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Motherhood, Abortion, and the Medicalization of Women's Poverty

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Abstract:

This article considers the impact of laws and policies that determine who experiences unplanned pregnancy, who has abortions, and how economic status shapes one's response to unplanned pregnancy. There is a well-documented correlation between abortion and poverty: poor women have more abortions than do their richer sisters. Equally well-documented is the correlation between unplanned pregnancy and poverty. Finally, the high cost of motherhood for poor women and their offspring manifests in disproportionately high lifelong rates of poverty, ill-health and mortality for offspring and mothers, alike. Read together, these factors offer a vivid illustration of the medicalization of poverty.

Keywords:

Abortion, pregnancy, medicalization of poverty, unplanned pregnancy, cost of motherhood, fertility policy, TANF, infant mortality

Introduction

The notion that poverty has been “medicalized” is often illustrated by pointing to healthcare settings where patients present with problems generated largely by the fact that they are poor. For example, in the emergency room, one finds some patients whose ailments derive not simply from an intrinsic disease, but rather from the impact of poverty on their health. Poverty is not simply a fact of life for the patient; it is also a factor that triggers or exacerbates the patient’s medical crisis. Indeed, poverty may be both a result and a cause of a patient’s impaired health status. A chronic condition such as mental illness, if untreated, may lead to poverty, which may then trigger homelessness, which in turn leads to new illnesses, causing emergency room admissions relating to exposure.

But the emergency room is not the only healthcare setting in which to measure the effects of poverty on Americans. The abortion clinic provides an equally compelling place to observe the ways in which poverty comes to be medicalized. In a country that has spent almost half a century battling over abortion’s legal status, the abortion clinic is a particularly charged healthcare setting. But one need not take sides in the abortion war to notice the perverse ways in which the colliding forces of poverty, healthcare, and gender manifest in the lives of many abortion patients.

What one learns from reckoning with the reasons women seek abortions is that poverty circumscribes the choices available to poor women. In the abortion clinic, one sees how motherhood comes with a price tag. Poverty drives rates of unintended pregnancies and then circumscribes women’s responses to those pregnancies. That is to say, for poor women, poverty becomes medicalized from the first missed period.

I. Poverty, Unintended Pregnancy, and the Abortion “Choice”

The best starting point for considering the role of poverty in the reproductive healthcare setting is to note that, in the U.S., women are disproportionately poorer than are men. That is to say, poverty itself is gendered: More than 1 in 8 U.S. women live in poverty.¹ Women are 38% more likely than men to live in poverty; among poor Americans, women are disproportionately likely to live in extreme poverty.

One of the negative consequences of the U.S.’s toxic discourse around abortion is that it blinds us to the obvious ways in which poverty is connected to both abortion and motherhood. For instance, in recent years, activists and scholars have called attention to the fact that U.S. women of color, and particularly black women, have abortions at higher rates than do their white counterparts. Black women are almost five times more likely to have an abortion than are white women, and a Latina woman is more than twice as likely.²

Abortion opponents seize on this fact to argue that abortion is racist, hoping to persuade black women to keep their pregnancies.³ Abortion-rights advocates note with concern the country’s growing “abortion deserts”—large geographic areas,

populated disproportionately by poor and minority women, with no access to abortion services.⁴

What is missing from both responses to the variations in abortion rates is a candid consideration of why minority women, and in particular black women, have abortions more often than white women. What is missing is a conversation about poverty and abortion.

Poverty matters because regardless of race and ethnicity, low-income women have higher rates of unintended pregnancy and abortion.⁵ In fact, poor women comprise half of all US women having abortions. A full 76% of abortions occur among women at or below 200% of the federal poverty level.⁶ The disproportionately high abortion rates among women of color is largely an artifact of poverty: blacks on average are at least twice as likely as whites to be poor.⁷ In terms of median net worth, white households are about 13 times as wealthy as black households.⁸

A frank consideration of the impact of poverty on women's lives reveals the way in which poverty undergirds the entire reproductive life cycle, shaping everything from rates of unintended pregnancy to how a woman will respond to that pregnancy. If she keeps the pregnancy, poverty will in turn shape not only her life options and health status, but also those of her child.

A. Unintended Pregnancy and Poverty

The abortion gap between poor women and their wealthier counterparts actually begins before the trip to the clinic, with the disproportionately high rates of unintended pregnancy among poor women. It is a well-established fact that poor women have higher rates of unintended pregnancy than do their wealthier sisters. The disparity is shocking: in 2011, the rate of unintended pregnancy among women with incomes below the federal poverty level was more than 5 times the rate of women with incomes of at least 200% of the federal poverty level, 112 per 1,000 versus 20 per 1,000.⁹

The high rates of unintended pregnancy among poor women are thought to reflect a constellation of factors at intersection of gender, poverty and our healthcare system, but the biggest culprit seems to be lack of access to nearby, publicly-funded family planning services. By way of proof, experts point to the sharp decline in the rates of unintended pregnancy among poor women after the federal government expanded access to contraception, beginning in 2009. Here's what happened. Between 1981 and 2008, unintended pregnancy among poor women was on the rise, while the rate among higher-income women declined steadily.¹⁰ Between 2008 and 2011, expanded family planning access led to dramatic declines in rates of unplanned pregnancy among poor women, bringing them in line with their wealthier sisters: rates among women of reproductive age with incomes below the federal poverty level dropped from 137 per 1,000 women to 112 per 1,000—an 18% decline in just three years. (During the same years, the rate among higher-income women decreased 20% between 2008 and 2011).¹¹

By 2014, experts conclude that the robust expansion of publicly-funded family planning services helped women avoid two million unintended pregnancies,

which would likely have resulted in 900,000 unplanned births and nearly 700,000 abortions.¹² Without publicly-funded family planning services, they estimate that U.S. rates of unintended pregnancy, unplanned birth and abortion for 2014 would have been 68% higher.¹³

As of this writing, these same women are caught in the cross-hairs of political fighting over government mandates to cover contraception. The Trump administration's has pledged to rollback federal funding for contraception, beginning by dismantling by expanding the rights and the ease with which employers can deny coverage on religious grounds.¹⁴ It is too soon yet to assess whether and how much the federal government's policies will affect the rates of unintended pregnancy among the poorest Americans. What is clear beyond dispute is that efforts to restrict federally funded contraception will disproportionately affect poor women.

B. Abortion and Poverty

Poverty not only shapes whether a woman will experience an unplanned pregnancy, it is also a potent force in shaping how she will respond to it. There is a well-founded correlation between poverty and abortion rates. In recent years, abortion rates have steadily declined across almost every category of women in the United States: younger, older, Northern, Southern.¹⁵ Yet rates have remained constant among poor women in the United States.

By way of explanation, consider the results of the largest research study into the question of why women choose abortion. It surveyed 1209 patients at abortion clinics around the country, asking them why they were terminating their pregnancies. The great majority, a full 73%, pointed to the high cost of motherhood, saying that they could not afford to have a baby now.¹⁶ These women are telling us something that should be obvious: class matters. It is expensive to be a mom.

To be sure, not all of the women presenting for abortions at clinics throughout the U.S. are poor. But make no mistake about it; the large majority of women having abortions today are poor. Their poverty drives their decision to seek an abortion. And given the challenges poor women face in paying for contraception, we might surmise that their need for an abortion stems at least in part from their lack of access to affordable contraception. In short, their visit to an abortion clinic is not simply a response to the crisis of an unplanned pregnancy, but rather, is an outgrowth of the fact that they are poor.

C. Abortion Politics and Intensifying the Medicalization of Poverty

Bearing in mind the factors that undergird the correlation between abortion and poverty, consider for a moment how the ongoing battle over abortion laws affects poor women. The Supreme Court's abortion jurisprudence permits the state to regulate abortion, just as they would any other health procedure.¹⁷ In the years since 1973, and in particular in the first two decades of the 21st century, pro-life leaning states have endeavored to deter abortion by making the procedure more expensive.¹⁸

This strategy is not new. In fact, the very first Congressional battle over abortion after *Roe* legalized abortion involved restrictions on federal funding for abortion. In 1976, Congress passed the Hyde Amendment, which prohibited the use of federal dollars for abortions except in cases of rape, incest, or medical necessity.¹⁹ The law was important for symbolic reasons: abortion opponents did not want their tax dollars to be spent on abortion. But lawmakers also saw in the law an opportunity to tip the balance away from abortion. Here's how Representative Henry Hyde explained the law's goals:

I certainly would like to prevent, if I could legally, anybody having an abortion: a rich woman, a middle-class woman or a poor woman. Unfortunately, the only vehicle available is the... Medicaid bill.²⁰

His strategy worked. In the wake of the ban on funding, poor women had fewer abortions and more babies. Researchers studying abortion rates between 1974 and 1988 aimed to examine what happened when the federal government and some states banned tax-payer funding for most abortions. When states denied public funding, they saw a 5% decline in abortion rates.²¹ The impact of denying funding was particularly stark among the poorest women, where data showed a 22% drop in the number of abortions one would have expected to find.

In the first twenty years following *Roe*'s legalization of abortion, states with pro-life majorities explored other ways of using the law to discourage abortion. Legal battles over these laws eventually made their way to the Supreme Court, which in 1992 announced a new standard to guide states, replacing *Roe*'s "trimester" standard. The case of *Planned Parenthood v. Casey* created the "undue burden" test, which permits states to use the law to disincentivize abortion.²²

Unless it [imposes an undue burden] on her right of choice, a state measure designed to persuade her to choose childbirth over abortion will be upheld if reasonably related to that goal. Regulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden.²³

The project of passing laws designed to raise the hurdles to abortion intensified in the first decades of the 21st century, as states with pro-life majorities have enacted numerous laws that regulate abortion.²⁴ In 2004, the pro-life group Americans United for Life launched a model legislation project. They drafted a broad set of anti-abortion laws, including provisions banning abortion after 20 weeks on the grounds that the fetus could feel pain, requiring mandatory waiting periods, and restricting the settings and the providers for abortions.²⁵ The group encouraged pro-life states to enact whole slates of anti-abortion laws, keeping track of their success with a national pro-life "report card" system.

To understand how these laws constrict poor women's reproductive health decisions, consider a series of restrictive abortion laws passed in one state: Wisconsin. In recent years, Wisconsin enacted a law requiring a 24-hour waiting period and another law banning the use of telemedicine by abortion providers. The state has

only three abortion providers, all in Madison or Milwaukee.²⁶ The abortion procedure itself costs on average \$593.00. For a single mother in rural Wisconsin, though, the actual costs are much higher. She bears additional costs triggered by the waiting period and the distance she must travel. Gas, lodging, childcare and missed work add up, so that in the end, an abortion actually costs her \$1,380.

In the end, abortion laws aim to deter women from having abortions by raising the costs of getting one. And the women most likely to be deterred by abortion's high cost are those who are poor. The same women who face higher risks of pregnancy because they cannot afford effective contraception. As the next Part shows, they are also the women for whom abortion remains attractive, in spite of the costs, because the cost of motherhood is so much higher.

II. The Price of Choosing Motherhood

Abortion decisions are an outgrowth of the medicalization of poverty, hastened by the price of carrying a pregnancy to term. Given that fewer than 1% of women respond to an unplanned pregnancy by placing the baby with adoptive parents,²⁷ motherhood is the alternative most confront when experiencing an unplanned pregnancy.

The connection between the cost of motherhood and abortion became apparent to me when I spent the day at Birth Choice, a pro-life crisis pregnancy center in Oklahoma City. Such centers are controversial; typically, they are faith-based counseling offices, staffed by volunteers who strive to persuade women not to have abortions. Their methods, which pro-choice advocates like me decry as intentionally misleading or misinforming women seeking abortion-related information, are the subject of ongoing legal disputes.²⁸

I was in Oklahoma working on a book about the battle over abortion law in the U.S. and was grateful for the chance to ask Birth Choice volunteers why they thought women considered having abortions. I also asked how hard it was to persuade women to keep their pregnancies.²⁹ By the end of the day, I could have taught a class on the ways in which poverty leads women to seek abortions.

Birth Choice sees three to four hundred women a month at its clinic on the far south side of Oklahoma City. It provides some medical care, as volunteers perform pregnancy tests and check blood pressure and weight. It does a great service by helping eligible women enroll for Sooner Care, the state's Medicaid provider. And Birth Choice makes prenatal referrals to a nearby Catholic hospital.

Their clients are poor. Many struggle with housing, living out of a car or sleeping on friends' couches. Some are being beaten and terrorized by violent partners, some are undocumented. Many have lost children to foster care. Some are mentally ill, others are addicts. Many come to Birth Choice not because they mistakenly think it is an abortion clinic; rather, they want to keep their pregnancy, but feel like they are too poor to do so.

In 1986, Birth Choice determined to provide real options for its clients. Breaking off from the international Birth Right movement, which supports only store-front operations and refuses to license centers that want to offer shelter to

their clients, it founded Rose Home. It is a house where the most vulnerable of their clients can live during and immediately after their pregnancies.

At Rose Home, the women get the support they need in order to do the work of mothering. They get sober and healthy, with access to mental health treatment, substance abuse treatment, and prenatal care. They have caseworkers who help them set goals and plan their futures. They get help with job searches and with making court dates, which is vital to their ability to regain custody of children currently in foster care. The home hosts quarterly meetings and support groups even after the women graduate.

Rose Home is an expensive proposition. At any given time, it serves 5 women and up to 13 of their children. And by considering the price tags on each of the services its clients receive, we quickly see how poverty gets medicalized in the lives of its residents, and of poor mothers in general.

Let's imagine a hypothetical pregnant woman who earns \$15,000 a year. SoonerCare, the state's Medicaid system, requires proof of citizenship and evidence of poverty. In 2017, to be eligible for full medical benefits under Medicaid, a pregnant woman must earn no more than \$16,044 per year.³⁰ If she is not a citizen, the "Soon to be Sooners" program will cover her prenatal care, but the law will strip the mother of her medical insurance immediately upon delivery of her baby.³¹

Imagine further that she is addicted to heroin. The optimal course of treatment, even without the complicating factors of pregnancy, would involve a month-long stay in an in-patient rehabilitation setting.³² High quality treatment centers routinely charge \$20,000 for the month, although some charge as little as \$6,000.³³ Even the cheapest treatment—an intensive three-month outpatient program—would cost on average \$5000, amounting to more than 1/3 of the woman's gross annual income.³⁴ A google search of "Oklahoma Inpatient Drug Rehabilitation" revealed every inpatient rehabilitation program requires either insurance or cash payment. Only a handful accepted SoonerCare. Her pregnancy will constitute another barrier—residential programs seem not to accept pregnant women.³⁵

What about housing costs? The average rent in Oklahoma City for a one-bedroom, 689 square foot apartment is \$656 per month.³⁶ The National Low Income Housing Coalition recommends spending no more than 30% of one's income on housing.³⁷ By this measure, our hypothetical pregnant woman could only afford a rent of \$375 per month. Even if she were to spend 50% of her gross income, she could pay no more than \$625 per month.

After rent, our hypothetical pregnant woman will need to make her remaining income cover the cost of transportation and food. If she wants to keep a roof over her head, her needs for substance abuse and mental health services, let alone vocational training to improve her job prospects, will go unmet. She does not have the money for them.

Each of these basic needs is vital to a woman's becoming healthy enough to be a mother. Each is essential to her ability to meet her future child's needs. The poorest of the women seeking care at Birth Choice already need most of the things

on this list. Pregnancy may intensify their healthcare needs, but let's be honest: the overwhelming majority of these challenges persist regardless of whether the woman has an abortion or a baby. As I said at the outset, a focus on the reproductive health issues faced by poor women simply brings into focus the myriad ways in which poverty is medicalized.

If our hypothetical woman decides to have this baby, we can predict both medical and economic consequences with surprising certainty. When poor women have children, both they and their children are likely to stay poor. More than 1 in 3 single-mother families lived in poverty in 2016.³⁸ The poverty rate for female-headed families with children was 36.5 percent, compared to 22.1 percent for male-headed families with children and 7.5 percent of families headed by married couples with children.³⁹

The American Academy of Pediatrics spells out the consequences—the medicalization of poverty for children—in this 2016 policy statement:

Children who experience poverty, particularly during early life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life course. Poverty has a profound effect on specific circumstances, such as birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury. Child poverty also influences genomic function and brain development.... Children living in poverty are at increased risk of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships. Poverty can make parenting difficult, especially in the context of concerns about inadequate food, energy, transportation, and housing. Child poverty is associated with lifelong hardship. Poor developmental and psychosocial outcomes are accompanied by a significant financial burden, not just for the children and families who experience them but also for the rest of society....⁴⁰

In short, when a poor, pregnant woman decides to keep her unplanned pregnancy, the odds are great that both she and her child will face a lifetime of poverty and ill health.

IV. Conclusion

It is so easy to be misunderstood in the abortion war; we are primed for attack. So let me be clear about the connection between abortion, motherhood, and the medicalization of poverty.

The reality is that poverty mines all paths available to girls and women. A given woman living in poverty may be lucky enough to dodge the mines, but the vast majority will not have such luck. Instead, many, if not most of a poor woman's encounters with her healthcare providers will be a testimony to the myriad ways in which poverty has worsened her health and constrained her life prospects.

For 45 years, the U.S. has fought over abortion in rhetorical terms that, upon scrutiny, are hollow. We speak of “choice” and “life” as if they reflect women’s actual experiences when opting for or against having an abortion. To examine the role poverty plays in abortion and mothering decisions is to give the lie to this framing of our discourse.

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