



Limiting Abortion Access Contributes to Poor Maternal Health Outcomes

By Anusha Ravi June 13, 2018

Access to abortion is a key component of women’s comprehensive health care. The ability to choose if, when, and how to give birth is linked to women’s economic success, educational attainment, and general health and well-being.¹

Anti-choice advocates, unfortunately, often use women’s health and maternal mortality as justifications for abortion restrictions.² Although abortion has been proven to be one of the safest medical procedures, anti-choice policymakers at state and federal levels continue to use the guise of protecting women’s health to promote restrictions on abortion providers and procedures such as medication abortion; add requirements for women to fulfill in order to receive an abortion; and limit the procedure after an arbitrary number of weeks into a pregnancy.³ Research shows, however, an inverse relationship between abortion restrictions and both maternal and child health outcomes and the number of policies intended to support women and children’s well-being, including Medicaid expansion and protections for pregnant workers, among others.⁴ Additionally, persistent structural racism plays a significant role in the connection between abortion restrictions and maternal mortality.

State and federal abortion restrictions and maternal mortality rates are on the rise. Between 2010 and 2015, states enacted more abortion restrictions than during any other five-year period since *Roe v. Wade* in 1973.⁵ The maternal mortality rate in the United States grew by 136 percent in the years between 1990 and 2013.⁶ This connection is no coincidence: Restrictions on women’s health care—including abortion—can have devastating impacts on women’s health. Although the anti-choice movement continues to posit abortion as dangerous for women, the procedure should be uplifted as what it often really is—life-saving, affirming, and integral to women’s health.

States with more abortion restrictions have higher rates of maternal and infant mortality

Abortion restrictions—especially gestational bans, which seek to ban abortion at an arbitrary point of gestation during pregnancy—are often proposed by anti-choice lawmakers as a way to protect women’s health. However, research has shown that the more abortion restrictions a state has, the worse women and children’s health outcomes in the state are. The Center for Reproductive Rights (CRR) conducted a study that created a state-level scoring system with the following categories: abortion restrictions; policies that support women and children’s well-being; women and children’s health outcomes ; and social determinants of health.⁷ The study used indicators such as parental involvement in and waiting periods for abortion, as well as expanded Medicaid and the existence of a maternal mortality review board.⁸ Ultimately, researchers found an inverse relationship between abortion restrictions and women and children’s health outcomes as well as the number of evidence-based policies passed to support women and children’s well-being. South Carolina, for example, has 14 abortion restrictions—one of every type identified by the study—and also some of the worst outcomes for women’s health in the country. In 2015, one-third of South Carolina had no dedicated health care provider, plus maternal mortality rates had risen 300 percent.⁹

This study shows that women’s health and well-being is a talking point the anti-choice movement wields in their favor—rather than a legitimate goal. If such individuals were genuinely invested in improving maternity outcomes, they would prioritize access to health care, Medicaid expansion, paid family and medical leave, affordable child care, and other public policies that support maternal health. They would also ensure access to safe, affordable abortion and contraception so that women can choose when and if to have a child. The CRR study indicates that the lack of these investments in the anti-choice movement’s priorities shows the movement is more interested in controlling women’s bodies than in supporting their reproductive decision-making and overall health.

Racism contributes to poor health outcomes for women of color

It is crucial to examine the extent to which racism worsens maternal and infant mortality. Communities of color, and primarily African Americans, are disproportionately affected by limitations to abortion and experience elevated rates of maternal and infant mortality compared with non-Hispanic white mothers.¹⁰ Indeed, racism is a motivating factor behind legislation that seeks to strip autonomy from women of color and limit their reproductive decision-making; restrictions on abortion and contraception disproportionately impact women of color, and anti-choice propo-

nents intentionally target communities of color in their advocacy and outreach.¹¹ Furthermore, racism can sometimes fuel neglect within the medical industry: Health care providers have been known to ignore the pain of women of color, which contributes toward preventable death, maternal mortality, and distrust of health care providers. Additionally, women of color—in particular, black women—experience higher levels of stress and discrimination compared with non-Hispanic white women across all age levels, which contributes to lower health outcomes and increased maternal mortality.¹² The ways in which women of color are discriminated against and excluded from the health care system provide insight into how reduced access to abortion may contribute to high rates of maternal mortality.¹³

Abortion restrictions can lead to unsafe abortions

Limiting abortion through various restrictions—such as waiting periods, mandatory ultrasounds, and parental consent—has been shown to increase rates of unsafe abortion rather than eliminate the need for abortion.¹⁴ Limitations place women in desperate situations, and some may attempt to have abortions through unsafe methods as a result. When the United States legalized abortion in 1973, pregnancy-related deaths and hospitalizations due to complications of unsafe abortions reduced significantly.¹⁵ The number of abortion-related deaths fell from 40 deaths per one million live births in 1970 to eight deaths per one million in 1976. After 1975, mortality due to legally induced abortion fell from three deaths per 100,000 abortions in 1975 to about one death per 100,000 abortions in 1976.¹⁶

Unsafe abortion is uncommon in the United States, but with the increase in policies that restrict access to reproductive health care—including state-based abortion restrictions, the restructure of Title X family planning clinics to distribute more funding toward crisis pregnancy centers rather than clinics that provide comprehensive information, and policies that reduce access to affordable contraception—there is a chance that the number of abortion-related deaths may rise.¹⁷ State-based abortion restrictions have grown in the 45 years since *Roe v. Wade* and have potentially contributed toward rising maternal mortality rates.¹⁸ For instance, in Texas, the rate of maternal deaths rose from 72 deaths per 100,000 live births in 2010 to 148 deaths per 100,000 live births in 2012.¹⁹ Reproductive health experts linked the uptake in maternal deaths to state-based limitations on abortion and reproductive health funding—including cuts to family planning services and a defunding of Planned Parenthood—that occurred during the same window of time.²⁰ Planned Parenthood and other family planning clinics often serve as a gateway into the health care system—providing health care and referrals for patients that may not otherwise have a regular provider. Thus, it is plausible that the unmet need for abortion and family planning services—such as cancer screenings and STI testing and treatment—that resulted from restrictions on funding led to increased maternal mortality in Texas.

Barriers to abortion access may delay critical prenatal care

In the case of an unintended pregnancy, the restrictions and barriers women face in pursuit of an abortion can result in stress and delay of critical prenatal care, further contributing to maternal mortality rates.

Unintended pregnancy in the United States has declined slightly over the past few years—51 percent of pregnancies were unintended between 2006 and 2010, while 45 percent were unintended in between 2009 and 2013.²¹ Increased access to contraception has been cited as at least partially responsible for this decline.²² However, these rates are still high compared with those of other developed countries and, importantly, vary disproportionately by race. In 2011, the unintended pregnancy rate for black women was more than double that of non-Hispanic white women.²³ While increased access to contraception may have helped improve the average unintended pregnancy rate, communities of color still experience significant barriers to contraception and abortion—including cost and geographic limitations—that could decrease maternal mortality rates.

Many unintended pregnancies end in abortion, and those that do not often result in poor health outcomes for both mother and child.²⁴ Unintended births are linked to negative physical and mental health outcomes for children compared with intended births. Women who experience unintended pregnancy and are forced to carry the pregnancy to term are likely to delay the initiation of prenatal care, which can result in higher incidences of maternity-related health problems.²⁵

From 2008–2011, there was a slight increase in the share of unintended pregnancies that ended in abortion.²⁶ However, there are still restrictions on abortion that can impact maternal and child health and well-being. Abortion restrictions vary by state and can require significant amounts of time, money, and other resources to acquire—especially depending on how far along a pregnancy is.²⁷ If a pregnancy is unintended, overcoming hurdles to obtaining an abortion—such as travelling hundreds of miles for a procedure, missing multiple days of work because of mandatory waiting periods, lack of access to child care for women who are already mothers, or fundraising as the cost of the procedure rises—can create negative stress for maternal and child health.²⁸ This stress can take a significant toll on the health and well-being of children if the woman pursuing the abortion is already a mother—and about 60 percent of women who get abortions are.²⁹ Additionally, the restrictions placed on abortion can prolong the process indefinitely. If the outcome of the pregnancy in this situation is birth rather than abortion, then the child and mother may be predisposed to negative health outcomes as a result of delayed prenatal care. Finally, delays in accessing care can move women to consider unsafe abortion methods. In one study, women considered self-induced abortion using unsafe methods such as blunt-force trauma as a result of frustration with delays in accessing safe abortion.³⁰

Conclusion

Access to comprehensive reproductive health care—including safe and legal abortion—is critical to promoting better maternal and infant health outcomes. Research suggests the delays, costs, and complications that result from barriers to abortion access could be contributing to poor maternal health outcomes—and even death—contrary to messaging from anti-choice proponents. Proactive measures, including improving access to abortion and other critical women’s health care services, must be taken in order to help address the maternal mortality crisis. A women’s right to choose abortion should be key to strengthening maternal and child health.

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Endnotes

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