BREAKING BARRIERS

Understanding Black Women's Abortion Access in the Post-Dobbs United States

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by

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Abstract

In 2022, the U.S. Supreme Court revoked the federal protections for abortion in the decision Dobbs v Jackson Women's Health Organization, leaving abortion laws up to the individual states. This decision exacerbated already present racial disparities in maternal health and health access. This thesis investigates the question: **In the post-Dobbs United States, what are the factors that influence safe abortion access for Black women, and how can U.S. policymakers ensure the provision of these services?** By using a Reproductive Justice lens and adapting the Socioecological model, a literature review was conducted to investigate personal, community, institutional, policy, and global factors that influence safe abortion access for Black women post-Dobbs. This study utilized a combination of grey and peer-reviewed literature from 2022 to 2025. Themes were then categorized and analyzed based on the adapted Socioecological model. Key findings include the pervasiveness of systemic racism, geographic regulations leading to inequality, and the lack of insurance coverage leading to high costs. Historical abuses of the Black community also continued to influence modern trust in the health system. International examples from the WHO, South Africa, Canada, and Mexico were then examined to provide best practices and comparisons for the U.S. system, and to formulate potential policy recommendations. The thesis concludes with short and long-term recommendations for policymakers in the U.S., including decriminalizing abortion, signing human rights treaties, establishing federally protected abortion services, repealing the Hyde Amendment, and centering Black narratives in public health initiatives.

Key words: United States, Abortion, Dobbs, Black women

Word Count: 11,690

Table of Contents

List of Tables and Figures

List of Abbreviations

ANA- American Nurses Association

APP- Advanced Practice Provider

BIPOC- Black, Indigenous, People of Color.

CAT- Convention Against Torture

CCPR- Covenant on Civil and Political Rights

CERD- Convention on the Elimination of All Forms of Racial Discrimination

CPC- Crisis Pregnancy Centers

CRC- Convention on the Rights of the Child

CTOPA- South African Choice on Termination of Pregnancy Act

D&E- Dilation and Evacuation

EU- European Union

HIC- High Income Country

HIPAA- Health Insurance Portability and Accountability Act

MAP- Massachusetts Abortion Access Project

OBGYN- Obstetrics and Gynecology

RJF- Reproductive Justice Framework

SEM- Socioecological Model

TRAP- Targeted Regulation of Abortion Providers

U.S.- United States of America

WHO- World Health Organization

Glossary of Terms

Abortion- A safe, effective procedure used to terminate a pregnancy either through medication or surgical intervention. Medication abortions are performed using a combination of Misoprostol and Mifepristone or only Misoprostol. Surgical or procedural abortions are generally used for later gestations and involve vacuum aspiration and/or a dilation and evacuation (D&E) (1).

Abortion Doula- A trained support person who works to provide non-medical emotional, physical, and educational support during the abortion process (2).

Maternity Care Desert- Counties where there is a lack of any maternity care, including hospitals with obstetric care, birth centers, and obstetric providers (3).

Reproductive Justice- "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (4).

Reproductive Health- "a framework that looks at service delivery and addresses the reproductive health needs of individual women. It focuses on the lack of health care, services, and information, including research and health data. Within the reproductive health structure, the goals are to improve and expand health-care services, research, and access, and particularly to improve and expand preventative services" (4).

Reproductive Rights- "a legal and advocacy-based model that is concerned with protecting individual women's legal rights to reproductive health care services, particularly abortion (often called the pro-choice movement). It addresses the lack of legal protection and weak enforcement of laws to protect individual women's reproductive choices regarding health care services. The goals are to have legal protection for all individuals and claim these protections as rights under the U.S. Constitution" (4).

Safe Abortion- Safe abortion refers to abortions performed in line with WHO Abortion Care Guidelines and safety standards (5).

Self-Managed Abortion- When someone seeks to end a pregnancy outside of the formal health system (6).

Unsafe abortions- Abortions that are performed by untrained individuals in settings that don't meet the "minimum medical standards" (5).

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This thesis is dedicated to the staff and patients of the OBGYN unit at the Hospital of the University of Pennsylvania. Thank you for teaching me what it means to be a nurse.

Introduction

When Roe v Wade was overturned in 2022, my housemates made me a cake that said, “We’re sorry you lost rights.” I was living in West Philadelphia and working as a nurse on a high-risk OBGYN unit. I had seen firsthand how access to reproductive healthcare could change someone’s life. Many of my patients were Black, low-income, pregnant women. Many struggled with hyperemesis, pre-eclampsia, or substance use disorders. Taking away these women’s right to choose, as well as my own, was devastating. This inspired me to pursue a master’s in public health, as well as this thesis focusing on Black women’s abortion access in the post-Dobbs United States.

Here, I would like to acknowledge my positionality as a white researcher, nurse, and student. I will never be able to fully comprehend the experiences discussed in this paper. However, I have been given a platform through this thesis, and I hope to highlight the experiences of Black women in the United States. I will also capitalize "Black" throughout this thesis as a deliberate choice to recognize the unique cultural and historical experiences of Black people, as many have done in advocacy and academic spaces (7).

This thesis will begin by situating the reader in the context of the United States’ healthcare system with a specific focus on maternal health, health financing, and the historical regulations on abortion and Black bodies. I will then describe the problem this thesis is working to solve, as well as my specific objectives and methodology. The results will be organized according to the adapted Socioecological model, beginning with individual/ community factors, then progressing outwards through institutional, policy, and international factors. Finally, I will describe three examples of how other comparable nations have handled abortion policy and discuss recommendations for the United States.

In this thesis, “women” will often be referenced with the understanding that women are not the only people who give birth. This note is added to be aware of and acknowledge the experiences of transgender, non-binary, and other birthing persons.

Chapter 1: Background

Demographics of the United States of America (U.S.)

According to the U.S. Census, there are approximately 340 million people in the United States as of 2024 (8). Of these, approximately 64 million (~19%) are women of childbearing age (9). Black people make up approximately 14.4% of the U.S. population. This population includes people who identify as African American, Hispanic Black, and multiracial (10). For this thesis, I will be using the term 'Black' to include the expansive backgrounds and diverse identities of this population.

The majority of the Black population in the U.S. live in the South (56%), followed by the Northeast and Midwest (17%). Texas, Florida, and Georgia have the largest Black communities in descending order (10).

The median age of Black people in 2023 was 32.6 years, compared to the total U.S. median, which was 38.2 years. Of the Black population, 44% were under 30 years old and 27% were under 18 (10). In 2022, approximately 27% of the Black population held a bachelor's degree or higher compared with 41% of white Americans (11). The median household income of households headed by at least one Black person was $54,000 in 2023. More than 35% of households earned $75,000 or more, including 25% that earned $100,000 or more (10). This equates to roughly 55% of the Black population living at middle or high income brackets compared to 70% of the American population as a whole living in these brackets (12).

U.S. Healthcare System

Despite being a high-income country (HIC), the U.S. does not have a national healthcare system. Citizens rely on private insurance through their employers or public insurance if they meet certain criteria. Public insurance is provided through Medicare and Medicaid. Medicare covers those over 65 or with a long-term disability. Medicaid is a complex combination of federal and state-level funding and caters to those below the poverty line. Both Medicare and Medicaid are overseen by the U.S. Department of Health and Human Services; however, Medicaid eligibility is determined by the state (13). As of 2025, 40 states and the District of Columbia expanded Medicaid under the Affordable Care Act (ACA), which means a larger percentage of the low-income population are covered under Medicaid. Essentially, the federal and state governments share the cost of covering the people with the lowest incomes in the U.S. Between 2014 and 2023, the expansion of Medicaid cut the number of uninsured people by almost 20 million (14).

If one does not have insurance through Medicare, Medicaid, or an employer; they either buy federal marketplace insurance through the Affordable Care Act at a high cost or risk being uninsured and paying expenses out of pocket (15). This leads to high levels of medical debt as some Americans may have an income too high for Medicaid but too low to afford marketplace insurance, leaving them uninsured and responsible for all medical bills. This coverage gap is especially salient in the ten states that did not expand Medicaid under the ACA (14). In 2023, there were approximately 25 million uninsured Americans (16).

Maternal Health

The maternal mortality rate in the entire U.S. in 2023 was 18.6 deaths per 100,000 live births (17). This is the highest maternal mortality rate of any high-income country (HIC) globally (18). When divided by ethnicity, all maternal mortality rates decreased from 2022 to 2023, except for Black women. Their rate rose from 49.5 to 50.3 maternal deaths per 100,000 live births (17). The maternal mortality rate also heavily depends on the state of residence. For example, the risk of maternal death was 155% higher in Texas than in California (19). In 2023, roughly 15% of the women of childbearing age identified as Black, and the general fertility rate was 5.8% among this population (9,10).

The U.S. is the only HIC that does not guarantee paid parental leave, meaning many new parents have to choose between work and childcare, further exacerbating income disparities (18). Approximately two-thirds of maternal deaths after childbirth happen in the 40 days postpartum, when mothers often miss their only postpartum checkup due to work constraints (18).

In 2022, the adolescent birth rate (births to people aged 15-19) in the U.S. was 13.6 births per 1,000 females. Among Black adolescents, the adolescent birth rate was higher at 20.3 births per 1,000 females. These numbers have significantly declined since 2000, showing some efficacy of adolescent sexual education and/or contraceptives (20). Similarly, infant mortality in the U.S. is 5.6 per 1,000 births but 10.6 per 1,000 births among Black women, and the preterm birth rate is 1.4 times higher among Black birthing people than all other races and ethnicities (21).

Key Events in the Violation of Reproductive Rights Against the Black Community

Throughout the centuries, Black women and their communities have undergone significant breaches of their reproductive rights. It is important to contextualize these events as their impact is still felt today. Some examples include:

Slavery laws- Starting in 1662, Virginia legislators enforced chattel slavery in which children of enslaved persons would follow the enslaved status of their mother. Therefore, many

enslaved women were encouraged (or forced) to get pregnant to expand their enslaver's workforce (22).

James Marion Sims- In the 19th century, Sims, who is considered the "Father of Gynecology," experimented on enslaved women without consent or anesthesia in order to research the surgical cure for vesicovaginal fistulas (22,23). Many advances in obstetrics and gynecology are credited to Dr. Sims without mention of his unethical practices.

Forced Sterilizations- During the eugenics movement in the U.S. in the early 20th century, Black women were forcibly sterilized at much higher rates than white women due to the portrayal that all Black women were single mothers, dependent on public assistance. This portrayal created the infamous "Welfare Queen" stereotype. This practice was also financially motivated, as Medicaid would pay for sterilizations of poor women but not abortions. Welfare benefits were often dependent on other coercive tactics, such as being required to be on Norplant (a long-acting contraceptive) (4).

Tuskegee Experiment- This 40-year experiment on Black men (without consent or treatment) studied the effects of Syphilis. Due to this study and lack of treatment, some women also contracted Syphilis from their partners. As a result of this experiment, many new codes of ethics have been added in the U.S., including the 1974 National Research Act (24).

A Legal History of Abortion Policy

The right to abortion has a tumultuous history in the U.S. Until the 19th century, abortion was legal in all states and was usually performed by traditional midwives or local physicians (4). In 1873, the passage of the Comstock Act restricted access to abortion and information on contraception due to its "indecency" (25). Black women were persistently viewed as irresponsible, hyper-fertile, and draining the U.S. welfare system despite no evidence for this (4). In 1973, the Supreme Court case Roe v Wade was decided, which gave Americans the right to an abortion across all 50 states. In 1992, Planned Parenthood v Casey further codified Roe v Wade but altered it to a fetal viability measure (24 weeks) rather than a trimester approach (25). This case did not guarantee the right to pay for the abortion. The case noted, "It simply does not follow that a woman's freedom of choice carries with it constitutional entitlement to the financial resources to avail herself of the full range of protected choices"(4). Shortly after Roe v Wade, the Hyde Amendment was adopted, which prohibited the use of federal insurance for abortion (25).

In 2022, with a rise in conservatism sweeping the U.S., Roe v Wade was overturned in the Supreme Court decision Dobbs v Jackson Women's Health Organization. This gave each state the power to decide on its abortion laws. Many states had "trigger bans" that went

into effect immediately after this court decision, leading to many states effectively banning abortion overnight (25,26). Some states, such as Kansas, Montana, and Maine, codified protections in their state constitutions to ensure abortion would remain legal. Other states instituted gestational limits such as 6-week or 12-week bans. Meanwhile, states such as Texas, Arkansas, and Alabama instituted full bans on abortion (27). This created a highly dysfunctional policy space in which citizens, communities, and even medical providers do not know the status of their own state's abortion regulations.

In 2024, the abortion rate in the U.S. was 15.4 abortions per 1,000 women ages 15-44, leading to an estimated 1 million abortions occurring in legal states (28). This number was likely underreported due to the exclusion of states with abortion bans and unsafe abortions performed without medical intervention (28). Therefore, it is likely that the true abortion rate is higher than the statistic above. Approximately one quarter of all women in the U.S. will experience an abortion in their lifetimes (29). More than half of these women already have one or more children (28).

Financing of Abortion

Unlike many medical services in the U.S., abortion is often not covered by private or public insurance plans. The Hyde Amendment prevents the use of federal Medicaid to pay for abortion services except in cases of rape, incest, or when there is a threat to maternal life (15,30). While some states have allowed their state Medicaid programs to include abortion, such as California, this is rare (31). Most people seeking an abortion must pay the costs out of pocket. In 2021-2022, approximately 75% of people seeking abortions in the U.S. were living at or below the poverty line. Most were people of color and already had one or more children at home (32).

Chapter 2: Problem Statement and Justification

In one of the wealthiest countries in the world, giving birth can still be a death sentence for women and even more so for Black women. The U.S. has the highest rate of maternal mortality among any HIC (18). Among Black women, this disparity increases even further, with a maternal mortality rate 2.6 times the maternal mortality of non-Hispanic White women (33). With the 2022 Supreme Court decision *Dobbs v Jackson Women's Health Organization,* the threat to Black maternal life increases even further.

It has been well-documented that abortion bans disproportionately affect marginalized groups such as Black, Indigenous, and People of Color (BIPOC) communities (19,34). Approximately half of the women in the U.S. live in abortion restrictive or abortion-banned states, and 60% of these women are Black (35). This shows the inequitable impact of abortion legislation, as it has a greater effect on birthing people of one racial group. In states with abortion bans, the Black maternal mortality rate increased to 3.3 times the rate of non-Hispanic White women in 2023 (19). These disparities have always existed; however, with the Dobbs decision, they are exacerbated. Furthermore, a recent study noted that the 16 states with the most restrictive abortion laws cost the U.S. economy more than $64 billion per year due to women leaving the workforce, limiting their earnings, or leaving their resident states to ensure childcare for an unaffordable pregnancy (36).

These statistics demonstrate that abortion restrictions have a disproportionate physical, mental, social, and economic impact on Black women. Due to rapidly changing laws, there is also a significant risk to maternal life: Medical providers are afraid of criminal charges for assisting with abortion care, and women are afraid to seek help for abortion or miscarriage management (35).

While previous research, both pre- and post-Dobbs, has explored barriers to abortion access and state-level abortion policies, there remains a gap in understanding the barriers and facilitators of abortion specific to Black women in the U.S. This thesis will work to not only describe access in terms of legality and physical distance; but also examine access through the lens of equity, intersectionality, and systemic racism. Utilizing a literature review approach enables the analysis of existing evidence on factors that influence abortion access in a rapidly changing political environment. This thesis will work to answer the question: **In the post-Dobbs United States, what are the factors that influence safe abortion access for Black women, and how can U.S. policymakers ensure the provision of these services?**

Objectives

Main Objective: To understand factors that influence safe abortion access among Black women in the United States post-Dobbs in order to formulate recommendations to U.S. policymakers on how to provide safe, accessible abortion services.

Specific Objectives:

1. Describe factors that influence Black women's access to safe abortion services at the personal and community level.
2. Explore how American institutions, particularly the health system, impact Black women's access to safe abortion services.
3. Describe facilitators and barriers to Black women's safe abortion access in the U.S. from a policy, equity, and human rights lens.
4. Identify best practices and examples for abortion access from comparable international settings to inform policy options for the U.S.
5. Make recommendations to policymakers on how to ensure the provision of safe, accessible abortion services to Black women in the U.S.

Chapter 3: Methodology

This thesis investigates the objectives above through a literature review with a systematic approach. Due to the sensitive nature of this topic, my sources originated from a combination of grey and peer-reviewed literature. I utilized the databases Google Scholar and PubMed to access a diverse range of perspectives. Other articles were found through snowballing and published reports from research institutes, such as the Guttmacher Institute and Kaiser Family Foundation. These reports helped provide up-to-date data on abortion policy and demographics to cover the short timeframe of this literature review. This search combined terms from the adapted Socioecological model and Reproductive Justice framework, as well as keywords such as "Black," "U.S.," and "abortion." Refer to Annex 1 for a comprehensive list of search terms. Keywords were developed based on the combined framework described below and the keywords from the research objectives. For the international examples, some earlier studies were included to reflect the changes in abortion legislation in these countries.

Table 1: Inclusion and Exclusion Criteria

Inclusion/Exclusion Criteria	
Date published	2022-2025 or "post-Dobbs"
Study setting	United States (except for international considerations section)
Language	English
Study Topic	Inc: Abortion- safe and unsafe. Exc: Contraception, birth, sex education.
Population	Black women Excluded if fewer than 20% of study participants identified as Black

There are several limitations to this methodology that need to be acknowledged. First, I limited my time frame to post-Dobbs, which is only a three-year window. Even within these three years, there have been many policy changes, so research may quickly have become out of date. Many studies don't disaggregate the data by race, so not all results are generalizable to the Black population. For this reason, I gave priority in my analysis to sources that centered Black female narratives.

The analysis was performed using the framework described below.

Framework

Socioecological Model

To structure my analysis, I will be using the Socioecological model (SEM), originally developed by Bronfenbrenner in 1979 (37,38). This model displays multiple layers of analysis from the personal, community, institutional, national policy, and international levels. Due to compounding layers of social determinants of health that influence Black women and their health outcomes in the U.S., it is important to be able to analyze these different layers to thoughtfully make policy suggestions (39). This model will allow me to evaluate the different factors associated with Black women's access to abortion care at the various levels that may impact them. For example, a restrictive hospital policy could be considered at the institutional level, whereas Medicaid restrictions could be considered at the policy level.

Reproductive Justice Framework

The Reproductive Justice Framework was written by 12 Black women to create a framework that acknowledges intersectional identities and the systemic lack of "choice" that wasn't common in abortion discourse in the 1990s (4). It considers the lived experiences and systemic racism felt by communities of color. It diverges from the reproductive rights framework, which focuses more on legal discourse, by acknowledging how "Socioeconomic status, gender identity, and race shape one's experiences with reproductive health care and health policy" (40). As a white author, I value the importance of utilizing a framework that was written for and by Black women to acknowledge their lived experiences.

There are three main facets of the RJF.

1. "Right to have a child,"
2. "Right not to have a child," and
3. "Right to nurture the children we have in a safe and healthy environment."(4)

This framework combines reproductive rights with social justice to create reproductive justice. In this way, it works "across social justice movements to build a united struggle for universal human rights in a way that includes everyone" (4).

There are certain requirements listed for using and adapting the RJF, including intersectionality, bridging the personal to the global, utilizing a human rights basis, and centering the analysis on marginalized communities (41). This thesis will work to satisfy all requirements to use this model authentically.

Adapted model

To get the most thorough analysis, I combined the layers of the SEM with the concepts of the RJF. Similar to the SEM, there are concentric circles with individual, community, institutional, and law & policy layers. I centered Black women and their intersectional identities as the personal layer. I also clarified that the policy level is specifically referring to American law and policy. A key part of the RJF is contextualizing the analysis within the sphere of equity and global human rights, so I added that as an international layer of the analysis. This new model was created and illustrated by the author, as seen in Figure 1. Each chapter of this thesis will follow one layer of this model, starting with Black women and their intersectional identities and moving outwards to international human rights. The 'Black women and their intersectional identities' and 'Community' chapters were combined as these factors interact in a way that is important to analyze.

Figure 1: Adapted Socioecological Model (Illustrated by Author in July 2025)

Chapter 4: Black Women, Intersectional Identities, and Community Factors

This chapter works to center Black women and their diverse, intersectional identities, both as individuals and within a community. Black women, like all human beings, are not a homogenous group. Therefore, it is vital to discuss personal variables that may impact their access to abortion and how those factors interact with the community.

4.1: Bodily Autonomy

One of the key issues of reproductive justice and a large concern regarding Black women's access to reproductive health is the right to bodily autonomy. Historically, Black women's bodies were highly regulated, especially regarding birth. During slavery, children of Black women inherited the enslaved status of the mother so slave owners would be able to expand their workforce (22,30). Furthermore, during the eugenics movement in the 20th century, Black women were forcibly sterilized due to being perceived as "unfit" for motherhood due to poverty, incarceration status, or welfare beneficiary status (22,41). Due to this history, it is not surprising that many Black women self-manage their abortions rather than risk getting involved with a medical system that has historically abused them (42,43). Ralph et.al, compared self-managed abortion attempts before and after the Dobbs decision and found that not only did the adjusted proportion of self-managed abortion attempts increase by 1.0% (95% CI, 0.2%-1.7%; P = .03), but Black women were also more likely to have attempted self-managed abortion than did other racial and ethnic groups (44). This study found that one-fifth of women required medical intervention due to a complication after self-managed abortion (44). Note: These were unsafe self-managed abortions, not using approved abortion medications such as Mifepristone and Misoprostol. As noted in Coates et.al, "banning abortions will not prevent pregnancies from being terminated, but will instead lead to more women undergoing unsafe and unregulated abortion procedures"(30). If the women did seek medical attention for a complication of a self-managed abortion, they are more likely to face prosecution. In a report by IfWhenHow, it was noted that in 45% of cases investigated for suspicion of self-managed abortion, patients were reported to police by their health provider or social worker (45).

4.2: Health Literacy

Several studies have noted lower health literacy among Black women, often due to racial inequalities in the traditional education system (46,47). This increases the risk of misinformation and disinformation surrounding abortion, as women with lower health literacy are more likely to use social media for pregnancy information (46). In one study, 81.9% of Black, female participants found information about pregnancy on social media

and found it “useful or very useful” to help in their decision making (46). Young people, particularly, are more likely to believe misinformation about birth control and other health topics than other age groups (48). Not all social media information is bad, but the key is being able to differentiate real information from misinformation. One study did find that people from abortion-hostile states (where most Black women live) were better at differentiating biased abortion information than people from abortion supportive states (48). Furthermore, the community aspect of social media is not to be dismissed. In 2021, 77% of Black adults reported using social media, and in another study, 84% of participants noted using social media friends as a form of social support (46,49).

Anti-abortion organizations take advantage of this lower health literacy to spread disinformation. For example, crisis pregnancy centers (CPC) target Black and low-income women by offering free ultrasounds or posing as abortion clinics in neighborhoods where pregnancy and abortion care may not be accessible (50). CPCs are centers that represent themselves as reproductive care clinics but do not provide legitimate health services and work to dissuade people from accessing abortion and other reproductive health services. Their tactics include providing false risk information, over-estimating someone’s gestational age, and using ultrasounds to attempt to induce guilt (51). Higher prevalence of CPC attendance among Black women was specifically noted in both Ohio and Louisiana (50). Furthermore, some states require mandated counselling before obtaining an abortion, which provides inaccurate information about risks. If the abortion seekers have low health literacy, they may not know that this information is false, leading them to go through with pregnancies, thus perpetuating the cycle of poverty and low health literacy (48,50). Some states, such as Texas and Oklahoma, are trying to criminalize researching or disseminating medically accurate abortion information as a way of “aiding and abetting abortion” (47).

4.3: Age

The intersection of being a Black woman and being an adolescent or minor is important to examine. Adolescents are more likely to have lower health literacy and are more likely to trust what they read online (48). Adolescents are also less likely to recognize early pregnancy (52). This could lead to more expensive abortions due to passing the gestational limit for medication abortion, or to missing the gestational limit of the state, as in Florida, which has a six-week abortion ban (53).

In one study, approximately 18% of adolescents stated that they went to their abortion facility because it was recommended by a friend or family member. This was especially true for younger respondents (52). While this demonstrates the importance of community support for young people, it also demonstrates a significant barrier when states require parental consent. If parents are supportive, the adolescent will receive their consent and

know where to go. If unsupportive, the adolescent will not be able to access abortion care and may be more likely to seek unsafe methods (54,55).

Cost is also a large factor for Black adolescents seeking abortion. Many adolescents obtain health insurance through their parents, either through their parents' employer or through Medicaid (52). Some adolescents expressed concern about privacy if they used their parents' insurance, so they paid for it out of pocket, even if their private insurance would have covered it. In one study, 11% of adolescents reported selling something to help cover costs, compared with 7% of adults (52).

4.4: Community

Despite the systemic issues facing the Black population, there are some ways in which Black women obtain support from their community. The first is through social support. In a qualitative study in Georgia, most women described having some form of social support, whether emotional, financial, logistical, or practical, such as childcare (43). Storytelling is also a key form of information communication in many Black communities (56). Many women noted that they only knew where to go to obtain abortion services because of stories told to them by friends and family (43).

A clear barrier to this is stigma. Most literature discussed external stigma, either from health providers or anti-abortion groups. Again, this has historical roots as anti-abortion groups have pushed the message that abortion is a form of Black genocide (57). This idea permeates Black culture and music, with Hip Hop lyrics describing abortion as sinful, morally wrong, and a perpetuation of Black genocide, as found by Premkumar et. al (57,58). This creates a strong discourse between fighting for individual choice and wanting to prevent Black genocide. Fear of stigma from health providers also traces its roots to reproductive coercion, which was discussed in chapter 2. Stigma perception is especially prevalent at religiously affiliated hospitals (59). Several studies also mentioned women not wanting abortion on their medical record due to privacy concerns (42,59).

Within the Black community, studies have found that there is lower stigma about abortion than in white and Latinx communities. Interestingly, there was higher miscarriage stigma among Black and Latinx communities after an abortion, but less overall abortion stigma. This could be due to the false perception that safe abortions can impact your future fertility (48,57).

As mentioned previously, most women who have abortions in the U.S. already have one or more children at home. Childcare is a vital way for communities to support abortion seekers (28). Depending on the abortion procedure, i.e. surgical or medication, abortion seekers may also need transport to and from the clinic due to the effects of anesthesia

(45). For example, in a study in Georgia, one participant noted that she had accompanied a friend to the abortion clinic previously, so knew where to obtain one (43).

4.5: Finances

While community support is vital, examples of financial support were quite rare. Many abortion seekers had to look outside their immediate network to obtain sufficient funds (43). Abortion care in the U.S. is not covered by public insurance, leading many abortion seekers to struggle to pay (15). One study noted that having insurance made one more likely to have accessed an abortion than without insurance, even though Medicaid doesn't cover the abortion itself. This statistic could be related to private insurance or simply better access to care due to having insurance. This finding divided along racial lines, as Black and Latinx participants were less likely to report having had an abortion after one month than their white counterparts (60). As private insurance is most often obtained through an employer, this points to higher disparities in Black women having access to a job that provides insurance coverage (45,61). In 2021, more than 10% of women of reproductive age and 7.5% of Black women and girls did not have health insurance (62).

To help combat this economic disparity, abortion funds were created. Abortion funds created at the local, state, or national level help provide financial support for the procedure, transportation, accommodation, and other key costs (63). For example, the Kentucky Health Justice Network (KHJN) is a reproductive justice network and abortion fund. Kentucky is an abortion hostile state, meaning that the abortion fund largely helps patients navigate the complex health system to get out of state and identify abortion clinics elsewhere. This fund also works to ensure payment, transportation, and language interpretation services if necessary. KHJN has a high percentage of Black callers, as well as young people and people who are greater than 14 weeks' gestation (64). The abortion funds provide access to many people who may not independently have the resources to obtain an abortion.

Sometimes abortion funds are not sufficient. For example, in Indiana, among abortion fund recipients, Black abortion seekers were less likely to have obtained the procedure after one month of follow-up. A study found that 64% of participants cited that they needed to gather money to pay for either the procedure itself or the cost of travel and lodging. After one month, 81% of people who had obtained an abortion noted that "their ability to pay for bills, rent, food, or childcare was impacted by the cost of the abortion" (60). This demonstrates the need for 'holistic' abortion funds as mentioned by Mosely et. al (31). In practice, this means abortion funds should not only focus on the financial resources but on the intersectional ways that access to abortion can be impacted. KHJN is a holistic abortion fund that provides the financial support but also more diverse support to cover

those intersectional needs of its population, such as childcare, transportation, and language services (64).

4.6: Religion

Very little was published about the effects of religion on Black people's perceptions of abortion. Black protestants were initially against abortion; however, they have become more supportive over time. Other than Catholicism, there were no strong correlations between Black people's religion and their attitudes towards abortion, despite almost 75% of Black Americans identifying as religious (65,66).

Chapter 5: Institutional and Health System Factors

5.1: Cost

As mentioned in the previous chapter, cost is one of the most inhibiting factors to abortion access for Black women in the U.S. Paradoxically, one of the top reasons people seek abortions is that they feel they wouldn't be able to afford another child (15,43). This leads to many abortion seekers deferring rent, utilities, food, and other expenses to pay for their abortion (15,60). In 2021-2022, approximately 75% of abortion recipients were living below 200% of the federal poverty level, which means a proportion of these participants would be entitled to Medicaid coverage (15). However, the Hyde Amendment prohibits federal public insurance from covering abortion services, so the poorest people in America cannot get access to abortion, regardless of whether or not they have insurance (15). Furthermore, depending on the state, there are bans on whether private or marketplace insurance can cover abortion services as well (67). The average out-of-pocket cost of a medication abortion at Planned Parenthood is $580. For a surgical abortion, the average cost is $715, but it can be as high as $2,000 depending on the gestational age (68).

There are some ways in which abortion providers attempt to bypass these restrictions by providing pay-as-you-can/sliding scale programs (31,43,56). For example, the Massachusetts Abortion Access Program (MAP) provides medication abortion pills by mail on a sliding scale with a minimum payment of $5 (69,70). The MAP charges a fee of $150 for the abortion pills (for current or future use) but if financial aid is needed, this service collaborates with more than 12 abortion funds and offers sliding scale fees without proof of income. The MAP asks any patient who can pay more than the $150 fee to pay it forward through a donation (69). Over a six-month period in 2023-2024, the MAP provided abortion pills to 45 states and almost 2,000 patients. Of these patients, 29% identified as Black, and 29% of patients paid less than $25 (70).

Another way to reduce costs is through telehealth and flexible scheduling. In a retrospective cohort study for medication abortion, there was no statistically significant difference in adverse outcomes for patients who received abortion pills in person vs by mail (71). This same study screened patients by history only, rather than in-person ultrasounds or multiple clinic visits. Some states require multiple visits; however, there is no evidence that these visits offer any additional safety or prevent someone from carrying out the procedure (31,56,71). With the growth of AI, there are new opportunities to improve access to abortion information, scheduling, and treatment (72). While this research is still in its infancy, it offers options for expanding abortion information to a wider population. There is some concern about breaches of confidentiality and the lack of trust among Black communities of the medical system. However, the study by Bull et.al suggested embedding

the chatbot on health sites and using AI not to provide direct treatment but to help navigate the complex health system (72).

5.2: Diversity of Providers

A more structural issue with the U.S. health system is the lack of diversity among medical providers, particularly in the abortion space. The most common providers of abortions in the U.S. are OBGYNs (72%), family medicine physicians (9%), and nurse practitioners (8%) (73). However, only 5.7% of physicians in the U.S. in 2022 identified as Black or African American (74). In one study, participants noted how they "trusted information from other Black and Latinx women – both in their networks and at abortion clinics – to keep them safe"(31). This could stem from the history of abortion providers being perceived as pressuring women to get long-acting birth control (31). Furthermore, most abortion providers are white and serve largely non-white and low-income populations. Historically, there has been a systemic exclusion of people of color from medical schools in the U.S., resulting in fewer qualified abortion providers of color today. Since the Dobbs decision, there has been a continuous decrease in the number of residents applying to OBGYN positions in abortion hostile states, leading to an increase in maternity care deserts (75).

The history of Black people being mistreated by the American Health System generates a "warranted mistrust" (31) in providers, especially if the provider and patient are not of the same race. From 2000 to 2020, many people were investigated by police for attempting to obtain an abortion on their own or helping someone. One study found that of 61 people investigated, 39% were reported by healthcare workers, 56% were low-income, and most were people of color (76). As abortion becomes criminalized in many states, people of color may be less likely to seek treatment for miscarriage or self-managed abortion because of the threat of prosecution. Additionally, many providers may not feel comfortable treating people who come in for miscarriage care due to the possible legal ramifications of assisting with an abortion (75,76).

Several studies noted that the lack of diverse providers led to more implicit bias, as the providers didn't necessarily understand the barriers their patients faced (31,56,75,76). By diversifying the nurse and physician workforce, maternal health outcomes may also improve, as well as clinical and non-clinical abortion care support (45). This is where the Reproductive Justice framework applies, to allow for a greater understanding of the issues faced by people of color when seeking medical care. Another suggestion was to increase the provision of abortion doulas to act as patient advocates. Some clinics provide them as an extra form of support in case the person does not have the social support mentioned in the previous chapter (31).

One way to combat the decrease in providers and the maternity care deserts created by abortion bans, is to diversify the prescribing rights of other providers such as nurse practitioners, pharmacists, midwives, and physician's assistants (31,56). While there is little data in the U.S. as most states do not allow these medical providers to prescribe abortion pills, there are studies demonstrating the willingness of these providers (77,78). In California, for example, almost 70% of pharmacists felt willing to prescribe medication abortion pills if given the legal authority to do so. Less than half felt confident in their knowledge, however, so more training would be required (77).

Overall, there are ways in which medical providers and abortion clinics can attempt to circumvent the structural and policy restrictions in place. Hiring diverse staff, utilizing sliding scale programs, and decreasing the number of clinic visits are all ways to make care more accessible for the Black population. While these programs help, it is not the solution as structural inequalities cannot be rectified only at an institutional level. With policy restrictions such as the Hyde Amendment and state-level abortion bans, greater change must come at the government level.

Chapter 6: American Law and Policy

The 14th Amendment to the U.S. Constitution guarantees equal protection under law. Despite this, many U.S. policies and laws discussed in this chapter deliberately disadvantage specific demographics, especially women and Black people. As mentioned in the background, centuries of systemic racism have led to a large distrust in the medical system, in the government, and even within communities. In a qualitative study, several participants cited the history of medical experimentation (also described in the background) on Black communities as a reason for distrust (31). This led to fears surrounding abortion medication and forced sterilizations during procedures, which increases the stigma and perceived barriers in the Black community (22,31,79).

6.1: Geographic Location

Many of the abortion restriction laws occur at a state government level. This means that geographic setting can determine access to health services. For example, in Tennessee, abortion is banned at any gestational age except to save the life of the mother. This trigger ban was enacted in August 2022 after the Dobbs decision and replaced the former 6-week abortion ban, which included a 48-hour waiting period between scheduling and receiving abortion services (31,80). Meanwhile, in Pennsylvania, abortion is legal until 24 weeks. Patients still face some restrictions, including a 24-hour waiting period, intentionally biased mandatory counselling, and parental consent for minors (27). Other restrictions, depending on the state, include multiple physician visits, mandatory ultrasound viewing, and Targeted Regulation of Abortion Providers (TRAP) laws, which limit the facilities and providers that can provide abortion care (27). Black women aged 18-49 are more likely to live in abortion-restrictive or banned states, meaning these laws are more likely to impact their access to abortion care (35).

Due to obstetricians' and other birth workers' practice being limited, many are leaving states with restrictive abortion laws, leaving large maternity care deserts in their wake. This is particularly prominent in southern states and rural areas. Texas was one of the earliest states to ban abortion after 6 weeks. One study found that Texans would have to travel an additional 457 miles to the closest abortion services out of state (81). Another author found that for every 25-mile increase in distance to an abortion clinic, there is a 5% decrease in the number of abortions, as more people are unable to access them. This puts additional pressure on the clinics out of state that do provide abortions, leading to longer wait times (75). The closest abortion clinic may be in a state with additional limitations, such as waiting periods or multiple visits. This increases the amount of time women must travel, pay for accommodation, and miss work. As previously discussed, this disproportionately affects low-income women of color who may not have the resources to pay for this and the

abortion procedure itself (35,81). Furthermore, having transportation is not guaranteed, especially if you do not have the social capital in the state you are travelling to or do not have a car (43). Black women are less likely to live in a household with access to a car than their white counterparts (35). Black adolescents were also notably less likely to have access to a car and to need transportation assistance (52). This issue is especially salient for surgical abortions where anesthesia is involved, and the person cannot drive themselves home after the procedure. This requires the abortion-seeker to have transportation and a trusted person to accompany (45).

Restrictive abortion policies not only affect abortion access but also total maternal mortality. Vilda et al. found that restrictive states had a total maternal mortality increase of 7% compared to less restrictive states (82). This is even more salient when comparing rural and urban areas, with maternal mortality being over 80% higher for women in rural areas (82). Considering Black women's maternal mortality already being considerably higher than the average birthing person, a Black woman living in a rural area in an abortion-restrictive state is at a notably high risk of death due purely to her location (35,82).

6.2: Fetal Personhood Laws

Twenty-four out of the 50 states have fetal personhood language in their abortion laws (83). Fetal personhood is the "idea that a fertilized egg, embryo, or fetus has the same legal rights as a person"(45). While fetal personhood doesn't directly criminalize abortion, it can be used to conflate miscarriage and self-managed abortion with murder, thus causing women to face charges up to life in prison or the death penalty depending on the state (35). In the last few years, several states have worked to charge women with child abuse, neglect, and homicide for inducing abortions or having miscarriages (45). For example, Brittany Watts, a Black woman from Ohio, was charged with the felony of "abuse of a corpse" after miscarrying at home. The charges were eventually dropped (84). While this case did not result in a conviction, it is a prime example of how Black women are disproportionately targeted by fetal personhood laws (35). Brittany Watts is just one example of many. In the first year after Dobbs, more than 200 women faced criminal charges for "crimes" related to their pregnancies (85).

6.3: Exceptions in the case of rape or incest

According to a systematic scoping review of abortion stigma in the U.S. the "most acceptable" abortion is for a low-income Black woman who was raped (57). This paternalistic approach of deciding who and under what circumstances abortion is allowed has led to many state and federal policies that create exceptions to abortion bans in cases of rape or incest. Among the 21 states that have abortion bans or gestational limits, 11 have exceptions for pregnancies due to rape or incest (86). Despite these exceptions, seven out

of the 11 states with exceptions require police reporting either by the survivor of the assault or their physician before accessing abortion care. Some still impose gestational limits on this reporting. With only 21% of sexual assaults ever reported due to fear of retaliation or gaslighting, this exception is not a feasible avenue for many women seeking abortion care (86). Furthermore, in states where abortion is criminalized, women may not want to report rape so as not to inform police of their possible pregnancy if they choose to terminate (87,88).

For Black women specifically, despite more than 20% experiencing sexual assault in their lifetimes, only one in 15 will report it to formal networks (89). Due to the systemic racism in the police department against Black communities, many Black women would not be comfortable reporting their assault to police. Furthermore, studies have shown that Black women are also less likely to be believed, so even if they do report, they will be less likely to get justice (89). When it comes to reporting requirements for rape and incest, Black women will again be less likely to receive the exceptions and access to care they need.

These laws are not only at the state level. The federal Hyde Amendment offers exceptions for Medicaid coverage for abortions due to rape or incest; however, many states have pre-authorization requirements, medical restrictions, or reporting mandates as mentioned above. This means that, realistically, the exception for rape or incest is not supportive financially, mentally, or physically for survivors of assault (86).

6.4: Telehealth and Shield Laws

One way that state law and policy can support abortion access is via shield laws. After Dobbs, the need for telehealth abortion medication rose significantly (90). People in banned states could go online and obtain mail-order medication abortion pills. The first of these shield laws was in Massachusetts. This law protects clinicians and support people from criminal prosecution for providing abortion care. It also states that when receiving telehealth from a Massachusetts Commonwealth clinician, the patient is defined as a resident of Massachusetts (70). Now, 22 states and Washington D.C. have shield laws that protect reproductive healthcare administration. Of these states, 14 have laws protecting clinicians from any legal action, such as arrests or subpoenas (91).

There is mounting evidence that abortion pills provided through telehealth are safe and effective (70,71). This overcomes significant barriers, including transportation, fear of stigma, and cost; as mentioned in chapter 2. According to a #WeCount survey, in 2023, shield law providers administered abortion care services to 40,000 people in banned or restricted states (70). There is some resistance from banned states, with federal lawsuits reaching the Supreme Court to attempt to ban the use of telemedicine for abortion (92). In Louisiana, for example, a bill was passed in May 2024 to classify Mifepristone and

Misoprostol as controlled substances, which means abortion seekers would be criminalized for possessing them (45).

6.5: Parental Consent Laws

Some states, in addition to having gestational restrictions, also have parental consent laws. For example, in Arizona, if an abortion seeker is under 18, she needs to have permission from at least one parent before getting an abortion. In Kansas, permission is needed from both parents (53). This raises many issues about privacy, safety, and disclosure. There are ways to get a legal waiver, however, this can take time and may put the adolescent past the gestational limit of getting a medication abortion or any abortion at all in specific states (53). This also increases the cost as abortions at later gestations are more expensive.

In conclusion, U.S. abortion policy is diverse, complex, and dangerous. While the 14th Amendment may guarantee equal protection, it does not guarantee equal access.

Chapter 7: International Human Rights and Best Practices

"Reproductive justice activists believe that human rights should not depend on geography" (4). This chapter will utilize international comparisons to analyze U.S. abortion policy in a global context, with special attention to human rights and equity.

7.1: International Reactions to the Dobbs Decision

As a global power, the policies of the U.S. have an impact on the international stage. As noted by Gostin and Reingold, "High-profile Supreme Court cases have the power to influence courts and legislatures in many countries—potentially stalling further expansion of abortion access or even reversing hard-won gains" (93).

The landmark Roe v Wade decision had a global impact. Many courts in Asia and Africa had used Roe v Wade to justify their own abortion law liberalization. For example, Kenya's Constitutional Court decided in March 2022 to recognize abortion as a human right, basing the decision on Roe v Wade. After the Dobbs decision, the Attorney General of Kenya moved to hold the implementation of this policy (94). In contrast, the European Union (EU) moved to solidify abortion rights as part of its regulations in reaction to the Dobbs decision (95).

While the U.S. does not directly impact the legalization of abortion in any other country, it has the power to influence other nations either positively or negatively. As of writing, 72 countries broadly allow abortion, which accounts for roughly 59% of women of reproductive age globally (94).

7.2: Human Rights Treaties

As of writing, the U.S. has only ratified four human rights treaties: The Convention on the Elimination of All Forms of Racial Discrimination (CERD), The Covenant on Civil and Political Rights (CCPR), The Convention Against Torture (CAT), and the Convention on the Rights of the Child (CRC). In contrast, Canada has ratified 12 human rights treaties (96). Without an international legal commitment, it is difficult for abortion rights activists to hold the U.S. government accountable for its human rights violations. Human rights bodies such as the UN have established that abortion access is a vital part of the human rights to health, privacy, life, and non-discrimination (94,95). It has also been debated concerning children's rights (abortion access for minors) and freedom of religion and conscience (95). The challenge for abortion activists in the U.S. is to align abortion rights with the human rights treaties that the U.S. has committed to. For example, the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) has suggested the need for decriminalizing abortion; however, the U.S. didn't ratify CEDAW, so it has no strong commitment to abide (94). However, with the U.S. commitment to CCPR, it could be

argued that the impact of the Dobbs decision on marginalized communities is a form of discrimination (94).

7.3: Abortion Best Practices

Abortion should be safe, accessible, patient-centered, effective, efficient, evidence-based, and in an enabling environment. The World Health Organization (WHO) Abortion Care guideline outlines ethical, medical, and surgical recommendations for abortion best practice globally. This guideline also highlights three cornerstones to successful implementation:

1. "Respect for human rights, including a supportive framework of law and policy,"
2. "Availability and Accessibility of Information," and
3. "A supportive, universally available, affordable, and well-functioning health system"(97).

All abortion care guidelines recommend the full decriminalization of abortion. The right to privacy is recognized both by the WHO and by the US healthcare system through the Health Insurance Portability and Accountability Act (HIPAA). This also acknowledges criminalization and fear of law enforcement as a significant barrier to accessing abortion (76,97,98). The WHO takes this a step further by recommending *against* restricting abortion based on any grounds, including gestational limits, mandatory waiting periods, ultrasound requirements, and conscientious objection by providers (97).

Conscientious objection is also discussed in *The Ethical Care for Patients with Self-Managed Abortion* in the American Journal of Nursing, with specific reference to emergency care. This article suggests that, according to the American Nurses Association (ANA), it is unethical to refuse treatment in an emergency due to conscientious objection. However, nurses may refuse care in non-emergent settings, but this does not give them permission to break confidentiality or excuse them from all duties to the patient (76).

The literature also discussed the importance of non-discrimination as part of equitable and patient-centered care. The WHO outlines this as:

> The quality of care does not vary based on the personal characteristics of the person seeking care, such as their gender, race, religion, ethnicity, SES, education, if they are living with a disability, or based on their geographic location within a country (97).

The Ethical Care for Patients with Self-Managed Abortion warns against any action that would have a disproportionate impact on marginalized communities, especially when it comes to the documentation and reporting of self-managed abortion or miscarriage (76).

Gender is also an important lens of potential discrimination in abortion, as gender-diverse people access abortion and should have equitable access regardless of their gender identity (99).

There is also a large body of literature that recommends expanding who can provide abortion services. Medical management can be performed by the patient, with several articles mentioning the accuracy of self-evaluation of the need for abortion and its completion (97,98,100). The WHO also recommends allowing nurses, doctors, advanced care providers (APPs), and pharmacists to prescribe and dispense abortion medications (97).

Overall, abortion best practice is to have abortion available on demand and for health systems to follow a harm reduction approach to providing safe, equitable care (76,97,98).

7.4: International Comparisons

The U.S. is one of four countries in the world that have actively regressed in the legalization of abortion; the others being Poland, Nicaragua, and El Salvador (101). In this chapter, I look to international examples with comparable traits to the U.S. to see how these countries handled abortion rights in their contexts. I have chosen three countries: South Africa, Canada, and Mexico. While there are differences between these countries and the U.S., each has specific points of comparison. South Africa, with a similar history of apartheid and discrimination against Black persons, is a useful comparison point for Black maternal mortality and how abortion legalization can impact that. Canada, as the U.S.'s northern neighbor, is culturally similar to the U.S. but is an interesting example of the impact of full decriminalization of abortion and how this does not necessarily equal access. Lastly, Mexico is the only other country where abortion is governed at the state level, although with recent federal protections legislation, this is slowly changing (101).

South Africa

South Africa has struggled with a dark history of racial discrimination and inequity. The 1975 Abortion and Sterilization Act worked to decrease the number of unsafe abortions while working with the Apartheid government to attempt to increase birth rates among White women. Instead, White women were more able to access abortions due to their higher socioeconomic status, and Black women continued to have access only to illegal or unsafe abortions (102).

In 1996, the South African Choice on Termination of Pregnancy Act (CTOPA) legalized abortion on request until 12 weeks' gestation, including for minors without parental consent. From 13-20 weeks, abortion is allowed under the conditions of rape, incest, or to protect the mother's life, with the approval of one physician. After 20 weeks, if the mother

or fetus is at risk of harm, abortion is allowed with approval from two physicians or a physician and a midwife. All abortion services are provided free of charge (103). This legislation is the most liberal on the African continent and one of the most liberal in the world (104).

In 1994, unsafe abortion led to 32.69 deaths per 1,000 abortions. From 1998-2001, there was a 91% drop in deaths from unsafe abortion as compared to 1994 (103). While there is not current data on maternal mortality by race, the total maternal mortality rate in 2023 was 111.7 maternal deaths per 100,000 live births. The maternal mortality rate has been steadily decreasing since 2017, with a spike related to the COVID-19 pandemic. Current data shows that it is decreasing from the COVID rates but has not yet reached its 2019 baseline (105).

One of the challenges South Africa faced in its legalization of abortion was training the volume of providers necessary. The CTOPA does not regulate conscientious objection, however it does have guidelines that state providers cannot invoke conscientious objection in an emergency related to abortion complications (102). The fear of provider abuse or stigma led many women to continue seeking unsafe abortions (104). In 1995, more than 4,000 nurses, midwives, and primary care physicians were enrolled in values clarification workshops, which showed greater understanding and acceptance of providing abortion services. To counteract the provider shortage, South Africa expanded its abortion workforce under the National Abortion Care Program to include training for nurses, midwives, and other practitioners, who could then train other practitioners in their home districts. This training included safe abortion, incomplete abortion management, and post abortion contraceptive counselling (103).

In 2014, Bathabile Dlamini, the Social Development Minister, even noted that Reproductive Justice was the conceptual framework she would be using to create policies for South Africa (4). This trend has continued with the current Social Development Minister reaffirming her commitment to bodily autonomy and reproductive justice (106).

Canada

Despite being culturally and geographically close to the U.S., Canada has a very different health system and approach to abortion access. Similar to the U.S., Canada's large land mass is separated into provinces (states), each with its unique geography, culture, and health disparities (107).

Canada took a different approach to most countries when it came to legalizing abortion. Instead of using a human rights perspective, Canadian lawmakers medicalized the procedure, giving doctors the right to "gatekeep" abortion. While this does not align with

the RJF in that it doesn't center marginalized communities and their rights, it did shift the debate into recognizing abortion as healthcare. This drew the medical community into the fight for abortion rights, which created a stronger basis for future legislation (108). By 1988, 69% of Canadians polled believed that abortion decision-making should be only between women and their physicians (108). To quote former Prime Minister Pierre Trudeau, "There's no place for the state in the bedrooms of the nation" (108). Abortion was fully decriminalized in 1988, citing that it was a form of sex discrimination (4).

However, decriminalization does not guarantee access. In rural areas of Canada and among Indigenous communities, abortion access is still not equitable. To combat this, Canada has expanded its abortion workforce to include nurse practitioners and has attempted to expand access to medication abortion. From 2017 to 2022, the number of medication abortion prescribers in Alberta increased from 67 to 229. The number of pharmacies dispensing abortion medications increased from 52 to 208. Despite the concerted effort to increase access, in Alberta, there was no significant change in the travel time and distance to access abortion care in the province (107). This points to the necessity of the Reproductive Justice framework in abortion systems. The barrier does not exist in legislation (decriminalized), and it does not exist in the number of prescribers (health access). This points to more systemic and multifaceted issues that need to be explored (107).

Another potential limitation of decriminalization is that it does not specifically enshrine protections of abortion rights; it just eliminates any legal framework for prosecution (108). This is a strongly debated topic in the literature, as decriminalization of abortion is recommended by the RJF and the WHO (4,97). However, after Roe v Wade was overturned, 78% of Canadians believed that the government needed to pass a specific law to protect the right to abortion (108). Although, as noted by Gordon and Johnstone, having a specific law (e.g., Roe v Wade) gives anti-abortion movements a specific target to organize against. By having no law and only the foundational right to healthcare and non-discrimination, abortion rights may be more protected long term (108).

Mexico

On the other side of the continent, the Mexican Supreme Court recently decriminalized abortion at the federal level. In 2021, the criminalization of abortion seekers and providers was declared unconstitutional, and as of 2023, abortion was taken out of the federal penal code (109). This removed federal restrictions and required federal health centers and public hospitals to provide abortions. However, like the U.S., Mexico is made up of states, each with its own penal code; and before 2018, each state determined its own abortion

laws (as it is in the U.S. currently). As of 2024, 20 Mexican states still had criminal laws against abortion, which demonstrates the slow pace of changing abortion laws and attitudes. Despite this, if abortions were provided in federal facilities, they could not be criminalized at the state level (110). This decriminalization not only extends to the abortion seeker but also to the healthcare provider and/or anyone who assists in accessing the procedure (109). This is in stark contrast to the trend of American states creating vigilante laws, as in Texas, which criminalize anyone who assists an abortion seeker (47).

Unlike Canada, Mexico took a human rights and gender-based argument to their abortion decriminalization (109). The Mexican Constitution guarantees "men and women are equal before the law" and "everyone has the right to decide in a free, responsible, and informed manner about the number and spacing of their children." Based on these principles, the Mexican Supreme Court guaranteed the right to an abortion (110).

The Mexican Supreme Court also considered the country's context when creating these laws based on reproductive self-determination. The court recognized that to achieve reproductive choice, factors such as socio-economic status, gender-based violence, and cultural practices would have to be considered (as in the SEM model). For this reason, the court determined that criminal punishment for seeking abortion actually had a paradoxical effect, whereby it harmfully impacted gestation and drove women to seek alternative methods of pregnancy termination, such as unsafe abortions (109).

Similar to some U.S. states, Mexico used to have a 12-week gestational limit on seeking abortion for a pregnancy that resulted from rape. However, the court again took a human rights approach and acknowledged that, "the legal 12-week time frame did not consider the conditions women endure when they are victims of violent acts that cause pregnancy"(109). Therefore, women should not be criminalized for seeking an abortion after the 12-week limit and should instead be given additional support and assistance in their decision-making process (109).

The support and assistance come in many forms, but in particular from acompañantes, or abortion doulas. These non-medical personnel provide emotional, evidence-based support to women seeking abortions regardless of the criminal status in their state. Some work with allied providers or larger NGOs to provide financial support as well as medical advice. This helps to limit stigma and fears around criminalization as both respect for autonomy and emotional support are essential parts of acompañantes' practice (111).

It is also important to note that Mexico had a later transition to democracy than the U.S. The first democratic elections were held in Mexico in 2000, after one authoritarian regime for most of the 20th century. There is also less of a partisan divide in the Mexican Supreme

Court, and religious organizations have less power to lobby the government than in the U.S (110). This could explain why the Mexican government moved to legalize abortion at the same time as the U.S. moved to restrict it.

In conclusion, the U.S. does not subscribe to many international human rights guidelines or treaties. However, there is a wide range of international role models and frameworks that can be utilized to formulate and redesign the abortion care system in the U.S. These examples not only demonstrate the necessity of abortion care but also how much political and grassroots support can change a country's policies.

Chapter 8: Discussion

This thesis intended to understand the factors influencing safe abortion access among Black women in the United States post-Dobbs. I utilized a combined framework of the SEM and RJF to analyze factors at an individual, community, institutional, policy, and international level. Using this analysis, I then formulated recommendations for more equitable, safe, and accessible abortion services. Using the adapted, combined framework allowed me to center Black women and their lived experiences while still being able to view the intersecting layers of policy, institutions, and community factors.

The most pervasive influence across all levels of the adapted SEM was systemic racism. At the individual and community level, systemic racism affected trust in the healthcare system, created over-policing of Black communities, and perpetuated the cycle of poverty. At an institutional level, it affected provider demographics and healthcare payment options. When comparing U.S. law and policy to other countries with a history of systemic racism (e.g. Apartheid in South Africa), the U.S. continues to create restrictive abortion policies that harm Black women (75).

One of the key quotes from the book Reproductive Justice: An Introduction was, "Reproductive justice activists believe that human rights should not depend on geography." (4) Despite this, geography determines many of the barriers to abortion access for Black women in the U.S. Due to the Dobbs decision, abortion policy is entirely dependent on the state in which you live. With 60% of Black women living in states with restrictive abortion policies, it is not surprising that these women struggle to obtain access. While some states allow exceptions for rape, incest, or danger to maternal life; obtaining these exceptions often presents complications, such as proving rape or contending with an already discriminatory police force. While some states are working to circumvent these laws by creating shield laws and telehealth abortion practices, it remains a difficult legal landscape to traverse. Especially as some states, such as Louisiana, are attempting to ban telehealth abortion as well by criminalizing the possession of Mifepristone and Misoprostol.

Cost was the other major factor in accessing abortion. The Hyde Amendment, preventing the use of public insurance for abortion services, forced many Black, low-income women to pay for the procedure out of pocket. Furthermore, the discriminatory practices of employment in the U.S. dictate that Black women are less likely to have higher-paying jobs with private insurance. As women save for their procedures, they are more likely to be further in gestation and then have to pay for the more expensive option of surgical abortion. This is all without considering geography and how some women will have to travel more

than 400 miles to reach the closest abortion clinic, which may or may not have appointment openings. Peripheral expenses such as childcare, gas, transportation, and accommodation further exacerbate this cost inequity. Abortion funds and pay-as-you-can programs exist to attempt to overcome these barriers; however, few are holistic enough in understanding the intersectional factors that Black abortion seekers face.

Black women are not all the same, and part of this research attempted to understand how their intersectional identities impacted their access to abortion care. The literature did not describe religion as much as expected, given the number of Black people who identify as religious. Often, intersectional identities such as being Black and low-income or Black and Queer further exacerbate the inequities already present in these marginalized groups.

At an international level, the U.S. used to be a pioneer in abortion policy with many countries basing their abortion laws on the landmark Roe v Wade decision. Now, as the U.S. reverses, other countries are working to advance in reproductive justice. Newer democracies such as South Africa and Mexico were able to integrate reproductive justice and a human rights approach into their constitutions. Both Canada and Mexico have decriminalized abortion, which is the WHO's recommendation based on the WHO abortion care guideline. Despite the wave of conservatism sweeping many Western nations, by implementing abortion or reproductive rights into national policy, abortion rights remain protected. To change the U.S., the American government needs to recognize human rights and align its policy accordingly, starting with signing more than four international human rights treaties.

This research is very recent. The long-term impact of the Dobbs decision on Black women's maternal mortality and healthcare access is not yet known. We do know that it is already having an impact. Black women are more likely to give birth prematurely, have low-birth-weight infants, and are three times more likely to die during or directly after childbirth than white women. We also know that abortions are happening even with the multitude of restrictions in place. Across all international examples and examples from banned states, women will find a way to access abortion care. By limiting safe abortion access, the consequence is an increase in the risk of unsafe abortion and maternal death.

The literature did offer some suggestions for interventions. What is important to note is that these interventions are at the individual, community, and institutional level, but true systemic change needs to occur to create a safe abortion environment for Black women in the U.S. The suggestions included diversifying the workforce so that the physicians, nurses, and other health providers reflect the populations they are treating. Several also proposed Black abortion doulas or other support people to add to the feeling of safety at

abortion clinics. Some studies recommended the use of storytelling as a method of destigmatization and pointed to the history of storytelling in the Black community. This was evident by the importance of social support in accessing abortion. In lieu of federal abortion decriminalization, the American health system needs to find a way to offer flexible, low-cost abortion services. This could follow a Massachusetts Abortion Program model of offering a pay-as-you-can model and partnering with abortion funds to provide medication abortions. Or this could follow a Mexican model of offering abortions in federally funded public clinics in states where abortion is illegal. Without federal policy protections, however, these remain patchwork solutions with limited effectiveness.

Future studies would benefit from utilizing a reproductive justice lens as they evaluate abortion policy. If reproductive choice is not accessible for certain members of the population, then it cannot constitute justice. The adapted SEM works to combine the RJF with the SEM framework utilized by many public health professionals. Further research is needed on why maternal mortality is so high among Black women in the U.S. and how the Dobbs decision has impacted that. It would benefit authors to consider the RJF or adapted SEM to prevent the perpetuation of white paternalism in their studies of Black women's abortion access and maternal mortality. Furthermore, with current policies on immigration, contraception, and abortion; there will be lasting effects on maternal health both in the U.S. and abroad.

There are limitations to this study and to using this framework. First, the SEM required significant adaptation to be relevant to the globalized world. The broad categories allowed me to situate my findings but may have left this thesis open to errors of exclusion. By using a more specific, validated framework, some issues may have been included that I missed in my analysis. Second, not all studies separate their findings by demographics. When possible, I only included articles with at least a 20% Black study population; however, sometimes this couldn't be determined based on the data available. Finally, I did not look specifically at Black birthing people who do not identify as women. While they may have been included in the analysis, this community was not specifically investigated. Further research must be done on the intersectional identities of Black non-binary and transgender birthing people and how they access abortion care.

Chapter 9: Conclusion and Recommendations

In conclusion, there are many factors that influence Black women's access to abortion services in the U.S. post-Dobbs. Cost, geography, systemic racism, and distrust of the medical system prevent many women from being able to access their fundamental human right to make choices about their bodies. The U.S. Pledge of Allegiance concludes "with liberty and justice for all." It is therefore an American duty to fight for personal liberty and reproductive justice for all humans, regardless of their skin color.

Accordingly, this thesis recommends the following interventions to policymakers to expand the access of Black women to abortion services in the U.S.:

Short term:

1. Work with Black storytelling networks and community funds to center Black women in their advocacy and combat stigma within communities of color.
2. Continue passing shield law legislation and blocking legislation banning telehealth services for abortion.
3. Recognize and encourage the implementation of abortion doulas, especially BIPOC doulas. Continue to uplift BIPOC health workers to create a more diverse health workforce.

Long term:

1. Completely decriminalize abortion as recommended by the WHO abortion care guideline.
2. Sign the human rights treaty: The Convention on the Elimination of All Forms of Discrimination Against Women.
3. Establish federal abortion clinics in each state where abortion remains illegal, to provide abortions free of charge. This follows the Mexican model and would guarantee access to abortions until federal protections can be passed.
4. Repeal the Hyde Amendment.

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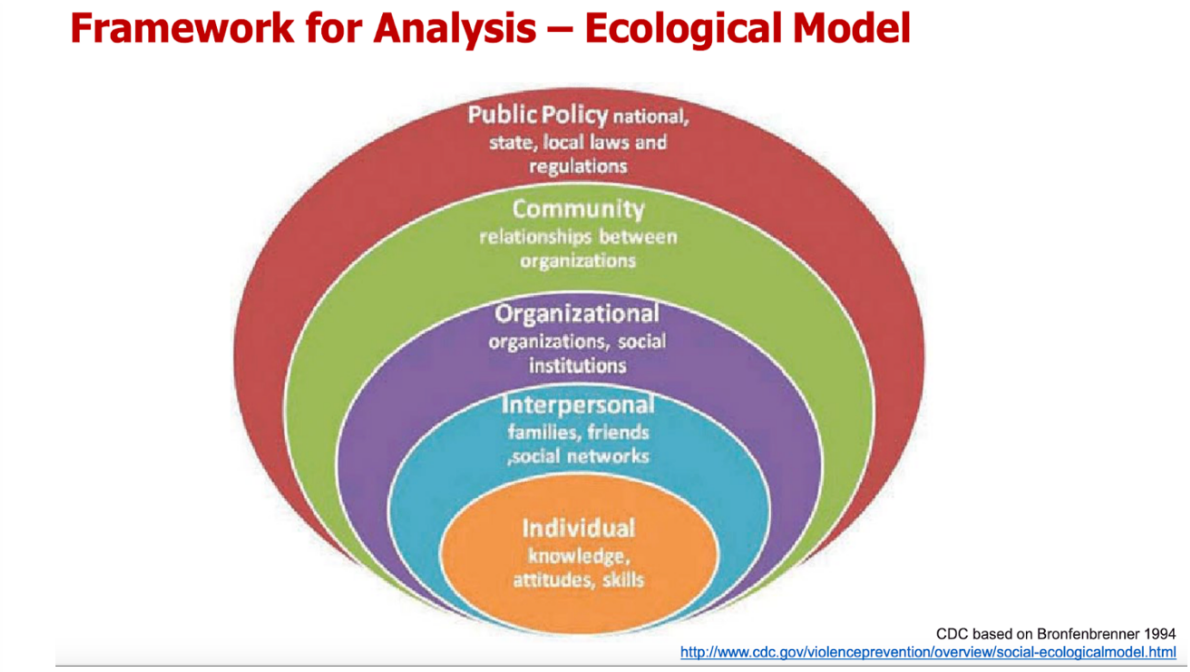
Annex 1: Search Terms

Population	Country	Framework	Subject	Time Frame
Black women	U.S.	Personal	Abortion	2022-2025
African American Women	America	Community		Post-Dobbs
Women of Color	United States	Institutional		Post-Roe
BIPOC	South Africa	Policy		
	Canada	Human Rights		
	Mexico	Intersectionality		
		Reproductive Justice		
		Socioecological model		

Annex 2: Socioecological Model

This is the CDC adaptation of the Bronfenbrenner 1994 Socioecological model (38).



Annex 3: Declaration of AI Use

KIT Institute Masters Participant
Declaration for Use of Generative AI (GenAI)

Check the box that applies to your completion of this assignment:

☐ I confirm that **I have not used** any generative AI tools to complete this assignment.

☒ I confirm that **I have used** generative AI tool(s) in accordance with the ***"Guidelines for the use of Generative AI for KIT Institute Master's and Short course participants".*** Below, I have listed the GenAI tools used and for what specific purpose:

Generative AI tool used	Purpose of use
1. Grammarly	Spelling and grammar check
2. ChatGPT	Brainstorming different factors for they layers of the SEM
…	