

# Disparities in Abortion Rates: A Public Health Approach

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Women of lower socioeconomic status and women of color in the United States have higher rates of abortion than women of higher socioeconomic status and White women. Opponents of abortion use these statistics to argue that abortion providers are exploiting women of color and low socioeconomic status, and thus, regulations are needed to protect women. This argument ignores the underlying causes of the disparities. As efforts to restrict abortion will have no effect on these underlying factors, and instead will only result in more women experiencing later abortions or having an unintended childbirth, they are likely to result in worsening health disparities. We provide a review of the causes of abortion disparities and argue for a multifaceted public health approach to address them. (*Am J Public Health*. 2013;103:1772–1779. doi:10.2105/AJPH.2013.301339)

The abortion rate in the United States is higher than that in most other developed countries.<sup>1</sup> Although this fact alone requires attention, looking deeper within these statistics reveals an additional area of concern: similar to many health outcomes in the United States, there are substantial disparities in abortion rates in the United States, with low-income women and women of color having higher rates than affluent and White women. In 2008, the abortion rate for non-Hispanic White women was 12 abortions per 1000 reproductive-age women, compared with 29 per 1000 for Hispanic women, and 40 per 1000 for non-Hispanic Black women.<sup>2</sup> Disparities in abortion rates also exist by socioeconomic status (SES), with women with incomes less than 100% of the federal poverty level (FPL) having an abortion rate of 52 abortions per 1000 reproductive-age women, compared with a rate of 9 per 1000 among those with incomes greater than 200% FPL. In analyses assessing both income and race/ethnicity, both are independently associated with abortion rates.<sup>2</sup>

In the past several years, the differences in rates of abortion have received increasing political attention, with those opposed to abortion rights citing differences in abortion rates as evidence of the diabolical nature of the “abortion industry.” Abortion rights opponents point to racial/ethnic differences in abortion rates as evidence of racism and coercion among those who support the right to obtain

abortions.<sup>3,4</sup> Not only do these messages explicitly blame those providing abortion for targeting communities of color, they also assign guilt to women of color who decide to have abortions by implying that they are falling victim to a racist conspiracy. Differences in abortion rates by income are also seen as evidence of exploitation by abortion providers, who are claimed to be aggressively profiting from public funding of abortion for low-income women.<sup>5</sup> Although there is no evidence of racial targeting<sup>6</sup> or routine profiteering by abortion providers, from the perspective of those who espouse these views, the problem of disparities in abortion rates can only be solved by limiting access to and utilization of abortion services.

Motivated by a concern that this politicized perspective on disparities in abortion rates fails to consider their actual underlying causes, and thus will not ultimately lead to meaningful policy or programmatic outcomes, we review what is known about the origins of disparities in abortion rates by both race/ethnicity and SES. We discuss what can be done to address the root causes of these disparities in abortion, as well as to minimize their negative effects. By moving beyond a focus on abortion rates in isolation, we hope to shift the focus from abortion alone to the overarching issue of how to improve all women’s health outcomes, as well as women’s ability to make decisions about their reproductive health and life trajectories.

Although we focus on issues related to Black, Hispanic, and low-SES women, as these are the groups for which data on abortion rates are available, we note that many of the issues discussed are likely also relevant to other disadvantaged racial/ethnic groups such as American Indians, Alaska Natives, Asians, and Pacific Islanders.

In discussing these issues, it is essential to consider that abortion is not in and of itself an adverse outcome. Although popular discourse often focuses on making abortion “rare,” this does not allow for the reality that, for a woman with an unintended pregnancy who desires an abortion, being able to obtain this procedure in a timely and safe manner is in fact a desirable outcome. In addition, the framing of abortion as something that needs to be rare may actually contribute to the ongoing stigmatization of abortion and of women who seek it, which in turn can lead to delayed or unsafe abortion.<sup>7,8</sup> However, as it is desirable to avoid an unintended pregnancy that leads to abortion in the first place, we suggest that it is constructive to address disparities in abortion rates that result from structural social inequalities—especially racism and poverty—without seeing abortion as a bad outcome once an unintended pregnancy has occurred. When such an approach is taken, the focus shifts from the overall number of abortions to helping women achieve their personal fertility desires.

## ABORTION DISPARITIES IN CONTEXT

The documented disparities in abortion rates in the United States mirror other fundamental inequalities: people of color and those with lower income and less education fare worse across a wide range of health outcomes, including infant mortality, cancer incidence, and life expectancy.<sup>9–11</sup> These disparities are related to systemic hardships experienced by disadvantaged communities, including decreased access to health care, higher levels of stress, exposure to racial discrimination, and

poorer living and working conditions.<sup>9,12,13</sup> Understanding the systemic nature of these disparities and their relationship to health outcomes provides an essential context to the consideration of disparities in abortion rates. This broader understanding is of particular importance given the cultural tendency for discussion of abortion and sexual health to engender judgment of individual women's behavior, as well as a historical propensity for negative stereotyping about the sexual and reproductive behavior of non-White and lower-income individuals.<sup>14</sup>

We share the perspectives of important theorists of race and health who have noted that the continued use of classifications of race, ethnicity, and SES are important, not because they identify meaningful differences at the level of individual behavior or biology, but rather because they reflect larger systems of structural inequality, including racism and systematic inequalities in both opportunities and power.<sup>15-17</sup> In this approach race is understood as a social and political rather than a biological category.<sup>18,19</sup> As a consequence, data presented throughout this article on higher rates of both poor health outcomes and higher risk behaviors in women of color and low-SES women should be seen as reflective of adverse social circumstances rather than individual failings. In a similar way, data on lower rates of adverse health outcomes and risk behaviors in White and more affluent women should be seen as reflective of the privileges and advantages that accompany membership in a dominant social group.

Race/ethnicity and SES (and gender) intersect to form a person's identity, and these dimensions of identity affect all aspects of day-to-day life.<sup>20</sup> Among other things, they influence where people live, the nutritional value of food to which they have ready access, and the degree of discrimination or respect people experience. In addition, race/ethnicity and SES circumscribe educational and vocational opportunities, and access to quality health care and to health insurance.<sup>21</sup> These factors have also played significant roles in the ways in which reproduction has historically been allowed, required, or denied for populations of women.<sup>14,22-24</sup> Therefore, although we do present data about individual-level factors influencing disparities in reproductive health

indicators, our ultimate goal is to create greater understanding of the pervasive economic and social forces that underlie them.

## INDIVIDUAL-LEVEL INFLUENCES ON DISPARITIES IN ABORTION RATES

Disparities in abortion rates are, not surprisingly, related to racial/ethnic and socioeconomic disparities in unintended pregnancy, as well as related disparities in contraceptive use.

### Unintended Pregnancy

Although the proportion of pregnancies that are unintended is high for all women at 51%, there are significant differences among population subgroups.<sup>25</sup> Rates of unintended pregnancy are highest among Blacks, Hispanics, and women with lower SES.<sup>25,26</sup> The most recent data in which the independent effects of race/ethnicity and SES have been examined come from the 2008 National Survey of Family Growth (NSFG). By race/ethnicity, 70% of all pregnancies among Black women and 57% among Hispanic women were unintended, compared with 42% among White women. With respect to income, 64% of pregnancies among women with an income of less than 100% FPL were unintended, whereas only 37% of pregnancies were unintended among women with an income of more than 200% FPL.<sup>25</sup> There were similar findings by educational level. Furthermore, this analysis demonstrated that both Black and Hispanic race/ethnicity and being lower-income were independent predictors of unintended pregnancy.

With regard to unintended pregnancy, an additional important consideration is the rate of adolescent pregnancy, of which more than 80% are unintended.<sup>26</sup> Significant racial/ethnic disparities exist in this outcome as well, with a rate of 44 pregnancies per 1000 females between ages 15 and 19 years among non-Hispanic Whites, 124 per 1000 among non-Hispanic Blacks, and 129 per 1000 among Hispanics.<sup>27</sup> Although the overall rate of adolescent pregnancy has declined over the past decade, disparities between groups have persisted, and similar disparities exist by socioeconomic variables.<sup>28,29</sup>

### Sexual Activity and Contraceptive Use

Risk of unintended pregnancy is associated with sexual activity, either without use of contraceptive protection or with the use of a contraceptive method that is ineffective in that instance. In addition, age of initiation of sexual activity is itself a risk factor for adolescent pregnancy. Though recent data show that adolescents are delaying sexual initiation to older ages,<sup>27</sup> the proportion of adolescents who engage in sexual intercourse varies by race/ethnicity and by SES. National studies have consistently shown that Black adolescents initiate intercourse at younger ages than White adolescents.<sup>30,31</sup> By contrast, Hispanics have the oldest mean age of sexual initiation, at age 18 years.<sup>30</sup> Researchers have also shown an inverse relationship between sexual experience and SES.<sup>32,33</sup>

For women and girls who are sexually active and who do not currently desire children, use of contraceptive methods is clearly associated with the ability to prevent pregnancy. Studies performed at the national and regional levels have found that there are differences in effective use of contraception by women's race/ethnicity and SES that likely influence disparities in unintended pregnancy. The most striking disparities in contraception use are those in the percentage of women at risk for unintended pregnancy who report using no contraceptive method. In the most recent NSFG, which includes data from 2006 to 2010, 17.2% of Black women and 10.4% of Hispanic women at risk for unintended pregnancy were using no contraceptive method, compared with 9.5% of non-Hispanic White women.<sup>34</sup> Although there were no differences by education and income in these most recent data, previous versions of the NSFG have found differences by these socioeconomic variables.<sup>35</sup> Analyses of the NSFG have not isolated the independent effects of race/ethnicity and socioeconomic factors, but other studies have found that generally differences by education and race/ethnicity persist after adjustment, and income is not as strongly associated.<sup>36-38</sup>

Among women using contraception, race/ethnicity has also been found to be associated with decreased likelihood of using highly effective methods, whereas socioeconomic variables have not been associated with this

finding. In the most recent NSFG, 14.1% of non-Hispanic White women who used contraception relied on condoms, compared with 18.1% of Hispanics and 19.5% of Blacks.<sup>34</sup> Although this analysis did not control for confounding factors, studies using multivariate techniques have also found that race/ethnicity is associated with use of less effective methods such as condoms.<sup>39,40</sup> Although higher rates of condom use may be appropriate for the prevention of sexually transmitted infections, including HIV, they are less efficacious at preventing pregnancy.<sup>41</sup>

Other studies have looked at contraceptive failure rates by sociodemographic factors, and have found that both income and race/ethnicity are associated with a higher likelihood of failure among those using contraception. Data from the 2002 NSFG found that Blacks and Hispanics had a 21% and 15% rate, respectively, of contraceptive failure in 1 year, compared with 10% among non-Hispanic Whites, and those with an income less than 100% FPL had a 20% failure rate, compared with 8% for those with an income greater than 200% FPL.<sup>42a</sup> Although some of these differences are likely attributable to differences in the contraceptive methods used, this study found differences in condom failure rates by both race/ethnicity and income, suggesting that differences in failure rates may exist even among those using the same method. Continuation of a chosen contraceptive method also has an impact on the risk of unintended pregnancy, as discontinuation can be associated with gaps in contraceptive use.<sup>42b</sup> While studies of predictors of method discontinuation have been limited, analyses with NSFG data have found that Black and low-SES women have higher rates of discontinuation of the oral contraceptive pill.<sup>42b,43</sup> These analyses indicate that both race/ethnicity and SES are associated with selection of contraceptive methods, as well as women's use of their chosen method.

## UNDERLYING INFLUENCES ON DISPARITIES IN ABORTION RATES

As noted previously, chronic disadvantage and stress experienced by low-SES individuals and people of color in the United States influence disparities in multifaceted ways. For example, living in disadvantaged

neighborhoods is associated with adverse health behaviors such as smoking,<sup>9</sup> and experiences of discrimination are associated with decreased likelihood of seeking preventive health services.<sup>13</sup> These same hardships may underlie disparities in timing of initiation of sexual activity and contraceptive use, and the resulting disparities in unintended pregnancy and abortion rates. Although the pathways by which this occurs have not been comprehensively investigated, topics that have been studied include differences in neighborhood-level resources and opportunities, access to and quality of family planning care, mistrust of health care providers and contraceptive technologies, perceived infertility, and pregnancy attitudes. In combination, these areas of research begin to indicate the pervasiveness of the disadvantage that women of color and low-SES women face in the context of their reproductive lives.

An important influence on sexual initiation is the neighborhood in which adolescents live. Studies have found higher sexual risk for young people living in neighborhoods where there are higher levels of poverty, idle youths, and social disorganization, and lower proportions of working women and lack of economic and educational opportunities.<sup>33,44,45</sup> Analyses controlling for both neighborhood and individual-level characteristics that have found little or no differences by race or individual socioeconomic variables suggest the importance of these structural influences on sexual activity.<sup>44,46</sup>

With respect to contraceptive use, factors underlying the findings (i.e., lower-SES women and women of color being less likely to use contraception, less likely to use highly effective methods, and more likely to discontinue methods than higher-SES and White women) include differences in access to, quality of, and acceptability of family planning, as well as differences in perceived need for family planning. With respect to access, lack of insurance coverage for contraception and family planning care is a significant barrier, as it is estimated that more than half of US women of reproductive age are in need of publicly funded family planning care, and only 40% of these women actually receive these services.<sup>47</sup> Low-SES women and Black and Hispanic women are more likely to be uninsured<sup>48</sup>

and, therefore, lack of insurance coverage is a likely contributor to disparities in contraceptive use.

Even when receiving family planning care, poor and non-White women may continue to face barriers to contraceptive use. Quality of care is one factor, as non-White patients have been found to be less likely to rate their family planning visits positively.<sup>49</sup> In addition, studies have suggested that women of color may experience pressure to utilize contraceptives and limit their family size,<sup>50,51</sup> and also may receive different recommendations from their providers about family planning methods.<sup>52</sup> One survey study found that approximately two thirds of Black women reported having experienced race-based discrimination when receiving family planning care.<sup>53</sup> As pressure to utilize a method<sup>54</sup> and lower quality of care have been associated with lower contraceptive use,<sup>49,55</sup> these factors may contribute to disparities in reproductive outcomes.

Another potential related contributor to differences by race/ethnicity in contraceptive use is the finding that women of color may have less knowledge and more concerns about contraceptive methods than do White women.<sup>56-66</sup> One potential explanation for lower knowledge is that Black and Hispanic adolescents are less likely to receive sexuality education that includes information about birth control methods.<sup>67</sup> Skepticism of contraception may relate to distrust of the health care system in general,<sup>68</sup> as well as concern about the motivation of family planning programs grounded in the historical context of coercive family planning policies targeted at these same groups of women.<sup>69</sup> A recent analysis of a nationally representative survey indicated that skepticism about the motivation of family planning providers is widespread; 42% of Blacks and 51% Hispanics surveyed believed that the government promotes birth control to limit minorities, compared with only 25% of Whites.<sup>70</sup>

Finally, women of color have been found to be more likely to perceive themselves to be infertile, which may decrease their motivation to use contraception.<sup>71</sup> In fact, these fears of infertility are not unfounded as women of color and low-SES women have substantially higher rates of infertility than White women and women of higher SES.<sup>72</sup>

Pregnancy ambivalence—defined as having a lack of definitive intention regarding pregnancy planning—has increasingly been studied as a central concept in women’s reproductive health, and may have relevance to reproductive health disparities. Studies have found that women who are ambivalent about pregnancy are more likely not to use contraception at all,<sup>37</sup> to use it infrequently,<sup>73</sup> to have gaps in use,<sup>37</sup> and to use less effective methods of contraception.<sup>74</sup> Studies investigating differences in pregnancy attitudes by race/ethnicity include one that found that 39% of Latinas and 37% of Black women provided ambivalent responses about pregnancy, compared with 16% of White women.<sup>74</sup> In addition, there are differences by race/ethnicity in pregnancy intention among adolescents, with the 2002 NSFG reporting that 66% of White female adolescents would be “very upset” if they were to become pregnant, compared with only 51% of Blacks and 46% of Hispanics.<sup>67</sup> No similar studies have investigated differences in pregnancy ambivalence by SES. Although the reasons behind these racial/ethnic differences in pregnancy ambivalence have not been well-studied, they may relate to the presence or absence of alternative life opportunities, the perception of control over one’s life course, the availability of social supports for early childbearing, and lack of perceived adverse effects of unplanned childbearing.<sup>75–79</sup>

## ADDRESSING DISPARITIES IN ABORTION

Disparities in abortion rates are related to disparities in unintended pregnancy, and associated disparities in contraceptive use. Structural factors, including economic disadvantage, neighborhood characteristics, lack of access to family planning, and mistrust in the medical system underlie these findings.

Understanding this context allows us to critically consider the efforts of abortion rights opponents to politicize disparities in abortion rates as part of a larger effort to limit access to abortion care through such means as expanding regulations on abortion care, including increased waiting periods and counseling and facilities requirements. This focus on limiting access to abortion does nothing to mitigate the underlying inequities in wealth, education,

health care, discrimination, or other life experiences that may influence reproductive health disparities, nor do they address specific disparities in contraceptive use or unintended pregnancy that lead to disparities in abortion rates. Instead, the resulting policies result in more women experiencing later abortions or having an unintended childbirth.<sup>80,81</sup> As later abortions are associated with higher medical risk and greater cost to women, and unintended childbirth is associated with decreased opportunities for education and paid employment,<sup>82</sup> as well as with adverse maternal and infant health effects,<sup>83,84</sup> this orientation has the potential to cause worsened health and social outcomes and to increase medical and social disparities.

By contrast, a multifaceted approach that includes prevention of unintended pregnancy and management of unintended pregnancies when they occur, including increasing access to safe abortion care, would be expected to have a positive impact on reproductive and maternal health outcomes by addressing disparities in a more comprehensive manner. This approach, which incorporates both primary prevention of unintended pregnancy and secondary prevention of adverse outcomes once an unintended pregnancy occurs,<sup>85</sup> focuses on the goal of improving women’s health outcomes, not decreasing rates of abortion in isolation. Three potential avenues for addressing disparities are consistent with this framework: prevention of unintended pregnancy, access to quality abortion care, and prenatal care and economic supports for women who continue their unintended pregnancies to term.

With respect to preventing unintended pregnancies, strategies to address barriers to use of contraceptive methods, including increasing insurance coverage for family planning methods, are essential. The Affordable Care Act has the potential to decrease financial barriers to contraceptive care, as contraceptive services are included as core preventive services to be covered without a copayment.<sup>86</sup> However, as the Affordable Care Act will leave up to 30 million people uninsured,<sup>87</sup> barriers to care will still exist for many women, and especially for those who are undocumented. Efforts to expand access to contraceptive services are also necessary, especially in the context of abortion care in which restrictive

insurance reimbursement policies lead to women being unable to obtain contraception at their time of their abortion.<sup>88</sup>

Additional barriers to contraceptive use that can be addressed include gaps in knowledge about contraceptive methods and concerns about safety, especially among women of color. Improving contraceptive counseling is one strategy to accomplish this goal; further research is needed on ways to assist women in making informed decisions about their contraceptive use.<sup>89,90</sup> One focus of this counseling can be ensuring that women have accurate knowledge about the most highly effective reversible methods—intrauterine devices and the contraceptive implant—as expanded use of these methods would have a substantial impact on unintended pregnancy.<sup>91</sup> However, because of the history of coercive family planning care in the United States,<sup>69</sup> particular attention should be paid to ensuring that patient autonomy is prioritized in this counseling and that issues of possible patient mistrust are addressed. Indeed, we are in need of data about how women in general—and low-income women and women of color in particular—experience the recent push among family planning specialists to increase use of these methods.<sup>92,93</sup> For clinicians, these methods may be understood simply as a means to decrease unintended pregnancy, but to women—and perhaps low-income and women of color in particular, in light of historical atrocities<sup>14,69</sup>—they may carry different meanings, such as coercion, lack of trust in patients, or that doctors do not want poor or minority women to reproduce.

Interventions outside the clinic setting should also be utilized, including increasing the availability of comprehensive sexual education. Because there is extensive variation in the sexual education that is provided in schools,<sup>94</sup> more standardized curriculums and laws to ensure compliance<sup>95,96</sup> could have an impact on disparities. Given the documented importance of neighborhood environment on adolescent pregnancy specifically, engaging with communities directly to develop interventions that function on the community level and take into account peer and family context have particular potential for positive impact. This process of community engagement could be a powerful means of overcoming the legacy of

coercive family planning policies, and the mistrust of family planning it has engendered. Finally, strategies utilizing social media, including recent efforts by the National Campaign to Eliminate Teen and Unintended Pregnancy,<sup>97</sup> have potential to disseminate evidence-based information to diverse groups of women in novel ways.

Although these approaches are likely to have some effect, we note that they do not address the issues of structural poverty, racism, and lack of opportunity that underlie the disparities in contraceptive use and unintended pregnancy. Differences in neighborhood environments, discrimination in health care and other settings, and stratified educational and employment opportunities all reflect social and economic realities in the United States that are not addressed by these incremental approaches. Efforts to promote a realignment of priorities to improve economic and social equality are necessary to address these fundamental causes of unintended pregnancies, and health care providers and public health advocates can continue to advocate more progressive policies designed to create a more egalitarian society. The more immediate strategies we describe can, in the meantime, mitigate the adverse effects of these inequalities.

Once an unintended pregnancy has occurred, the availability of timely and high-quality abortion<sup>98</sup> and pregnancy services, including prenatal care<sup>99</sup> is essential to ensure that women have the best possible outcomes. This attention to preventing adverse consequences associated with unintended pregnancy is equivalent to secondary prevention in diabetes; although attention should be paid to preventing diabetes and disparities in incidence of diabetes, we also need to prevent adverse outcomes associated with diabetes—such as lower-extremity amputations and vision loss—as well as disparities in these outcomes. The importance of secondary prevention of adverse outcomes in women's reproductive health is highlighted by the presence of racial disparities in abortion-related mortality, which is at least in part attributable to disparities in the timing of abortion care.<sup>100</sup> Whereas abortion is overall lower risk than continuing a pregnancy to term, abortions at later gestational ages are associated with greater risk than those performed earlier.<sup>100</sup> As Black women and

women with lower levels of education are more likely to have later abortions,<sup>101</sup> this exposes them to greater health risks. Improving access to abortion would therefore have a positive impact on disparities in abortion-related morbidity. In addition, disparities in maternal morbidity and mortality and infant mortality<sup>102</sup> illustrate the importance of ensuring quality care for women who continue their pregnancies and in providing economic supports to reduce the contribution of poverty to these outcomes.

Providing public and private insurance coverage for abortions is an important component of improving access to abortion, and would enable low-income women who desire abortions to obtain them in a safe and timely manner. This would have a beneficial impact on health outcomes through helping to ensure that women receive abortion care at the earliest and, therefore, safest gestational age possible. Currently, federal money, including Medicaid funds, cannot be used to pay for abortions unless the pregnancy is a result of rape or incest or the pregnant woman's life is in danger. In addition, 33 states ban the use of state funds except in cases where federal funds are available.<sup>103</sup> Even in cases where women should be eligible for federal funds, few are able to access this financial support.<sup>104</sup>

As the mean charge for a nonhospital abortion at 10 weeks gestation is \$543, and the mean charge for a nonhospital abortion at 20 weeks is \$1562,<sup>105</sup> there are substantial financial barriers to access, particularly among low-SES populations. These barriers affect women's ability to obtain timely abortion services, as indicated by a study that found that low-SES women reported that the cost of paying for an abortion delayed their access to abortion,<sup>106</sup> and other studies that have found that the cost of abortion is in general a barrier to care.<sup>107,108</sup> A study in California, in which Medicaid funding is available, further supports the importance of the availability of public funding on access to abortion. Women who reported difficulties obtaining Medicaid coverage experienced 4-times-greater odds of having an abortion in the second trimester compared with those who did not experience barriers to this coverage.<sup>109</sup>

Additional steps that can be taken to improve access to abortion services include

decreasing state regulations, such as mandatory waiting periods, which pose barriers to care, and increasing the number of providers. Currently, 87% of all counties in the United States do not have an abortion provider, and 35% of women of reproductive age live in these counties.<sup>105</sup> This lack of available services results in many women accessing abortion services having to travel long distances.<sup>110</sup>

This attention to expanding and facilitating access to abortion care is in direct contradiction to the approach taken by those whose focus is on decreasing abortions, and reflects a focus on optimizing and decreasing disparities in health outcomes, rather than emphasizing a goal of reducing the absolute number of abortion procedures. In addition to these benefits on the timing of abortion, improving access to abortion care would ensure that all women are able to make the decision that is best for them regarding childbearing when faced with an unintended pregnancy. It is not surprising that studies have found that restricted access to abortion services can limit women's ability to abort a pregnancy when they wish to do so, and that these effects may be particularly pronounced for Black women and women with lower educational attainment.<sup>111,112</sup> As unintended childbearing is associated with adverse effects,<sup>83,84</sup> this can further exacerbate health and social disparities. Although there is a general social discomfort with conceptualizing an increase in the number of abortions as a positive outcome,<sup>7</sup> consideration of the interrelated aspects of women's reproductive health makes clear that limiting abortion does not address the largest underlying cause of abortion—unintended pregnancy—but rather only results in increasing disparities, in addition to limiting women's ability to control their reproductive lives.

Women who continue their pregnancies should have access to quality prenatal care to help reduce disparities in birth outcomes among women of color and low-SES women compared with White women and women with more financial resources. Although public financing for prenatal care was expanded substantially in the 1980s,<sup>113</sup> there continue to be documented disparities in receipt of prenatal care and in the quality of care provided,<sup>114–116</sup> as well as disparities in maternal and infant outcomes by race and SES.<sup>102,117</sup> Efforts to

improve the accessibility and quality of these services can further ensure that all women who continue their unplanned pregnancies have the best possible pregnancy outcomes.

An additional consideration in supporting women who wish to continue their pregnancies is the fact that women may decide to terminate pregnancies out of a realistic assessment of the level of economic social supports available to them after a child is born. This is especially true with the presence of maximum family size policies, which deny increases in welfare benefits after the birth of additional children, in many states.<sup>118</sup> Indeed, research suggests that inability to afford a(nother) child is a commonly expressed reason for seeking an abortion.<sup>119</sup> Policies that provide additional economic supports for low-income parents are an important component of ensuring that women are making the reproductive decisions that are best for them.

## CONCLUSIONS

The recent expansion of efforts to use disparities in abortion rates as a political strategy to justify limiting access to abortion has the potential to increase disparities in women's health by increasing abortions at later gestational ages and raising rates of unintended childbirth. In addition, decreased access to abortion limits women's ability to make the best decisions about childbearing for themselves and their families. Research and policy that recognizes the importance of all aspects of women's reproductive health—including pregnancy prevention, abortion care, pregnancy services, and economic supports—are essential to meeting the reproductive health care needs of low-SES women and women of color. This work must recognize that, although disparities are associated with differences in individual-level factors, these factors are constrained and produced by larger structural inequities, including racism and poverty, and by a legacy of coercive reproductive health policies. ■

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### Contributors

C. Dehlendorf led the writing of the article. L. H. Harris participated in writing and conceptualization. T. A. Weitz led the conceptualization and participated in writing.

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