

Putting Your Money Where Your Mouth Is: Maternal Health Policy After *Dobbs*

Elizabeth Tobin-Tyler*

“What is ‘pro-life’ about putting a woman in a situation where she must risk pregnancy without proper medical, social and emotional support? What is ‘pro-life’ about forcing the birth of a child, if that child will enter a world of rejection, deprivation and insecurity, to say nothing of the fear, anxiety and danger that comes with poverty, crime and a lack of educational and employment opportunities?”

—Reverend Rob Schenk¹

INTRODUCTION

Evangelical minister Rob Schenk made headlines when he renounced his previous leadership of “operation rescue,” an anti-abortion group that often blocked the doors of abortion clinics. In a 2019 *New York Times* op-ed, he declared that he had come to see that his opposition to abortion, rather than being “pro-life,” was instead “destructive of life.”² He wrote that he came to this conclusion when he had “witnessed firsthand and now appreciate[d] the full significance of the terrible poverty, social marginalization and baldfaced racism that persists in many of the states whose legislators are now essentially banning abortion.”³ One can criticize Schenk’s late acknowledgement of the harms for women and children of unplanned pregnancy and forced birth. But Schenk’s renunciation of the pro-life movement’s focus on criminalizing abortion while largely ignoring the conditions in which women get pregnant, give birth, and parent, exposes antiabortion politicians’ and the Supreme Court’s magical

*Elizabeth Tobin-Tyler, JD, MA is Associate Professor of Health Services, Policy and Practice, Brown University School of Public Health.

¹ Rob Schenk, *I Was an Anti-Abortion Crusader. Now I Support Roe v. Wade*, N.Y. TIMES (May 30, 2019), <https://www.nytimes.com/2019/05/30/opinion/abortion-schenck.html>.

² *Id.*

³ *Id.*

thinking when it comes to maternal and child health and well-being in the United States.

In *Dobbs v. Jackson Women's Health*, the majority displayed a jaw-dropping disregard for the realities of women's lives, especially those living in poverty.⁴ Washing its hands of the "abortion controversy," the Court not only ignored the embarrassing state of maternal health in the United States as compared with other wealthy countries, but it did not even tip its hat to the despicable rates of Black maternal morbidity and mortality that have only recently been recognized in the media and by some politicians. In delegating to state legislatures whether to ban abortion, the Court also entrusted to states that have some of the worst rates of maternal morbidity and mortality to somehow now protect and promote maternal and child health as birth rates rise.⁵

This Article considers the effects of the legal and policy landscape, pre- and post-*Dobbs*, on existing and future maternal health. Citing public health and clinical research, Part I briefly describes the state of maternal and child health in the United States. Part II traces the misinformation perpetuated by pro-life activists and adopted by the Supreme Court about the negative effects of abortion on women's health. It then highlights the *Dobbs* majority's erasure of women's health from its consideration of the constitutional right to abortion. Part III describes the failure of existing federal and state laws and policies to protect and promote maternal health, ties this failure to existing maternal health outcomes and disparities, and documents how states that have enacted abortion bans post-*Dobbs* have the least generous and most punitive policies for mothers. Part IV critiques policy proposals by antiabortion politicians that they purport will improve maternal and child health and well-being, but in reality, will

⁴ See Elizabeth Tobin-Tyler, *Women's Lives and Health: Mere Abstractions in the Leaked Dobbs Abortion Opinion*, HEALTH AFFS. FOREFRONT (May 19, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220516.882360>.

⁵ Emily Badger et al., *States with Abortion Bans Are Among Least Supportive for Mothers and Children*, N.Y. TIMES: THE UPSHOT (July 28, 2022), <https://www.nytimes.com/2022/07/28/upshot/abortion-bans-states-social-services.html>. The article documents how rates of child poverty, the number of uninsured women and children, low birthweight babies, teen births, infant mortality and maternal mortality are all higher in states that have banned abortion compared to those that have not. See also, Asha Banerjee, *The Economics of Abortion*, ECON. POL'Y INST. (Jan. 18, 2023), <https://www.epi.org/publication/economics-of-abortion-bans> (finding that states that have enacted abortions bans and restrictions have significantly lower minimum wage rates than states in which abortion is legal. These states also have lower unionization rates, fewer unemployed people receiving unemployment insurance, and incarceration rates that are 1.5 times that of states with legal abortion).

do little to improve the conditions for pregnancy, birth, and parenting. Finally, Part V proposes a post-*Dobbs* policy agenda based on the principles of reproductive justice to promote maternal health.

I. MATERNAL AND CHILD HEALTH BEFORE *DOBBS*: HOW WERE WE DOING?

United States maternal health outcomes can only be described as atrocious. The United States has the highest maternal mortality rate among the thirty-six developed countries tracked by the Organization for the Economic Cooperation and Development (OECD). There are twenty-four deaths per 100,000 births in the United States—nearly double that of New Zealand (thirteen deaths per 100,000 births) which has the second-highest rate, and almost twenty-four times that of the Netherlands (one death per 100,000), which has the lowest rate.⁶ Most egregious is that Black women in the United States die at three times the rate of white women (fifty-five versus nineteen per 100,000 births, respectively). Even more stunning is that the maternal mortality rate continues to rise,⁷ even though two-thirds of maternal deaths are preventable.⁸ But maternal mortality is only one piece of the maternal health puzzle. Severe maternal morbidity⁹ in the United States is strongly correlated with race, income, and access to care.¹⁰ Maternal

⁶ Munira Z. Gunja et al., *The US Maternal Mortality Crisis Continues to Worsen: An International Comparison*, COMMONWEALTH FUND (Dec. 1, 2022), <https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison>.

⁷ *Id.*

⁸ Linda Brubaker & Kirsten Bibbins-Domingo, *Health Care Access and Reproductive Rights*, 328 JAMA 1707, 1707 (Nov. 1, 2022).

⁹ The World Health Organization defines maternal morbidity as “any health condition attributed to or complicating a pregnancy and childbirth that has a negative impact on well-being or functioning.” *Maternal Morbidity and Well-Being*, WORLD HEALTH ORG., <https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/maternal-health/maternal-morbidity-and-well-being> (last visited Apr. 29, 2023). The Centers for Disease Control and Prevention defines severe maternal morbidity as “unexpected outcomes of labor or delivery resulting in significant short- or long-term consequences for health.” *Severe Maternal Morbidity in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html> (last visited Apr. 29, 2023).

¹⁰ Clare C. Brown et al., *Associations Between Comorbidities and Severe Maternal Morbidity*, 136 OBSTETRICS & GYNECOLOGY 892, 899 (2020).

mortality, too, has been on the rise,¹¹ with Black, Native,¹² and disabled women¹³ experiencing higher rates of preterm and low birthweight births, delayed or no prenatal care, and a range of pregnancy-related health issues.

United States child health outcomes, too, are abysmal when compared to other wealthy nations.¹⁴ Since the 1980s, child mortality has been higher in the United States than virtually all other wealthy nations, despite higher health care spending.¹⁵ A study in *Health Affairs* found that from 2001 to 2010, the risk of death for infants in the United States was 76 percent higher than in peer nations, while the risk of death for children ages one to nineteen was 57 percent higher.¹⁶ Mississippi—the state that brought *Dobbs v. Jackson Women’s Health Organization* to the Supreme Court—has the highest infant mortality rate of any state in the United States at 8.6 deaths per 1,000 births.¹⁷ Economists who study infant mortality in the United States attribute its high rate to family poverty and socioeconomic disadvantage.¹⁸ Infant mortality is highest among Black and Native children.¹⁹ In addition to socioeconomic status, barriers in access to health care, racism, and structural drivers—such as unsafe housing and neighborhood and

¹¹ *Severe Maternal Morbidity in the United States*, *supra* note 9.

¹² Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KAISER FAM. FOUND. (Nov. 1, 2022), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them>.

¹³ Willi Horner-Johnson et al., *Perinatal Health Risks and Outcomes Among US Women with Self-Reported Disability, 2011–19*, 41 HEALTH AFFS. 1477, 1477 (2022).

¹⁴ Ashish P. Thakrar et al., *Child Mortality in the US and 19 OECD Comparator Nations: A 50-Year Time-Trend Analysis*, 37 HEALTH AFFS. 140, 143 (2018).

¹⁵ Among all thirty-six OECD countries, the United States ranks thirty-third for infant mortality, with a rate of 5.8 deaths per 1,000 births, just above Chile, Turkey, and Mexico. *Id.*

¹⁶ *Id.* at 146.

¹⁷ AM.’S HEALTH RANKINGS: UNITED HEALTH FOUND., 2019 ANNUAL REPORT 40 (2019), <https://www.americashealthrankings.org/learn/reports/2019-annual-report/international-comparison>.

¹⁸ Alice Chen et al., *Why Is Infant Mortality Higher in the United States than in Europe?*, 8 AM. ECON. J.: ECON. POL’Y 89, 89 (2016).

¹⁹ *Infant Mortality*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#mortality> (last visited Apr. 18, 2023).

environmental conditions—are all thought to play a role in disparate child health outcomes.²⁰

A. *The Role of Allostatic Load in Maternal Health*

Scientists are increasingly pointing to the role of stress in high rates of chronic disease and mental health problems in the United States. The prolonged elevation of stress hormones, known as “allostatic load,” induces inflammation, weakens the immune system, and advances cardiovascular disease, and contributes to mental health problems, such as depression and anxiety.²¹ Overall, women report substantially higher rates of stress than men.²² Women’s heavier burden of caregiving no doubt plays a role in their increased levels of stress. Pregnant and parenting women, especially those who are socially disadvantaged, are particularly prone to the effects of allostatic load. One-in-five women experience a mental health disorder during pregnancy or during the first year after birth.²³ Rates of maternal

²⁰ Hill, *supra* note 12. See also N. Tanya Nagahawatte & Robert L. Goldenberg, *Poverty, Maternal Health, and Adverse Pregnancy Outcomes*, 1136 ANNALS N.Y. ACAD. SCIS. 80, 80–84 (2008). Beyond infant mortality, low-income, Black, and children on Medicaid have higher rates of preventable diseases such as childhood lead poisoning and asthma related to social environment. See Am. Acad. of Pediatrics Pol’y, *Lead Exposure in Children: Prevention, Detection, and Management*, 116 PEDIATRICS 1036, 1036–46 (2005); Emily Rosenbaum, *Racial/Ethnic Differences in Asthma Prevalence: The Role of Housing and Neighborhood Environments*, 49 J. HEALTH & SOC. BEHAV. 131, 141 (2008). Child health disparities are also linked to toxic stress and adverse childhood experiences (ACEs). See Jack P. Shonkoff & Andrew S. Garner, *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 AM. ACAD. PEDIATRICS e232, e236, e237 (2012). Children exposed to poverty, deprivation, and violence have worse health outcomes during both childhood and adulthood. Black and Latinx children are more likely to experience poverty-related ACEs. See Vanessa Sacks & David Murphey, *The Prevalence of Adverse Childhood Experiences, Nationally, by State, and by Race/Ethnicity*, CHILD TRENDS (Feb. 12, 2018), <https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity>. America’s high rates of gun violence also lead to high rates of injury for children. Gun violence is now the leading cause of death for children, surpassing car accidents, in 2020. Dan Keating, *Guns Killed More Young People Than Cars Did for the First Time in 2020*, WASH. POST (May 25, 2022, 4:20 PM), <https://www.washingtonpost.com/health/2022/05/25/guns-kill-more-kids-than-cars>.

²¹ See generally Bruce S. McEwen, *Neurobiological and Systemic Effects of Chronic Stress*, 1 CHRONIC STRESS 1, 2 (2017) (describing how stress can cause an imbalance in neural circuitry that, in turn, affects systemic physiology).

²² *Stress in America: The State of Our Nation*, AM. PSYCH. ASS’N 2 (2017), <https://www.apa.org/news/press/releases/stress/2017/state-nation.pdf>.

²³ *The Maternal Mental Health Crisis Undermines Moms’ and Babies’ Health*, NAT’L P’SHP FOR WOMEN & FAMS. (2021), <https://www.nationalpartnership.org/our-work>

mental health problems have increased during the COVID-19 pandemic, with one-in-three perinatal women reporting depression.²⁴ Not surprisingly, low-income single mothers have a higher risk of stress-induced depression and preterm birth,²⁵ and postpartum depression is two-to-four times more likely for low-income mothers than middle and upper income mothers.²⁶ Low-income women and women of color are also at heightened risk for maternal mental health problems due to poor access to health care, experiences of discrimination in health care, and lack of access to child care and other supports.²⁷

Overall, when compared with other wealthy countries, the United States stands out for its socially driven poor health outcomes. U.S. adults are more likely to have a mental health diagnosis than people in other wealthy countries and are more likely than adults in those countries to report emotional distress related to community safety and the ability to afford food and housing.²⁸ Prenatal and postpartum stress is also associated with neuropsychiatric disorders in offspring, and growing up in poverty is highly correlated with childhood mental health disorders.²⁹ Indeed, maternal mental health is a canary in a coal

/health/moms-and-babies/the-maternal-mental-health-crisis-undermines-moms-and-babies-health.html.

²⁴ Lauren C. Shuffrey et al., *Improving Perinatal Maternal Mental Health Starts with Addressing Structural Inequities*, 79 JAMA PSYCH. 387, 387 (2022).

²⁵ N.T. Nagahawatte & R.L. Goldenberg, *Poverty, Maternal Health, and Adverse Pregnancy Outcomes*, 1136 ANNALS N.Y. ACAD. SCIS. 80, 82 (2008).

²⁶ Elinor Hansotte et al., *Positive Postpartum Depression Screening Practices and Subsequent Mental Health Treatment for Low-Income Women in Western Countries: A Systematic Literature Review*, 38 PUB. HEALTH 3 (2017).

²⁷ *Maternal Mental Health Factsheet*, MATERNAL MENTAL HEALTH LEADERSHIP ALL. (July 2020), <https://www.mmhla.org/wp-content/uploads/2020/07/MMHLA-Main-Fact-Sheet.pdf>.

²⁸ Roosa Tikkanen et al., *Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries*, COMMONWEALTH FUND (May 21, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries>.

²⁹ Shuffrey et al., *supra* note 24. Children's mental health in the United States is at a crisis point. When Surgeon General Vivek Murthy issued his report calling the mental health of children, adolescents, and young adults an "urgent public health issue" that is "widespread," he noted that this was true long before the COVID-19 pandemic. U.S. SURGEON GENERAL'S ADVISORY: PROTECTING YOUTH MENTAL HEALTH (2021), <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf>. Studies show that children's mental health is closely linked to social factors such as poverty, food insecurity, racial discrimination, and neighborhood safety, and to relational factors such as parental mental health, substance use, and a

mine, for “mental health is an important indicator of a society’s overall well-being.”³⁰ Long before *Dobbs* was decided in 2022, the United States had embarrassing maternal and child health outcomes. Now in the aftermath of *Dobbs*, it is even more urgent that policymakers be held accountable for these outcomes, particularly since most states with the most egregious maternal and infant mortality rates are the very same states that have enacted abortion bans.³¹

II. THE ABORTION DEBATE AND MATERNAL HEALTH POLICY

The fifty-year fight over abortion rights since *Roe v. Wade* was decided in 1973 has served to obscure other crucial discussions about reproductive and maternal health in the United States. In addition to arguing that prohibiting abortion was “pro-child,” many antiabortion activists, policymakers, and judges continue to claim that abortion is bad for women’s health.³² At the same time, few have pursued policies to protect and promote maternal health or the health of infants and children, despite the shocking statistics reported above. As reproductive justice scholar Reva Siegel described, the antiabortion movement shifted in the 1990s after the *Casey* decision from the sole narrative of fetal rights to claiming that abortion is harmful to women’s health as a way to convince lawmakers and the public that its goals were also “pro-woman.”³³ Some courts have embraced this narrative:

[A]bortion jurisprudence and antiabortion advocacy in fact evolved together in response to an emergent understanding of women as equal rights-holders in the American constitutional order . . . [I]n the years after *Casey*, a movement calling itself “pro-life” increasingly came to call

caregiver’s ability to cope. Christina D. Bethell et al., *Social and Relational Health Risks and Common Mental Health Problems Among US Children The Mitigating Role of Family Resilience and Connection to Promote Positive Socioemotional and School-Related Outcomes*, 31 CHILD & ADOLESCENT PSYCH. CLINICS N. AM. 45 (2022).

³⁰ Tikkanen et al., *supra* note 28.

³¹ States receiving an “F” on the March of Dimes annual report card rating maternal and child health outcomes all have imposed abortion bans. *2021 March of Dimes Report Card*, MARCH OF DIMES, <https://www.marchofdimes.org/2021-march-dimes-report-card> (last visited Apr. 18, 2023).

³² Reva B. Siegel, *Why Restrict Abortion? Expanding the Frame on June Medical*, 7 SUP. CT. REV. 277, 281–282 (2020).

³³ *Id.* at 292.

itself “pro-woman” and to advocate women’s-health-justified restrictions on abortion.³⁴

The health and well-being of women was reduced to saving them from the evils of abortion. Meanwhile, poor or no access to perinatal health and mental health care, worsening economic and housing insecurity for families, inadequate or inaccessible family and medical leave, poor-quality and high-cost child care, and high rates of intimate partner violence during and after pregnancy, were all relegated to the zone of the personal problems that families, and particularly women, should navigate on their own, no matter how difficult and harmful to maternal and child health.

In the 1990s, antiabortion activists began arguing that abortion damages women’s mental and emotional health; antiabortion activists named this phenomenon “post-abortion syndrome.”³⁵ This claim was widely refuted, including in a report by the Institute of Medicine in 1995.³⁶ The medical community continues to dismiss the “syndrome” as without any evidentiary basis.³⁷ Indeed, a recent study found that women who are denied abortions are more likely to experience

³⁴ Siegel traces how antiabortion leaders used market research to determine that they needed to shift their narrative to pro-woman to address the perception that the pro-life movement was not “compassionate to women.” Jack Wilke, a longtime antiabortion activist, created the slogan “[l]ove them both” in order to persuade policymakers, judges, and the public that the movement was supportive of women’s health and well-being. *Id.* at 299.

³⁵ E.M. Dadlez & William L. Andrews, *Post-Abortion Syndrome: Creating an Affliction*, 24 *BIOETHICS* 445, 450 (2009); for studies suggesting mental health and other negative behaviors associated with abortion, see, e.g., Priscilla K. Coleman et al., *Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey*, 43 *J. PSYCH. RES.* 770 (2009). The same authors also published an article in the *Internet Journal of Pediatrics and Neonatology* claiming that women who have had abortions are more likely to abuse their children. Priscilla K. Coleman et al., *Induced Abortion and Child-directed Aggression Among Mothers of Maltreated Children*, 6 *INTERNET J. PED. & NEONATOLOGY* 13 (2007), <http://ispub.com/IJPN/6/2/9364>.

³⁶ *INST. OF MED., THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES* 51 (Sarah S. Brown & Leon Eisenberg eds., 1995). The report notes that “[m]ost of the 250 studies dealing with the psychological effects of induced abortion suffer from substantial methodological shortcomings and limitations.” *Id.* The American Psychiatric Association also says that there is no evidence of abortion causing a mental health condition. See *Position Statement of Abortion*, AM. PSYCH. ASSOC. (Jul. 2018), <https://www.psychiatry.org/getattachment/74c76710-2c6f-4edd-bc7e-cb04c4966b7a/Position-2018-Abortion.pdf>.

³⁷ Zawn Villines, *Post Abortion Syndrome: Is It Real?* *MED. NEWS TODAY* (June 27, 2022), <https://www.medicalnewstoday.com/articles/post-abortion-syndrome>.

psychological and emotional distress.³⁸ Despite this utter lack of evidence for the mental and emotional harms that abortion causes, the Supreme Court cited these alleged harms when upholding abortion restrictions. Famously, in *Gonzales v. Carhart*, Justice Kennedy acknowledged the lack of evidence for the “post abortion syndrome,” but employed it nonetheless:

Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow.³⁹

The Court’s acceptance, without evidence, that abortion is harmful to women’s mental and emotional health encouraged state lawmakers to assert “protecting women’s health” arguments when enacting abortion restrictions, especially Targeted Restrictions on Abortion Providers (TRAP) laws that “impose on abortion providers burdensome health and safety regulations not imposed on other medical practices of similar or even greater risk.”⁴⁰

The antiabortion trope of “protecting women’s health” became so engrained in conservative rhetoric about the harms of abortion that by the time *Dobbs* made it to the Supreme Court in 2022, Justice Alito did not even feel compelled to address women’s health at all. Indeed, he dismissed any concerns about women’s health, economic security or safety in the debate about abortion rights as irrelevant or insignificant.⁴¹ Nor did he concern himself with child health and well-

³⁸ DIANA GREENE FOSTER, *THE TURNAWAY STUDY: THE COST OF DENYING WOMEN ACCESS TO ABORTION* (2021).

³⁹ *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007). In her dissent, Justice Ruth Bader Ginsburg called out the Court’s assertion for what it was:

The Court invokes an antiabortion shibboleth for which it concededly has no reliable evidence: Women who have abortions come to regret their choice . . . Though today’s majority may regard women’s feelings on the matter as “self-evident,” this court has repeatedly confirmed that “[t]hat a woman’s destiny ‘must be shaped . . . on her own conception of her spiritual imperatives and her place in society.’”

Id. at 183–85 (Ginsburg, J., dissenting) (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992)).

⁴⁰ See Siegel, *supra* note 34, at 306.

⁴¹ *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2258 (2022). Alito says:

Americans who believe that abortion should be restricted press countervailing arguments about modern developments. They note that attitudes about the pregnancy of unmarried women have changed drastically; that federal and state laws ban discrimination on the basis of

being. He spends less than two pages of his sixty-seven page opinion addressing the concerns raised by Jackson Women’s Health and amici documenting the effect of banning abortion on women’s health and lives, treating these concerns as flies to be swatted away. He takes no notice of the voluminous data demonstrating the horrendous state of maternal and child health in the United States, let alone the fact that Mississippi, the state seeking to overturn *Roe*, has some of the worst rates of maternal mortality, morbidity and infant death in the country. Instead, he embraces wholeheartedly Mississippi’s and their amici’s argument that American law and its robust safety net will take care of pregnant women and mothers.⁴²

Alito notes the dissent’s attention to “the effects of pregnancy on women, the burdens of motherhood, and the difficulties faced by poor women,” but dismisses these concerns as out of balance when weighing them against “protecting prenatal life.”⁴³ He also rejects any consideration of women’s reliance interest in abortion as articulated in *Casey*,⁴⁴ saying: “That form of reliance depends on an empirical question that is hard for anyone—and in particular, for a court—to assess, namely, the effect of the abortion right on society and in

pregnancy; that leave for pregnancy and childbirth are now guaranteed by law in many cases; that the costs of medical care associated with pregnancy are covered by government assistance; that States have increasingly adopted “safe haven” laws, which generally allow women to drop off babies anonymously; and that a woman who puts her newborn up for adoption today has little reason to fear that the baby will not find a suitable home.

⁴² *Id.* See also Tobin-Tyler, *supra* note 4.

⁴³ *Dobbs*, 142 S. Ct. at 2263.

⁴⁴ The *Casey* court explicitly rejected the argument that reliance interests were limited to economic activity, saying:

To eliminate the issue of reliance that easily, however, one would need to limit cognizable reliance to specific instances of sexual activity. But to do this would be simply to refuse to face the fact that for two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives . . . The Constitution serves human values, and while the effect of reliance on *Roe* cannot be exactly measured, neither can the certain cost of overruling *Roe* for people who have ordered their thinking and living around that case be dismissed.

Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 843, 856 (1992). The *Dobbs* court rejects out of hand that the principle of reliance should play any role in assessing abortion rights. *Dobbs*, 142 S. Ct. at 2225–28.

particular on the lives of women.”⁴⁵ The dissent rakes the majority over the coals for its abstraction of the realities of women’s lives: “By characterizing *Casey*’s reliance arguments as ‘generalized assertions about the national psyche,’ it reveals how little it knows or cares about women’s lives or about the suffering its decision will cause.”⁴⁶ In particular the dissent highlights the disproportionate effects on low-income women,⁴⁷ and after reviewing Mississippi’s unwillingness to proactively enact laws or policies that are supportive of maternal and child health, they assert: “[P]erhaps unsurprisingly, health outcomes in Mississippi are abysmal for both women and children.”⁴⁸

Ignoring medical, public health, and social science evidence, the *Dobbs* majority invents a world in which maternal and child health are thriving and will only be made better by abolishing abortion. The Court’s unwillingness to look squarely in the face of the realities of America’s atrocious maternal and child health outcomes is only made worse by its absurd depiction of U.S. law and policy as supportive of mothers and children. Indeed, U.S. laws and policies are an international embarrassment in their failure to protect maternal and child health.

⁴⁵ *Dobbs*, 142 S. Ct. at 2227.

⁴⁶ *Id.* at 2343 (Breyer, Sotomayor, and Kagan, Js., dissenting). The dissent attends closely to the data presented by the medical community, economists, and public health experts about the consequences of banning abortion on women’s health, equality and economic security. They also note the majority’s vague reference to “protection of maternal health” as a factor to be weighed under its new rational basis standard applied to states’ regulation of abortion:

This Court will surely face critical questions about how that test applies. Must a state law allow abortions when necessary to protect a woman’s life and health? And if so, exactly when? How much risk to a woman’s life can a State force her to incur, before the Fourteenth Amendment’s protection of life kicks in? Suppose a patient with pulmonary hypertension has a 30-to-50 percent risk of dying with ongoing pregnancy; is that enough? And short of death, how much illness or injury can the State require her to accept, consistent with the Amendment’s protection of liberty and equality?

Id. at 2336 (Breyer, Sotomayor, and Kagan, Js., dissenting).

⁴⁷ *Id.* at 2344.

⁴⁸ *Id.* at 2337.

III. LAWS AND POLICIES AFFECTING MATERNAL AND CHILD HEALTH
BEFORE *DOBBS*

Laws and policies serve as critical social drivers of maternal health.⁴⁹ Here, I present the ways in which, to date, state and federal policymakers' failure to enact evidence-based policies aimed at improving maternal and child health have led to the "abysmal" health outcomes described by the dissent in *Dobbs* and by the data presented earlier. Not surprisingly, the states that have enacted the most draconian abortion bans in the wake of *Dobbs* are the same states that have laws and policies that are the least supportive of maternal and child health.

A. *Poverty and the Broken Social Safety Net*

For decades, women have been more likely to live in poverty than men, regardless of race.⁵⁰ But women of color—Black, Latina and Native women—are far more likely to be poor than white women.⁵¹ Almost a quarter of unmarried mothers with children live in poverty.⁵² Consequently, the child poverty rate in the United States is high, especially compared to other wealthy nations; this is due largely to income inequality.⁵³ Children of color and young children, ages zero to five, are much more likely to live in poverty than white and older

⁴⁹ See generally Joia Crear-Perry et al., *Social and Structural Determinants of Health Inequities in Maternal Health*, 30 J. WOMEN'S HEALTH 230 (2021); Elizabeth Tobin-Tyler, *Black Mothers Matter: The Social, Political and Legal Determinants of Black Maternal Health Across the Lifespan*, 25 J. HEALTH CARE L. & POL'Y 49 (2022).

⁵⁰ Robin Bleiweis et al., *The Basic Facts About Women in Poverty*, CTR. FOR AM. PROGRESS (Aug. 3, 2020), <https://www.americanprogress.org/article/basic-facts-women-poverty>.

⁵¹ *Id.*

⁵² *Id.*

⁵³ The Organization for Economic Cooperation and Development (OECD) for reports:

Children in the United States enjoy some of the highest average levels of disposable income in the OECD, but high income inequality also means that child relative income poverty rates are very high—around 20 [percent] of children in the U.S. live in relative income poverty, compared to just over 13 [percent], on average across OECD countries.

How Does the United States Compare on Child Well-Being?, OECD: CHILD WELL-BEING DATA PORTAL COUNTRY FACTSHEET (Nov. 2017), https://www.oecd.org/els/family/CWBDP_Factsheet_USA.pdf.

children, respectively.⁵⁴ In 2020, a study suggested that the feminization of poverty resulted from several factors, including: segregation of women into low-paying jobs, lack of supportive work-family policies, domestic violence, and inadequate and inaccessible public support.⁵⁵ All of these problems are amenable to policy solutions; indeed, they reflect policy choices. In particular, a large body of evidence shows that socioeconomic status and poverty are fundamental social drivers of health disparities.⁵⁶ Thus, “[f]inancial insecurity can affect the health of the entire family both directly, through material hardships, and, in the case of children, also indirectly, through parental stress.”⁵⁷

Poorly designed and enforced safety net policies exacerbate the inability for parents to meet both their own and their children’s basic needs. The Temporary Assistance for Needy Families (TANF) program is a prime example. TANF is a cash assistance program specifically targeted to low-income parents and children, and it has been shown to improve child health and educational achievement.⁵⁸ But in 1996, when Congress transitioned the safety net from the federally administered Aid to Families with Dependent Children (AFDC) program to TANF, it enacted harsh time limits, sanctions, work requirements, and left implementation and enforcement to the states.⁵⁹ To maintain benefits, parents, usually mothers, must jump

⁵⁴ AREEBA HAIDER, THE BASIC FACTS ABOUT CHILDREN IN POVERTY, CTR. FOR AM. PROGRESS (Jan. 12, 2021), <https://www.americanprogress.org/article/basic-facts-children-poverty>.

⁵⁵ Bleiweis, *supra* note 52.

⁵⁶ See, e.g., Marmot, M. *Status Syndrome: A Challenge To Medicine*, 295 JAMA 1304 (2006); Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099 (2005); Paula A. Braveman et al., *Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*, 100 AM. J. PUB. HEALTH, 186 (2010); Paula A. Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381 (2011); Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, 21 HEALTH AFFS. 50 (2002); Dhruv Khullar & Dave A. Chokshi, *Health, Income, & Poverty: Where We Are & What Could Help*, HEALTH AFFS.: HEALTH POL’Y BRIEF (Oct. 4, 2018), <https://doi.org/10.1377/hpb20180817.901935>.

⁵⁷ Kess Ballentine et al., *How Low-Paid Parents Navigate the Complex Financial Landscape of Benefits Cliffs and Disincentive Deserts*, 41 HEALTH AFFS. 1707, 1713 (2022).

⁵⁸ See, e.g., John T. Cook et al., *Welfare Reform and the Health of Young Children: A Sentinel Survey in 6 US Cities*, 156 ARCHIVES PEDIATRICS & ADOLESCENT MED. 678 (2002).

⁵⁹ See ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: LAW, POLICY AND STRUCTURAL CHANGE 128–29 (2022); *Policy Basics: Temporary Assistance for Needy Families*, CTR. FOR BUDGET & POL’Y PRIORITIES (Mar. 1, 2022), <https://www.cbpp.org/research/family-income-support/temporary-assistance-for-needy-families>.

through a series of hoops, and if they stumble at any point, they risk sanctions in the form of lost cash benefits.⁶⁰ Studies of the federal government's devolution of administration authority over cash assistance programs to states post-welfare reform has left many mothers and children, especially women and children of color, in extreme poverty.⁶¹ In 2022, a study highlighted how mothers in Illinois who do not participate in child support enforcement face sanctions that put their family's health at risk.⁶² The study found that Black families were 111 percent more likely to be sanctioned than white families.⁶³ The authors noted that racially inequitable sanctioning is not just a problem in Illinois.⁶⁴ Research shows that "states with larger shares of Black residents have implemented stricter, more punitive TANF policies than states with smaller shares of Black residents."⁶⁵ Notably, it is the states with the largest Black populations that have banned abortion since *Dobbs*.⁶⁶ These states are also among those with the lowest TANF monthly benefits in the country and highest percentages of Black women and children living in poverty.⁶⁷ A review of social service provision in states with abortion bans found that while Mississippi is far from the only state with atrocious maternal and child health policies and outcomes, "Mississippi embodies a national pattern: States that have banned abortion, or are expected to, have among the nation's weakest social services for women and children, and have higher rates of death for infants and mothers."⁶⁸

⁶⁰ Ballentine et al., *supra* note 57, at 1707.

⁶¹ Anna Kerregen, *Welfare Reform & the Devaluation of Women's Work*, 12 DEPAUL J. FOR SOC. JUST. 1, 9–10 (2019).

⁶² There are a number of reasons why mothers may not want to cooperate with child support enforcement. Mothers experiencing intimate partner violence may fear retribution by their abuser. Mothers may believe they are more likely to receive support from the father by arranging it informally. They may also fear that working with a government agency will jeopardize their family stability. For example, they may fear that the child support agency will refer them to Child Protective Services.

⁶³ Kathryn Kaplan et al., *Temporary Assistance for Needy Families: Sanctioning and Child Support Compliance Among Black Families in Illinois*, 41 HEALTH AFFS. 1735, 1735 (2022).

⁶⁴ *Id.* at 1736.

⁶⁵ *Id.*

⁶⁶ Elizabeth Tobin-Tyler, *Abortion Rights and the Child Welfare System: How Dobbs Exacerbates Existing Racial Injustice and Further Traumatizes Black Families*, J.L. MED. & ETHICS (forthcoming summer 2023).

⁶⁷ *Id.*

⁶⁸ See Badger et al., *supra* note 5.

Furthermore, the inadequate, punitive, and racialized nature of state TANF policies plays a significant role in child welfare policies and outcomes. Another study found that a decline in TANF caseloads (often as a consequence of states imposing greater barriers and sanctions) is strongly associated with child welfare system involvement.⁶⁹ The study found that state restrictions imposed on TANF recipients were associated with increases in neglect cases reported to Child Protective Services (CPS) agencies and in children placed in foster care.⁷⁰ Despite the *Dobbs* majority's glib assertion that safe haven laws are an answer to unplanned pregnancy and parents' inability to provide for a child, and that there are plenty of good adoptive homes available,⁷¹ most parents do not wish to give away⁷² or have their child removed from them. Since states with abortion bans have some of the most restrictive and least generous TANF policies,⁷³

⁶⁹ Donna K. Ginther & Michelle Johnson-Motoyama, *Associations Between State TANF Policies, Child Protective Services Involvement, and Foster Care Placement*, 41 HEALTH AFFS. 1744, 1744 (2022).

⁷⁰ *Id.* at 1744. The restrictions included in the study were: Time limits on TANF benefits of less than sixty months; the most severe and maximum sanction for failure to meet work requirements being either loss of the entire benefit or a case is closed for twelve or more months; work requirements for mothers of children younger than twelve months; no change in the earnings disregard (that is, the portion of earned income that is not considered in determining eligibility for cash assistance) to qualify for benefits since 2004; one-time diversion payments that are made in lieu of TANF benefits that restrict access to TANF for six or more months; and suspicion based drug testing of TANF applicants.

Id. at 1745.

⁷¹ Safe haven laws allow a parent to anonymously surrender an infant within a specific time after birth to a designated safe haven provider, such as a fire station or hospital. *See Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2259 (2022).

⁷² The dissent in *Dobbs* notes that studies show that when women are unable to obtain a desired abortion, they are more likely to keep their baby than put it up for adoption. *Id.* at 2239 (Breyer, Sotomayor, and Kagan, Js., dissenting).

⁷³ In 2019, Mississippi had the lowest maximum benefit in the country (\$170 per month), compared to \$1066 per month in New Hampshire. Alabama's maximum monthly benefit is \$215; Georgia's is \$280; Louisiana's is \$240; Texas's is \$290. Katie Shantz et al., *Graphical Overview of State TANF Policies as of July 2019*, URBAN INST. (Oct. 2020), https://www.urban.org/sites/default/files/publication/103516/graphical-overview-of-state-tanf-policies-as-of-july-2019_1.pdf. All of these states have imposed abortion bans. These states also have very low TANF-to-poverty ratios, meaning that very few poor families even access cash benefits. *State Fact Sheets: Trends in State TANF-to-poverty Ratios*, CTR. FOR BUDGET & POL'Y PRIORITIES (Apr. 5, 2022), <https://www.cbpp.org/research/family-income-support/state-fact-sheets-trends-in-state-tanf-to-poverty-ratios>.

it is highly likely that these states will see an uptick in neglect cases as more women are forced to give birth without the resources to provide for a child's needs.⁷⁴ Racial injustice is already endemic in state child welfare systems, with Black children removed from their parents at much higher rates than other children, most often based on poverty-associated allegations of neglect.⁷⁵ The stress and trauma experienced by both parents and children when the state removes children from their homes only exacerbates existing health inequities.⁷⁶

B. *Access to Health Care: Abortion Bans and the Failure to Expand Medicaid*

Numerous studies demonstrate that health outcomes are worse in states that have not expanded Medicaid to all low-income adults living below 138 percent of the federal poverty level.⁷⁷ Since the Supreme Court gave states the option not to expand Medicaid in *NFIB v. Sebelius*,⁷⁸ many Republican-led states have continued to reject the federal incentives to do so. As of February 2023, eleven states have not expanded Medicaid.⁷⁹ All of these states have enacted abortion bans or restrictions, though some state or federal courts have blocked these bans and restrictions.⁸⁰ Furthermore, states that have imposed abortion bans post-*Dobbs* are more likely to have regional “maternity

⁷⁴ Tobin-Tyler, *Abortion Rights and the Child Welfare System*, *supra* note 67.

⁷⁵ See generally DOROTHY ROBERTS, *TORN APART: HOW THE CHILD WELFARE SYSTEM DESTROYS BLACK FAMILIES—AND HOW ABOLITION CAN BUILD A SAFER WORLD* (2022); Tobin-Tyler, *Abortion Rights and the Child Welfare System*, *supra* note 66.

⁷⁶ Roberts, *supra* note 75.

⁷⁷ Madeline Guth et al., *The Effects of Medicaid Expansion Under the ACA: Studies from January 2014 to January 2020*, KAISER FAM. FOUND. (Mar. 17, 2022), <https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report>.

⁷⁸ *Nat'l Fed'n Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

⁷⁹ These states are: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 16, 2023), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map>.

⁸⁰ Elizabeth Nash & Isabel Guarnieri, *Six Months Post-Roe, 24 US States Have Banned Abortion or Are Likely to Do So: A Roundup*, GUTTMACHER INST. (Jan. 10, 2023), <https://www.guttmacher.org/2023/01/six-months-post-roe-24-us-states-have-banned-abortion-or-are-likely-to-do-so-roundup>. Kansas voters rejected a constitutional amendment which would have made abortion unconstitutional in the state. *After Roe Fell: Abortion Laws by State, Kansas*, CTR. FOR REPROD. RTS., <https://reproductiverights.org/maps/state/kansas> (last visited Mar. 9, 2023).

care deserts”—counties with a lack of maternity care resources—where there are no hospitals or birth centers offering obstetric care and no obstetric providers.⁸¹

Recent attention to the maternal mortality crisis in the United States has raised awareness about the need to extend Medicaid coverage during the postpartum period. In states that have not expanded Medicaid coverage to all eligible low-income adults, mothers lose their healthcare coverage sixty days after birth.⁸² Roughly one-third of the states with abortion bans have extended postpartum coverage by amending their state Medicaid plan, an option provided under the American Rescue Plan Act of 2021.⁸³ While postpartum coverage is critical to addressing the maternal mortality and morbidity crisis, the failure of Congress and some states to extend Medicaid coverage to low-income girls and women signifies policymakers’ ignorance about and indifference to maternal health.

American women have high rates of stress-related chronic disease compared to women in other wealthy countries.⁸⁴ Women with chronic disease are much more likely to experience maternal morbidity and mortality.⁸⁵ The U.S. approach to maternal health, which fails to recognize well-documented links in the public health and clinical literature between lifelong health—often driven by social conditions—and maternal health outcomes, is extremely short sighted. It is also unjust. Black women, who contend with a wide range of social factors, including higher rates of poverty, low-wage work without benefits, and racial discrimination, consequently experience

⁸¹ *Maternity Care Deserts Report: Nowhere to Go: Maternity Care Deserts Across the US*, MARCH OF DIMES (2022), <https://www.marchofdimes.org/maternity-care-deserts-report>; Eugene Declercq et al., *The US Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, COMMONWEALTH FUND (Dec. 14, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes>.

⁸² *Medicaid Postpartum Coverage Extension Tracker*, KAISER FAM. FOUND. (Feb. 13, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/#:~:text=The%20Medicaid%20program%20finances%20about,coverage%20through%2060%20days%20postpartum.>

⁸³ *Id.*; American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 212 § 9812.

⁸⁴ Munira Z. Gunja et al., *What Is the Status of Women’s Health and Health Care in the U.S. Compared to Ten Other Countries?*, COMMONWEALTH FUND (Dec. 2018), <https://doi.org/10.26099/wy8a-7w13>.

⁸⁵ See generally Priya Agrawal, *Maternal Mortality and Morbidity in the United States of America*, 93 BULL. WORLD HEALTH ORG. 135 (2015).

the worst maternal health outcomes.⁸⁶ Since many states that have enacted abortion bans have failed to expand Medicaid to all low-income women and have failed to even provide extended coverage postpartum, maternal morbidity and mortality are likely to increase in these states as birthrates rise.

C. *Mothers, Low-Wage Work, and Employment Law*

Justice Alito devotes one paragraph in *Dobbs* to laws and policies that promote maternal health and well-being. He notes that unlike in 1973, it is much easier for mothers to financially support unplanned children because “leave for pregnancy and childbirth are now guaranteed by law in *many* cases.”⁸⁷ Perhaps in using the word “many,” he is acknowledging that the Federal Family and Medical Leave Act of 1993 (FMLA), which guarantees unpaid leave for covered medical and family reasons, does not cover all employees.⁸⁸ Or perhaps he is referring to the fact that there is no federal requirement that employers provide paid leave for pregnancy and childbirth and that, to date, only thirteen states do.⁸⁹ Either way, it appears that Justice Alito is unconcerned with the large number of women who fall into the massive gaps in the law: low-income women who cannot afford to take unpaid leave under the FMLA, those who work in jobs that are not covered by the Act because their workplace employs fewer than fifty employees, or those who do not meet the annual hourly requirements of the FMLA—an issue that disproportionately affects women.⁹⁰ Indeed nearly half of all women are ineligible to take unpaid leave under the FMLA.⁹¹ Or perhaps he was referring to those living

⁸⁶ See Tobin-Tyler, *Black Mothers Matter*, *supra* note 49, at 55.

⁸⁷ *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2258–59 (emphasis added).

⁸⁸ *Fact Sheet #28: The Family and Medical Leave Act*, U.S. DEP’T OF LAB.: WAGE & HOUR DIV. (Feb. 2023), <https://www.dol.gov/agencies/whd/fact-sheets/28-fmla>.

⁸⁹ *State Paid Family Leave Laws Across the US*, BIPARTISAN POL’Y CTR. (Jan. 13, 2022), <https://bipartisanpolicy.org/explainer/state-paid-family-leave-laws-across-the-us/#:~:text=T%20thirteen%20states%20and%20the,enacted%20laws%20not%20yet%20in.>

⁹⁰ Diana Boesch, *Rhetoric vs. Reality: Not All Paid Leave Proposals Are Equal*, CTR. AM. PROGRESS (Oct. 10, 2019), <https://www.americanprogress.org/article/rhetoric-vs-reality-not-paid-leave-proposals-equal>.

⁹¹ Kathleen Romig & Kathleen Bryant, *A National Paid Leave Program Would Help Workers, Families Should Prioritize Workers of Color and Those with Low Wages*, CTR. BUDGET & POL’Y PRIORITIES (Apr. 27, 2021), <https://www.cbpp.org/research/economy/a-national-paid-leave-program-would-help-workers-families#:~:text=families&hx0027;%20economic%20security.->

in one of the thirty-seven states that do not offer any type of paid leave.⁹² But it is also noteworthy that he only mentions leave laws pertaining to pregnancy and childbirth as though once a baby is born there is no more need for family leave, either for the mother's medical needs beyond childbirth, for maternal-child bonding, or for childcare.

Policymakers and the *Dobbs* majority cannot be oblivious to the fact that the United States stands out as only one-of-six countries in the world that offer no federally guaranteed paid family leave.⁹³ Now that antiabortion activists and policymakers have gotten what they wished for from the Supreme Court, they must be held accountable for the deplorable state of maternal and child health in the United States and the underlying policy failures that contribute to it. Will policymakers use this opportunity to enact evidence-based policies to support maternal and child health? Next, I analyze some of the post-*Dobbs* political rhetoric and policy proposals that purport to acknowledge the need to enact “pro-family” policy.

IV. POLICY MATTERS: PROTECTING MATERNAL AND CHILD HEALTH POST-*DOBBS*

In his concurring opinion in *Dobbs*, Justice Kavanaugh proudly asserts the Court's “neutrality” regarding abortion, happily tossing to state legislators the job of “evaluat[ing] the interests of the pregnant woman and the interests in protecting fetal life throughout pregnancy.”⁹⁴ The *Dobbs* Court expressed confidence that state legislators, who, in most states to date, have done a poor job of enacting policies promoting maternal health, would somehow now be equipped to deal with increasing births from unplanned pregnancies, worsening rates of maternal morbidity and mortality, and a declining health care system. Among the many maternal health issues facing states that the Court failed to consider were: abortion care required to

,Paid%20medical%20and%20caregiving%20leave%20lets%20workers%20care%20for%20themselves,can%20boost%20labor%20force%20participation.

⁹² See *State Paid Family Leave Laws Across the US*, *supra* note 89. Low-income women of color are most likely to benefit from paid leave policies. Amanda Novello, *For Women and Workers of Color in Every State, Paid Leave Is a Lifeline*, NAT'L P'SHIP FOR WOMEN & FAMILIES 1 (Oct. 2021), <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/paid-leave-lifeline-in-states.pdf>.

⁹³ Claire Cain Miller, *The World 'Has Found a Way to Do This': The US Lags on Paid Leave*, N.Y. TIMES (Nov. 3, 2021), <https://www.nytimes.com/2021/10/25/upshot/paid-leave-democrats.html>.

⁹⁴ *Dobbs*, 142 S. Ct. at 2309 (Kavanaugh, J., concurring).

protect a pregnant person's health and prevent death;⁹⁵ inadequate health insurance coverage⁹⁶ and maternity care deserts, especially in states likely to impose abortion bans;⁹⁷ the importance of reproductive health care in a wide range of women's health issues;⁹⁸ initiation and exacerbation of intimate partner violence during pregnancy;⁹⁹ and women's labor force participation, reduced wages¹⁰⁰ and higher healthcare costs associated with increased births.¹⁰¹ All of these maternal health issues disproportionately affect low-income women of color and women with disabilities.

The Court's and anti-abortion policymakers' magical thinking about how all of these problems will sort themselves out post-*Dobbs* demonstrates either a willful disregard for the facts or a willful

⁹⁵ After the Center for Medicaid and Medicare issued guidance saying that the federal Emergency Medical Treatment and Labor Act (EMTALA) preempts state abortion bans when an emergency medical condition requires abortion care, Texas sued the Biden Administration arguing that EMTALA does not override state abortion laws. See Greer Donley, Kimi Chernoby & Skye Perryman, *Two Courts Ruled on Abortion in Emergency Situations. One Got It Right*, TIME (Aug. 26, 2022), <https://time.com/6208656/abortion-emtala-texas-idaho-emergency-situations>. The Biden Administration sued Idaho arguing that its state abortion law violates EMTALA by failing to provide for a health exception. *Id.* While the federal district court in Idaho agreed with the Biden Administration that the Idaho unlawfully conflicts with EMTALA, the Texas District Court found in favor of Texas, holding that EMTALA protects both the pregnant person and the fetus. See *id.*

⁹⁶ *Medicaid Postpartum Coverage Extension Tracker*, *supra* note 75.

⁹⁷ MARCH OF DIMES, *supra* note 81, at fig. 1; Declercq, *supra* note 81.

⁹⁸ Brubaker & Bibbins-Domingo, *supra* note 8, at 1707–08.

⁹⁹ Elizabeth Tobin-Tyler, *A Grim New Reality—Intimate-Partner Violence after Dobbs and Bruen*, 387 NEW ENG. J. MED., 1247, 1247 (2022) (“Pregnancy is associated with both the initiation of IPV and an increase in IPV severity, making it a particularly dangerous time. Homicide is the leading cause of pregnancy-associated death in the United States; pregnant and postpartum women are more than twice as likely to die from homicide as from either hemorrhage or hypertensive disorders. In addition, the rate of homicide during pregnancy and the postpartum period (per 100,000 live births) among non-Hispanic Black women is more than five times as high as the rate among White women.”).

¹⁰⁰ Laura Valle Gutierrez, *The Dobbs Decision's Cost to Women and Families*, CENTURY FOUND. (Aug. 18, 2022), <https://tcf.org/content/commentary/the-dobbs-decisions-cost-to-women-and-families>.

¹⁰¹ Matthew Rae et al., *Health Costs Associated with Pregnancy, Childbirth, and Postpartum Care*, PETERSON-KFF, HEALTH SYS. TRACKER (Jul. 13, 2022), <https://www.healthsystemtracker.org/brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care> (“We find that health costs associated with pregnancy, childbirth, and post-partum care average a total of \$18,865 and the average out-of-pocket payments total \$2,854 for women enrolled in large group plans.”).

devaluing of women’s health and lives. Most policymakers have remained silent, though a few have acknowledged that “pro-family policies” are called for now that *Roe* has been struck down.

A. *Antiabortion Lawmakers’ Responses to Concerns About Maternal and Child Health After Dobbs*

After the leaked *Dobbs* opinion in May 2022, a number of Republican congressional lawmakers were asked how they would support women and children if *Roe* were overturned.¹⁰² They provided vague answers, such as this one from Republican Senator Josh Hawley of Missouri:

I do think if the court does ultimately overturn *Roe*, it will be a big sea change politically, and I think there will be all kinds of new opportunities to think about what that means for us from a policy perspective, and I hope we’ll come forward with new and interesting policy perspectives.¹⁰³

Republican Senator Marco Rubio of Florida was willing to be more concrete in laying out a specific policy proposal. He wrote an op-ed in the *Washington Examiner* in May 2022, in which he declared: “Being truly pro-life requires an understanding of the pain and struggle, arising from serious difficulties and responsibilities motherhood entails, which lead a woman to abort her baby. As we take steps to protect the unborn, we have a duty to address those challenges.”¹⁰⁴ Rubio introduced three bills aimed at protecting mothers post-*Dobbs*. First, the Standing with Moms Act, which would require the Department of Health and Human Services (HHS) to develop a website with “pregnancy-related resources”—including information on the “risks of abortion” and forbidding any information about how to obtain one.¹⁰⁵ Second, the Community Mentors for Moms Act, which would develop maternal mentoring and a peer support network for mothers.¹⁰⁶ Third, the Providing for Life Act, which would extend the child tax credit, require cooperation with child support agencies as an

¹⁰² Jeff Stein, *With Roe at Risk, GOP Faces Pressure to Support Families After a Birth*, WASH. POST: U.S. POL’Y (May 3, 2022, 5:39 PM), <https://www.washingtonpost.com/us-policy/2022/05/03/gop-families-roe-wade>.

¹⁰³ *Id.*

¹⁰⁴ Marco Rubio, *How to Protect Mothers and Their Babies: Being Pro-Life Also Means Helping Low-Income Moms*, WASH. EXAM’R (May 11, 2022), <https://www.washingtontimes.com/news/2022/may/11/how-to-protect-both-mothers-and-their-babies>.

¹⁰⁵ Standing with Moms Act, S.B. 4541, §§ (a)–(b) 117th Cong. (2022).

¹⁰⁶ Community Mentors for Moms Act, S.B. 4761, 117th Cong. (2022).

eligibility criterion for the Supplemental Nutrition Assistance Program, enable parents to borrow from their Social Security savings to pay for family or medical leave, and prohibit discrimination against religious organizations in federal funding so they will be incentivized to support new mothers.¹⁰⁷

Unlike many of his Republican colleagues, Rubio publicly acknowledged the disparate burden carried by low-income mothers¹⁰⁸ and the benefits to maternal and child health and well-being that would result from extending the child tax credit.¹⁰⁹ But apart from this proposal, many of Rubio's policy proposals for supporting low-income mothers are tone-deaf to the realities of their lives. Low-income pregnant and parenting women need more than information about pregnancy resources; they need concrete material supports—income, housing, health care, childcare, and so on. If those resources do not exist or are inaccessible, posting information on a website is useless. Similarly, mentoring may provide some important community support for new mothers, but federal grants to community and religious organizations for such services are not new; furthermore, these types of services have done little to address the current maternal health crisis. Additionally, the emphasis on child support enforcement, and in particular, requiring mothers to participate in it as means to accessing Supplemental Nutrition Assistance Program (SNAP) simply drums up the same failed TANF system which makes access to a support for basic needs contingent on certain behaviors that may not be in a mother's best interest. Finally, the proposal that low-income mothers, predominantly women of color, borrow from their retirement savings to enable them to take medical or family leave is simply an exercise in "taking from Peter to pay Paul." Women are far more likely to be poor in older age than men.¹¹⁰ Proposing that women sacrifice their own health and well-being in old age in order to care for themselves and their children is far from "pro-family."

¹⁰⁷ Providing for Life Act, S.B. 4868, 117th Cong. (2022).

¹⁰⁸ Rubio, *supra* note 104.

¹⁰⁹ See *infra* for further discussion of the child tax credit.

¹¹⁰ Roughly 15.6 percent of women over age 65 live in poverty compared with 12.2 percent of men. Women of color are far more likely to live in poverty in old age: 26.1 percent of Black women, 25.2 percent of Latinas, and 23.4 percent of Native women live in poverty. AMBER CHRIST & TRACEY GRONNIGER, OLDER WOMEN IN POVERTY: SPECIAL REPORT, JUSTICE IN AGING 4 (Dec. 2018), <https://justiceinaging.org/wp-content/uploads/2020/08/Older-Women-and-Poverty.pdf>.

Antiabortion state legislators' responses to questions about the need, post-*Dobbs*, to enact more "pro-family" policies have rebuffed the idea that government owes a duty to mothers and children. For example, Mississippi State representative Bubba Carpenter outright rejected the idea that the state should extend Medicaid to mothers postpartum now that abortion is illegal.¹¹¹ He argued that doing so would be a "slippery slope" and that the state was already "doing enough."¹¹² Another state legislator rejected a call from the state's attorney general to broaden the safety net after *Dobbs*, saying, "[t]his is an area for the community and the Church to step up and develop programs to help these women. We are called as Christians to help each other and that's what we should do, but we should do it in the private sector alone."¹¹³ Persuading antiabortion lawmakers, who have stubbornly remained committed to small government, that new social spending is needed post-*Dobbs* is a tall task. Some conservative commentators, however, have embraced government investments, arguing that Republicans "might find themselves politically vulnerable—unless they lean into the ongoing political realignment and put themselves on the side of working-class parents."¹¹⁴

V. PUTTING YOUR MONEY WHERE YOUR MOUTH IS: AN EVIDENCE-BASED APPROACH TO REPRODUCTIVE JUSTICE

Should federal and state policymakers decide that it is in their political interests to expand investments in maternal and child health and family security, they do not have to look hard for evidence to support policy change. But even more importantly, if policymakers are genuinely interested in promoting healthy families, they should start by listening to women, especially women of color who have historically been marginalized by policymakers and who will be most harmed by *Dobbs*. Reproductive justice requires that elected officials listen and respond to the demands and needs of women who are subject to the laws and policies they enact. Policymakers should start by listening to SisterSong Women of Color Reproductive Justice Collective.

¹¹¹ *Republicans Divided in Support for a Policy Response to Roe*, AP NEWS (Jul. 4, 2022), <https://apnews.com/article/abortion-health-mississippi-medicaid-91f7da074e7fc4ca7c3a755a51ffcd63>.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ Patrick T. Brown, *The Pro-Family Agenda Republicans Should Embrace After Roe*, N.Y. TIMES (May 7, 2022), <https://www.nytimes.com/2022/05/07/opinion/rep-publican-policy-after-ro.html>.

SisterSong was founded in 1997 “to improve institutional policies and systems that impact the reproductive lives of marginalized communities.”¹¹⁵ SisterSong promotes the following values of reproductive justice: “The human right to own our bodies and control our future[;] [t]he human right to have children; [t]he human right to not have children[;] and [t]he human right to parent the children we have in safe and sustainable communities.”¹¹⁶ Academic partners can assist by supplying the evidence base for policies that promote reproductive justice and by holding policymakers and courts accountable when they ignore the facts on the ground. Below are evidence-based policies that have been shown to improve maternal health and promote the values of reproductive justice.

¹¹⁵ SISTERSONG, <https://www.sistersong.net/mission> (last visited Apr. 17, 2023).

¹¹⁶ SisterSong issued *Visioning New Futures for Reproductive Justice Declaration 2023* in January 2023, which reads:

We are dreaming ourselves into the future, fighting like revolutionaries. Our vision is a future rooted in human dignity and worth, bodily autonomy, joy, love, and rest. Reproductive justice is our framework, intersectionality is our lens, and liberation is the goal. Reproductive justice leads to futures we do not yet know but dare to imagine:

Liberation is giving the land back to Indigenous people who stewarded and protected it for generations before colonization, and who live on it today.

Liberation is having what you need to keep your kids, care for your kids, and keep your family safe and together.

Liberation is being able to have healthy and supported pregnancy options, and prenatal, birth, and postpartum care. This is birth justice.

Liberation is choosing your family, and being able to care for yourself and your community.

Liberation is an end to police, prisons, family surveillance, and detention centers which are designed to harm Black and Brown bodies and break up our families.

Liberation is building communities where we all feel safe, able to experience joy, and live together with our loved ones.

Liberation is ending the war on drugs and providing physical and mental health care, help and support for everyone who needs it.

Liberation is reparations.

Liberation is abortion care for any person who needs it.

Liberation is sexual consent, pleasure, and joy.

We will not be silenced. We will take up all the space we need. We will lead with love. We will reclaim our power for ourselves, our beautiful families, our children, and the generations to come.

Visioning New Futures for Reproductive Justice Declaration 2023, SISTERSONG <https://www.sistersong.net/visioningnewfuturesforj>.

A. *Abortion That Is Accessible to All Promotes Maternal Health*

Clearly, antiabortion lawmakers in states that have imposed abortion bans are not likely to be persuaded by widespread evidence of the benefits to women's health from access to abortion care. Still, it is vitally important that reproductive justice advocates continue to challenge the antiabortion movement's misinformation campaign about the harms of abortion for women's health. Despite the *Dobbs* majority's willingness to turn a blind eye to the facts, which expert amici presented in persuasive detail,¹¹⁷ the Court cannot have the last word on the role of abortion in women's health. At a time in which misinformation in public health is rampant, federal and state policymakers must be confronted with evidence supporting the connections between banning access to abortion and poor maternal-health outcomes.¹¹⁸ Low-income women of color living in states with abortion bans and residing in states that prohibit the use of Medicaid funding for abortion will continue to suffer the greatest health and economic burdens.¹¹⁹ Research and advocacy should focus on documenting these burdens, promoting abortion access for low-income women, and holding policymakers accountable for failing to listen to the needs of women of color.

B. *Medicaid Expansion Supports a Comprehensive Approach to Maternal Health*

Until the United States joins other wealthy nations in providing federally sponsored universal healthcare coverage, state policymakers must be confronted with their failure to expand Medicaid and its impact on maternal and child health. While extending postpartum coverage is an important incremental step, full expansion to all low-income adults is necessary to improve outcomes. Medicaid expansion

¹¹⁷ For a catalogue of amici briefs submitted in *Dobbs v. Jackson Women's Health Organization*, see *Amicus Briefs: Dobbs v. Jackson Women's Health Association*, CTR. REPROD. RTS., <https://reproductiverights.org/case/scotus-mississippi-abortion-ban/amicus-briefs-dobbs-v-jackson-womens-health-organization> (last visited Apr. 30, 2023).

¹¹⁸ For discussion of the role of researchers and universities post-*Dobbs*, see *The US Abortion Ruling Is a Tragedy; Here's What Research Bodies Must Do Now*, NATURE (June 30, 2022), <https://www.nature.com/articles/d41586-022-01760-6.pdf>.

¹¹⁹ Sixteen states currently allow Medicaid to pay for some or all abortions; seven states do so voluntarily, and nine do so under court order. *State Funding of Abortion Under Medicaid, as of January 1, 2023*, GUTTMACHER INST. (Jan. 1, 2023), <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>; Ushma D. Upadhyay et al., *Trends in Self-pay Charges and Insurance Acceptance for Abortion in the United States, 2017–20*, 41 HEALTH AFFS. 507 (2022).

is associated with both reduced maternal¹²⁰ and infant mortality,¹²¹ and research shows that the greatest mortality reductions are among Black mothers and infants.¹²² Medicaid expansion has also been shown to reduce postpartum hospitalizations.¹²³ Importantly, Medicaid expansion improves pre-conception health, which is vital to improving maternal and child health outcomes.¹²⁴

Medicaid expansion is also associated with reducing other negative social drivers of health. A recent study reported in the *Journal of the American Medical Association* found that Medicaid expansion is associated with reductions in eviction.¹²⁵ Since mothers, and in particular Black mothers,¹²⁶ have the highest rates of eviction, access to Medicaid may not only promote access to care, but it may also help to address health-harming social needs, like housing insecurity. But clearly, Medicaid expansion alone will not negate the gendered poverty and racial discrimination that lead to poor maternal health outcomes. Other social policy changes are needed to achieve equity and reproductive justice.

C. *Paid Family Leave Reduces Postpartum Depression and Maternal Morbidity*

The *Dobbs* majority's assertion that "many" women have access to leave from work for pregnancy and childbirth blithely ignores the utter failure of U.S. policymakers to address what is, in reality, a grave injustice: most mothers, especially poor mothers, in the United States are not able to take the time they need to recover from childbirth and to bond with their babies without risking job loss or foregoing the income they need for their families to survive. That the United States

¹²⁰ Erica L. Eliason, *Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality*, 30 *WOMEN'S HEALTH ISSUES* 147, 147 (2020).

¹²¹ Chintan B. Bhatt & Consuelo M. Beck-Sague, *Medicaid Expansion and Infant Mortality in the United States*, 108 *AM. J. PUB. HEALTH* 565, 565 (2018).

¹²² Eliason, *supra* note 120, at 147.

¹²³ Maria W. Steenland & Laura R. Wherry, *Medicaid Expansion Led to Reductions in Postpartum Hospitalizations*, 42 *HEALTH AFFS.* 18 (2023).

¹²⁴ See generally Claire E. Margerison et al., *Impacts of Medicaid Expansion on Health Among Women of Reproductive Age*, 58 *AM. J. PREVENTATIVE MED.* 1 (2020).

¹²⁵ Sebastian Linde & Leonard E. Egede, *Association Between State-level Medicaid Expansion and Eviction Rates*, 6 *JAMA NETW OPEN* (2023), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800212>.

¹²⁶ Matthew Desmond, *Poor Black Women Are Evicted at Alarming Rates, Setting Off a Chain of Hardship*, MACARTHUR FOUND. (Mar. 2014), https://www.macfound.org/media/files/hhm_-_poor_black_women_are_evicted_at_alarming_rates.pdf.

stands alone among wealthy nations in failing to provide paid medical and family leave is an embarrassment. While some states are picking up the mantle to offer some form of paid leave,¹²⁷ delegating this responsibility to the states leaves the majority of mothers unprotected. None of the states that have enacted abortion bans currently have paid leave policies.¹²⁸

Income is strongly associated with whether a woman takes family leave. Nearly 80 percent of women earning less than \$40,000 a year and more than half of women earning between \$40,000 and \$60,000 a year report that they either take no leave or take unpaid leave.¹²⁹ Black and Latina mothers are less likely than white women to take paid family leave.¹³⁰ The inability to take paid family leave has serious ramifications for maternal health. Mothers who are unable to take paid leave experience higher rates of postpartum depression and these rates are higher for low-income women of color.¹³¹ Furthermore, given the horrendously high rates of maternal morbidity and mortality in the United States, especially for Black women, forcing mothers to go back to work too soon after childbirth only exacerbates adverse maternal health outcomes. Allostatic load is closely correlated with maternal morbidity, and protective factors, including economic security and a supportive environment for parenting, are fundamental to countering maternal stress.¹³² Policymakers should consider this: “More than half of the total costs of maternal morbidity for US births in 2019 were due to adverse maternal mental health conditions, including postpartum depression.”¹³³ This fact stands in stark contrast to antiabortion activists, policymakers, and some in the judiciary, who have alleged that abortion is more harmful to women’s mental health than childbirth. Reproductive justice demands that all women be able to give birth and

¹²⁷ *State Paid Family Leave Laws Across the US*, *supra* note 89.

¹²⁸ For states with abortion bans, see Nash & Guarnieri, *supra* note 80; for states with paid family leave policies, see *State Family and Medical Leave Laws*, NAT’L CONF. OF STATE LEG. (Sept. 9, 2002), <https://www.ncsl.org/labor-and-employment/state-family-and-medical-leave-laws#:~:text=Paid%20Family%20Leave,paid%20family%20and%20medical%20leave>.

¹²⁹ Daria Grayer et al., *Paid Leave: A Health Justice Imperative for Maternal Mental Health*, AAMC CTR. FOR HEALTH JUST. (Nov. 1, 2022), <https://www.aamchealthjustice.org/news/policy/paid-leave>.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² Elizabeth Mollard et al., *Postpartum Stress and Protective Factors in Women Who Gave Birth in the United States During the COVID-19 Pandemic*, 17 *WOMEN’S HEALTH* 1, 1 (2021).

¹³³ Grayer et al., *supra* note 129.

care for their newborn in a safe and supportive environment. Reducing maternal stress is “pro-family.”

D. *No-strings-attached Income Supports Target Social Drivers of Poor Maternal and Child Health*

There is robust literature on the role of economic insecurity in perpetuating health inequities.¹³⁴ As described earlier, research demonstrates that access to cash assistance improves maternal and child health,¹³⁵ “however, the complexity of public benefits’ work requirements and phase-outs creates a treacherous financial landscape for low-paid parents to navigate to provide for their families.”¹³⁶ Cash assistance through TANF comes with heavy “administrative and redemption costs” and requires significant “time, energy and stress,” to access benefits.¹³⁷ COVID-19 provided an important opportunity to test what happens when certain TANF restrictions and requirements are lifted. A 2022 study found that recipients in states that waived work requirements, paused sanctions, and employed automatic recertification of benefits during the pandemic had fewer mentally or physically unhealthy days than those in states that did not implement these changes.¹³⁸

Researchers are also increasingly studying the effects of different models of government support to parents, without strings attached, on adult and child health. One example is the child tax credit, which Congress established in 1997 as a way to support parents to defray childrearing costs.¹³⁹ But due to the income requirements, the tax credit primarily applied to middle income parents.¹⁴⁰ In 2021, during the COVID-19 pandemic, Congress temporarily extended the child tax credit under the American Rescue Plan, making it available to parents with low or no income, and making payments monthly rather than annual.¹⁴¹ The temporary expansion of the child tax credit has given

¹³⁴ See generally Adler & Newman, *supra* note 56.

¹³⁵ See TOBIN-TYLER & TEITELBAUM, *supra* note 59.

¹³⁶ Kess Ballentine et al., *How Low-Paid Parents Navigate The Complex Financial Landscape of Benefits Cliffs And Disincentive Deserts*, 41 HEALTH AFF. 1707, 1707 (2022).

¹³⁷ *Id.* at 1711.

¹³⁸ Emily C. Dore et al., *Easing Cash Assistance Rules During COVID-19 Was Associated With Reduced Days Of Poor Physical And Mental Health*, 41 HEALTH AFF. 1590 (2022).

¹³⁹ *Policy Basics: The Child Tax Credit*, CTR. BUDG. & POL’Y PRIORITIES (Dec. 7, 2022), <https://www.cbpp.org/research/federal-tax/the-child-tax-credit>.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

researchers an opportunity to study the potential benefits of direct government assistance focused on boosting the income of families with children. Although results have been mixed with regard to the expanded child tax credit's effects on parental mental health,¹⁴² other studies show that the 2021 expanded child tax credit improved self-reported overall parental health.¹⁴³ It also lifted more than two million children out of poverty¹⁴⁴ and reduced food insecurity,¹⁴⁵ two significant social drivers of health.

There is also growing attention to benefits of unconditional cash transfers for improving population health and reducing health disparities.¹⁴⁶ A synthesis of the research on these types of programs found that “[t]here is consistent evidence across contexts for improvements to health status and to the myriad behavioral and social factors that are linked to leading causes of premature ill health, disability, and death.”¹⁴⁷ Many of these programs target parents, especially low-income mothers.¹⁴⁸ Recognizing that they suffer the greatest burden of economic injustice, some programs specifically

¹⁴² See, e.g., Akansha Batra et al., *Effects of the 2021 Expanded Child Tax Credit on Adults' Mental Health: A Quasi-Experimental Study*, 42 HEALTH AFF. 74 (2023) (finding that the extended child tax credit improved parental mental health). But see Benjamin Glasner et al., *No Evidence the Child Tax Credit Expansion Had an Effect on the Well-Being and Mental Health of Parents*, 41 HEALTH AFF. 1607 (2022) (finding no evidence that the child tax credit expansion affected parental mental health).

¹⁴³ *The Child Tax Credit Benefits Whole Families: Preliminary Data Show Improved Food Security and Parental Health*, CHILDS. HEALTH WATCH (May 2022), <https://childrenshealthwatch.org/wp-content/uploads/Childrens-HealthWatch-Preliminary-CTC-findings-vf.pdf>.

¹⁴⁴ Kalee Burns & Liana E. Fox, *The Impact of the 2021 Expanded Child Tax Credit on Child Poverty*, U.S. Census Bureau, Social, Economic, and Housing Statistics Division, (SEHSD Working Paper #2022-24, 2022), <https://www.census.gov/content/dam/Census/library/working-papers/2022/demo/sehscd-wp2022-24.pdf>.

¹⁴⁵ *The Child Tax Credit Benefits Whole Families: Preliminary Data Show Improved Food Security and Parental Health*, *supra* note 143; see also, Zoe Bouchelle et al., *Food Insufficiency Following Discontinuation of Monthly Child Tax Credit Payments Among Lower-Income US Households*, 3 JAMA HEALTH F. (2022).

¹⁴⁶ Arne Ruckert et al., *Reducing Health Inequities: Is Universal Basic Income the Way Forward?*, 40 J. PUB. HEALTH 3, 3–4 (2017).

¹⁴⁷ REBECCA HASDELL, WHAT WE KNOW ABOUT UNIVERSAL BASIC INCOME: A CROSS-SYNTHESIS OF REVIEWS, STANFORD BASIC INCOME LAB 17 (July 2020), <https://basicincome.stanford.edu/research/papers/what-we-know-about-universal-basic-income>.

¹⁴⁸ See Andy Newman, *How \$1,000 a Month in Guaranteed Income Is Helping N.Y.C. Mothers*, N.Y. TIMES (Jan. 18, 2022), <https://www.nytimes.com/2022/01/18/nyregion/guaranteed-income-nyc-bridge-project.html>.

target Black women. For example, in 2022 the global non-governmental organization Give Directly and the Georgia Resilience and Opportunity Fund launched the “In Her Hands” program in Atlanta, Georgia. The program distributes monthly payments of \$850 per month to Black women, many of whom are mothers.¹⁴⁹ The organizations are studying the effects on social, health, and economic well-being.

Despite the Republican mantra that government assistance will increase dependency, studies do not find that these types of programs negatively impact work participation.¹⁵⁰ Furthermore, pilot studies of guaranteed income programs in cities across the country show that beneficiaries spend the added income on basic needs, such as food, housing, transportation, and clothing.¹⁵¹ Given the clear linkages among poverty, maternal stress, and adverse maternal health outcomes, this direct approach to helping mothers meet their and their children’s basic needs is an evidence-based maternal health intervention. It also promotes the dignity of low-income women of color who have been scapegoated and stigmatized for decades by policymakers, by recognizing that poverty is not a personal choice but instead the legacy of decades of racial and gender discrimination. But pilot-guaranteed income programs in cities will not, in-and-of-themselves, address the serious maternal health crisis in the United States—one that will be exacerbated in states that have banned abortion care. If they truly care about mothers and children, federal and state lawmakers should take notice of the growing evidence coming from these pilot studies that no-strings-attached income supports have considerable benefits for maternal and child health by targeting root causes of poor health and family instability.

CONCLUSION

Dobbs will have serious ramifications for maternal health, especially for low-income women of color who already have poor access to reproductive healthcare and who bear the burdens of intersectional racial and gender discrimination, economic inequality, and health disparities. But now that the binary question—should abortion be a

¹⁴⁹ Jenna Romaine, *Guaranteed Income Program for Black Women Launching in Atlanta in Honor of MLK*, HILL (Jan. 17, 2022), <https://thehill.com/changing-america/respect/equality/589845-guaranteed-income-program-for-black-women-launching-in>.

¹⁵⁰ HASDELL, *supra* note 147.

¹⁵¹ See *The Guaranteed Income Pilots Dashboard*, STANFORD BASIC INCOME LAB (Mar. 31, 2023), <https://guaranteedincome.us>.

constitutional right or not—has been, at least for the foreseeable future, removed from political discourse, policymakers should not be able to shirk their responsibility for worsening maternal and child health. Policymakers must confront what it means to get pregnant, give birth, and parent in the United States. Academics and advocates should partner to hold policymakers and courts accountable for their ignorance of, indifference to, and sometimes outright denial of the facts about maternal health in America. Pro-life activists, politicians and judges should no longer be able to claim that they are “pro-woman” and “pro-child” while turning a blind eye to the realities and consequences of unplanned pregnancy in a country that does not value maternal and child health. Hammering away at the facts—including the growing evidence demonstrating the benefits to maternal health of government supports and “pro-family” policies, as well as elevating the voices of women’s lived experiences, particularly those of low-income women of color—is more critical than ever. As SisterSong’s recent declaration on reproductive justice says, “[w]hen we fight for reproductive justice—we show up for people who are harmed the most.”¹⁵²

¹⁵² *Visioning New Futures for Reproductive Justice Declaration 2023*, SISTERSONG <https://www.sistersong.net/visioningnewfuturesforj>.

