on empirical evidence surrounding this topic. Following are key examples used throughout the paper to make crucial, overarching points of a given section, listed as they are used in the paper and their key findings:

Table 3. Representative Sample Source Summarization

Source Name:	Source Title:	Author and Year:	Key Finding:	Location in Narrative Review:
Centers for Disease Control and Prevention	Maternal Mortality Rates in the United States, 2020	Hoyert, 2022	Black women face a mortality rate almost three times greater than White,	Health Problems Without Abortion Access

			non-Hispanic and Hispanic women.	
American Journal of Public Health	Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records	MacDorman et al., 2021	Black, non-Hispanic women saw higher mortality from cardiovascular conditions during birth and postpartum with many deaths from these conditions considered preventable.	Health Problems Without Abortion Access
Current Hypertension Report	Racial Disparities in Diagnosis, Management, and Outcomes in Preeclampsia	Suresh, et al., 2022	Women of color, especially Black, non-Hispanic women saw higher rates of preeclampsia that were not proportionate with their makeup of the	Health Problems Without Abortion Access

			pregnant population.	
Obstetrics and Gynecology	Racial and Ethnic Disparities in Perinatal Insurance Coverage	Daw et al., 2020	Racial minorities experience higher rates of discontinuous insurance coverage from conception to postpartum.	Increase in Health Disparities
International Journal of Population Data Science	Risk Factors for Hospitalizations Associated with Depression Among Women During the Years Around a Birth: A Retrospective Cohort Study	Fairthorne et al., 2021	Higher rates of prenatal and postpartum depression were experienced by low-income women and was associated with more hospitalizations.	Increase in Health Disparities
Psychiatric Services	Racial and Ethnic Disparities in Postpartum Depression Care	Backes Kozhimannil et al., 2011	Racial minorities were less likely to be diagnosed, started, and remain compliant with	Increase in Health Disparities

	Among Low- Income Women		postpartum depression medications and care plans compared to White women.	
American Journal of Public Health	Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States	Greene Foster et al., 2018	Women face greater economic hardship following pregnancy and are more likely to rely on pregnancy than those able to receive abortions.	Non-Medical Consequences

The gendered terms associated with the populations mentioned throughout this paper will be cited as they were defined in the sources. While language today recognizes the ability to give birth does not lie with just one gender identity, this paper will use terms for people able to give birth as they were used in the context of the time in which these issues occurred.

3.0 Findings

The previous section established the background on abortion care by establishing terminology and the history of abortion care in the United States to build the foundation for current research on policy and its influence on those living in the United States. Going forward, findings from the narrative review analysis will be presented to cover three main areas of policy impact resulting from *Dobbs v. Jackson*: barriers to accessing safe abortions, increase in health disparities from restricted access, and non-medical consequences of restricted access.

3.1 Barriers to Accessing Safe Abortion

The purpose of studying the barriers to safe abortion access is to highlight inequities in being able to reach care sites either because of spatial or cost barriers. Specifically, this section emphasizes that attempts to reach a provider can be halted by the barriers to care access being discussed. In many cases, someone does not have the ability to deliver themselves to a care facility or cannot afford to have the visit with a provider. Meaning, those without economic or social resources will have higher chances of failing to receive a safe abortion, leading to potentially undesirable health outcomes that will be discussed later. Evidence collected from the research included in this paper provides context on the cost and location barriers faced previously, but also the worsening of these circumstances. The specific types of abortion being focused on in this section include both self-managed, medication abortions and surgical abortions that would both be handled in a care setting instead of telemedicine options, which will be discussed later in this paper.

The focus of this section is to bring recognition to spatial and economic barriers being faced to reach care facilities post-*Dobbs*.

Prior to the *Dobbs v. Jackson* case, all states were required to provide access to abortion, but states were able to make restrictions to an extent. Previously, states were able to restrict access to abortion at the point of viability, when a fetus would likely be able to survive outside of the uterus (Oyez, n.d.). At this time, viability was considered to be around 24 weeks, based on the developmental stage a fetus would be (National Health Service, 2021). However, following the *Dobbs* decision, access to abortion has been completely eliminated in 13 states (Planned Parenthood, n.d.). This means millions of residents of these states have had their access to abortion care completely cut off unless they travel to another state. In regards to travel time, research from the University of California San Francisco has already shown drastic jumps in travel time to abortion providers. In one instance, almost the entire population of Texas was found to have their drive to abortion care increase to eight hours, on average (Rader et al., 2022). Meanwhile, researchers using census data determined approximately 42 percent of women in America now lived greater than a one-hour drive to an abortion provider (Rader et al., 2022). As of 2023, 45 percent of Americans had no access to public transportation (American Public Transportation Association, 2023). Considering this condition, access to personal transportation is integral to being able to reach an abortion provider today as the commute to care only increases. Not only will those trying to access abortion care options face increased spatial barriers, they will also incur higher costs to receive the same care.

The cost of abortion care under *Roe v. Wade* made abortions more accessible than under *Dobbs v. Jackson*. Previously, the average abortion costs in the United States were approximately \$500, but now those costs are changing for those located in states where abortions are illegal, also

known as abortion deserts (Kaiser Family Foundation, 2023). In the coming years, under *Dobbs* people will need to travel further to access care, meaning costs to travel will be incurred that have not been previously reflected. Kaiser Family Foundation released a report of strictly the procedural costs for receiving abortions in 2021, which means travel costs are not considered. At the time, costs for a medication abortion ranged between \$520-650, with the Western region reporting the highest costs and average cost for the United States at \$568 (Kaiser Family Foundation, 2023). A first trimester abortion cost between \$555-750 with the average price being \$625 and the Western region having the highest costs, once again (Kaiser Family Foundation, 2023) As for second trimester abortions, the average cost was \$775 and ranged between \$650-926; the highest cost coming from the West (Kaiser Family Foundation, 2023). Under *Dobbs v. Jackson* states are able to completely ban the right to receive an abortion, which means those who need an abortion will then have to incur costs of traveling outside of the state in order to receive care. Considering approximately 37.9 million individuals in the United States were living in poverty in 2021 (Creamer et al., 2022), and the Hyde Amendment preventing Medicaid from covering abortion services, many would not be able to pursue care without their insurance coverage. In fact, the Federal Reserve estimated one-third of Americans did not have \$400 available on-hand (Kaiser Family Foundation, 2023), so the procedure or medication abortion alone would not be possible. So, with approximately 84 million Americans enrolled in Medicaid at the end of 2022 (Centers for Medicare & Medicaid Services, 2022), those without the economic privilege are left without the ability to practice reproductive autonomy that others are able to with the funds necessary to travel and pay for the care.

While Medicaid will cover prenatal and postpartum care costs for those enrolled, and it commonly does, there are still issues with coverage (Rudowitz, et al., 2022). Specifically, of the

13 states with complete abortion bans in effect, six of them are not Medicaid expansion states (Rudowitz, et al., 2022). Without expansion of the Medicaid program made available from the Affordable Care Act, fewer people in these states qualify for Medicaid coverage (Rudowitz, et al., 2022), meaning more low-income populations are unable to access care. Furthermore, of the states with complete abortion bans, eight states also do not have 12-month postpartum Medicaid coverage; five do not have 12-month continuous coverage of children on the Children's Health Insurance Program (Rudowitz, et al., 2022). What this means in practice is that low-income parents who have just given birth are not guaranteed insurance coverage in the year following giving birth in these states, even though there are postpartum care visits. The same applies for children born in these states without this expansion program. These are significant policies to consider when refusing abortion care, as 42% of births are covered by Medicaid, and 75% of people receiving abortions have a household income less than 200% of the Federal Poverty Line (Rudowitz, et al., 2022).

Following the *Dobbs v. Jackson* decision, abortion care is not only physically harder to reach due to elimination or severe restriction of abortion in many states, but is also more financially unobtainable due to cost of travel on top of the cost of care. Since Medicaid cannot cover any abortion care costs, the financial hardship of seeking out abortion care disproportionately impacts those that are economically disadvantaged and living in abortion deserts. What is especially important to point out is that those that cannot afford to pay for abortions without insurance are those that would inherently also be unable to afford to give birth and raise a child, which is significantly more expensive, especially if they are without a support network. While many states do offer Medicaid coverage for giving birth and postpartum care, many of the states with abortion

bans did not undergo Medicaid expansion, leaving many gaps in care accessibility as residents of these states are forced to give birth.

3.2 Health Problems Without Abortion Access

The purpose of this segment is to establish the medical dangers people with uteruses can face when they are unable to easily access abortion care. Evidence supporting racial disparities in maternal health outcomes, either from giving birth or receiving delayed miscarriage care, will be used to explain the risk of dangerous health outcomes that can arise during pregnancy and birth. Giving birth, while routine, is not an uncomplicated procedure in which someone receives outpatient care and leaves to recover over a matter of days. While the hospital stay is a couple of days, on average, physical recovery can extend weeks to months, even with vaginal birth (Cleveland Clinic, 2022). After birth, there may be physical recovery needed for tearing of the perineum and anus, surgical recovery from a Cesarean section, large hormonal fluctuations, and pain (American Pregnancy Association, 2023). This section establishes the negative externalities of being denied an abortion in the United States, including death and other peripartum complications.

The Hoyert report published on behalf of the Centers for Disease Control and Prevention presented the trend in mortality rates per 100,000 live births in the United States from 2018-2020, with Non-Hispanic Black patients having the highest mortality rates, at almost triple the rate of the other two racial categories. Maternal mortality is defined as the death of the birthing parent during or within one year of giving birth with the cause attributed to giving birth (Hoyert, 2022). According to the Centers for Disease Control and Prevention report, the maternal mortality rate in

2020 for Black women was 55.3 compared to 19.1 for White women per 100,000 live births (Hoyert, 2022). By comparison, the average mortality rates between the three race and ethnicity groups collected (Non-Hispanic White, Non-Hispanic Black, and Hispanic) was 23.8 deaths per 100,000 live births, making Non-Hispanic Black mortality rates significantly higher (Hoyert, 2022). Furthermore, mortality rates only increased over the three years, but the highest rate of increase once again being Non-Hispanic Black parents (Hoyert, 2022). As for causes of death, a surveillance study found that non-Hispanic Black women died most often from eclampsia and preeclampsia, but also experienced high rates of postpartum cardiomyopathy, obstetric embolism, and obstetric hemorrhage (MacDorman et al., 2021). In fact, researchers found non-Hispanic Black women to be up to five times more likely to die from eclampsia and preeclampsia than non-Hispanic White women (MacDorman et al., 2021). An important finding from this study is that the analysis of these death records revealed many of the maternal deaths could be considered preventable (MacDorman et al., 2021). What these studies and reports go to show is that United States healthcare has poorer maternal health outcomes compared to other countries, especially for non-Hispanic Black women. Considering abortion laws where more women are now unable to receive abortions, maternal mortality incidence rates will likely only increase and follow the same trends where non-Hispanic Black women will be disproportionately harmed.

Considering other complications that can arise with giving birth, the United States reports 60-70,000 severe maternal morbidity cases annually (Declercq & Zephyrin, 2021). Maternal morbidity refers to short- or long-term unexpected health problems associated with pregnancy and birth (National Institute of Child Health and Human Development, 2020). Maternal morbidity can include infection, high blood pressure, gestational diabetes, preeclampsia, and blood clots (National Institute of Child Health and Human Development, 2020). One study found that the

incidence rate of severe maternal morbidity had increased between 2012 and 2019, but had no clear attribution for the cause (Hirai et al., 2022). A study on preeclampsia found that, while Black, non-Hispanic women comprised 14% of deliveries in their study timeframe, they made up 20% of the preeclampsia cases and 17% of gestational hypertension cases (Suresh et al., 2022). Meaning, Black, non-Hispanic women are disproportionately carrying a larger burden of maternal morbidity cases in the United States.

One risk factor that can be linked to changing policies is the delay in treatment for miscarriages. Miscarriage is a common occurrence in pregnancies, with an estimated 30% of pregnancies resulting in miscarriage, and of those, 50% will require a dilation & curettage (D&C) procedure (Weigel et al., 2019). However, following the passage of *Dobbs*, the ability to provide such care, even in emergency situations has become confusing for providers. While it will take time to fully study the results on care delays caused by *Dobbs*, work has been established on the harm in delaying treatment of miscarriage. For incomplete miscarriages, in which the entirety of fetal tissue is not expelled from the uterus, severe complications can include heavy bleeding and infection of the uterus or blood (The Royal Women's Hospital, n.d.). Therefore, medical intervention is necessary in order to remove fetal tissues and prevent complications for the patient (The Royal Women's Hospital, n.d.). Fortunately, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency care to be provided for life-threatening conditions, which the Biden Administration clarified that this includes emergency abortions in all states (U.S. Department of Health and Human Services, 2022). A concern for usage of EMTALA is the provider discretion that could be involved in escalating a condition to be life-threatening and emergent. Relying on providers to make decisions in the clinical setting will undoubtedly lead to mistakes, and misdiagnosing the seriousness of a spontaneous abortion will be one of those

mistakes. Going forward, it is important that researchers be prepared to capture data for any failures to escalate and provider perspectives on escalation to give emergency abortions, including fear of legal ramifications once provided.

Several severe complications can arise from pregnancy. Even if a pregnant person does not seek out an abortion to intentionally end a pregnancy, they can experience spontaneous abortion that can call for medical intervention. Severe maternal morbidities and maternal mortalities are on the rise in the United States with people of color, especially non-Hispanic Black women being disproportionately impacted by these conditions. By restricting access to abortion services and not addressing the healthcare systems to prevent the rise in poor maternal outcomes, it stands to reason the number of people experiencing poor outcomes during pregnancy and birth will only increase.

3.3 Increase in Health Disparities

Following a pregnancy and birth, the six weeks afterward are considered the postpartum period (Cleveland Clinic, 2022). In that time, a person will recover from vaginal or Cesarean birth and face pain, hormone changes, mood and mental health impacts, etc. (Cleveland Clinic, 2022). Giving birth has a significant impact on the body and overall health and wellbeing that requires long recovery periods and support. One potential condition to arise from giving birth is postpartum depression (PPD), which approximately 700,000 women are estimated to experience each year in the United States (Liu et al., 2022). In regards to postpartum mental health care, a study found that White women were more likely to initiate treatment for PPD than Black and Latina women; in fact, the minority populations in the study were less likely to have any follow-up care than White women (Backes Kozhimannil et al., 2011). Furthermore, this study also found follow-up for initial

use of antidepressant medication amongst White women to be 44% compared to 27% and 23% for Latina and Black women, respectively (Backes Kozhimannil et al., 2011). Within the acute treatment time period from the initiation of PPD care, Black and Latina participants were significantly less likely to refill their antidepressant prescription after their first bottle (Backes Kozhimannil et al., 2011). Considering all of the participants were considered low-income, it is the racial identities of these participants that is key in understanding the differences in PPD care and treatment compliance. However, the Backes Kozhimannil, et al. (2011) paper noted low levels of treatment across all participants. So, when it comes to the ability to access PPD treatment from a low socioeconomic status, there is a negative correlation. A retrospective study found lower socioeconomic status to be a determinant for both prenatal and postpartum depression rates (Fairthorne et al., 2021). Not only were rates of PPD in low-income participants higher, the risk of hospitalization related to depression was higher among this population, as compared to higher income participants (Fairthorne et al., 2021). In summation, being a racial minority or having a low socioeconomic status can result in higher rates of postpartum depression, lower treatment rates and compliance, and greater risk of hospitalization associated with the condition. One potential determinant of these poor health outcomes may be due to discontinuous insurance throughout the entirety of pregnancy and postpartum care, which is an ongoing issue in the United States and will be discussed further.

During pregnancy, a pregnant person will be recommended to attend approximately 15 prenatal visits over the course of 40 weeks (Cleveland Clinic, 2022). The Kaiser Family Foundation found that the costs associated with pregnancy and giving birth were about \$18,000 USD (Kaiser Family Foundation). Meanwhile, the average wage of an American was approximately \$60,000. Meaning, a third of the average salary can be consumed by getting

pregnant and giving birth without insurance. While the Affordable Care Act did close the gaps on the uninsured rate in America, the space has not been completely filled and many are still left uninsured. The Kaiser Family Foundation reported White and Asian populations faced the lowest uninsured rates in America as of 2021 at seven and six percent, respectively (Kaiser Family Foundation, 2022). Asian Islander/Alaskan Native populations faced the highest rates of being uninsured, and Hispanic and Black populations being the following highest. Specifically, Hispanic populations faced an uninsured rate of 19%, American Indian or Alaska Native was 21%, and both Black and Native Hawaiian or Other Pacific Islander were at 11% uninsured (Kaiser Family Foundation, 2022). In 2021, following the implementation of the Medicaid expansion, insurance rates increased as the population qualified for Medicaid coverage increased. However, there are restrictions in Medicaid coverage that reduce access to options for reproductive health. As previously discussed, the Hyde Amendment prevents any Medicaid funding from being used to cover the costs of abortion care (Planned Parenthood, n.d.). As it relates to pregnancy care in the United States, a study used the Pregnancy Risk Surveillance and Monitoring System to surveil insurance rates and continuity through conception, pregnancy, and birth. This study found that almost half of Black, non-Hispanic women had unstable insurance coverage and a quarter had loss of Medicaid coverage in the pregnancy timeline (Daw et al., 2020). Furthermore, 50.1% of Indigenous women faced issues with discontinuous insurance and Spanish-speaking Hispanic women faced ongoing uninsurance throughout the entirety of their preconception, pregnancy and postpartum monitoring timelines for surveillance (Daw et al., 2020). Not only were racial and ethnic minorities faced with the complications of discontinuous insurance for their perinatal care, but these minority populations faced higher rates of living on a household income less than 138% of the Federal Poverty Line (Daw et al., 2020). The loss of continuous insurance in the timeframe

of getting pregnant, carrying a pregnancy, and through the postpartum period was associated with disruption in primary care, higher emergency department utilization, and poorer health outcomes (Daw et al., 2020). This paper illustrated that racial minorities were more likely to experience discontinued insurance coverage from pre-conception to postpartum, as compared to their White, non-Hispanic counterparts, and the loss of insurance coverage is linked to poorer care access and resulting health outcomes.

Health disparities introduced or exacerbated by going through a pregnancy and giving birth can be linked to higher rates of poor outcomes for people of color or low socioeconomic status. Common issues that arise from pregnancy and birth, such as postpartum depression, further separate people of color from better health outcomes since they face higher rates of maternal morbidities and lower rates of diagnosis and proper treatment. One consideration for poorer outcomes is a distinct difference in insurance coverage for people of color, which determines their ability to access not just perinatal and peripartum care, but also their access to abortion services. Kaiser Family Foundation displayed gaps in insurance coverage for racial minority populations while the Daw et al. research displayed issues of continuous insurance for people of color compared to their White counterparts, and the resulting negative correlation with health outcomes specifically surrounding pregnancy. These systemic barriers to quality care access will only serve to further deteriorate health outcomes for the economically disadvantaged and racial minority populations.

3.4 Non-Medical Consequences

Problems caused by lack of abortion access are not only the medical implications of care denial, and that view alone would not encapsulate its entire public health significance. Part of public health is looking at health and healthcare, but also at how physical and mental health or wellbeing bleed into a multitude of other aspects of life. This section encapsulates the ramifications of restricted abortion access, including incarceration, violence, and economic hardship outside of peripartum care.

As of March 2023, a bill has been introduced in South Carolina considering a fertilized egg to have the same protection under homicide laws, meaning someone receiving an abortion at any stage of pregnancy could receive punishment up to the death penalty (Jones, 2023). Specific verbiage under this proposal includes the idea that a fertilized egg would be granted personhood, meaning even access to emergency contraceptives could be threatened, as the emergency contraceptive prevents implantation, not fertilization of an egg (Jones, 2023). This ties into a larger issue of incarceration for receiving abortion care or pregnancy termination under suspicious circumstances. In its current state, the United States offers varied permissions to receive abortion care to end a pregnancy. Meaning, some pregnant people will be able to receive abortions up to a certain point of viability, whereas others will face serious charges that can result in incarcerations and criminal records due to their geography.

An unexpected, but serious consequence of pregnancy in the United States is intimate partner violence (IPV) that can be associated with pregnancy. There are several factors contributing to the issue of IPV, including gun laws and access to community resources, but also being able to access abortion and contraceptives. Specifically, a New Zealand study found women actually listing IPV as a reason for pursuing abortion care, as they were concerned about being

tied to an abusive partner or exposing the child to physical or psychological violence from their partner (Roberts et al., 2014). So, not only are pregnant individuals concerned about the danger posed to themselves, but also future danger posed to their children, and for good reason. A study found experiences of IPV to increase poor maternal health outcomes, including the risk of spontaneous abortion and perinatal death, along with low birth weight and preterm birth for the fetus (Alhusen et al., 2015). Considering approximately 3-9% of women experience IPV during the millions of pregnancies in the United States, it is no small issue health (Stockman et al., 2015). Furthermore, racial and ethnic minority groups are found to experience higher rates of lifetime IPV, leading to issues like poor physical and sexual health, as well as poor mental health (Stockman et al., 2015). While intimate partner violence is not a medical consequence of pregnancy, experiencing IPV can contribute to serious ramifications on health outcomes of both parents and children.

Regarding economic prosperity of those who are unable to receive an abortion when desired, one study found that participants suffered financial hardship following their denial. For approximately 50% of the recruited population, they were already living in poverty, and for those denied abortions, financial hardship continued; those turned away were found to be six times more likely to be receiving benefits from the Temporary Assistance for Needy Families program compared to those who received an abortion (Greene Foster et al., 2018). In the six months following giving birth, 33% of participants were receiving benefits from the Supplemental Nutrition Assistance Program (Greene Foster et al., 2018). Turnaways from abortion services continued to observe a lower household income, and had odds four times higher than their counterparts of living below the federal poverty line six months after giving birth (Greene Foster et al., 2018). The point made through this study was that many of those seeking out abortions were

already economically disadvantaged, but being denied an abortion was associated with continued poverty and inability to afford basic expenses. Another study following similar groups of women that either were close to an abortion denial or were denied an abortion due to gestational age restriction found similar results regarding economic prosperity. Once again, greater financial stress, including lower credit scores, significant increases in the amount of debt past due, and significant increases in court actions for bankruptcies, evictions, etc., was noted for those denied abortion compared to those who were able to receive an abortion (Miller et al., 2023). Interestingly, researchers found that the women who were denied an abortion were reporting greater financial hardship after giving birth compared to those in similar financial situations that did not seek out an abortion during their pregnancies, indicating some financial consequence related to abortion denial (Miller et al., 2023). Beyond the ability to afford to care for a child, women in the workplace who have children will also face financial challenges they otherwise would not, which needs to be discussed.

Workplace discrimination after giving birth, specifically for female-identifying employees, is another issue in which reducing the ability to receive abortions will impact life beyond physical or mental health. One study conducted looked at both skilled and unskilled positions with varying education requirements to see if women with children were less likely to receive callbacks to interview compared to childless women during the hiring process. When résumés and applications were submitted with volunteer activities indicative of having children, this study found a statistically significant difference in the increased number of callbacks childless women received compared to women with children across all occupations (Ishizuka, 2021). This study supports the idea that women with children face an increased barrier to being in the workplace as a result of having kids. It is reasonable to suggest, then, that having children places an additional burden on

financial and career success if applicants with children do not have equal access to job opportunities.

Lack of abortion access has lasting impacts far beyond medical consequences, which can invade many other aspects of life for those denied. As legislation develops on ramifications of receiving abortion care illegally, serious consequences, such as criminal charges will be pursued. Research also suggests that some of those that would have previously pursued an abortion will face intimate partner violence associated with their pregnancies, or will now worry about exposing their future children to domestic violence from their abusive partners. Not to mention, chances of economic prosperity will be harmed from being forced to carry out a pregnancy, either through inability to support a household with an additional child, or through workplace discrimination associated with women having children.

4.0 Discussion

Throughout this narrative review, research and reports have been presented from peer-reviewed articles and sources, such as Kaiser Family Foundation, in order to display the extent to which *Dobbs v. Jackson* will introduce or impact health disparities for racial minorities and low-income populations. Health problems that will arise from inability to access abortion care will include increased prevalence of maternal morbidity and mortality, as well as complications associated with delays in miscarriage care. Health disparities are expected to worsen due to inequalities in insurance coverage for racial minorities, especially during the conception to postpartum timeline, which can be associated with poorer health outcomes. As for non-medical consequences from lack of abortion access, people will face more economic hardship, greater rates of intimate partner violence, and criminal or civil charges for pursuing abortion care illegally. The Discussion section will review potential policy changes and implication of current policy based on the work reviewed in the Findings section. Methods or practices that could reduce disparities and their impacts will be discussed as a way to provide suggestions for moving forward, followed by concluding the essay.

4.1 Future State Predictions and Considerations

The overturning of *Roe v. Wade* has already created vast and lasting impacts since June 24th, 2022. In the long-term, the effects will only continue to grow, and new legislation will be presented based on the ability of states to make individual decisions on abortion care options,

including any additional states outlawing abortions. Reasonable concerns about future harm consist of further removal of telemedicine abortions, criminal charges being pursued for suspected illegal abortions, and rise in use of herbs and home remedies to intentionally trigger abortions. This section will highlight the severity of the impact of these future consequences of being denied abortion care access.

One future state prediction that can be made is an increased reliance on telemedicine to request medication abortions for early-stage pregnancy termination. In 2021, the FDA removed the requirement for in-person dispensing for medicated abortions (Kaiser Family Foundation, 2023). One study found that, with the increase in travel needed to receive abortion care, requests between the months immediately preceding the *Dobbs* decision and immediately following saw an increase in these telemedicine requests by more than double, and saw an increase in reasoning being the current abortion restrictions by approximately 31% (Rader, et al., 2022). Given this trend, telehealth will likely provide a wave of abortion care to those without in-person access. However, states with tightened restrictions have already begun to combat this trend by introducing a requirement for in-person visits to receive abortion care, once again restricting those unable to travel (Kaiser Family Foundation, 2023). According to the Kaiser Family Foundation, 13 states do not allow any type of abortion; another 13 states that have abortion currently available have some type of telehealth medication abortion restriction (Kaiser Family Foundation, 2023). Due to the current and growing restrictions on medicated abortions in the United States, it is difficult to say telehealth practices will be able to bridge some of the care gaps observed post-*Dobbs*. As a result, those that are already facing abortion bans will still be unable to receive medication abortions in their home states. Once again, the requirement to travel for treatment will remain a factor, and many will remain out of reach of care. As previously discussed, out-of-pocket costs for medication

abortions leave care out of reach for a significant portion of Americans. So, without physical ability to reach medications for self-managed abortions and no way to afford the care, disparities in access will persist, especially for those in states with abortion bans or low socioeconomic status.

Due to restrictions to safe abortions, people with unwanted pregnancies will undoubtedly resort to unsafe, self-managed abortions. Prior to *Roe v. Wade*, an estimated 800,000 illegal abortions were performed each year (Harris & Grossman, 2020). According to the study, *Complications of Unsafe and Self-Managed Abortion*, self-managed abortions were being induced through herbs, one being rue, which is known to present risk for trauma and death (Harris & Grossman, 2020). Risks of self-managed abortions include incomplete abortion, meaning fetal tissue remains in the uterus and can cause bleeding and infection, hemorrhage and injury to the uterus, and infection (Harris & Grossman, 2020). Considering these risks and the legal ramifications of pursuing an illegal abortion, it is reasonable to suggest people will likely not seek care from providers if they experience any of these complications. If an injury to the uterus is left untreated, the ramifications could include death or loss of fertility (Harris & Grossman, 2020). Moving forward, it can be expected circumstances like the above will become more prevalent with restrictions on abortion care access and serious consequences continuing.

Following the continued persecution of those who receive abortions and providers of abortions, people will be at risk of serving prison time. Data on the incarceration rates of women in the United States show that Black women, in 2020, faced incarceration rates 1.7 times higher than White women, even during the Covid-19 pandemic when downsizing measures were taken with prisoner populations (The Sentencing Project, 2022). The rate at which Black women are indicted compared to White women is not proportionate to current population distributions in the country, with the White population consisting of approximately 209 million people in contrast to

the approximately 47 million Black or African American people reported in the 2020 census (Jones et al., 2021). This indicates an impending trend that racial minority populations receiving illegal abortions will be more heavily pursued for felonious or civil charges, per the laws of their states. Allowing this practice trend to persist will only serve to further impede quality of life and opportunities for racial minority populations, contributing to a cycle of poverty and poor outcomes for generations as a result of reduced opportunity and access after incarceration.

In summation, current trends in abortion laws following the *Dobbs* decision indicate further stratification of access to abortion care and positive outcomes across the United States. Black women are likely to be disproportionately prosecuted for pursuing illegal abortions. At-home abortions using home remedies will be pursued at a higher rate by those living in states banning abortions and without the means to travel to other states. Also, even with the attempt at making telemedicine medication abortions available, it is likely that conservative states will search for options to block off this avenue of care as much as possible. Undoubtedly, the ones most impacted by these future conditions will be low-income or racial minority individuals.

4.2 Addressing Disparities

Addressing disparities is not intended to solve the entirety of the issues discussed throughout this narrative review, but to draw attention to areas of improvement or work being done as the United States faces the consequences of removing abortion access to millions.

Now that the decision on whether abortions are accessible is left to the states to decide, non-profit organizations will be faced with taking on the burden to increase access to care. Abortion funds operate to connect people to abortion providers and provide them financial support and social

networks to rely on, whether someone needs to travel outside of their state or just needs assistance in paying for an abortion (National Network of Abortion Funds, 2023). Considering the Hyde Amendment denies Medicaid the ability to cover any abortion care costs (Planned Parenthood, n.d.), abortion funds could be beneficial to bridging the gaps in care access for low-income populations.

While not all unintended pregnancies can be prevented, improving contraceptive access, including emergency contraceptive, can be beneficial to at least reducing unintended pregnancy. A Kaiser Family Foundation survey found that more people obtained emergency contraceptive and started birth control, with higher rates of uptake in states with abortion bans or restrictions (Kaiser Family Foundation, 2023). Providing more preventive measures can assist in reducing the policy impact of the removal of abortion access.

As for healthcare systems, there are serious issues with quality outcomes for people of color in the United States. Addressing the issue of insurance coverage for pregnant people to allow them continued access to care, as well as addressing the increased risk of maternal mortality and morbidities and the poorer health outcomes of racial minority and low-income populations is necessary.

In the years to come, data on the impact of *Dobbs v. Jackson* will come in, but based on the issues that were prevalent prior to the repeal of *Roe v. Wade*, some of these outcomes could be predicted. Work like this narrative review call attention to these areas of concern and aims to allow public health to work to prevent negative externalities of this policy change.

4.3 Conclusion

Following *Dobbs v. Jackson Women's Health Organization*, which eliminated the constitutional right to abortion in the United States, racial and socioeconomic health disparities only continue to be amplified. People of color face higher rates of being uninsured, higher risk of death and complications when giving birth, and impacts on their socioeconomic status. Historically, the United States developed a society that survived by creating a greater disadvantage for people of color, allowing these disparities in the first place. The *Dobbs* decision impacts the individual state policies, including the 13 states with abortion bans in place (Planned Parenthood, n.d.), in the years to come, it is necessary to start addressing the severe harm that will disproportionately impact vulnerable populations.

Bibliography

- Acevedo, Z. (1979). Abortion in Early America. *Women & Health*, 4(2), 159-167. Taylor & Francis Online.
- Aiken, A. R.A., Starling, J. E., & Scott, J. G. (2022). Requests for Self-managed Medication Abortion Provided Using Online Telemedicine in 30 US States Before and After the Dobbs v Jackson Women's Health Organization Decision. *JAMA*, 328(17), 1768-1770. <https://jamanetwork-com.pitt.idm.oclc.org/journals/jama/fullarticle/2797883>
- Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes. *Journal of Women's Health*, 24(1), 100-106. National Library of Medicine.
- American Pregnancy Association. (2023). *Postpartum Recovery*. American Pregnancy Association. Retrieved March 27, 2023, from <https://americanpregnancy.org/healthy-pregnancy/first-year-of-life/postpartum-recovery/>
- American Public Transportation Association. (2023, March 10). *Public Transportation Facts*. American Public Transportation Association. Retrieved April 11, 2023, from <https://www.apta.com/news-publications/public-transportation-facts/>
- Backes Kozhimannil, K., Hassan, A., & Hardeman, R. R. (2022). *Abortion Access as a Racial Justice Issue*. *New England Journal of Medicine*. Retrieved February 28, 2023, from <https://www.nejm.org/doi/full/10.1056/NEJMp2209737>
- Backes Kozhimannil, K., Mah Trinacty, C., Busch, A. B., Huskamp, H. A., & Adams, A. S. (2011). Racial and Ethnic Disparities in Postpartum Depression Care Among Low-Income Women. *Psychiatric Services*, 62(6), 619-625. PubMed Central.
- Blackmun, H. A. (n.d.). *Roe v. Wade*. Oyez. Retrieved February 1, 2023, from <https://www.oyez.org/cases/1971/70-18>
- Bridges, K. M. (2022). *Deploying Death*. *U.C.L.A. Law Review*. Retrieved March 2, 2023, from <https://web-s-ebshost-com.proxy.lib.umich.edu/ehost/pdfviewer/pdfviewer?vid=0&sid=45f7db54-2208-40be-b1de-bde82a212c87%40redis>
- Center for Intersectional Justice. (n.d.). *What is Intersectionality*. Center for Intersectional Justice. Retrieved April 20, 2023, from <https://www.intersectionaljustice.org/what-is-intersectionality>

- Center for Reproductive Rights. (2022). *After Roe Fell: Abortion Laws by State*. Center for Reproductive Rights. Retrieved March 24, 2023, from <https://reproductiverights.org/maps/abortion-laws-by-state/>
- Center for Reproductive Rights. (2022). *State Constitutions and Abortion Rights*. Center for Reproductive Rights. Retrieved February 1, 2023, from <https://reproductiverights.org/state-constitutions-abortion-rights/>
- Centers for Medicare & Medicaid Services. (2022). *November 2022 Medicaid & CHIP Enrollment Data Highlights*. Medicaid. Retrieved March 26, 2023, from <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>
- Cheung, H. K., Anderson, A. J., King, E. B., Mahabir, B., Warner, K., & Jones, K. P. (2022). Beyond the Baby Bump: Subtle Discrimination Against Working Mothers In the Hiring Process. *J Bus Psychol*, 37(6), 1181-1198. PubMed Central.
- Cleveland Clinic. (2022, January 14). *How Often Do You Need Prenatal Visits?* Cleveland Clinic Health Essentials. Retrieved February 1, 2023, from <https://health.clevelandclinic.org/prenatal-appointment-schedule/>
- Cleveland Clinic. (2022, October 31). *Postpartum Recovery Timeline – Cleveland Clinic*. Cleveland Clinic Health Essentials. Retrieved February 1, 2023, from <https://health.clevelandclinic.org/postpartum-recovery/>
- Creamer, J., Shrider, E. A., Burns, K., & Chen, F. (2022, September 13). *Poverty in the United States: 2021*. Census Bureau. Retrieved March 25, 2023, from <https://www.census.gov/library/publications/2022/demo/p60-277.html>
- Daw, J. R., Kolenic, G. E., Dalton, V. K., Zivin, K., Winkelman, T., Kozhamannil, K. B., & Admon, L. K. (2020). Racial and Ethnic Disparities in Perinatal Insurance Coverage. *Obstetrics and Gynecology*, 135(4), 917-924. PubMed Central.
- Declercq, E., & Zephyrin, L. (2021, October 28). *Severe Maternal Morbidity in the United States: A Primer*. Commonwealth Fund. Retrieved March 25, 2023, from <https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer>
- Fairthorne, J. C., Oberlander, T. F., Brant, R., & Hanley, G. E. (2021). Risk Factors for Hospitalizations Associated with Depression Among Women During the Years Around a Birth: A Retrospective Cohort Study. *International Journal of Population Data Science*, 4(1), 1-14. <https://ijpds.org/article/view/453>
- Greene Foster, D., Biggs, M. A., Ralph, L., Gerds, C., Roberts, S., & Glymour, M. M. (2018). Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. *American Journal of Public Health*, 108(3), 407-413. National Library of Medicine.

- Gyn Choices of Central Jersey. (2022, July 15). *What are the different types of abortion? - GYN Choices Of Central Jersey*. GYN Choices of Central Jersey. Retrieved March 22, 2023, from <https://www.gynchoicesofcentraljersey.com/blog/what-are-the-different-types-of-abortion/>
- Harned, E. B., & Fuentes, L. (2023, January 25). *Abortion Out of Reach: The Exacerbation of Wealth Disparities After Dobbs v. Jackson Women's Health Organization*. Guttmacher Institute. Retrieved March 21, 2023, from <https://www.guttmacher.org/article/2023/01/abortion-out-reach-exacerbation-wealth-disparities-after-dobbs-v-jackson-womens>
- Harris, L. H., & Grossman, D. (2020). Complications of Unsafe and Self-Managed Abortion. *The New England Journal of Medicine*, 382(11), 1029-1040. <https://www.nejm.org/doi/full/10.1056/NEJMra1908412>
- Haydel, J. (2009). *Privacy | The First Amendment Encyclopedia*. Middle Tennessee State University. Retrieved February 1, 2023, from <https://www.mtsu.edu/first-amendment/article/1141/privacy>
- Hirai, A. H., Owens, P. L., Reid, L. D., Vladutiu, C. J., & Main, E. K. (2022). Trends in Severe Maternal Morbidity in the US Across the Transition to ICD-10-CM/PCS From 2012-2019. *JAMA Network Open*, 5(7), 1-12.
- Hoyert, D. L. (2022, February 23). *Maternal Mortality Rates in the United States, 2020*. Centers for Disease Control and Prevention. Retrieved February 1, 2023, from <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm>
- Ishizuka, P. (2021). The Motherhood Penalty in Context: Assessing Discrimination in a Polarized Labor Market. *Demography*, 58(4), 1275-1300. Duke University Press.
- Jones, J. (2023, March 14). South Carolina Republicans float the death penalty for abortion. *South Carolina Republicans float the death penalty for abortion*. Retrieved March 20, 2023, from <https://www.msnbc.com/the-reidout/reidout-blog/abortion-death-penalty-south-carolina-rcna74957>
- Jones, N., Marks, R., Ramirez, R., & Ríos, M. (2021, August 12). *Improved Race, Ethnicity Measures Show U.S. is More Multiracial*. Census Bureau. Retrieved March 25, 2023, from <https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html>
- Kaiser Family Foundation. (2022, July 13). *Health Costs Associated with Pregnancy, Childbirth, and Postpartum Care*. KFF. Retrieved February 1, 2023, from <https://www.kff.org/health-costs/issue-brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care/>
- Kaiser Family Foundation. (2022, December 20). *Health Coverage by Race and Ethnicity, 2010-2021*. KFF. Retrieved February 1, 2023, from <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>

- Kaiser Family Foundation. (2023, January 20). *Key Facts on Abortion in the United States*. KFF. Retrieved February 1, 2023, from <https://www.kff.org/womens-health-policy/report/key-facts-on-abortion-in-the-united-states/>
- Kaiser Family Foundation. (2023, February 24). *The Availability and Use of Medication Abortion*. KFF. Retrieved March 2, 2023, from <https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/>
- Kaiser Family Foundation. (2023, April 4). *After Dobbs, Survey Seeks to Understand Telecontraception Clients Better*. KFF. Retrieved April 12, 2023, from <https://www.kff.org/womens-health-policy/press-release/after-dobbs-survey-seeks-to-understand-telecontraception-clients-better/>
- Kaufman, R., Brown, R., Martínez Coral, C., Jacob, J., Oyango, M., & Thomasen, K. (2022, November 16). *Global impacts of Dobbs v. Jackson Women's Health Organization and abortion regression in the United States*. NCBI. Retrieved March 2, 2023, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9673802/>
- Kimport, K. (2022, September). Abortion After Dobbs: Defendants, Denials, and Delays. *ScienceAdvances*, 8(36). <https://www.science.org/doi/10.1126/sciadv.ade5327>
- LegiScan. (2021). *TX SB8*. LegiScan. <https://legiscan.com/TX/text/SB8/id/2395961>
- Liu, S., Ding, X., Belouali, A., Bai, H., Raja, K., & Kharrazi, H. (2022, 10 17). Assessing the Racial and Socioeconomic Disparities in Postpartum Depression Using Population-Level Hospital Discharge Data: Longitudinal Retrospective Study. *JMIR Pediatrics and Parenting*, 5(4), 1-17. <https://pediatrics.jmir.org/2022/4/e38879/>
- MacDorman, M. F., Thoma, M., Declercq, E., & Howell, E. A. (2021). Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016–2017. *American Journal of Public Health*, 111(9), 1673-1681.
- Miller, S., Wherry, L. R., & Greene Foster, D. (2023). The Economic Consequences of Being Denied an Abortion. *American Economic Journal*, 15(1), 394-437.
- Monea, E., & Thomas, A. (2011). Unintended Pregnancy and Taxpayer Spending. *Perspect Sex Reprod Health*, 43(2), 88-93. PubMed.
- National Health Service. (2021). *You and your baby at 24 weeks pregnant*. NHS. Retrieved February 1, 2023, from <https://www.nhs.uk/pregnancy/week-by-week/13-to-27/24-weeks/>
- National Institute of Child Health and Human Development. (2020, May 14). *About Maternal Morbidity and Mortality | NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development*. National Institute of Child Health and Human Development. Retrieved March 27, 2023, from <https://www.nichd.nih.gov/health/topics/maternal-morbidity-mortality/conditioninfo>

- National Network of Abortion Funds. (2023). *Abortion Funds 101*. National Network of Abortion Funds. Retrieved April 12, 2023, from <https://abortionfunds.org/about/abortion-funds-101/>
- Oyez. (n.d.). *Planned Parenthood of Southeastern Pennsylvania v. Casey*. Oyez. Retrieved February 1, 2023, from <https://www.oyez.org/cases/1991/91-744>
- Planned Parenthood. (n.d.). *Abortion in U.S. History*. Planned Parenthood Action Fund. Retrieved February 1, 2023, from <https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america>
- Planned Parenthood. (n.d.). *The Significance of Griswold v. Connecticut*. Planned Parenthood Action Fund. Retrieved February 1, 2023, from <https://www.plannedparenthoodaction.org/issues/birth-control/griswold-v-connecticut>
- Poux, S. (2017, August 5). *Social-Ecological Model Offers New Approach to Public Health*. The Borgen Project. Retrieved April 11, 2023, from <https://borgenproject.org/social-ecological-model/>
- Rader, B., Upadhyay, U., & Seghal, N. (2022). Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the Dobbs v Jackson Women’s Health Decision. *JAMA*, 328(20), 2041-2047. <https://jamanetwork.com/journals/jama/fullarticle/2798215>
- Reagan, L. J. (2022). *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973, with a New Preface*. University of California Press.
- Roberts, S. C., Biggs, M. A., Chibber, K. S., Gould, H., Rocca, C. H., & Greene Foster, D. (2014). Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Medicine*, 12(144), 1-7. BMC Med.
- The Royal Women's Hospital. (n.d.). *Treating miscarriage*. The Royal Women's Hospital. Retrieved March 27, 2023, from <https://www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-problems/early-pregnancy-problems/treating-miscarriage>
- Rudowitz, R., Tolber, J., Salganicoff, A., & Gomez, I. (2022, July 15). *After Roe: Options to Address Medicaid Coverage Policy Related to Maternal and Child Health*. KFF. Retrieved April 15, 2023, from <https://www.kff.org/policy-watch/after-roe-options-to-address-medicaid-coverage-policy-related-to-maternal-and-child-health/>
- The Sentencing Project. (2022). *Incarcerated Women and Girls*. The Sentencing Project. Retrieved March 14, 2023, from <https://www.sentencingproject.org/app/uploads/2022/11/Incarcerated-Women-and-Girls.pdf>
- Social Security Administration. (2022). *National Average Wage Index*. SSA. Retrieved February 1, 2023, from <https://www.ssa.gov/oact/cola/AWI.html>

- Stockman, J. K., Hayashi, H., & Campbell, J. C. (2015). Intimate Partner Violence and Its Health Impact on Disproportionately Affected Populations, Including Minorities and Impoverished Groups. *Journal of Women's Health, 24*(1). National Library of Medicine.
- Suresh, S., Amegashie, C., Patel, E., Nieman, K. M., & Rana, S. (2022). Racial Disparities in Diagnosis, Management, and Outcomes in Preeclampsia. *Current Hypertension Report, 24*, 87-93. SpringerLink.
- U.S. Department of Health and Human Services. (2022, July 11). *Following President Biden's Executive Order to Protect Access to Reproductive Health Care*. HHS.gov. Retrieved April 12, 2023, from <https://www.hhs.gov/about/news/2022/07/11/following-president-bidens-executive-order-protect-access-reproductive-health-care-hhs-announces-guidance-clarify-that-emergency-medical-care-includes-abortion-services.html>
- Weigel, G., Sobel, L., & Salganicoff, A. (2019, December 4). *Understanding Pregnancy Loss in the Context of Abortion Restrictions and Fetal Harm Laws*. KFF. Retrieved March 15, 2023, from <https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/>
- Winny, A. (2022, October 26). *A Brief History of Abortion in the U.S.* Hopkins Bloomberg Public Health Magazine. Retrieved March 24, 2023, from <https://magazine.jhsph.edu/2022/brief-history-abortion-us>