NOTE

ADDRESSING THE BLACK MORTALITY CRISIS IN THE WAKE OF *DOBBS*: A REPRODUCTIVE JUSTICE POLICY FRAMEWORK

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ABSTRACT

Black people who can become pregnant and give birth were dying from pregnancy-related causes at rates more than double the national average before the Supreme Court decided Dobbs v. Jackson Women's Health, *and the* Dobbs *decision is expected to make America's maternal mortality crisis worse. This Note discusses the expected effects of abortion restrictions on maternal mortality rates and the causes of racial disparity in maternal outcomes. This Note argues that existing policy is insufficient to respond to the seismic change in the reproductive rights landscape caused by* Dobbs, *and that to mitigate the consequential expected rise in maternal mortality among Black women, states must implement a comprehensive policy framework to advance reproductive justice. The Note concludes with recommendations for such a reproductive justice policy framework.*

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INTRODUCTION

The United States (U.S.) was a dangerous place for Black women[1] to give birth before the Supreme Court decided *Dobbs v. Jackson Women's Health*. Prior to *Dobbs*, Black women in America were dying from pregnancy-related causes at rates more than double the already high national average.[2] The *Dobbs* decision is expected to worsen America's maternal mortality[3] crisis, and existing policy is insufficient to respond to this seismic change in the reproductive rights landscape.[4] In order to mitigate a considerable rise in maternal mortality among Black people who can become pregnant and give birth, states with abortion restrictions or bans must implement a comprehensive policy framework to advance reproductive justice.

Section I of this Note explains how abortion restrictions are linked to increased rates of maternal mortality, while access to abortion improves maternal outcomes. Section II articulates how maternal mortality and morbidity disproportionately affect Black people who can become pregnant and give birth; explains that this disparity is not a result of race, but *racism*; and argues that framing poor maternal outcomes as a product of race instead of racism impermissibly excuses inaction. Section III argues that existing policies to address the maternal mortality crisis are insufficient in the wake of *Dobbs* because they fail to connect abortion access to maternal outcomes. The section discusses examples of how existing

1. Though this Note uses the term "women," here, not all people who may become pregnant, give birth, or receive an abortion identify as "women" or "mothers." Non-binary, gender-fluid, gender-nonconforming, and people who are transgender may become pregnant, give birth, or receive abortions, and their experiences must be respected and recognized when discussing the problem of and solutions to the maternal mortality crisis. This Note uses "people who can become pregnant and give birth" where language is not tied to a source or data that supports a proposition. Where this Note uses traditionally gender-specific terms such as "women," or "maternal," it does so to preserve the language of a cited source, to maintain that language for clarity, or to use recognizable phrases or terms like "maternal mortality."

2. *See* Donna Hoyert, NAT'L CTR. FOR HEALTH STATS., MATERNAL MORTALITY RATES IN THE UNITED STATES, 2020, at 1 (Feb. 2022), https://perma.cc/43WT-23G3.

3. This Note uses the terms "maternal mortality," "maternal mortality and morbidity," "maternal health crisis," and "poor maternal outcomes." While mortality refers to a death, morbidity refers to a serious medical condition. "Maternal health crisis" and "poor maternal outcomes" are broad phrases, and intended to reflect that pregnant and birthing people are suffering both death and serious health conditions. This Note tries to preserve the language of studies when citing them, however where this Note uses either mortality or morbidity independently, they should be read broadly in recognition of the impossibility of addressing mortality without addressing morbidity and vice versa.

4. *See* Amanda J. Stevenson, Leslie Root, & Jane Menken, *The Maternal Mortality Consequences of Losing Abortion Access*, SOCARXIV 1, 3 (June 29, 2022), https://perma.cc/2PJY-ZTSH.

policy falls short, and how it can be improved. Finally, Section IV suggests that a reproductive justice policy framework can best address maternal mortality in a post-*Dobbs* America because it would respond to racial disparities in outcomes, promote healthcare access, and save lives. The section provides policy recommendations and highlights topics that cannot be erased from discussions about how to address America's maternal health crisis.

I. ABORTION RESTRICTIONS AND BANS ARE HARMFUL TO THE HEALTH OF PEOPLE WHO CAN BECOME PREGNANT AND GIVE BIRTH AND ARE LINKED TO INCREASED RATES OF MATERNAL MORTALITY

Abortion restrictions and bans make critical healthcare unavailable to people who can become pregnant and give birth and cause maternal mortality rates to rise.[5] However, it is critical to understand that the issue is about more than numbers and how those numbers compare to the rest of the world. Numbers and rates cannot fully capture the gravity of what it means that hundreds of Americans who can become pregnant and give birth are dying each year, and thousands of families and loved ones are mourning because the American healthcare system fails to value the health of women and other people who can become pregnant and give birth, and to adopt a reproductive justice framework that can save lives.

A. SINCE *ROE V. WADE* AND *PLANNED PARENTHOOD V. CASEY* WERE OVERTURNED, MANY STATES HAVE ADOPTED, OR ARE MOVING TOWARD THE ADOPTION OF, TOTAL ABORTION BANS

Dobbs was decided by the Supreme Court on June 24, 2022.[6] Since then, the landscape surrounding abortion rights has changed significantly. The decision overturned long-standing precedents *Roe v. Wade* and *Planned Parenthood v. Casey* and opened the door for states to pass total abortion bans.[7] As of December 2022, twelve states have made abortion illegal.[8] More states are actively moving toward passing bans, and fourteen states are considered "hostile" to abortion.[9] The Center for Reproductive Rights defines a state as "hostile" to abortion when it has "expressed a desire to prohibit abortion entirely" and is "extremely vulnerable to the revival of old abortion bans or the enactment of new ones."[10]

5. *Id.*
6. *See generally*, Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).
7. *Id.* at 2242.
8. These states include the following: Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia. *See After Roe Fell: Abortion Laws by State*, CTR. FOR REPROD. RTS., https://perma.cc/93H3-NCTY (last visited Feb. 19, 2023).
9. These states include the following: Arizona, Georgia, Indiana, Iowa, Nebraska, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Utah, Wyoming, and Wisconsin. *See id.*
10. *See* CTR. FOR REPROD. RTS., *supra* note 8.

While it is significant that *Dobbs* permits states to abandon all protections of abortion, even prior to *Dobbs*, states that were hostile to abortion were actively creating an environment that was hostile to abortion providers.[11] In 2019, six states had only one abortion provider.[12] Only 26% of the 808 abortion providers operating pre-*Dobbs* were in hostile states, even though 58% of women of reproductive age lived in hostile states.[13] In a post-*Dobbs* America, states that protect abortion will be required to provide critical reproductive healthcare to the 58% of women living in hostile states.[14] They will also need to adjust to meet the needs of the population that was once served by the 26% of providers in hostile states.[15]

B. ABORTION IS A SAFE MEDICAL PROCEDURE WITH FEWER RISKS THAN GIVING BIRTH

Giving birth in America is significantly more dangerous than having an abortion in America.[16] More than 90% of abortions take place within the first twelve weeks of pregnancy.[17] The increasing availability of medication abortion allows abortions to be performed even earlier, and it is expected that medication abortion will cause the proportion of abortions that take place before six weeks of pregnancy to grow.[18] This is significant because abortion is safest early in pregnancy.[19] Additionally, abortions can be performed outside of a hospital environment.[20] Less than 5% of abortions that occurred in 2014 were performed in a hospital.[21] This is because complications from abortion are rare.[22] On the other hand, complications from pregnancy are tragically common, with more than twenty-six women in America dying per 100,000 live births, and seventy women experiencing severe maternal morbidity for every person who was pregnant or gave birth and died.[23] Research and history demonstrate that the health of people who can become pregnant and give birth is harmed by *restricting* abortion because restricting abortion removes the option of undergoing a safe medical procedure and forces pregnant people into giving birth—an experience that is

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11. *See* Rachel Rebouché*, The Public Health Turn in Reproductive Rights*, 78 WASH. & LEE L. REV. 1335, 1417 (2022).
12. *See id* at 1417.
13. *See id.*
14. *See id.*
15. *See id.*
16. *See* Adebayo Adesomo, *Pregnancy is Far More Dangerous Than Abortion*, SCI. AM. (May 30, 2022), https://perma.cc/LM5K-K4L9.
17. *See* Jeff Diamant & Besheer Mohamed, *What the Data Says About Abortion in the U.S.*, PEW RSCH. CTR. (June 24, 2022), https://perma.cc/T9JV-X8U3.
18. *See* NAT'L ACAD. SCI.'S, ENG'G, & MED., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 5 (Nat'l Acads. Press, 2018), https://perma.cc/QZ53-NMRR.
19. *See* Alison Kodjak, *Landmark Report Concludes Abortion in U.S. is Safe*, NPR (Mar. 16, 2018), https://perma.cc/7FKE-ERSK.
20. *See* NAT'L ACAD. OF SCI.'S, ENG'G, & MED., *supra* note 18, at 6.
21. *Id.*
22. *See* Kodjak, *supra* note 19.
23. *See* BLACK MATERNAL HEALTH CAUCUS, ABOUT BLACK MATERNAL HEALTH, https://perma.cc/J5XY-GJ2Q (last visited Feb. 17, 2023).

increasingly dangerous for American women, particularly Black American women.[24]

C. MATERNAL MORTALITY RATES DECREASE WHERE ABORTION ACCESS IS EXPANDED AND INCREASE WHERE IT IS RESTRICTED

While the *Dobbs* decision was seen as a victory for the "pro-life" movement, it is *access* to abortion that is empirically connected to promoting life.[25] In states and countries where abortion access has been expanded, maternal mortality rates have noticeably decreased, while they have increased where abortion access is restricted.[26] Studies in Romania and South Africa showed that after abortion became legal and available in those countries, maternal mortality rates fell by nearly half.[27] States with limitations on abortion access had a 7% greater increase in maternal mortality rates between 2015 and 2018 than states with expanded abortion access.[28] Maternal mortality rates in states with the most abortion restrictions were significantly higher than states without restrictions.[29] The study that found these connections between state abortion restrictions and maternal mortality was conducted using the restrictions on abortion that a state had in place in 2015.[30] Since 2015, numerous additional restrictions have been implemented, and numerous states have adopted abortion bans.[31] As a result, the policies restricting abortion that were correlated with increased maternal mortality rates have expanded, or been replaced with, total prohibitions on abortion. Therefore, the disparities in maternal health between abortion-restrictive states and states with abortion protections are likely to grow.

The disparities in maternal health outcomes between abortion-restrictive and abortion-protective states is clear.[32] In 1995, American maternal mortality rates were comparable among the various states, but as some states increased restrictions on abortion, maternal mortality rates in those states also increased.[33] By 2009, maternal death rates in restrictive states were nearly double those of states protective of abortion.[34] In states protective of abortion, maternal death rates

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24. *Id.*
25. *See* Meghan Boone, *Perverse & Irrational*, 16 HARV. L. & POL'Y REV. 393, 445–46 (2022).
26. *See id.* at 442.
27. *See id.*
28. *See* Dovile Vilda, Maeve E. Wallace, Clare Daniel, Melissa Goldin Evans, Charles Stoecker, & Katherine P. Theall, *State Abortion Policies and Maternal Death in the United States, 2015–2018*, 9 AM. J. PUB. HEALTH 1696, 1701 (2021).
29. *See id.*
30. *Id.*
31. *See id.*; CTR. FOR REPROD. RTS., *supra* note 8.
32. Abortion-protective refers to states where the right to abortion is enshrined in the state constitution or protected by state statute, but access to that right may be limited by state law or policy. *See* CTR. FOR REPROD. RTS., *supra* note 8.
33. *See* Philip D. Darney, Marcos Nakamura-Pereira, Lesley Regan, Feiruz Serur, & Kusum Thapa, *Maternal Mortality in the United States Compared With Ethiopia, Nepal, Brazil, and the United Kingdom*, 135 OBSTET. & GYNECOL. 1362, 1363 (2020).
34. *See id.*

improved or were steady.[35] When this study was completed, there were twenty-nine restrictive, twelve neutral, and nine protective states.[36] As of December 2022, there remain twenty-nine states where abortion is restricted in some way—ranging from being unprotected to being entirely illegal.[37] Though the number of restrictive states remains the same, the *Dobbs* decision intensifies that category as it now includes states where abortion is illegal, thereby worsening the caliber of restriction and maternal outcomes. Today, the six states where maternal mortality rates are the highest are all states where abortion is illegal.[38] On the other hand, maternal death rates are presently the lowest in California, Illinois, Colorado, and Connecticut, in that order.[39] In each of these states but Colorado, there is expanded access to abortion.[40] Abortion is protected in Colorado.[41]

1. Specific Restrictions on Abortion Have Been Linked to Noticeable Increases in Maternal Death

A study on abortion restrictions in place between 2007 and 2015 showed the impact that different abortion restrictions had on maternal mortality rates.[42] Gestational limits on abortion were linked to a 38% increase in maternal death, and reducing the number of Planned Parenthood clinics by 20% was linked to an 8% increase in maternal death.[43] States with requirements that abortion providers be licensed physicians had a 51% higher total maternal mortality rate than states

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35. *See id.*

36. *See* Amy N. Addante, David L. Eisenberg, Mark C. Valentine, Jennifer Leonard, Karen E. Joynt Maddox, & Mark H. Hoofnagle, *The Association Between State-Level Abortion Restrictions and Maternal Mortality in the United States*, 1995–2017, 104 INT'L REPROD. HEALTH J. 496, 496 (2021).

37. *See* CTR. FOR REPROD. RTS., *supra* note 8.

38. The CDC has sufficient data to calculate a maternal mortality rate for nine of the twelve states where abortion is illegal. There is no calculated rate for West Virginia, South Dakota, or Idaho. The other nine states all fall within the top fifteen states with the highest maternal mortality rates. The six states with the worst maternal mortality rates are all states where abortion is illegal. The other six spots in the top fifteen are occupied by five states where abortion is hostile, and New Jersey. CTRS. FOR DISEASE CONTROL & PREV., MATERNAL DEATHS AND MORTALITY RATES BY STATE FOR 2018-2020, https://perma.cc/HVH2-JY2R (last visited Mar. 20, 2023). The top fifteen states with the highest maternal mortality rates, their abortion status, and their maternal mortality rate are as follows, from highest rate to lower rates per 100,000 live births: Arkansas (illegal, 40.4), Kentucky (illegal, 39.7), Alabama (illegal, 36.2), Tennessee (illegal, 34.6), Louisiana (illegal, 31.8), Mississippi (illegal, 30.2). South Carolina (hostile, 28.9), Georgia (hostile, 28.8), Arizona (hostile, 28.3), Nebraska (hostile, 28.2), Indiana (hostile, 28.2), Missouri (illegal, 25.2), Oklahoma (illegal, 24.6), New Jersey (expanded access 24.1), and Texas (22.9). *Id.* These rankings should be interpreted with caution because data could not be garnered from every state. Only thirty-one states had an assigned maternal mortality rate. *Id.*

39. *See id.* These rankings should be interpreted with caution because data could not be gathered from every state. Only thirty-one states had an assigned maternal mortality rate. *Id.*

40. Expanded access states are those where the right to receive an abortion is protected, either by statute or the state constitution, and where additional laws provide for increased access to abortion care. *See* CTR. FOR REPROD. RTS., *supra* note 8.

41. *See id.*

42. *See* Vilda, Wallace, Daniel, Evans, Stoecker, & Theall, *supra* note 28, at 1697.

43. *See id.*

without such a requirement.[44] States which forbid the public funding of abortion have a 29% higher maternal death rate than states that allow public funding of abortion healthcare.[45] In states where abortion is banned, gestational limits are reduced to zero, and clinics that provide abortion care will be reduced by 100%. The impact of *Dobbs* and the abortion bans and restrictions subsequently passed will have a noticeable and unacceptable effect on maternal death rates.[46]

2. Protecting Abortion Care Has Been Shown to Decrease Maternal Death Rates

Access to safe abortion has proven to be one of the most successful and cost-effective remedies for soaring maternal death rates.[47] The Global Health Policy Summit's Maternal Health Working Group determined that access to safe abortion was one of the top seven factors explaining decreases in maternal mortality rates across the globe, and that it was the second most cost-effective action that reduced death rates.[48] The first most cost-effective intervention was access to contraception.[49] The ability to make reproductive choices directly affects one's ability to make choices about their health. The Turnaway Study[50] reported that of the women seeking an abortion who were included in the study, one in eight did so because they had a health concern, even though women who had imminent health risks were excluded from the study.[51] Women who were turned away when seeking an abortion were more likely to report life-threatening birth complications, including eclampsia and hemorrhage.[52] Protecting abortion access protects a person's decisions about their own health. When people who can become pregnant or give birth make unrestricted decisions about their health, informed by conversations with their physicians, maternal lives are saved.

44. *See id.* at 1700.
45. *See id.*
46. *See* Summer Hawkins, Marco Ghiani, Sam Harper, Christopher Baum, & Jay Kaufman, *Impact of State-Level Changes on Maternal Mortality: A Population-Based, Quasi-Experimental Study*, 58 AM. J. PREV. MED. 165, 172 (2019).
47. *See* Darney, Nakamura-Pereira, Regan, Serur, & Thapa, *supra* note 33, at 1365.
48. *See id.*
49. *See id.*
50. *See Turnaway Study*, ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, https://perma.cc/62HG-BEYR (last visited Feb. 12, 2023). The Turnaway Study is a longitudinal study that consisted of interviews with women who received the abortion they sought, and women who were turned away from receiving a wanted abortion because their pregnancy had advanced past the clinic's gestational limit. The study used the findings from these interviews to examine the effects of "receiving versus being denied a wanted abortion on women and their children." *Id.*
51. *See* Vilda, Wallace, Daniel, Evans, Stoecker, & Theall, *supra* note 28, at 1697.
52. *The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study*, ADVANCING NEW STANDARDS IN REPROD. HEALTH 2, https://perma.cc/V6Y7-VUBM (last visited Mar. 6, 2023).

3. Ending Abortion Access Is Estimated to Increase American Maternal Mortality Rates

In September of 2022, U.S. Senator Lindsey Graham (R.-S.C.) introduced a bill that proposed a nationwide ban on abortion after fifteen weeks.[53] Though the ban's timing was unpopular among Republicans in the Senate because it put Republicans who were on the ballot "in a difficult situation going into the mid-terms,"[54] a twenty-week federal abortion ban was voted on in 2018, and only two Republican Senators opposed it.[55] A nationwide abortion ban would increase maternal deaths by an estimated 24%.[56] Though this increase is significant and shocking, the disparate impact that a nationwide ban would have on maternal death among Black people is even worse.[57] A nationwide abortion ban would result in the death of 39% more Black people from maternal causes.[58] Considering Black people already die at disproportionately high rates from maternal causes, a 39% increase in maternal deaths means that hundreds more Black people who can become pregnant and give birth would die per year simply as a result of this legislation's proposed abortion ban.[59]

Researchers expect that maternal death rates will rise the most in Florida and Georgia if a nationwide ban were in place.[60] Georgia is hostile to abortion rights.[61] The highest increases in maternal death rates are not limited to hostile states, though the expected rise in maternal death rates in non-hostile states is, in part, related to the consequences of abortion bans and restrictions in hostile states. For example, states that border hostile states will face increases in maternal mortality rates as a consequence of their neighbor state's bans.[62] For example, the Florida state constitution protects the right to abortion (though a fifteen-week ban was enacted in 2022), but Florida is surrounded by states where abortion is banned or states are working to enact bans.[63] Florida, and other such border states with abortion protections, serve as "haven states."[64] These states will receive an influx of people needing abortions, which will strain resources and leave people waiting longer periods of time for critical care.[65] When pregnant people have to

53. Maggie Buchanan, *What You Need to Know About the Bill to Ban Abortion Nationwide,* CTR. FOR AM. PROGRESS (Sept. 16, 2022), https://perma.cc/NZ7C-EX4F.

54. Daniel Payne & Krista Mahr, *The Federal Abortion Ban Bill is Here—and It Has Some Republicans Stunned*, POLITICO (Sept. 14, 2022, 10:00 AM), https://perma.cc/3SAN-VQH7.

55. *See* Buchanan, *supra* note 53.

56. Stevenson, Root, & Menken, *supra* note 4.

57. *See id.*

58. *Id.*

59. *See id.* at 6.

60. *See* Elyssa Spitzer, Tracy Weitz, & Maggie Jo Buchanan, *Abortion Bans Will Result in More Women Dying,* CTR. FOR AM. PROGRESS (Nov. 2, 2022), https://perma.cc/X6VY-K59H.

61. *See* CTR. FOR REPROD. RTS., *supra* note 8.

62. *See* Spitzer, Weitz, & Buchanan, *supra* note 60.

63. *See* CTR. FOR REPROD. RTS., *supra* note 8.

64. *See* Spitzer, Weitz, & Buchanan, *supra* note 60

65. *See id.*

wait extended time-periods to receive abortion care, by the time an appointment becomes available, their pregnancy may have surpassed the gestational limit and they are left with no option but to carry the pregnancy to term. A nationwide ban would also limit the level of "haven" that "haven states" could provide. A nationwide fifteen-week abortion ban would not raise the floor to require states with total bans to allow abortion up to fifteen-weeks, but rather lower the ceiling so that states protective of abortion rights cannot provide abortion care after fifteen weeks.[66] The compounding effects of more people traveling to protective states to access abortion care and the diminished time frame under which providers can provide care to both in-state and out-of-state pregnant people would result in a lower quality of healthcare available for all. This will make giving birth more dangerous—even in protective states.

II. MATERNAL MORTALITY AND MORBIDITY DISPROPORTIONATELY AFFECT BLACK PEOPLE WHO CAN BECOME PREGNANT AND GIVE BIRTH, EVEN THOUGH THESE ADVERSE OUTCOMES ARE LIKELY THE MOST PREVENTABLE

Maternal death is defined by the World Health Organization as "deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within forty-two days of termination of pregnancy, irrespective of the duration and site of the pregnancy."[67] The Pregnancy Mortality Surveillance System includes deaths up to one-year postpartum.[68]

The U.S. has shocking rates of maternal death, which continue to rise. The primary cause of its worsening maternal mortality rates is that the U.S. has failed and continues to fail to address systemic problems causing the deaths of Black people who can become pregnant and give birth, even though their deaths are the most preventable.[69] Black people who can give birth are dying at rates four-times higher than white people who can give birth in some American states.[70] They die at rates more than twice the overall national average.[71] As a consequence, responses to American maternal mortality must acknowledge and address these racial disparities.

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66. *See* Eleanor Lutz & Allison McCann, *How a Proposed 15-Week Abortion Ban Compares With State Laws*, N.Y. TIMES (Sept. 13, 2022), https://perma.cc/5JLE-HQCS.

67. *Global Health Observatory: Maternal Deaths*, WORLD HEALTH ORG., https://perma.cc/LX5F-G7GH (last visited Nov. 2, 2022).

68. *Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREV., https://perma.cc/6HDC-T73W (last visited Feb. 24, 2023).

69. *See* Nisha Verma & Scott Shainker, *Maternal Mortality, Abortion Access, and Optimizing Care in an Increasingly Restrictive United States: A Review of the Current Climate*, 44 SEMINARS IN PERINATOLOGY 1, 4 (2020).

70. *See e.g.,* Sarah Owermohle, *Why Louisiana's Maternal Mortality Rates are So High*, POLITICO (May 19, 2022, 4:06 PM), https://perma.cc/3L7P-794M.

71. *See Pregnancy Mortality Surveillance System*, *supra* note 68.

A. THE U.S. HAS HIGH, AND INCREASING, RATES OF MATERNAL MORTALITY AND MORBIDITY

The U.S. is the most dangerous place in the industrialized world to give birth.[72] Between 1990 and 2015, global maternal mortality rates decreased by 44%.[73] However, over the same time period, rates in America increased 16.7%.[74] Approximately 26 maternal deaths occur per 100,000 live births in the U.S.[75] This rate is 55.3 deaths per 100,000 live births among non-Hispanic Black women.[76] The difference between maternal death rates in the U.S. and abroad is not insignificant. Based on 2018 data, the maternal death rate per 100,000 live births in Canada was 8.6, 6.5 in the United Kingdom, and just 1.8 in Norway.[77]

America's maternal health crisis is not limited to maternal *death*. For every maternal death in America, seventy other women suffer a "near miss."[78] A "near miss," or "severe maternal morbidity," includes unexpected outcomes of labor and delivery that can result in significant short-term or long-term consequences to a woman's health."[79] Women who suffer from severe maternal morbidity commonly undergo blood transfusions, hysterectomies, and ventilation or temporary tracheostomy.[80] These rates have risen alongside maternal mortality rates.[81] The rate of hysterectomy as a result of severe maternal morbidity rose 55% from 1993 to 2014, ventilation or temporary tracheostomy by 93%, and blood transfusions rose from 24.5 to 122.3 per 10,000 delivery hospitalizations; this resulted in a 200% rise in severe maternal morbidity rates over this twenty-one-year time period.[82] Severe maternal morbidity also disproportionately affects Black women.[83] Black women are 166% more likely to experience a "near miss" than white women.[84]

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72. *See* BLACK MATERNAL HEALTH CAUCUS, *supra* note 23.
73. *Id.*
74. *Id.*
75. *Id.*
76. Hoyert, *supra* note 2, at 1.
77. *See* Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald, & Laurie Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), https://perma.cc/9XU9-T8RN.
78. *See* OFF. OF RSCH. ON WOMEN'S HEALTH, NAT'L INSTS. OF HEALTH, MATERNAL MORBIDITY AND MORTALITY: WHAT DO WE KNOW? HOW ARE WE ADDRESSING IT? 2 (2020). A "near miss" in this context refers to cases where a person "survived a life-threatening medical condition, organ failure, or complication with respect to their pregnancy or childbirth." Shazia Sultana, Shahina Ishtaique, Sundus Fareed, Samina Kamal, Zarnigah Aslam, Rubina Hussain, & Sanam Lashari, *Clinical Spectrum of Near-miss Cases in Obstetrics*, 11 CUREUS 1, 1 (2019), https://perma.cc/8D9M-RCRQ.
79. *See Severe Maternal Morbidity in the United States*, CTRS. FOR DISEASE CONTROL & PREV. (2021), https://perma.cc/3HGQ-VQ89.
80. *See id.*
81. *Id.*
82. *Id.*
83. *See* OFF. OF RSCH. ON WOMEN'S HEALTH, NAT'L INSTS. OF HEALTH, *supra* note 78, at 3.
84. *Id.*

B. BLACK PEOPLE WHO CAN BECOME PREGNANT AND GIVE BIRTH ARE MOST AT RISK OF SUFFERING MATERNAL DEATH AND MORBIDITY—THIS IS TRUE EVEN WHEN SIGNIFICANT FACTORS ARE CONTROLLED FOR

There is no scientific reason why pregnancy and childbirth are more dangerous for Black people than people of other races.[85] Unfortunately, some of the framing of maternal risk improperly places the brunt of the responsibility for adverse maternal outcomes on Black people who can become pregnant and give birth instead of on the conditions and circumstances they have been disproportionately required to endure.[86] For example, the National Institutes of Health identified "racial, ethnic, and socioeconomic backgrounds" as "factors that increase a woman's risk for maternal morbidity and mortality."[87] In another publication, they concluded that "[g]enerally, risk factors are highest and health-promoting factors lowest for: women ages thirty-five to forty-four, Black women, women without insurance, and those residing in Southern states."[88] These presentations of maternal risk suggest that there *is* something inherent about being Black that increases maternal risk and that Black individuals make choices during pregnancy that are not "health-promoting."[89] This mischaracterizes the problem. The Centers for Disease Control and Prevention (CDC) noted that "[i]t is not entirely clear why [severe maternal morbidity] is increasing, but changes in the overall health of the population of women giving birth may be contributing to increases in complications."[90] It *should* be, at least in part, clear why severe maternal morbidity is increasing for Black people. Black people are dying and suffering "near misses" at disproportionate rates from maternal causes because they are suffering the effects of structural racism.[91]

Black women are more likely to suffer maternal death even when studies control for different factors.[92] For example, Black women with college degrees are still five times more likely than white women with college degrees to die from pregnancy-related causes.[93] Further, pregnancy and childbirth is still more dangerous for Black women than women of other races in America when studies control for "increased prevalence of preexisting conditions."[94] Recognizable

85. *See* Khiara Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1255 (2020).
86. *Id.*
87. *See* NAT'L INST'S. OF HEALTH, WHAT FACTORS INCREASE THE RISK OF MATERNAL MORBIDITY AND MORTALITY?, https://perma.cc/83MW-LA58 (last visited Feb. 24, 2023).
88. *See* OFF. OF RSCH. ON WOMEN'S HEALTH, NAT'L INSTS. OF HEALTH, *supra* note 78, at 6.
89. *See* Bridges, *supra* note 85, at 1255.
90. *Severe Maternal Morbidity in the United States*, *supra* note 79.
91. *See* Bridges, *supra* note 85, at 1257–67.
92. *See* Latoya Hill, Samantha Artiga, & Usha Ranji, *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KAISER FAM. FOUND. (Nov. 1, 2022), https://perma.cc/32PX-X67A.
93. *Id.*
94. *See* Bridges, *supra* note 85, at 1281.

examples of Black mothers experiencing adverse maternal outcomes show that this is a problem based on racism, not resources.

Allyson Felix, a Black American track-and-field sprinter with eleven Olympic medals and a net worth of $4.5 million,[95] suffered from preeclampsia that forced her to undergo a life-saving emergency cesarean section two months before her due date.[96] Serena Williams, a Black American tennis player who spent many years as the number-one ranked female player in the world and earned $94,816,730 in prize money over her career[97] nearly died after suffering a pulmonary embolism just after the birth of her daughter.[98] Both Allyson and Serena were healthy enough to be some of the world's best athletes, and each had significant resources, yet neither their strength nor their resources protected them from the dangers posed for birthing Black people in America.

Even though Black women are more likely to die from pregnancy-related causes than other women, their deaths are more likely to be preventable than maternal deaths of women of other races.[99] It is estimated that more than 60% of pregnancy-related deaths among Black women are preventable, while a study out of Louisiana determined that only about 9% of pregnancy-related deaths among white women are preventable.[100] This means that Black women are disproportionately suffering maternal death because prevention and emergency intervention methods are either inaccessible to Black women or are underutilized when providing them with care.

C. THE DISPARATE OUTCOMES FOR BLACK PEOPLE WHO CAN BECOME PREGNANT AND GIVE BIRTH ARE THE RESULT OF STRUCTURAL RACISM, IMPLICIT BIAS, VARIATIONS IN HEALTHCARE QUALITY, AND SOCIAL AND UPSTREAM DETERMINANTS OF HEALTH

Poor maternal outcomes for Black people should not be framed as resulting from race. Maternal health disparities are not on account of race, but rather are the consequence of Black people experiencing racism as it manifests within structures in the form of implicit bias, variations in healthcare quality, and social determinants of health.[101] Framing adverse outcomes as being on account of race instead of on account of racism allows Black people who can become pregnant and give birth to be blamed for their deaths or poor health, and allows for the real causes of disparity to be ignored.[102]

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95. *See Allyson Felix*, TEAM USA, https://perma.cc/ET44-HM8A (last visited Feb. 26, 2023).

96. *See* Claudia Harmata, *Allyson Felix on the Maternal Mortality Rate for Black Women: We 'Are at Risk No Matter What'*, PEOPLE (Aug. 1, 2019), https://perma.cc/KL27-7949.

97. *See Serena Williams*, WTA OFFICIAL, https://perma.cc/HB9Q-T7WG (last visited Feb. 26, 2023).

98. *See* Alex Portée, *Serena Williams on Her Near-Death Experience After Giving Birth: 'No One Was Really Listening'*, TODAY WOMEN'S HEALTH (Apr. 6, 2022), https://perma.cc/Q2NV-RMBN.

99. Verma & Shainker, *supra* note 69, at 4.

100. *Id.*

101. *See* Bridges, *supra* note 85, at 1257–67.

102. *Id.* at 1254–55.

1. Structural Racism

Structural racism describes how racism is reinforced through disparities built into the regular function of society, its systems, and its structures.[103] Systemic racism plays a role in the disparity within maternal health outcomes because it has created and perpetuated barriers to health and healthcare for Black people. For example, "redlining," the name given to a Federal Housing Administration practice of marking Black neighborhoods with red lines indicating these neighborhoods were high risk for investments, resulted in "unequal access to resources that affect birth outcomes and overall health and wellbeing."[104] As a result of redlining, investment in Black neighborhoods dwindled and funding for pre-existing structures and programs slowed.[105] This meant that hospitals, schools, grocery stores with fresh and nutritious food, and quality housing were harder to access in redlined neighborhoods.[106] Though redlining was outlawed in 1977, the effects of the practice remain today.[107]

The effects of redlining compound with other adverse experiences related to discrimination and the repeated exposure to such discrimination and inequality to result in "weathering," or deterioration of health at an early age.[108] Birth is generally more dangerous for people thirty-five and older,[109] and weathering causes Black women to suffer the additional risks that come with birth later in life at an earlier age.[110]

2. Implicit Bias

"Implicit bias is a form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors."[111] From an early age, people develop implicit biases as a result of living in a world where stereotypes are embedded in, and reinforced by, societal structures.[112] These biases are not conscious decisions, but rather form within us, undetected, as we absorb attitudes and ideas about the world around us. Though the development of these implicit biases may be unintentional, they have meaningful consequences. These

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103. *See, e.g.*, *What Is Structural Racism?*, AM. MED. ASS'N (Nov. 9, 2021), https://perma.cc/MQS7-T3HW.

104. *See The Impact of Institutional Racism on Maternal and Child Health*, NAT'L INST. FOR CHILD.'S HEALTH QUALITY, https://perma.cc/6KV4-TJ7M (last visited Mar. 6, 2023).

105. *See id.*

106. *See id.*

107. *See id.*

108. *See* Arline Geronimus, Margaret Hicken, Danya Keene, & John Bound, *"Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, 96 AM. J. PUB. HEALTH 826, 826 (2006).

109. *See* Lisa Rapaport, *Severe Birth Complications More Common with Older Mothers*, REUTERS (May 30, 2017), https://perma.cc/K9RZ-HQAM.

110. *See* Bridges, *supra* note 85, at 1260–61.

111. *Implicit Bias*, NAT'L INSTS. OF HEALTH, https://perma.cc/MQU5-NCLF (last visited Feb. 25, 2023).

112. *See* Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, 30 J. WOMEN'S HEALTH 270, 270–71 (2021).

consequences are evident in maternal healthcare. Studies have shown that implicit bias particularly affects stressful working conditions, including those for labor and delivery.[113] Responding to stressful situations requires quick and often automatic responses.[114] However, making decisions quickly leaves little time for one to reflect on the reasons undergirding a decision, and thus bias can sneak into that process undetected.[115] For example, healthcare providers often underestimate the pain that Black patients experience because of implicit biases about pain tolerance and race.[116] As a result, Black people who give birth are less likely to receive epidural analgesia than white people who give birth,[117] and are more likely to receive medically unnecessary cesarean sections than white people who give birth.[118] Cesarean deliveries may result in hemorrhage, anesthesia complications, and infection—three of the top causes of maternal death.[119]

Healthcare providers may do their best to provide equal, quality care for their patients, but ensuring that this goal is achieved requires humility when reflecting on and assessing one's biases. Healthcare providers acknowledge that implicit bias generally affects their practice, but are less willing to acknowledge that *their own* implicit biases impact the quality of care *they* provide to their patients.[120] As such, many Black women forgo hospital births and instead opt for midwives, doulas, birth centers, or home births to avoid medical maltreatment.[121] When Black

113. Se*e id.* at 271.

114. *See id.*

115. *See id.*

116. *See* Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. 4296, 4296–97 (2016). It would be remiss to fail to acknowledge the history of harm to Black women that has resulted from the false beliefs about Black people, particularly Black women, and pain. Enslaved African American women were the victims of experimental surgeries performed by physicians, including James Marion Sims, the "Father of Modern Gynecology." These surgeries were performed without anesthesia and included procedures like cesarean sections and ovariotomies. *See* Cynthia Prather, Taleria R. Fuller, William L. Jeffries, IV, Khiya J. Marshall, A. Vyann Howell, Angela Belyue-Umole, & Winifred King, *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity*, 2.1 HEALTH EQUITY 249, 251–52 (2018). The medical knowledge that we have about female reproduction is built upon the trauma of Black women. The performance of experimental procedures without anesthesia on Black women is clearly not an example of *implicit bias* at work, but an example of explicit, intentional racism. However, this history gives us insight into a source of the misconceptions about Black women and pain and should demonstrate the importance of recognizing this bias and taking active steps to address it. *Id.*

117. *See* Saluja & Bryant, *supra* note 112, at 271.

118. *See id.*

119. *See id.*

120. *See* Jose Jain & Leslie Moroz, *Strategies to Reduce Disparities in Maternal Morbidity and Mortality: Patient and Provider Education*, 41 SEM. IN PERINATOLOGY 323, 324 (2017). When asked to select the best response to "I feel that disparities (racial/ethnic and socioeconomic) have a significant impact on my day-to-day practice," 83% of respondents agreed. *Id*. When asked to select the best response to "I feel that my personal biases affect how I care for my patients," only 29% of respondents agreed. *See id*. at 324–25.

121. *See* Saluja & Bryant, *supra* note 112, at 271.

women do give birth in hospitals, they report provider mistreatment 9% more than white women.[122]

3. Variation in Healthcare Quality

Where Black people who can become pregnant and give birth receive maternal care plays a role in the disparity of maternal outcomes.[123] Nearly 75% of Black people give birth at hospitals that are classified as high or medium Black-serving hospitals.[124] High Black-serving hospitals are those within the top 5% of hospitals providing the highest proportion of Black deliveries, while medium-serving are those in the top 5% to 25% of hospitals providing the highest proportion of Black deliveries.[125] This means that a large number of Black people are giving birth at a small number of hospitals, and that these hospitals are not serving high proportions of white patients.[126] In fact, under 18% of white deliveries occurred at these high and medium Black-serving hospitals.[127] The hospitals that white patients deliver at are not serving many Black patients.[128] Black-serving hospitals are more likely to be located in urban areas, located in the South, be teaching hospitals, have higher delivery volumes, have larger bed sizes, and have higher proportions of Medicaid deliveries."[129] These hospitals also have higher rates of severe maternal morbidity.[130] The study that came to this conclusion adjusted for patient and hospital characteristics and still determined that adverse outcomes were more likely at high and medium Black-serving hospitals.[131] White women who give birth at medium and high Black-serving hospitals also experienced higher rates of morbidity than white women at high white-serving hospitals.[132] This indicates that the quality of care at high and medium, Black-serving hospitals is lower than at hospitals that primarily serve white patients.[133] It is estimated that if Black mothers gave birth in the same hospitals as white mothers, the severe maternal morbidity rates would decrease by 47.7%.[134]

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122. *See id.* 21% of white women who gave birth in a hospital reported provider mistreatment, compared to 30% of Black and Hispanic women. *Id.*

123. *See* Bridges, *supra* note 85, at 1266.

124. *See* Elizabeth Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin, & Paul Hebert, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTET. GYNECOL. 122.e1, 122.e3 (2016).

125. *See id.*

126. *See id.*

127. *See id.* at 122.e4.

128. *See* Bridges, *supra* note 85, at 1265.

129. Howell, Egorova, Balbierz, Zeitlin, & Heber, *supra* note 124, at 122.e3.

130. *See id.*

131. *See id.* at 122.e5.

132. *See id.*

133. *See id.*

134. *See* Bridges, *supra* note 85, at 1266.

4. Social and Upstream Determinants of Health

The U.S. Department of Health and Human Services (HHS) defines social determinants of health as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[135] The action verbs within this definition, like "live, learn, work, play, and worship," imply a level of independence, agency, and choice in these social determinants of health. One tends to understand these actions as individual choices, instead of choices determined by structures, but the reality is not so simple.[136] The HHS social determinants are further categorized into five different domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[137] An article by Joia Crear-Perry, Rosaly Correa-de-Araujo, Tamara Lewis Johnson, Monica R. McLemore, and Elizabeth Neilson aptly points out that "[i]ndividuals are unlikely to be able to control directly many of the upstream determinants of health: governance, policy, and cultural or societal norms and values that shape who has access to health-promoting resources and opportunities and who does not."[138] For example, economic stability is less a function of individual choice and more a function of having access to a living wage that provides enough for necessities and enough left over to invest and build savings.[139] Educational access and quality depends on policymakers prioritizing and investing in education in a way that does not advantage landowners and disadvantage students.[140] The "upstream determinants of health" determine who has access to the best social determinants of health.[141] As a result, it is critical that the social determinants of health framework does not serve as a proxy for blaming Black women for making poor choices that lead to poor health and poor maternal outcomes.[142] Structural and upstream determinants have created and defined social determinants. The function of those structures in creating poor outcomes for people who can become pregnant and give birth, not the people themselves, needs to be recognized as the cause of negative health consequences.[143]

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135. *Social Determinants of Health*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://perma.cc/8KQB-RXBT (last visited Feb. 17, 2023).

136. *See* Bridges, *supra* note 85, at 1280.

137. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 135.

138. Joia Crear-Perry, Rosaly Correa-de-Araujo, Tamara Lewis Johnson, Monica R. McLemore, & Elizabeth Neilson, *Social and Structural Determinants of Health Inequities in Maternal Health*, 20 J. WOMEN'S HEALTH 230, 231 (2021).

139. *See e.g.*, Jeff Thompson & Jeff Chapman, *The Economic Impact of Local Living Wages*, ECON. POL'Y INST. (Feb. 15, 2006), https://perma.cc/EB48-2P98.

140. *See e.g.*, Alana Semuels, *Good School, Rich School; Bad School, Poor School*, ATLANTIC (Aug. 25, 2016), https://perma.cc/T76N-RS3N.

141. *See* Crear-Perry, Correa-de-Araujo, Johnson, McLemore, & Neilson, *supra* note 138, at 231.

142. *See* Bridges, *supra* note 85, at 1279.

143. *See* Crear-Perry, Correa-de-Araujo, Johnson, McLemore, & Neilson, *supra* note 138, at 231.

D. MISCHARACTERIZING MATERNAL RISKS CREATES BARRIERS TO SOLUTIONS

Identifying race as a risk factor for maternal morbidity and mortality is accepting defeat—it frames the crisis as one that is unfixable. The idea that because race is immutable there is nothing that can be done to avoid the heightened risk of adverse maternal outcomes that correlates with one's race is a straw man fallacy. The risk factor for maternal mortality and morbidity is not race—it is suffering the symptoms of racism.[144] Framing the risk factor as race ignores the need to address the actual risk factors that contribute to maternal mortality and morbidity and permits us to "throw up [our] hands" and say there is no "cure" for race as a risk factor, instead of working to *treat* the symptoms of racism.[145]

Framing race, instead of racism, as a risk factor for poor maternal outcomes also allows the connection between abortion restrictions and poor maternal outcomes to be overlooked. For example, abortion access has been shown to increase economic stability, particularly for Black women.[146] A Black woman's ability to postpone becoming a mother by a year is connected with a $1,784 increase in yearly earnings.[147] If a risk factor for Black maternal mortality is defined as "economic instability," then access to abortion would be a congruent solution to that problem—a treatment that alleviates this symptom of racism. However, if the risk factor is simply "race," abortion access is no longer so fitting a "treatment" or "cure." Abortion can affect a person's economic status but cannot affect a person's race. Therefore, when race is used as a catch-all for maternal risk, banning abortion is not patently at odds with working to solve the maternal mortality crisis. When the actual factors that put Black people at greater risk for adverse maternal outcomes are named as risk factors for maternal mortality and morbidity, banning abortion presents as incongruent with addressing the maternal mortality crisis.

III. CURRENT POLICY ADDRESSING THE AMERICAN MATERNAL MORTALITY CRISIS FAILS TO CONNECT ABORTION ACCESS TO MATERNAL OUTCOMES AND IS THEREFORE INSUFFICIENT TO RESPOND TO THE MATERNAL HEALTH CRISIS IN THE WAKE OF *DOBBS*

American policymakers have acted in recent years to respond to the maternal mortality crisis. However, these actions are insufficient to address the maternal mortality crisis in a post-*Dobbs* America. *Dobbs* has changed what it looks like to be pregnant and give birth in America. *Dobbs* increases the risk of maternal deaths resulting from the denial of a medically necessary abortion,[148] creates additional need for expanded healthcare coverage to address the consequences of

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144. *See* Bridges, *supra* note 85, at 1233–34.
145. *See id.* at 1257.
146. *See* Ali Abboud, *The Impact of Early Fertility Shocks on Women's Fertility and Labor Market Outcomes*, SSRN 1, 27 (Sept. 14, 2020), https://perma.cc/ZTX8-5PHK.
147. *See id.*
148. *See e.g.*, Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get An Abortion*, CNN HEALTH (Nov. 16, 2022), https://perma.cc/Y7RW-CMC8.

being denied an abortion,[149] and intensifies urgency in implementing state policies to respond to the maternal mortality crisis. *Dobbs* will exacerbate the maternal health crisis and policies that are blind to its effects will be insufficient to ensure that all people who can become pregnant and give birth are cared for.

A. THE EFFECTIVENESS OF THE PREVENTING MATERNAL DEATHS ACT OF 2018 IS LIMITED BECAUSE IT DISCUSSES NEITHER RACIAL DISPARITY NOR ABORTION

The Preventing Maternal Deaths Act of 2018 (PMDA) is one example of a policy that responds to the maternal mortality crisis, but is insufficient in the wake of *Dobbs*. The PMDA was enacted with bipartisan support in December 2018.[150] This law provides twelve million dollars per year for five years to create and fund state maternal mortality review commissions (hereinafter MMRCs).[151] These MMRCs identify maternal deaths, collect data, and work to identify "an underlying or contributing cause" of each maternal death.[152] The PMDA amends the "Safe Motherhood" section of the Public Health Service Act.[153] While the "Safe Motherhood" section provides that there *may* be actions to expand research on "the identification of the determinants of disparities in maternal care . . . including an examination of the higher rates of maternal mortality among African American women and other groups of women with disproportionately high rates of maternal mortality," there is no mandate for research or action on racial disparities in maternal death rates.[154] The PMDA does not include any discussion or mention of race.[155] In doing so, "it allows for the work that is conducted under its banner to ignore the race of the epidemic."[156] As a result, even where the PMDA does work to improve maternal outcomes, there is no mandate for improving *Black* maternal outcomes—therefore, policies could focus exclusively on the needs of white people who become pregnant and give birth and make progress in the national crisis overall, but do nothing to improve outcomes for Black people who can become pregnant and give birth.[157] The PMDA's bipartisan success is likely a result of the exclusion of any discussion or acknowledgement of race.[158] It is a tragic injustice that Black women provide significant and loyal political

149. *See e.g.*, Christine Vestal, *More States Extend Postpartum Medicaid Since Roe's Demise*, PEW STATELINE (Sept. 20, 2022), https://perma.cc/VLQ2-3SXN.
150. *See* 42 U.S.C. § 247b–12.
151. *See* Nina Martin, *"Landmark" Maternal Health Legislation Clears Major Hurdle*, PROPUBLICA (Dec. 12, 2018), https://perma.cc/H8JA-EDSK.
152. *See* 42 U.S.C. § 247b–12.
153. *See generally* 42 U.S.C. § 247b–12.
154. 42 U.S.C. § 247b–12(b)(2)(H).
155. *See* Bridges, *supra* note 85, at 1295.
156. *Id.*
157. *See id.* at 1295–96.
158. *See id.* at 1297.

support to Democrats,[159] but Democrats erased them from the PMDA in exchange for bipartisan support.

Neither the PMDA, nor the Safe Motherhood section that is nested within it, include any discussion or mention of abortion.[160] While these laws predate the *Dobbs* decision, they do not predate the connection between abortion restrictions and maternal mortality. The absence of any discussion of abortion, or mandate for research into how abortion restrictions and bans affect maternal death, means that people who can become pregnant and give birth may experience a hemorrhage or develop sepsis and die, and the MMRC may identify their deaths as caused by "hemorrhage," or "sepsis" when the *reason* they experienced hemorrhage or sepsis was because a state ban denied them a life-saving abortion.

Consider the story of Elizabeth. Elizabeth was excited to have a baby, but experienced a premature rupture of membranes when she was eighteen weeks pregnant.[161] Elizabeth's fetus had an "almost nonexistent" chance of surviving, and Elizabeth was at a heightened risk of severe infection and postpartum hemorrhage if her pregnancy was not terminated.[162] However, Elizabeth was at a Texas hospital, and even though this took place before *Dobbs*, because her fetus had a heartbeat, abortion was not available to her until her pregnancy became a "medical emergency"—a term left undefined in the Texas law.[163] Elizabeth was forced to wait—she passed blood clots, experienced cramping and discharge, she vomited—but none of this was enough to constitute a "medical emergency."[164] She was told to wait until the odor and color of the discharge got worse, upon which she would need to go to the emergency room.[165] When this happened, the infection in her uterus became severe enough for her to be induced and she gave birth to a stillborn daughter.[166] Some are not even as fortunate as Elizabeth. What about the people who are pregnant who are forced to wait too long and die as a result? Would their deaths be categorized by MMRCs as the result of not receiving an abortion? If this had happened to Elizabeth, would her death have been classified as caused by infection or caused by denial of abortion care? The answers to these questions are significant, and because the PMDA does not mandate an answer, the effects of abortion bans may either be erased altogether or be reflected differently in each state.

For example, a death of this kind in a state with an abortion ban in effect may neglect to view the lack of abortion access as a cause of maternal death, while a

159. Ninety-percent of Black women voted for Joe Biden in the 2020 Presidential Election. *Exit Polls 2020*, NBC, https://perma.cc/24VH-G8TD (last visited Feb. 16, 2023).

160. *See generally* 42 U.S.C. § 247b–12.

161. *See* Carrie Feibel, *Because of Texas' Abortion Law, Her Wanted Pregnancy Became a Medical Nightmare*, NPR (July 26, 2022, 5:04 AM), https://perma.cc/Y9ZW-FJWA.

162. *See id.*

163. *See id.*

164. *See id.*

165. *See id.*

166. *See id.*

"haven state" that could not provide care to a pregnant person soon enough might acknowledge that lack of abortion access played a role in the pregnant person's death. This incongruence could distort, minimize, or even erase data about the effect of *Dobbs* on maternal outcomes in states with abortion bans. If decreased abortion access is not included in the conversation about causes of adverse maternal outcomes, then expanded abortion access will certainly not be part of the conversation about solutions.

B. States Refusing to Adopt the Medicaid Coverage Extension for Postpartum Care Are Leaving People Who Give Birth Vulnerable to Adverse Outcomes

As part of the American Rescue Plan of 2021, states were permitted to extend Medicaid postpartum coverage from sixty days to twelve months.[167] Approximately 40% of births in the U.S. are funded by Medicaid, so the program and the access to care it creates are incredibly important when discussing the maternal health crisis.[168] However, when it comes to the Medicare extension, states were provided with the opportunity to *choose* whether to implement this extension or not.[169] Approximately one-third of pregnancy-related deaths occur one week to twelve months after delivery.[170] This means that the Medicaid extension would provide millions of people who give birth in America health insurance for the entirety of the time that they are at risk of pregnancy-related death. The *Dobbs* decision will result in more people carrying unwanted pregnancies to term.[171] Consequently, people who are denied abortions due to a post-*Dobbs* abortion ban will need healthcare in the months after giving birth. Extending Medicaid provides a tool for states to ensure that if and when people need healthcare to address pregnancy and birth-related conditions they have access to that care.[172]

As of December 8, 2022, only twenty-seven states and D.C. have implemented the postpartum Medicaid extension.[173] Seven additional states are planning to implement the extension, and Texas and Wisconsin have proposed a more limited extension.[174] Mississippi, Arkansas, Missouri, Oklahoma, South Dakota, and Idaho have all refused to extend Medicaid—all are states where abortion is illegal.[175] Alabama, another state where abortion is illegal, has a plan to implement

167. *See Medicaid Postpartum Coverage Extension Tracker*, KAISER FAM. FOUND., https://perma.cc/Y85H-J8XN (last visited Feb. 16, 2023).
168. *Id.*
169. *See id.*
170. *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREV., https://perma.cc/ZM7T-YZEA (last visited Feb. 20, 2023).
171. Vestal, *supra* note 149.
172. *See id.*
173. KAISER FAM. FOUND., *supra* note 167.
174. *Id.*
175. *Id.*

the extension, but has yet to do so.[176] The people who can become pregnant and give birth in these states are deprived of both abortion access and coverage for the care that they will need after giving birth. The Biden–Harris administration recognized that extending Medicaid postpartum coverage is "among the most impactful commitments" to address the maternal health crisis and has called for Congress to require states to provide this extended coverage.[177] Until all fifty states adopt the extension to Medicaid, or until Congress requires all states to implement this extension, people who have given birth will experience dangerous gaps in healthcare coverage. These gaps in coverage are entirely preventable, but only if states choose to prioritize the health of mothers.

C. STATES WITH ABORTION BANS HAVE ADOPTED THE FEWEST POLICIES TO ADDRESS MATERNAL MORTALITY

The Commonwealth Fund tracked the number of actions that each state has taken to improve maternal health outcomes and categorized these policies into three categories—coverage and benefits, care delivery transformation, and data and oversight.[178] States who responded to the *Dobbs* decision by making abortion illegal have, on average, taken fewer actions to respond to the maternal mortality crisis than the states where there is expanded access to abortion.[179] States where abortion is illegal have taken, on average, 12.25 actions to improve maternal health outcomes.[180] This drops to 11.6 when Texas is excluded, a state that has implemented nineteen of the twenty-five actions that the Commonwealth Fund

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176. *Id.*

177. *See White House Blueprint for Addressing the Maternal Health Crisis,* WHITE HOUSE 22 (June 2022), https://perma.cc/88A3-7VLS.

178. *State Policies to Improve Maternal Health Outcomes*, COMMONWEALTH FUND (Nov. 19, 2020), https://perma.cc/D5GR-CP3R. The policies that the Commonwealth Fund tracked are as follows:

> Coverage and Benefits: Added pregnancy-related education as a benefit, added benefits for high-risk subpopulations, offers presumptive eligibility for pregnancy-related services, mentions pregnancy related conditions in telemedicine benefits, waived the five-year waiting period, provides midwifery services as a covered benefit, provides doula services as a covered benefit, offers Medicaid coverage for Free Standing Birth Centers, offers home-visiting services as a covered benefit, has taken steps to expand postpartum coverage, has added telehealth coverage during COVID-19 public health response.
>
> Care Delivery Transformation: Implemented or funded a quality improvement program, implemented obstetric care workforce enhancement initiatives, increased access to treatment and support services for women at high risk of maternal mental health conditions, added mental health screening or treatment during pregnancy and postpartum, has implemented a provider bias training program, provides SUD services as a benefit during pregnancy and postpartum period, provides monetary incentives as a covered benefit, has implemented at least one of three maternity care models as a covered benefit.
>
> Data and Oversight: Adopted a recognition resolution for maternal health promotion, enhanced maternal health data collection, has funded institutions to expand maternal health research, as required health data to be stratified by race, established a maternal mortality review committee, established maternal or perinatal health advisory council.

Id.

179. *See id.*

180. *See id.*

identified.[181] States where access to abortion is expanded have taken, on average, 15.5 actions to improve maternal health outcomes.[182] This is significant because total-ban states have higher maternal mortality rates than expanded-access states.[183] In general, the states with the *most* need for action on the maternal health crisis have done the *least* to address the crisis, even though there are demonstrably effective policy options available that other states have successfully implemented.[184]

IV. A REPRODUCTIVE JUSTICE POLICY FRAMEWORK CAN BEST ADDRESS MATERNAL MORTALITY IN A POST-*DOBBS* AMERICA

Reproductive justice is the "human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[185] The reproductive justice movement emphasizes the importance of *access* to reproductive healthcare—that reproductive choice is meaningless without access.[186] To ensure all people have access to reproductive healthcare and bodily autonomy, the movement works to break down power dynamics that act as barriers, respond to people's intersectional needs, focus on marginalized voices, and build a broad and inclusive coalition.[187] A reproductive justice *policy* framework to address maternal mortality in a post-*Dobbs* America would respond to the crisis with those same values in mind. It would promote "a world in which your wealth, your social status, your access to power, and your zip code are irrelevant to your life expectancy or vulnerability to illness."[188]

This framework is broader than a reproductive *rights* one.[189] A rights-based policy framework would focus on protecting and expanding abortion rights and posing legal challenges to abortion bans.[190] Because a reproductive justice framework is broader than a rights framework, it is more suited to respond to the effects of *Dobbs*. There are policies that can improve maternal outcomes even while abortion rights remain gutted and a reproductive justice framework supports implementing those policies, because solutions come from multiple angles—economic, social, political, and others—and would center the most marginalized.[191]

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181. *See id.*

182. *See id.*

183. *See* CTRS. FOR DISEASE CONTROL & PREV., *supra* note 38.

184. *See* COMMONWEALTH FUND, *supra* note 178.

185. *Reproductive Justice*, SISTER SONG, https://perma.cc/T49Q-URU9 (last visited Feb. 26, 2023).

186. *See id.*

187. *See id.*

188. *See* Rebouché, *supra* note 11, at 1431 (quoting Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 766 (2020)).

189. *See generally Understanding Reproductive Health, Rights, and Justice: An NCJW Primer*, NAT'L COUNCIL OF JEWISH WOMEN, https://perma.cc/N3LG-6HDQ (last visited Feb 26, 2023).

190. *See generally id.*

191. *See* SISTER SONG, *supra* note 185.

If Black people who can become pregnant and give birth, the most severely impacted by poor maternal healthcare, are centered in the response to the maternal mortality and morbidity, everyone can be uplifted. Black and other marginalized people who can become pregnant and give birth could be left behind if the focus is only on restoring abortion rights in isolation from any consideration of race.

The impact of the *Dobbs* decision on maternal mortality and morbidity is best addressed through a reproductive justice policy framework because it is a reproductive justice issue. *Dobbs* directly and negatively impacts maternal outcomes and will increase racial disparities within these outcomes.[192] Black women, in particular, will be facing greater danger from pregnancy and childbirth.[193] This danger means that Black women are less able to choose if, when, and how[194] to have children. It means that Black women, when considering *if* they want to have children, must seriously consider the threat that pregnancy and birth may pose to their own life and health. When considering *when* they have children, they must consider the increased dangers of pregnancy and childbirth later in life—when age and weathering may have caused their health to deteriorate. When considering *how* to build their families, they must consider the effect that a pregnancy-related death could have on their families. *Dobbs* makes all this worse because, for many people who can become pregnant and give birth who live in total-ban or abortion-hostile states, these choices must be weighed along with additional concerns that a miscarriage could lead to prosecution,[195] that their health will not be prioritized over that of their fetus, and that their plans about their own reproduction could be upended by an unintended pregnancy.

A. ADOPTING PIECES OF A REPRODUCTIVE JUSTICE POLICY FRAMEWORK CAN HAVE A POSITIVE IMPACT ON ADDRESSING MATERNAL MORTALITY RATES, EVEN WHILE ABORTION BANS ARE IN EFFECT

Ideally, implementing a reproductive justice framework to address maternal mortality would begin by expanding access to abortion because the positive link between the availability of abortion and better maternal outcomes is meaningless unless abortion is accessible. This is unlikely to happen in all fifty states anytime soon, however. Expanding access to abortion in every state would first require

192. *See generally supra* Section I.

193. *See generally supra* Section II.

194. *See generally* IF/WHEN/HOW, https://perma.cc/6GUU-7DYY (last visited Feb. 26, 2023).

195. *See generally* Robert Baldwin III, *Losing a Pregnancy Could Land You in Jail in Post-Roe America*, NPR (July 3, 2022, 5:27 AM), https://perma.cc/54FT-JM8R. At least thirty-eight states have "fetal harm" laws that prohibit harm to fetuses. *Id*. These laws have been used to prosecute people for pregnancy loss, like miscarriage or stillbirth, by attributing the loss to the person's behavior while pregnant. *Id*. The majority of pregnancy loss prosecutions take place because the pregnant person used drugs while pregnant, however people have been prosecuted for losing pregnancies after falling down stairs or starting the fight that ended in the mother being shot. *Id*. These prosecutions have occurred even when scientific evidence does not support the conclusion that the pregnant person's behavior caused the pregnancy loss. *Id*. Legal experts expect pregnancy loss prosecutions to increase after *Dobbs*. *Id*.

intense structural change in states that are hostile to abortion or have made it illegal. This structural change would begin with changing societal attitudes about abortion, sex,[196] and race.[197] Even if that were broadly successful, those efforts would need to be followed by action to expand and protect voting rights, remedy disenfranchisement, and instill trust and respect for our voting and electoral systems.[198] Finally, expanding abortion access in every state would require broad shifts in our healthcare systems. It would be imperative that everyone have access to healthcare covering all facets of reproductive health, including abortion.[199] This requires abolishing the Hyde Amendment[200] and covering a broader range of care for people who can become pregnant and give birth before, during, and after birth or the termination of pregnancy. Just because all of this is unlikely to happen in abortion-hostile and total ban states in the near future does not mean that *nothing* can be done from a reproductive justice policy framework to improve maternal outcomes worsened by the *Dobbs* decision.

The perfect cannot be the enemy of the good, and there are several good policies that improve reproductive healthcare access beyond abortion. As a result, the recommendations here are twofold. First, states that are more favorable to abortion access should review the facts and data—particularly data showing that *expanded* access to abortion means that fewer maternal deaths will occur[201]—and structure a reproductive justice-focused response to the maternal mortality crisis that further expands abortion access and implements solutions that have proven successful elsewhere. Additionally, states that have restricted abortion access or made it illegal should act to implement reproductive justice policies. While it may not be persuasive to these states that the value of preventing hundreds of maternal deaths per year is far greater than their perceived value of preventing thousands of abortions, there are still reproductive justice policies that save lives without abortion access being expanded. Black people who can become pregnant and give birth living in states where abortion is restricted or illegal are the most marginalized, and a reproductive justice policy framework must center them.

The dichotomy between abortion-hostile and expanded-access states does not have to be so set in stone, either. Voters in Kansas and Michigan showed the country that they value access to abortion when they elected to protect abortion

196. *See generally* Aino Petterson & Robbie M. Sutton, *Sexist Ideology and Endorsement of Men's Control Over Women's Decisions in Reproductive Health*, 42 PSYCH. OF WOMEN Q. 1 (2017), https://perma.cc/2XDX-H358.

197. *See generally* Katy Backes Kozhimannil, Asha Hassan, & Rachel R. Hardeman, *Abortion Access as a Racial Justice Issue*, 387 NEW ENG. J. MED. 1537 (2022), https://perma.cc/X7JF-QEF5.

198. *See generally Voting Rights*, PLANNED PARENTHOOD ACTION FUND, https://perma.cc/G4SE-GM43 (last visited Feb. 26, 2023).

199. *See generally Facts Are Important: Abortion Is Healthcare*, AM. COLL. OF OBSTET. & GYNECOL., https://perma.cc/5SPN-LJ98 (last visited Feb. 26, 2023).

200. *See generally Hyde Amendment*, PLANNED PARENTHOOD ACTION FUND, https://perma.cc/F27Z-L8GQ (last visited Feb. 26, 2023).

201. *See* CTRS. FOR DISEASE CONTROL & PREV., *supra* note 38.

rights through 2022 ballot initiatives.[202] This provides hope that, while state political bodies may be working against abortion access, state voters have, and will, turn out to protect reproductive rights.

B. THERE ARE A BROAD RANGE OF POLICIES THAT PROMOTE REPRODUCTIVE JUSTICE AND ADDRESS THE BLACK MATERNAL HEALTH CRISIS THAT COULD BE ADOPTED EVEN WHERE ABORTION IS RESTRICTED OR ILLEGAL

This section outlines policies that can be enacted, or actions that can be taken, to address the maternal mortality crisis from a reproductive justice framework. First, the racial disparity in maternal mortality rates must be acknowledged and addressed. Second, Congress must implement a consistent standard for how MMRCs classify maternal deaths that occur because the decedent was pregnant and was denied an abortion. Third, policies that address maternal mortality must protect the privacy rights of people who can become pregnant or give birth. Finally, all states should extend Medicaid to cover twelve months of postpartum care and doula services. These policies would not in and of themselves solve the Black maternal health crisis but would be feasible and effective methods of reducing Black maternal deaths.

First, addressing the Black maternal mortality crisis begins by accurately acknowledging and addressing the racial disparity in maternal outcomes. This means recognizing the factors that put Black people who can become pregnant and give birth at higher risk for adverse outcomes and accurately acknowledging them as products of *racism*, not race itself. Inaction cannot be excused by mischaracterizing the problem.

Policy needs to embrace a discussion of the racial disparity in maternal health outcomes, instead of erasing the discussion to achieve political compromise. Systemic racism affects one's resources, resources affect the choices that one can make, and a lack of choices affects one's health outcomes.[203] "The disparities of any condition, let alone maternal health, cannot be discussed without also discussing the system-level factors that may contribute to them."[204] It is thus impossible to address systemic factors and the availability of resources without discussing how these disproportionately affect race.

To accomplish this goal, states should implement implicit bias training for maternal healthcare providers. For example, California implemented the California Dignity in Pregnancy and Childbirth Act in 2020 which, among other things, requires perinatal care providers to complete both implicit bias programming and refresher courses every two years.[205] The topics covered include "identifying unconscious biases and misinformation, power dynamics, impacts of

202. *See* Gabriella Borter, *Abortion Rights Wins in Michigan, Kentucky Give Fuel for Future Ballot Measures*, REUTERS (Nov. 9, 2022), https://perma.cc/7VHF-VBAD.

203. *See* discussion *supra* Section II.D.

204. Saluja & Bryant, *supra* note 112, at 272.

205. *See* Stephanie Teleki, *Challenging Providers To Look Within Themselves: A New Tool To Reduce Bias In Maternity Care*, HEALTH AFFAIRS (July 6, 2021), https://perma.cc/8SAR-WTTA.

historical oppression of minority communities, and local perspectives on provider-community relations."[206] Other states have followed California's lead and introduced bills to require implicit bias training.[207]

Second, Congress must implement a consistent standard for how MMRCs classify maternal deaths that occur because the person who was pregnant was denied an abortion. The PMDA provided significant resources for states to collect data about maternal deaths and directed state MMRCs to identify underlying and contributing causes related to these deaths when possible.[208] However, the PMDA never mentions abortion, and provides no mandate that MMRCs record when the lack of access to an abortion was a contributing cause of a maternal death.[209] Post-*Dobbs*, a lack of abortion access could increasingly become a contributing cause to maternal deaths, especially since the *Dobbs* decision is expected to dramatically increase the rate of maternal deaths. Even where there are exceptions to abortion bans for medical emergencies, stories like Elizabeth's demonstrate that doctors are unsure what qualifies as an "emergency," creating a chilling-effect on care.[210] Not every pregnant person will survive to share their story like Elizabeth. When a person who was pregnant or gave birth dies because they were denied a potentially life-saving abortion, it is critical that this injustice not be erased during MMRC data collection. Information and data on the extent of the harm that abortion restrictions and bans cause to maternal outcomes must be collected in a consistent manner across the states. Congress should thus implement a consistent standard for how state MMRCs classify maternal deaths that occur because a person was denied what could have been a life-saving abortion.

Though it is imperative that accurate information be collected, there must be policies in place that protect the privacy rights of people who can become pregnant or give birth. In a post-*Dobbs* world, it is critical that privacy be protected because pregnancy information can be criminalized.[211] Therefore, when policymakers create and implement policies to address the maternal mortality crisis and collect information on the success of those policies once they are implemented, they need to ensure there are effective mechanisms to protect the privacy and confidentiality of people who are pregnant. While the PMDA has provisions outlining confidentiality protections,[212] these protections are meaningless if pregnant people and their families do not trust that their confidentiality is indeed being

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206. *Id.*

207. *See, e.g.*, MD. CODE ANN., HEALTH – GEN. § 20–1305 (LexisNexis 2022) (implementing an implicit bias training program with recurring training for perinatal care providers).

208. *See* 42 U.S.C. § 247b–12.

209. *See id.*

210. *See* Feibel, *supra* note 161.

211. *See, e.g.*, Annie Blackman, *Criminalizing Pregnancy Loss*, REGUL. REV. (Feb. 8, 2022, 5:03 AM), https://perma.cc/NZ8Y-XGXA. People who have lost pregnancies have been arrested for not reporting stillbirths or miscarriages that occur at home to authorities. *Id*. Further, if a person engages in certain activities, like fights or drug use, they may be prosecuted for fetal endangerment if authorities discover the person is pregnant. *Id*.

212. 42 U.S.C. § 247b–12(d)(2), (4).

protected. On the other hand, accurate data cannot be gathered about the maternal health crisis if pregnant people and their families cannot share complete information about health conditions due to fear of criminalization.

The Substance Abuse and Mental Health Services Administration recommends that people who are pregnant be screened for substance use disorders in a number of settings.[213] While it is critical that people who are pregnant and suffering from substance use disorders receive care for their condition, without guarantees of confidentiality a pregnant person can trust, these screenings could put people who are pregnant at risk in states with fetal personhood statutes.[214] Legislatures in Alabama, Arizona, Georgia, Kansas, and Missouri have passed fetal personhood laws, though not all are in effect due to court orders.[215] In Alabama, for example, the Chemical Endangerment of a Child Law has been used to prosecute people who exposed their fetuses to drugs during pregnancy.[216] Meanwhile, substance overdose and toxicity were identified by the Alabama MMRC as one of the top three causes of maternal death in the state.[217] While the MMRC recommended that criminalization against pregnant women with substance use disorders be reduced, there is no promise that state law enforcement officials will accept that recommendation.[218] This example shows the incongruity between fetal personhood laws and preventing maternal deaths. Pregnant people with substance abuse disorders are less likely to get the help they need to treat their condition if doing so could subject them to criminal consequences.[219] This is likely particularly true for Black women who already suffer the greatest harm from the myths about the "crack baby."[220]

Fetal personhood laws are inconsistent with preventing maternal deaths, but they will likely become more common as states respond to the *Dobbs* decision.[221]

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213. *See* Taylor Platt & Carrie Hanlon, *State Maternal Mortality Review Committees Address Substance Use Disorder and Mental Health to Improve Maternal Health*, NAT'L ACAD. FOR STATE HEALTH POL'Y 5 (Aug. 9, 2021), https://perma.cc/4PR2-MLXW.

214. *See* Marisa Iati, *Pregnant Women Were Jailed Over Drug Use to Protect Fetuses*, WASH. POST (Sept. 8, 2022, 6:21 PM), https://perma.cc/CCV7-ACZA (describing that a woman in Alabama was arrested at the hospital because she tested positive for drugs during her pregnancy and the state considers drug use while pregnant "chemical endangerment of a child"); *see generally* Julia Winett, *The Persistent Criminalization of Pregnant People Who Use Drugs*, NETWORK FOR PUB. HEALTH L. (Sept. 16, 2022, 2:22 PM), https://perma.cc/C52G-EVFC (explaining different requirements for healthcare providers to report drug use, or suspected drug use, by a pregnant person).

215. *See* Kate Zernike, *Is a Fetus a Person? An Anti-Abortion Strategy Says Yes*, N.Y. TIMES (Aug. 21, 2022, 9:32 PM), https://perma.cc/2WS9-TW3M.

216. *See* Iati, *supra* note 214; ALA. CODE § 26-15-3.2 (West, Westlaw through 2022 Regular and First Special Sess.).

217. *See* ALA. DEP'T OF PUB. HEALTH, ALA. MATERNAL MORTALITY REV. 18 (Feb. 2022), https://perma.cc/87U5-GVDK.

218. *See id.* at 24.

219. *See* Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST. 1, 3 (2015).

220. *See* Sandhya Dirks, *Criminalization of Pregnancy Has Already Been Happening to the Poor and Women of Color*, NPR (Aug. 3, 2022), https://perma.cc/2NGT-T2S6.

221. *See, e.g.* Zernike, *supra* note 215.

Reproductive justice cannot be achieved if pregnant people and their families cannot trust that their health information will remain confidential. Therefore, privacy and confidentiality must be key parts of the conversation when implementing programs to respond to the maternal health crisis and collecting data about its effects.

Another policy to promote reproductive justice and address the Black maternal health crisis would be all states extending Medicaid to cover twelve months of postpartum care. The American Rescue Plan of 2021 provided the option for states to extend Medicaid programs to cover twelve months of postpartum care.[222] Eleven states still have neither implemented nor created a plan to adopt this extension and two states have only proposed limited coverage extensions.[223] Because Medicaid covers more than four in ten births in America and maternal deaths continue to occur up to one year postpartum, implementing this extension in all states would provide millions of mothers with critical healthcare coverage for life-threatening pregnancy-related conditions that occur months after giving birth.[224] This is one of the simplest, yet most impactful, solutions to promote reproductive justice because it significantly expands access to critical, potentially lifesaving reproductive care.

This is not the only change to Medicaid that could address the maternal health crisis. Maternal outcomes would improve if doula services were covered by health insurance programs, including Medicaid.[225] A doula is "a trained professional who provides continuous physical, emotional, and informational support to clients before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying birthing experience."[226] Doulas improve maternal and infant outcomes, particularly for marginalized women.[227] Those who give birth with the support of a doula are less likely to have cesarean sections and develop symptoms of depression after giving birth, and their babies are less likely to have low birth weights than non-doula assisted people.[228] There are no documented *negative* outcomes of doula utilization.[229] Doulas work with people who give birth and their families to identify specific wishes, concerns, and needs.[230] This allows them to both empower people who give birth and advocate for them.[231] This relationship can be a powerful tool for Black women who frequently report

222. *See* KAISER FAM. FOUND., *supra* note 167.

223. *Id.*

224. *Id.*

225. *See* Kenneth Gruber, Susan Cupito, & Christina Dobson, *Impact of Doulas on Healthy Birth Outcomes*, 22(1) J. PERINATAL EDUC. 49, 57 (2013).

226. *What is a doula?*, DONA INT'L, https://perma.cc/C4XU-BB2F (last visited Feb. 26, 2023).

227. *See* Gruber, Cupito, & Dobson, *supra* note 225, at 57.

228. *See id.* at 53; Kristen Gourlay, *Data show community-based doulas improve outcomes for Black mother*s, BLUECROSS BLUESHIELD (Apr. 11, 2022), https://perma.cc/WEM8-HYM6.

229. *See Benefits of a Doula*, DONA INT'L, https://perma.cc/6VCT-7BCX (last visited Feb. 26, 2023).

230. See Gruber, Cupito, & Dobson, *supra* note 225, at 49–50.

231. *See id.* at 52.

mistreatment within healthcare settings.[232] Eleven states have passed laws to include doula services in Medicare coverage, and others are working toward this goal.[233] However, seventeen states have neither proposed nor passed legislation to cover doula services under Medicaid.[234] The *Dobbs* decision heightens the need for people who can become pregnant and give birth to have advocates to provide support and accurate information. Doulas can provide this advocacy and support and tangibly improve maternal outcomes, but only if their care is accessible. Medicaid coverage of doula services makes these valuable services accessible to millions of people who can become pregnant and give birth.

CONCLUSION

As states continue to implement abortion restrictions and bans in response to the *Dobbs* decision, the maternal health crisis will worsen, particularly for Black people who can become pregnant and give birth. To realize the goals of reproductive justice—that everyone have access to the opportunity to determine if, when, and how to build their lives and families—it is imperative that policymakers act now to mitigate the effects *Dobbs* will have on maternal outcomes.

232. *See* Gourlay, *supra* note 228.
233. *See Improving Our Maternity Care Now Through Doula Support*, NAT'L P'SHIP FOR WOMEN & FAMS. 23, https://perma.cc/UHV8-2XTV (last visited Feb. 26, 2023).
234. *See id.*