ISSUE BRIEF

Maternal Health and Abortion Restrictions: How Lack of Access to Quality Care Is Harming Black Women

OCTOBER 2019

Those who could become pregnant deserve autonomy to make the decisions that are best for them and their families – and to receive high quality, evidence-based, supportive health care no matter their choices. But two of the most significant crises in reproductive health care are undermining women's ability to be safe and healthy: the rising maternal mortality rate and the increasing passage of laws that undermine access to abortion care.

Both crises are of course directly linked to health outcomes, but also have implications for women's short and long-term economic security, their well-being and quality of life, and their ability to live with dignity and participate equally and fully in society.

Both crises also disproportionately harm people of color, particularly Black women – and, at a fundamental level, reveal painful truths about whose bodies, needs and voices are valued by the medical and political establishment.

The time is now to comprehensively address maternal mortality and abortion access, and to do so in a way that acknowledges these issues as interconnected. Advocates, health care providers and policymakers who care about and are responsible for improving maternal health or about increasing access to abortion care must come together and insist on multi-faceted policy solutions that improve access to quality care for women, no matter their pregnancy decisions.

Maternal Health and Maternal Mortality

Nearly four million people give birth each year in the United States.[1] They deserve to have healthy and safe pregnancies, and high-quality maternity care significantly benefits not only women but also infants and families.

NationalPartnership.org
@NPWF

1875 Connecticut Avenue, NW, Suite 650
Washington, DC 20009

info@NationalPartnership.org
202.986.2600

BlackRJ.org
@BlackWomensRJ

1012 14th Street, NW, Suite 450
Washington, DC 20005

info@BlackRJ.org
202.545.7600

However, our country is facing a crisis around maternal health and mortality. Approximately 700 women die every year from pregnancy and birth,[2] and an additional 50,000 experience a pregnancy complication so severe that they nearly die.[3] And even though about 3 in 5 pregnancy related deaths could be prevented,[4] the maternal mortality rate has continued to rise with alarming speed.[5] Maternal deaths are emblematic of the broader challenges facing the health care system, such as high costs, gaps in insurance coverage, lack of access to quality and community-based care, and a failure to integrate women's voices into decisions around care delivery and payment and to respect and listen to women receiving care. Societal factors – also known as social determinants of health – such as lack of access to safe and affordable housing, nutritious food, adequate and reliable transportation and close proximity to hazardous environmental toxins also play a significant role in contributing to poor maternal health outcomes.

Disproportionate Impact on Black Women

The maternal health crisis is particularly acute – and alarming – for Black women.[6] Black women in the United States are three to four times more likely to experience a pregnancy-related death than white women.[7] Those deaths are also more likely to have been preventable.[8] Importantly, Black women's heightened risk of pregnancy-related death spans income and education levels,[9] suggesting that deeper societal factors, including racism in the health care system, are root causes of this crisis.

Black women are more likely to be exposed to negative social determinants of health; they experience higher rates of poverty, homelessness and housing insecurity, food insecurity and unreliable transportation,[10] and numerous studies show that disparities in birth outcomes are, at least in part, attributable to these factors.[11] For example, due to racism, sexism and other systemic barriers that have contributed to income inequality, Black women are typically paid just 61 cents for every dollar paid to white, non-Hispanic men. Median wages for Black women in the United States are $36,735 per year, which is $23,653 less than the median wages for white, non-Hispanic men.[12] These lost wages mean Black women and their families have less money to support themselves and their families, and may have to choose among essential resources like housing, childcare, food and health care. These trade-offs are evident in Black women's health outcomes and use of medical care. Compared to white women, Black women are more likely to be uninsured,[13] face greater financial barriers to care when they need it[14] and are less likely to access prenatal care.[15] Indeed, Black women experience higher rates of many preventable diseases and chronic health conditions, including higher rates of diabetes, hypertension and cardiovascular disease.[16]

In addition, systemic societal discrimination and the stress that it causes negatively affects women's health.[17] Black women experience physical "weathering," meaning their bodies age faster than white women's due to exposure to chronic stress linked to socioeconomic disadvantage and discrimination over the life course, thus making pregnancy riskier at an earlier age.[18] When, or if, Black women choose to become pregnant, these health conditions influence both maternal and infant health outcomes.

Compounding these social factors is historical and ongoing racism within the health care system itself. From scientific research and experimentation that exploited Black women, to disparities in the quality of facilities serving communities of color, to implicit bias that informs how providers assess and treat individuals, these factors have a significant negative impact on the type and quality of care that Black women receive.[19] Furthermore, Black women may delay or avoid seeking care because of a justifiable mistrust of providers – and then when they do seek care, their symptoms, pain or other needs are frequently minimized or ignored. Indeed, research has found that Black women are more likely than white women to report experiencing discrimination in the health care system,[20] and are also more likely to receive lower quality care than white women.[21]

Barriers to Abortion Access

Abortion is an essential part of health care and a basic human right. Nearly one in four women in the United States will have an abortion by age 45.[22] Access to abortion care facilitates people's autonomy, dignity and ability to make decisions about their bodies, their lives and their futures. It also enables people to adequately care for themselves and their families, and to fully contribute to American society. In short, abortion is fundamental to women's equality, and all people deserve access to abortion care and to comprehensive reproductive health care.

Yet across the country, access to abortion is under attack. Bans on abortion have been moving with alarming speed in state legislatures.[23] For example, just since January 2019, bans on abortion after 6 weeks – before most people even know that they are pregnant – passed in Louisiana, Ohio, Georgia, Kentucky and Mississippi. A ban on abortion after 8 weeks passed in Missouri, and the state is currently attempting to revoke the license to provide abortion care from the last remaining Missouri clinic, meaning the state could be the first without an abortion provider since before *Roe v. Wade*. Similarly, Alabama passed a law that criminalizes abortion at any stage in pregnancy. Trigger laws, which would automatically criminalize abortion in the event that *Roe v. Wade* is overturned, have recently passed in Arkansas, Kentucky, Missouri and Tennessee. And bans on a

commonly-used method of care for abortions after 14 weeks of pregnancy passed in Indiana and North Dakota.[24]

These bans are compounded by other efforts at both the federal and state levels to limit access to abortion care and family planning services, such as the Trump administration's rule prohibiting Title X recipients from referring patients for abortion care, state efforts to prohibit Planned Parenthood from receiving reimbursement under state Medicaid programs, and other strategies to limit who can provide abortion care and other reproductive health services. In addition, for decades, states have passed and continue to pass anti-abortion laws that ignore evidence and science and mandate how health care providers must practice medicine, regardless of the provider's professional judgment, ethical obligations or the needs of patients. These laws make care harder for patients to access and often drive up costs without improving patient experience or health. Examples of these laws include biased counseling requirements, which dictate the information that a health care provider must give to a patient, including requirements to provide biased or medically inaccurate information; mandatory delay laws that force providers to delay time-sensitive care regardless of the provider's medical judgment or the patient's needs and preferences; and other laws that impose burdensome and medically unnecessary requirements on providers and people seeking care. In addition, federal and state laws have restricted the availability of coverage for abortion care in both public and private insurance programs.

Disproportionate Impact on Black Women

As a result of many factors, including systemic racism, Black women disproportionately face geographic, transportation, infrastructure and economic barriers to obtaining abortion care, and are more likely to be harmed by these various bans and

THE HYDE AMENDMENT AND COVERAGE RESTRICTIONS

Since 1976, the Hyde Amendment has prohibited federal funds from covering abortion care for women enrolled in Medicaid, except in very narrow circumstances. Similar coverage restrictions apply to people enrolled in Medicare and the Children's Health Insurance Program (CHIP), as well as women in the military, in federal prisons and the Peace Corps; Native American women; and low-income women in the District of Columbia. In addition, 34 states and the District of Columbia prohibit the use of state funds to cover abortion under their state Medicaid programs, except in limited cases[25] – and many states restrict abortion coverage even further, for example by prohibiting private insurance coverage of abortion care.[26] As a consequence, abortion care is pushed out of reach for millions of women – with the burden falling heaviest on women of color, low-income women and young women. The ability to make personal health care decisions should not depend on how much money a woman makes, where she lives or where she gets her health insurance.

restrictions. For example, coverage bans – abortion restrictions that prohibit coverage for abortion in public or private health insurance, or make it more difficult to obtain – disproportionately affect women of color.[27] These bans – a result of the federal Hyde Amendment and similar state laws – effectively deny women access to abortion based on how much money they have. Women of color live at the intersection of multiple disparities and structural barriers that lead to a higher likelihood of being Medicaid-eligible and therefore, subject to Hyde. The high out-of-pocket costs only increase when care is delayed due to barriers imposed on those seeking abortion, such as TRAP laws, mandatory delays, biased counseling laws, ultrasounds requirements and more. This means that women of color are too often unable to afford abortion care and may be forced to decide between paying for things like rent or groceries and paying for an abortion. Not being able to access abortion care further increases the economic disparities that women of color face: women who are denied an abortion are more likely to fall into poverty than women who are able to obtain the care they need.[28] Aside from the economic impacts, the injustice of not being able to have control over one's own reproductive life and choices has detrimental effects on women's well-being and on their ability to participate fully in society.

For Black women in particular, abortion restrictions have a disproportionate impact on their ability to access care. For example, the majority of Black people in the United States live in the South, where many states, such as Louisiana and Mississippi, are hostile to abortion and have multiple types of abortion restrictions in place.[29]

The Connection between Abortion Restrictions and Maternal Health

The impacts of maternal mortality and increasing abortion restrictions are closely related to each other – both at the level of a person's health experiences and outcomes, and at the deeper level of our political and social values.

First, women who were denied an abortion and then gave birth report worse health outcomes up to five years later as compared to women who receive a desired abortion.[30] More specifically, according to a longitudinal study that is frequently cited in peer-reviewed journals, women who are denied abortion care are more likely to experience eclampsia, death and other serious medical complications during the end of pregnancy; more likely to remain in relationships where interpersonal violence is present; and more likely to suffer anxiety.[31]

Research has found that states with higher numbers of abortion restrictions are the exact same states that have poorer maternal health outcomes,[32] and various factors may be at the root of this correlation. For example, trying to obtain and then being denied abortion care can cause high levels of stress that negatively impact both maternal and

child health.[33] Women who are denied an abortion are also more likely to delay prenatal care, which can result in higher incidence of maternity-related and infant health problems.[34] For women who experience illnesses or conditions during pregnancy where abortion would be medically indicated – but where state law has made abortion inaccessible or entirely unavailable – being forced to carry a pregnancy to term can exacerbate their health conditions and put them at much higher risk for serious complications or death.

In addition, at the policy level, cuts to family planning providers and underfunding of state Medicaid programs, along with other similar government actions – common in states with restrictive abortion laws – also significantly limit women's ability to access affordable, timely and quality prenatal care, increasing the likelihood that women in those states will experience poor maternal and infant health outcomes. As *Roe v. Wade* is increasingly threatened, and even fewer women have access to abortion care, we can anticipate that the maternal mortality crisis will only worsen, particularly for women of color and low-income women.

IMPACT ON ECONOMIC SECURITY

- Research shows that women who are denied abortion care are worse off financially and significantly more likely to fall into poverty than women who are able to get the care they need.[35]
- Access to abortion is linked to greater workforce participation and higher lifetime earnings; women who are denied an abortion had more than three times greater odds of being unemployed six months later than women who were able to access an abortion.[36] In one study, women who were able to have an abortion were six times more likely to have positive life plans – most commonly related to education and employment – and are more likely to achieve them than women denied an abortion.[37]
- Access to abortion care also benefits children and families, most directly by allowing people to take on the costs of having children when they are best able or to have the resources necessary to care and provide for the children they already have. Research has found that denying women abortion care has negative developmental and socioeconomic consequences for their existing children.[38]

Disproportionate Impact on Black Women

The intersection of abortion restrictions and maternal health outcomes is particularly harmful to Black women. As described above, restrictions and bans on abortion care fall disproportionately on Black women and exacerbate existing health disparities, including in maternal health and maternal mortality. Black women also are more likely to face policy and structural barriers that inhibit their ability both to access abortion care and to

have healthy pregnancies – policies like paid sick days, pay equity, affordable health insurance, access to contraception and freedom from pregnancy discrimination at work – that compound the impact of these intersecting issues in their lives.[39]

More fundamentally, policies that undermine access to abortion care and quality maternal health care are rooted in persistent structural racism and sexism. In the field of reproductive and obstetric health care specifically, there is a history and ongoing legacy of reproductive control and years of coercive policies and practices based on race.[40] Consequently, Black women often distrust health care systems and providers, and can be reluctant to seek care. And the system and providers in it, as a result of embedded racism, often do not trust Black women and what they say they want or need in terms of their own care. This manifests both in the denial of abortion care and in the minimization or ignoring of pain that women report experiencing during maternity care. All too often, then, Black women do not get the care that they want or need.

Policy Solutions

To ensure meaningful access to abortion care and to improve women's maternal health – particularly for Black women – we need a multi-faceted, cross-issue approach that directly confronts how and where quality care has been undermined, responds to women's health needs across the lifespan, expands patient-centered and affordable care, and addresses social determinants of health including economic security.

- **Expand and maintain access to health coverage.** All people – regardless of race, income level, immigration status, gender identity or sexual orientation – should have high-quality, affordable, comprehensive insurance coverage. Plans should provide the benefits that women need to be healthy at all stages of their lives, including reproductive care, maternity care, behavioral health, preventive care and long-term services and supports. Insurance coverage should also not subject individuals and families to high health care costs and financial hardship.
- **Expand access to quality, patient-centered and comprehensive reproductive health care.** Reproductive health care, including abortion care, is essential, basic health care and should be available to all people no matter where they live, how they are insured or how much they earn. Federal and state level restrictions that prohibit insurance coverage for abortion care should be repealed, as should laws that erect burdensome and medically unnecessary barriers to timely, high-quality care. In addition, it is critical to expand access to contraception and related counseling, and to strengthen the Title X family planning program and protect it from political interference that undermines the program's integrity and compromises the quality of care that patients receive.

- **Provide patient-centered care that is responsive to the needs of Black women.** Black women should receive health care that is respectful, culturally appropriate, safe and of the highest quality. Public policies and medical practice should incentivize providing patient-centered care that focuses on Black women's individualized needs, including their non-clinical, social needs. Moreover, policies should endeavor to eradicate cultural biases and discrimination in medical practice and medical education, increase provider diversity in maternity and reproductive care, and hold individual providers and hospital systems accountable if they fail to provide unbiased, high-quality, evidence-based care.
- **Address the social determinants of health. Social determinants of health are the conditions under which people live, work and play.** These conditions have consequential and varying effects on health outcomes across race and ethnicity. For Black women who are affected by structural inequality and discrimination, the chronic stress of poverty and racism has been shown to have a harmful effect on health outcomes and is linked to their persistent maternal health disparities.[41] Importantly, though, these social factors can be modified to improve health outcomes, including through policies that raise incomes and build wealth; provide access to clean, safe and affordable housing and neighborhoods; improve the quality of education; prioritize reliable public transportation and transport for medical appointments; and increase the availability of healthy, affordable food.
- **Expand and protect access to trusted community providers of both maternity and abortion care.** A strong provider network – including advanced practice clinicians, midwives and doulas – practicing in a range of settings, including clinics and community-based health care centers, is necessary to support people's ability to access quality providers that they trust. The health care workforce should also be similar in background and identity to the people receiving care, and policies should support the development of a diverse workforce.
- **Invest in innovative approaches to care like community-based and more holistic care models.** Community-based care models (CBMs) provide an alternative model of care delivery tailored to address maternal and infant health disparities. The growing number of community-based perinatal health worker organizations across the country demonstrate that culturally-relevant services predicated on choice, autonomy and respect can improve maternal and infant health outcomes and have the potential to narrow health disparities.[42] Programs provided by CBMs play an essential role in providing services in communities and neighborhoods where many people experience barriers to care, including maternity care deserts and mistrust of conventional services, but there are not enough models to reach everyone who

needs assistance. Policies should promote increased development and sustained funding for CBMs.

- **Create and expand protections for pregnant and parenting people that help them manage work and family responsibilities**, including pregnancy non-discrimination laws, paid family and medical leave, paid sick days, affordable childcare and living wage laws.

Conclusion

In the face of the rising maternal mortality and severe maternal morbidity rates and increasing restrictions on abortion care, health care providers, advocates and policymakers must recognize the relationship between these issues and commit to tackling them in tandem. Black women – indeed, all women and those who could become pregnant – deserve access to the full spectrum of reproductive health care, including abortion and maternity care. Even more so, that care must be high quality, affordable and responsive to the social environments in which Black women work and live. Only then will Black women be able to live healthy, secure and full lives.

---

[1] Hamilton, B., Martin, J., Osterman, M., & Rossen, L. (2019, May) *Births: Provisional Data for 2018* (p. 1). Retrieved 5 September 2019, from https://www.cdc.gov/nchs/data/vsrr/vsrr-007-508.pdf

[2] Centers for Disease Control and Prevention. (2019, May 7). *Vital Signs: Pregnancy-Related Deaths*. Retrieved 5 September 2019, from https://www.cdc.gov/vitalsigns/maternal-deaths/

[3] Centers for Disease Control and Prevention. (2017, October). *Maternal Health: Advancing the Health of Mothers in the 21st Century.* Retrieved 19 September 2019, from https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-maternal-health.pdf

[4] See note 2.

[5] See Centers for Disease Control and Prevention. (2019, June 4). *Reproductive Health: Pregnancy Mortality Surveillance* System. Retrieved 5 September 2019, from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

[6] Ibid. Latina women, Asian and Pacific Islander women, and Native American women also have disproportionately high rates of maternal mortality. This issue brief, however, is focused specifically on Black women.

[7] See Tucker, M. J., Bero C. J., Callaghan, W. M., & Hsia, J. (2007, February). The Black-White disparity in pregnancy-related mortality from 5 conditions: Differences in prevalence and case-fatality rates. *American Journal of Public Health, 97*(2), 247-251.

[8] See Louis, J. M., Menard, M. K., & Gee, R. E. (2015). Racial and ethnic disparities in maternal morbidity and mortality. Obstetrics & Gynecology, 125(3), 690-694.

[9] Black Mamas Matter. Center for Reproductive Rights (2016, May). *Research Overview of Maternal Mortality and Morbidity in the United States*. Retrieved 5 September 2019, from https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf

[10] See, e.g., Noonan, A. S., Velasco-Mondragon, H. E., & Wagner, F. A. (2016). Improving the health of African Americans in the USA: An overdue opportunity for social justice. *Public Health Reviews 37*(12), 1-20.

[11] Office of Disease Prevention and Health Promotion. (n.d.). *2020 Topics & Objectives: Maternal, Infant, and Child Health*. Retrieved 5 September 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

[12] National Partnership for Women & Families. (2019, April). *Quantifying America's Gender Wage Gap by Race* (p. 2). Retrieved 5 September 2019, from http://www.nationalpartnership.org/our-work/resources/workplace/fair-pay/quantifying-americas-gender-wage-gap.pdf

[13] See National Partnership for Women & Families. (2019, April). *Black Women Experience Pervasive Disparities in Access to Health Insurance*. Retrieved 5 September 2019, from http://www.nationalpartnership.org/our-work/resources/health-care/black-womens-health-insurance-coverage.pdf

[14] The Commonwealth Fund. (n.d.). *Health Insurance Survey Data Explorer*. Retrieved 5 September 2019, from https://www.commonwealthfund.org/biennial-explorer-interactive

[15] Child Trends. (2019, May 3). *Late or No Prenatal Care*. Retrieved 5 September 2019, from https://www.childtrends.org/indicators/late-or-no-prenatal-care ("In 2017, late or no prenatal care was most likely to be reported by American Indian and Alaska Native, and non-Hispanic black women (12 and 10 percent of births, respectively). By contrast, only 6 and 5 percent of Asian or Pacific Islander and non-Hispanic white women, respectively, received late or no prenatal care.")

[16] Office of Minority Health. (2019, August 22). *Profile: Black/African Americans*. Retrieved on 5 September 2019, from https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61

[17] See Alhusen, J. L., Bower, K., Epstein, E., & Sharps, P. (2016, November). Racial discrimination and adverse birth outcomes: An integrative review. *Journal of Midwifery & Women's Health 61*(6), 707-720.

[18] See Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethnicity & Disease, 2*(3), 207-221.

[19] Feagin, J. & Bennefield, Z. (2014, February). Systemic racism and U.S. health care. *Social Science and Medicine*, *103*, 7-14.

[20] Robert Wood Johnson Foundation. (2017, December). *Discrimination in America: Experiences and Views of American Women.* Retrieved 5 September 2019, from https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf441994

[21] See Agency for Healthcare Research and Quality. (2019, September). *2018 National Healthcare Quality & Disparities Report* (AHRQ Publication No. 19-0070-EF). Retrieved 17 September 2019, from https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2018qdr-final.pdf; See note 9.

[22] Guttmacher Institute. (2017, October 19). *Abortion is a common experience for U.S. women, despite dramatic declines in rates*. [News release]. Retrieved 5 September 2019, from https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates

[23] Nash, E., Mohammed, L., Cappello, O., Naide, S., & Ansari-Thomas, Z. (2019, July). *State Policy Trends at Mid-Year 2019: States Race to Ban or Protect Abortion.* Retrieved 5 September 2019 from Guttmacher Institute website: https://www.guttmacher.org/article/2019/07/state-policy-trends-mid-year-2019-states-race-ban-or-protect-abortion

[24] Guttmacher Institute. (2019, August 15). *State Policy Updates: Major Developments in Sexual & Reproductive Health. Abortion: Abortion Bans*. Retrieved 5 September 2019, from https://www.guttmacher.org/state-policy

[25] Guttmacher Institute. (2019, September 1). *State Funding of Abortion Under Medicaid*. Retrieved 5 September 2019, from https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid

[26] Guttmacher Institute. (2019, September 1). *Restricting Insurance Coverage of Abortion*. Retrieved 5 September 2019, from https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion

[27] Salganicoff, A., Sobel, L, & Ramaswamy, A. (2019, July). *The Hyde Amendment and Coverage for Abortion Services* (p. 2). Retrieved 5 September 2019 from Kaiser Family Foundation website: http://files.kff.org/attachment/Issue-Brief-The-Hyde-Amendment-and-Coverage-for-Abortion-Services

[28] See Advancing New Standards in Reproductive Health: University of California San Francisco. (2018, August). *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions*. Retrieved 5 September 2019, from https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf

[29] See United States Census Bureau, American Fact Finder. (n.d.). Selected Population Profile in the United States. 2017 American Community Survey 1-Year Estimates. Retrieved 5 September 2019 from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S0201&prodType=table (From calculations based on regional data from the 2017 American Community Survey 1-Year Estimates, the estimates of Black alone or in combination with one or more races are spread out through the country as follows: 55.5 percent in the South, 17.5 percent in the Midwest, 17 percent in the Northeast, and 10 percent in the West.); See United States Census Bureau. (2011, September). The Black population: 2010 Census Briefs (C2010BR-06) (pp. 7, 9). Retrieved 5 September 2019, from https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf("The Black alone-or-in-combination population represented 38 percent of the total population in Mississippi (see Table 5). This was followed by Louisiana (33 percent), Georgia (32 percent), Maryland (31 percent), South Carolina (29 percent), and Alabama (27 percent)."); see also In Our Own Voice: Black Women's Reproductive Justice Agenda. (2017, June). *The State of Black Women & Reproductive Justice* (p. 23). Retrieved 5 September 2019, from http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf (noting that "Black women . . . are likely to live in states with both coverage restrictions and other legal barriers. Women living in states that have the largest percentage of Black residents (i.e., Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina) face numerous barriers to exercising their right to abortion.") (Citation omitted.); Guttmacher Institute. (2019, September 1). An Overview of Abortion Laws. Retrieved 5 September 2019, from https://www.guttmacher.org/state-policy/explore/overview-abortion-laws (Guttmacher notes that Louisiana has nine types of abortion restrictions [must be performed by a licensed physician; second physician must participate if at viability; prohibited except in cases of life or health endangerment at 20 weeks; "partial-birth" abortion banned; public funding limited to cases of life endangerment, rape and incest; providers may refuse to participate; mandated counseling on fetal pain and

negative psychological effects; 24 hour waiting period; and parental consent for minors] and Mississippi has nine types as well [must be performed by a licensed physician; prohibited in cases of life or health endangerment at viability; "partial-birth" abortion banned; public funding limited to cases of life endangerment, rape and incest; private insurance coverage limited; providers may refuse to participate; mandated counseling about negative psychological effects; 24 hour waiting period; and parental consent required for minors].)

[30] See Ralph, L. J., Bimla Schwarz, E., Grossman, D., & Greene Foster, D. (2019, June). Self-reported physical health of women who did and did not terminate pregnancy after seeking abortion services: A cohort study. *Annals of Internal Medicine 171*(4), 238-247.

[31] See Advancing New Standards in Reproductive Health: University of California San Francisco. (n.d.). *Turnaway Study*. Retrieved 5 April 2019, from https://www.ansirh.org/research/turnaway-study

[32] See note 9.

[33] See Jerman, J., Frohwirth, L., Kavanaugh, M. L., & Blades, N. (2017, June). Barriers to Abortion care and their consequences for patients traveling for services: Qualitative findings from two states. *Perspectives on Sexual and Reproductive Health 49*(2), 95-102.

[34] Thomas, A., & Monea, E. (2011, July). *The High Cost of Unintended Pregnancy* (p. 1). Retrieved 5 September 2019 from Brookings Institute website: https://www.brookings.edu/wp-content/uploads/2016/06/07_unintended_pregnancy_thomas_monea.pdf

[35] Foster, D., Roberts, S.C., & Mauldon, J. (2012, October). *Socioeconomic consequences of abortion compared to unwanted birth*. Paper session presented at the American Public Health Associations annual meeting, from https://apha.confex.com/apha/140am/webprogram/Paper263858.html

[36] See note 28.

[37] Upadhyay, U., Biggs, M., & Foster, D. (2015, October). The effort of abortion on having and achieving aspirational one-year plans (pp. e5-6). *Boston Medical Center Women's Health*, *15*(102), e1-10.

[38] See Foster, D., Raifman, S., Gipson, J., Rocca, C., Biggs, M. (2019, February). Effects of carrying an unwanted pregnancy to term on women's existing children. *Journal of Pediatrics*, *205*, 183-189.

[39] See note 29, In Our Own Voice: National Black Women's Reproductive Justice Agenda.

[40] See, e.g., Texas Freedom Network. (2017, March 3). On your left, empty seats symbolizing the politicians absent from today's "people's hearing." On your right, real medical experts here to talk about the lies and misinformation used to justify anti-abortion laws. [Facebook Live video]. Retrieved 5 September 2019, from https://www.facebook.com/TexasFreedomNetwork/videos/10154387134648034/ (During the hearing, Marsha Jones of the Afiya Center discusses how bad medicine laws exacerbate problems with patient-provider trust for Black women.); Becker, D., & Tsui, A. O. (2008, December). Reproductive health service preferences and perceptions of quality among low-income women: Racial, ethnic and language group differences (p. 208). *Perspectives on Sexual and Reproductive Health, 40*(4), 202-211. ("Finally, black women had higher odds than whites of reporting ever having been pressured by a health care clinician to use a contraceptive method."); See Minna Stern, A. (2005, July). Sterilized in the name of public health: Race, immigration, and reproductive control in modern California. *American Journal of Public Health, 95*(7), 1128-1138.

[41] See Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries IV, W. L. (2016, July). The impact of racism on the sexual and reproductive health of African American women. *Journal of Women's Health, 25*(7), 664-671.

[42] National Partnership for Women & Families. (2019). *Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches*. Retrieved 17 September 2019, from http://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help all people meet the dual demands of work and family. More information is available at NationalPartnership.org.

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national/state partnership with eight Black Women's Reproductive Justice organizations: Black Women for Wellness (CA), Black Women's Health Imperative (National), New Voices for Reproductive Justice (PA, OH), SisterLove, Inc (GA), SisterReach (TN), SPARK Reproductive Justice NOW (GA), The Afiya Center (TX), and Women With A Vision (LA). Our goal is to lift up the voices of Black women leaders on local, state, and national policies that impact the lives of Black women and girls. Our core strategies include leadership development, advocacy and policy change, and movement building.