**SPOTLIGHT
REPORT**

THE STATE OF REPRODUCTIVE HEALTH IN THE UNITED STATES

The End of Roe and the Perilous Road Ahead for Women in the Dobbs Era

JANUARY 19, 2023

GEPI

Executive Summary

In June 2022, the Supreme Court overturned *Roe v. Wade*, ruling in *Dobbs v. Jackson Women's Health Organization* that nothing in the United States constitution guarantees a women's right to abortion. Within six months of the decision, 15 states had banned abortion.[1] More are anticipated to do so in the 2023 state legislative sessions that will commence this month.

For 50 years, abortion was a protected, albeit highly endangered, constitutional right. The supportive legal environment, plus advances in birth control, fertility treatments, and other reproductive technologies, allowed women and pregnant people autonomy and freedom in their personal decisions about bearing children.[2] To be sure, legal and financial barriers prevented far too many people, particularly young, low-income, Black, Native American, and Latina women, from exercising their constitutional right.[3] Nevertheless, an extensive body of research demonstrates that legal access to reproductive health-care improved maternal and child health outcomes and advanced gender equity in the United States.[4]

The Dobbs decision has already dramatically changed the landscape. Abortion care in the U.S. is no longer simply difficult to access. It is illegal in 15 states. Abortion care providers and pregnant people seeking care are now subject to heavy fines, suspension, and in some cases, imprisonment. Criminalization has had a ripple effect; fear and suspicion have already resulted in the denial of necessary reproductive healthcare.

The freedom to control if and when to have children is globally recognized as a fundamental human right.[5] At Gender Equity Policy Institute (GEPI), we are committed to defending and advancing human rights, particularly for those marginalized on the basis of sex or gender, and to conduct research that helps the U.S. advance gender equity for all people.

This study reports on the state of reproductive and sexual health in the United States during the final years of the Roe era. The first in an annual series, "The State of Reproductive Health in the United States", analyzes data on key indicators such as teen births, maternal mortality, and newborn deaths, and compares trends between groups of states. Our objective in this inaugural report is to establish a baseline for future assessments of the effects of abortion bans on women's health and wellbeing in the coming years.[6]

The data is clear. For women, girls, and gender diverse people who can become pregnant, there are two Americas.

For this study, we evaluate the state of reproductive health and wellbeing in the U.S. by applying the framework adopted by the global community in the 2030 Agenda for Sustainable Development, specifically Sustainable Development Goal (SDG) 3, which calls for all nations to "ensure healthy lives and promote well-being for all at all ages."[7] (See Appendix 2.)

The U.S., despite being one of the 193 nations that have signed onto the 2030 Agenda, is the only developed nation that has not measured or publicly reported on its progress on any of the 17 sustainable development goals.[8] With only eight years remaining to reach the 2030 SDG targets, and the newly hostile environment for women's health and rights created by the Dobbs decision, a report putting the spotlight on women's reproductive and sexual health in the United States is in order.

To examine and compare annual levels and trends on key indicators of reproductive health, well-being, and equity, we first classified states into three groups—supportive, restrictive, and banned—based on their level of support for comprehensive reproductive health care, and then compared outcomes in the three groups over time. Outcome data was abstracted from high-quality, publicly available sources including the Centers for Disease Control and Prevention (CDC), the U.S. Census American Community Survey (ACS), and others. We analyzed all 50 states and the District of Columbia and primarily focused on the period between 2015 and 2021.[9]

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For those who live in one of the 22 states which support reproductive freedom, the trends are largely positive. The health and well-being of women and babies in these states outpaces that of those living in states which ban or restrict abortion care. This is true across nearly all indicators.[10]

The situation is dramatically different, and more precarious, for the 59% of women and girls who live in the 29 states which ban or restrict abortion care and other reproductive healthcare (See Table 1). On nearly every measure, people in banned and restrictive states have worse outcomes than their counterparts in supportive states. Moreover, these states are less likely to enact policies, like paid parental leave, which have been shown to improve outcomes for new parents and babies.[11]

The end of legal protection for abortion further threatens to increase maternal mortality, newborn and infant mortality, and teenage births in the U.S. These threats are not equal for all women. Women who live in states than ban or restrict abortion and other reproductive healthcare are likely to suffer the burden of these adverse consequences. Nationwide, Black and Native American women already face disproportionately higher maternal mortality rates and Latinas are more likely than other women to be uninsured. Therefore, for Black, Latina, and Native American women who live in states hostile to reproductive freedom, the health dangers will be compounded.

KEY FINDINGS

► **6 in 10 women** live in states that ban abortion or sharply limit reproductive freedom.

► **7 in 10 Black women** live in states that ban or restrict abortion care.

► **1 in 4 teens** live in states that banned abortion after Dobbs.

► **Mothers living in a state that banned abortion after Dobbs were up to 3x as likely to die** during pregnancy, childbirth, or soon after giving birth.

► **Babies born in banned states were 30% more likely to die** in their first month of life.

► **2x as many single mothers were uninsured** in banned states than in supportive states.

► **The teen birth rate was 2x** as high in banned states.

► **Maternal mortality nearly doubled** between 2018 and 2021.

► **Black women were almost 3x as likely to die** in pregnancy, childbirth, or right after giving birth as White women.

► **Black babies were more than 2x as likley to die** in their first month of life as White babies.

44 million women and girls live in states that ban or restrict abortion and reproductive healthcare
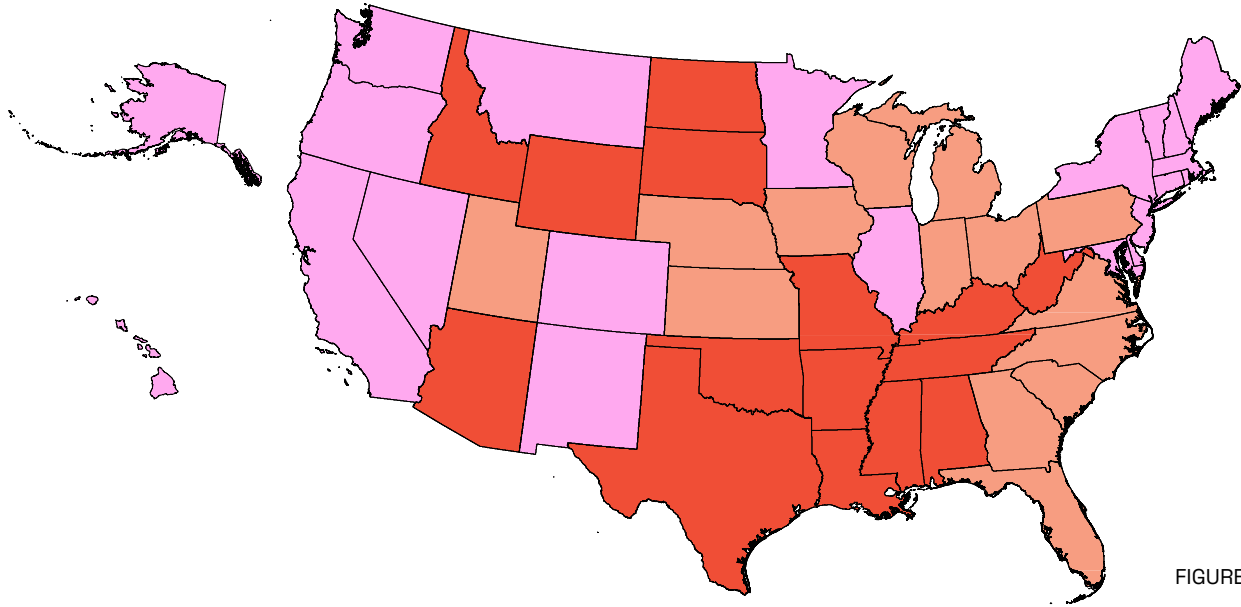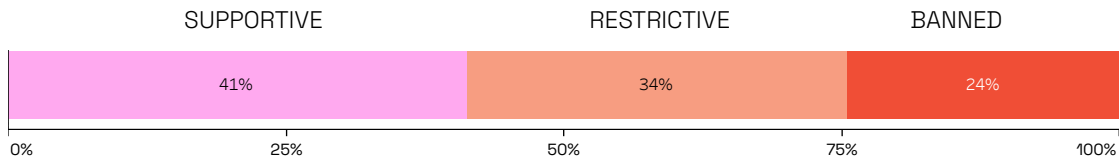

FIGURE 1

SUPPORTIVE	RESTRICTIVE	BANNED
41%	34%	24%

0%   25%   50%   75%   100%

Alaska	Florida	Alabama
California	Georgia	Arizona
Colorado	Indiana	Arkansas
Connecticut	Iowa	Idaho
Delaware	Kansas	Kentucky
District of Columbia	Michigan	Louisiana
Hawaii	Nebraska	Mississippi
Illinois	North	Missouri
Maine	Carolina	North Dakota
Maryland	Ohio	Oklahoma
Massachusetts	Pennsylvania	South
Minnesota	South	Dakota
Montana	Carolina	Tennessee
Nevada	Utah	Texas
New Hampshire	Virginia	West Virginia
New Jersey	Wisconsin	Wyoming
New Mexico		
New York		
Oregon		
Rhode Island		
Vermont		
Washington		

Women, ages 15-49, United States. Gender Equity Policy Institute analysis of ACS (2021).

Findings

The global consensus on health and wellbeing is reflected in the 2030 Agenda, as explained above. We evaluated the state of U.S. reproductive health from 2015-2021 on the indicators contained in SDG 3: *Ensure healthy lives and promote well-being for all at all ages.*[12] It includes the following targets related to reproductive and sexual health:

• Reduce the global maternal mortality ratio

• End preventable deaths of newborns and children under five years of age

• Ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programs

• Achieve universal health coverage

We identified and analyzed high-quality, publicly available data from on teen births, contraceptive use, maternal mortality, neonatal mortality, infant mortality, and health insurance coverage.[13] Our findings on these indicators are reported in this section.

Teen Births

The U.S. made significant progress in dramatically reducing teen births in the Roe era (1973-2021), a promising trend that has continued in recent years.[14] Between 2016 and 2021, births to teenagers dropped 32%, a reduction accompanied by a concomitant decline in abortions among teenagers.[15] Together, this data indicates that increased access to effective and affordable contraception provided teens with the ability to make choices about their reproductive health and thus limit unintended pregnancies.[16]

All three state groups experienced decreases in their teen birth rates. Teen births decreased the most in supportive states, by 30%, to a rate of 11.1 births per 1,000 adolescent women. In banned states, the teen birth rate started the period at a higher level, and proceeded to fall by 23%, to a rate of 22.3 births per 1,000 adolescent women.[17]

While the decline occurred across all groups, there remain large differences between states that track their reproductive healthcare policies. Throughout the period studied, the teen birth rate was nearly two times as high in banned states as in supportive states, a finding consistent with current research showing the negative impact of restrictions on reproductive freedom on teen pregnancy.[18] The gaps are even larger for white teens, with the teen birth rate 151% higher in banned states than in supportive states. Still, Black, Latina, and Native American women in banned states have the highest teen birth rates, demonstrating that the denial of reproductive freedom falls most heavily on women of color.

TEEN BIRTH RATE IS MORE THAN 2X AS HIGH IN BANNED STATES
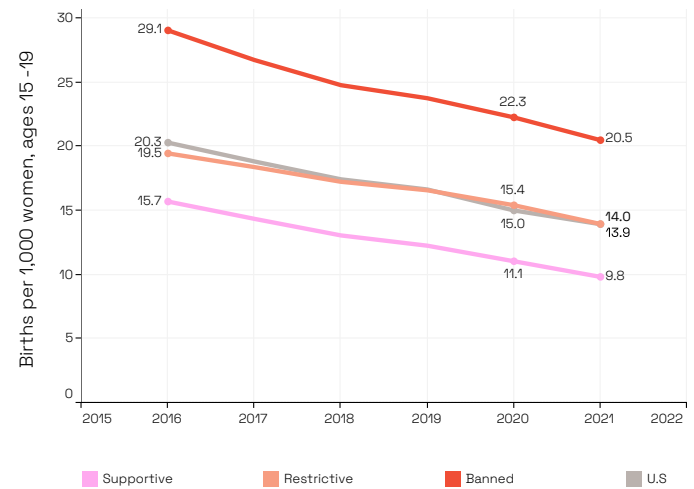
Gender Equity Policy Institute analysis of CDC (2015-2021).

Despite the promising trend, the U.S. overall continues to rank poorly among our our global peers, a distinction driven by higher adolescent fertility in states that ban or restrict abortion care. Our high rates have been associated by our inadequate provision of sexual and reproductive health education to young people. Only 29 states and D.C. require any sex education; of those, only 11 require the content to be medically accurate. Supportive states are more likely to require sex education than either restrictive or banned states.[19]

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Restricting and limiting access to abortion and reproductive healthcare negatively affects the health and economic well-being of teenage mothers and their children, leading to higher poverty rates, infant mortality, and health-threatening outcomes for the mother.[20]

Given that 1 in 4 teens live in states that banned abortion in the wake of Dobbs, it should be anticipated that the long-term reduction in births to teens will stall nationally and reverse in banned and restrictive states.

Contraceptive Coverage & Use

Contraceptive use in the United States increased 6% from 2006-2019 among women of reproductive age.[21] The use of highly effective methods increased even more—long-acting reversible contraceptive (LARC) use more than doubled. With increased contraceptive use, the unintended pregnancy rate fell to 35 per 1,000 women—a 23% decrease compared to the 1990-1994 period.[22]

Access to no-cost birth control provided by the Affordable Care Act (ACA) and Medicaid expansion played a critical role in increasing contraceptive use, as well as in narrowing the gap between Latina and Black women and White women.[23] Thirty states require ACA insurance plans to cover prescription contraceptives. A majority of states (26) have expanded eligibility for Medicaid coverage of family planning services.[24]

Still, disparities remain in accessing affordable and effective birth control. All supportive states have expanded Medicaid (or a comparable state program) to cover contraception and, likewise, require insurers to provide cost-free contraceptive care to patients. They were 18 times more likely than banned and restrictive states to require prescription contraceptive coverage. Nineteen of the 20 states that do not require insurance to cover contraceptives ban or restrict abortion.[25]

Reducing or eliminating the cost of birth control is particularly consequential for reproductive health. According to new research from the Kaiser Family Foundation, the high cost of contraceptives remains a barrier to use. About 20% of women reported having

to stop using a contraceptive method because they couldn't afford it, and 17% of low-income women cited cost as the leading reason for not using their preferred method.[26]

Maternal Mortality

The number of women in America who die in pregnancy, childbirth, and soon after giving birth is tragically high.[27] While the U.S. maternal mortality rate is below the global 2030 Agenda SDG target, the U.S. has one of the highest rates among wealthy advanced democracies.[28]

Maternal mortality in the U.S. increased in recent years, a trend that was amplified during the COVID-19 pandemic. In 2020, the maternal mortality rate was 37% higher, compared to 2018. In 2021, it was 89% higher than it had been in 2018.[29]

Still, mothers in states supportive of reproductive freedom were more likely to survive pregnancy and childbirth. In every year from 2018 to 2021, supportive states had the lowest maternal mortality rate. The rate for supportive states was likewise fairly stable until 2020, when it spiked during the pandemic.

MATERNAL DEATHS, BY STATE GROUP
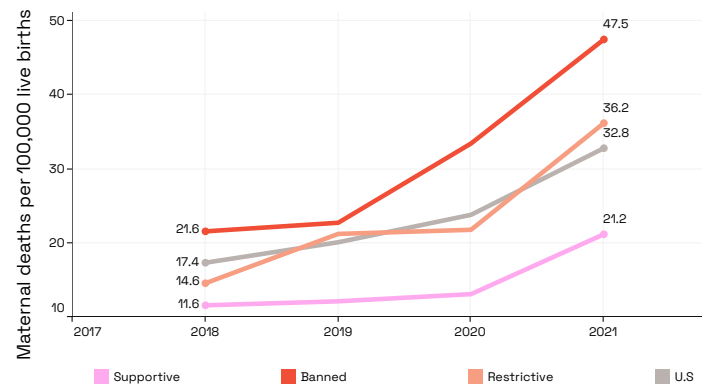
Graph shows maternal deaths for 100,000 live births for U.S. and state groups. Maternal death is defined as a death during pregnancy or within 42 days after pregnancy due to any cause related to or aggravated by pregnancy or its management, not including accidental/incidental causes. Gender Equity Policy Institute analysis of CDC (2018-2021).

Maternal mortality in banned states was significantly higher than in supportive states, with the size of the gap increasing over the period.

In 2018, the maternal mortality rate in banned states was nearly 2 times that in supportive states. By 2021, it was 2.4 times that in supportive states.[30]

Our findings on differences in maternal mortality rates based on state reproductive healthcare policy are consistent with previous research. For example, one study in the *American Journal of Preventive Medicine* concluded that restrictions on reproductive health services contributed to rising maternal mortality rates. Another in the American Journal of Public Health found that maternal mortality is higher in states with restrictions on abortion care, compared with states with fewer or no restrictions.[31]

Moreover, there are alarming and significant racial and ethnic disparities in U.S. maternal mortality rates, with Black and Native American mothers having a greater likelihood of dying during pregnancy and childbirth than those in other racial/ethnic groups. The maternal mortality rate for Native American mothers is consistently higher than that of White mothers. And in 2021, Native American women had the highest maternal mortality rate—4.5 times that of White mothers and 1.7 times that of Black mothers.[32]

In 2021, the maternal mortality rate for Black mothers was 2.6 times the rate of White mothers.[33] This has been consistently true for over 100 years.

As the award-winning journalist Linda Villarosa documents in *Under the Skin: The Hidden Toll of Racism on American Lives and on the Health of Our Nation*, high maternal mortality rates among Black women are not simply the result of higher rates of poverty or other socioeconomic disadvantages. **Consider that college-educated Black mothers, she writes, "are more likely to die, almost die, or lose their babies than white mothers who haven't finished high school."** Drawing on a large body of medical, public health, and social science research, Villarosa marshals extensive evidence to convincingly argue that racism is at the root of the health disparities experienced by Black Americans.[34]

During the pandemic, maternal mortality increased among all groups, even among Asian American and Latina mothers, who historically have low rates. For example, Latina mothers, long noted to have remarkable birth outcomes, experienced a notable increase in maternal mortality.[35] The rate went from 20% lower than that of White mothers in 2018 to about 5% higher in 2021. As the graph here shows, rates among Black and Native American mothers were more than two to three times the national average.[36]

MATERNAL DEATH RATES, BY RACE/ETHNICITY
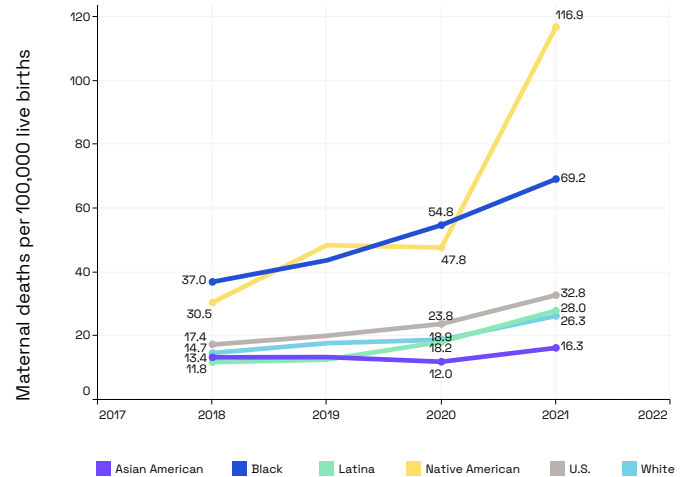
Maternal death is defined as a death during or within 42 days after pregnancy due to any cause related to or aggravated by pregnancy or its management, not including accidental/incidental causes. Gender Equity Policy Institute analysis of CDC (2018 – 2021).

Much of the excess maternal mortality in both 2020 and 2021, according to a report by the U.S. Government Accountability Office, was due to deaths from COVID-19. Pregnant and post-partum women are at risk of complications from COVID infection and more likely to have severe symptoms. Additionally, stress during pregnancy, such as the kind associated with job loss, unstable housing, or the loss of a loved one, is associated with worse maternal health outcomes.[37]

Nevertheless, there was substantial overlap between states that were reluctant to take COVID precautions

and those that banned abortion or restricted reproductive healthcare access, and abortion bans likely played a role. Women denied abortion care are more likely to experience serious pregnancy complications.[38] Ten states halted abortion care services at the beginning of the pandemic; seven of them went on to ban abortion after Dobbs.[39] Texas was the only state to enforce a ban on nearly all abortion care prior to Dobbs and more mothers die there than in any other state. Fewer than 1 in 10 people live in Texas, but **1 in 7 of all maternal deaths occurred in Texas.**[40]

Nearly a third of maternal deaths in the United States occur post-partum. Health insurance coverage before and after pregnancy has been shown to reduce maternal mortality. Countries with lower maternal mortality rates, such as Canada, France, and the U.K, typically provide healthcare during pregnancy and after childbirth.[41]

All supportive states have adopted Medicaid expansion. In these states, the percentage of mothers and single mothers with health insurance was higher than in banned states. In addition, these states were 6 times more likely to extend pregnancy-related coverage to one year postpartum than states that banned abortion post-Dobbs. Among restrictive and banned states, 17 states have not extended pregnancy-related Medicaid coverage to one year.[42] In the U.S. overall in 2021, 11% of mothers and 15% of single mothers still lacked health insurance (See Table 4).[43]

Newborn & Child Mortality

Recent progress in reducing deaths among babies and children has been made in the United States. From 2015 to 2021, the U.S. neonatal mortality rate decreased by 12% and the mortality rate for children under 5 years of age decreased by 7%.[44] Newborn and child mortality rates in the U.S. are below the global SDG targets. Still, the U.S. has the highest neonatal mortality rate among our global counterparts.[45]

Babies born in banned states are more likely to die than those who live in supportive states. In 2021, the

neonatal mortality rate in banned states was 30% higher than that in supportive states. These state group differences are true for young children, as well. The under-5 mortality in banned states rate was 38% higher than that in supportive states.[46]

There are likewise large racial disparities in newborn and child deaths in America. In 2021, Black newborns died at 2.3 times the rate of White newborns and 2.6 times the rate of Asian American newborns. Native American newborns died at 1.3 times the rate of White newborns. Research has shown that systemic racism and implicit racial bias may be factors in these racial disparities. For example, Black babies are more likely to die if they are treated by a non-Black physician than by a Black physician.[47]

NEWBORN MORTALITY RATES, BY RACE/ETHNICITY
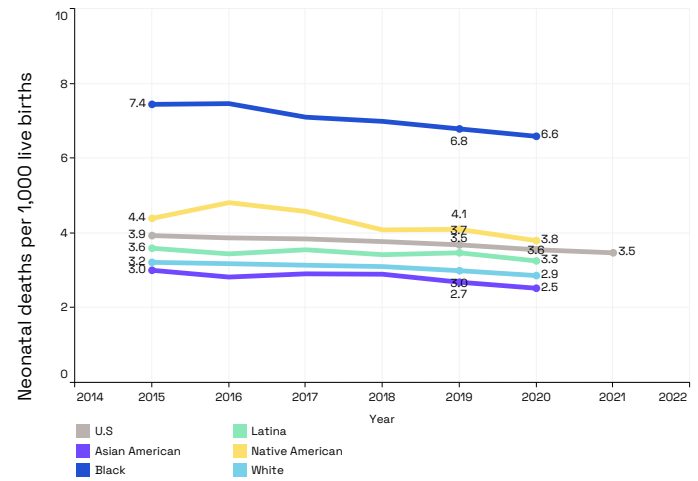
Newborn death is defined as a death in the first 30 days of life. Gender Equity Policy Institute analysis of CDC (2015-2020).

These racial inequities are most severe in states that restrict reproductive health services and abortion care. Black neonatal mortality is highest in restrictive states, for example, and lowest in supportive states.

Premature birth, low birth weight, and congenital abnormalities are some of the top causes of infant mortality; all would improve if mothers received comprehensive medical care. States that expanded

Medicaid significantly reduced infant mortality compared to states that did not.[48]

In supportive states, maternal healthcare coverage is more common. In these states, significantly more women reported being able to afford health care.[49]

However, as discussed above, many of the banned and restrictive states have failed to expand Medicaid or extend health insurance coverage to the post-partum period. Women of color are disproportionately impacted by these policies. Nearly seven in ten of all Black women in the U.S. live in a banned or restrictive state. Nearly half of all Latinas (47%) live in states that have not expanded Medicaid (See Table 3).

The failure to provide health insurance is of even greater concern because more women, mothers and otherwise, live below the poverty line in restrictive and banned states than in supportive states. Nearly one in five women in banned states have income below the federal poverty line. Among mothers, poverty is highest in banned states and lowest in supportive states (See Table 2). Nearly a third of Black and Native American women living in banned states are poor.[50] Compared to women in supportive states, a significantly higher percentage of women living in restrictive and banned states meet the definition of working poor.[51]

NEONATAL MORTALITY RATE, BY STATE GROUP
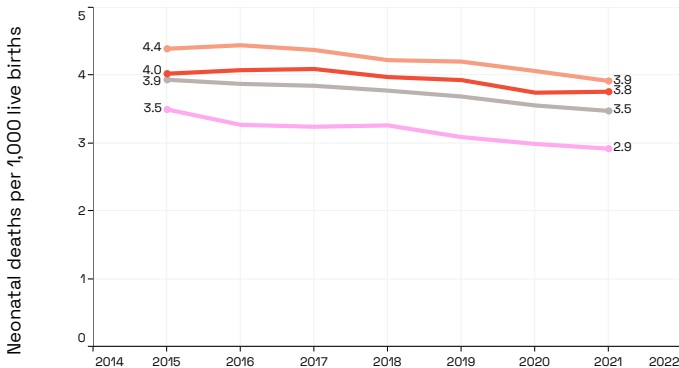
Gender Equity Policy Institute analysis of CDC (CDC 2015 – 2021).

Conclusion

To assess the impact of abortion bans on women's health and well-being, it is essential to track the data on reproductive and sexual health. Gender Equity Policy Institute's inaugural report in our series, "The State of Reproductive Health in the United States," is designed to establish the baseline for making that assessment in the coming years of the Post-Roe era. By understanding the data in the final years of Roe, we will be better able to evaluate the effects of ending the right to legal abortion on women, children, and gender diverse people.

Examining data for the years 2015 through 2021, we see a clear and disturbing pattern. There are two Americas for people in their reproductive years and their children. It is important to underscore that the *differences and divergence were well established before the Supreme Court overturned Roe and abortion bans were enacted and enforced beginning in 2022.* As abortion bans take effect in 2022 and beyond, the divergence between states is highly likely to widen, with historically marginalized people most likely to suffer harm.

Two countervailing forces have shaped this national landscape over the last ten to fifteen years. The Affordable Care Act (ACA) dramatically expanded health insurance for women, as well as increased access to and lowered costs for reproductive and sexual healthcare. At the same time, however, those benefits were denied to millions of women and girls, as conservative opposition to the ACA led many state legislatures to reject Medicaid expansion, leaving millions of people of reproductive age uninsured. Concurrently, in these same states, a resurgent anti-abortion movement was often successful in winning enactment of hundreds of state-level restrictions on abortion care and contraception.

On every indicator, pregnant people, women, and their children have healthier outcomes in states that are supportive of reproductive freedom. Conversely, on every indicator, those who live in states that ban abortion or restrict reproductive and sexual health services have poorer outcomes and face grave risks

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to their health and well-being during pregnancy, childbirth, and the postpartum period.

As this study has documented, in supportive states, we see improved access to contraception, lower rates of teen births and unintended pregnancies, and higher rates of survival for mothers, newborns, and young children. In addition, most of the trends in these states are moving in the right direction. The state of reproductive health in supportive states illustrates the kind of progress that is possible in an environment in which abortion is legal and accessible, health insurance is nearly universal, and laws, policies, and medical practices center women's autonomy, freedom, and health. Nevertheless, these states also suffer from racial, ethnic, and socioeconomic equity gaps that demand action.

States that ban or restrict abortion and other reproductive healthcare endanger women, pregnant people, and their children—and the harms go beyond the denial of the basic human right to bodily autonomy. These states have worse maternal and infant health and higher rates of poverty for mothers (See Table 2). They make contraception more difficult to access and fail to provide medically accurate sex education, both leading to more unintended pregnancies and the concomitant negative socioeconomic, psychological, and health effects of carrying and bearing an unwanted child.

Election results in 2022, after the Dobbs ruling, demonstrated that there is substantial bipartisan opposition to abortion bans. In addition, public opinion surveys have tracked growing support for abortion rights and reproductive freedom and falling support for abortion bans. This is true in Blue states, like Vermont and California, as well as in Red states like Kentucky and Kansas.

Despite this emerging national consensus in favor of reproductive freedom, the structure of the U.S. political system and current polarization mean it will be difficult to put the popular will into effect and restore the legal right to abortion quickly.

Thus, millions of women and girls in the United

States will remain at risk of being forced to carry an unintended pregnancy to term, with all the attendant dangers to their health, well-being, and economic security that entails. As policymakers and advocates work to restore rights and access, it is urgent that improvements in healthcare delivery and insurance coverage for pregnant and birthing people be prioritized, so as to prevent the most tragic outcomes that are all too frequent in the United States: the death of mothers, newborns, and infants.

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Appendix 1: Tables

TABLE 1: WOMEN OF REPRODUCTIVE AGE, BY STATE ABORTION ACCESS GROUP, 2021

Supportive	31,023,412	41%
Restrictive	25,683,368	34%
Banned	18,346,608	24%
Total	*75,053,388*	*100%*

Gender Equity Policy Institute analysis of ACS (2021)

TABLE 2: WOMEN IN POVERTY IN BANNED & RESTRICTIVE STATES, BY RACE/ETHNICITY, 2021

	All Women 15-49	Mothers	Single Mothers
All	19%	18%	36%
Asian American	13%	9%	29%
Black	27%	29%	40%
Latino	21%	23%	39%
Native American	31%	30%	45%
White	16%	12%	32%

Gender Equity Policy Institute analysis of ACS (2021)

TABLE 3: WOMEN OF REPRODUCTIVE AGE, RACE/ETHNICITY, BY STATE ABORTION ACCESS GROUP, 2021

	Asian	Black	Latina	Native American	White
Supportive	65%	31%	52%	38%	37%
Restrictive	21%	43%	21%	17%	39%
Banned	14%	27%	27%	45%	24%

Gender Equity Policy Institute analysis of ACS (2021)

TABLE 4: WOMEN, NO HEALTH INSURANCE, BY RACE/ETHNICITY, 2021

% Without Health Insurance

Race/Ethnicity	All	Asian American	Black	Latino	Native American	White
Women 15-49	11.1%	6.7%	11.7%	21.4%	21.9%	7.5%
Mothers	11.3%	5.6%	10.0%	24.9%	20.4%	6.7%
Single Mothers	14.5%	8.4%	11.1%	25.1%	23.0%	10.1%

Gender Equity Policy Institute analysis of ACS (2021)

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Appendix 2:
The 2030 Agenda for Sustainable Development: Holding the United States Accountable on Global Equity Goals

The 2030 Agenda for Sustainable Development was adopted at the 2015 United Nations Summit. Signed by all 193 UN members, the framework calls for an end to poverty in all forms and the pursuit of a sustainable future for all. The 2030 Agenda reflects a recognition that poverty, inequality, health, human rights, and climate change are interrelated challenges in all countries, regardless of their income level, and established 17 Sustainable Development Goals (SDGs). These goals include: ending poverty and hunger; achieving gender equality; ensuring quality health, well-being, and education for all; reducing inequalities within and between countries; guaranteeing sustainable development that leaves no one behind; and protecting the planet.[52]

Member states have pledged to achieve specific SDG targets by 2030. In order to assure progress toward these goals, the 2030 Agenda encourages countries to conduct voluntary reviews of progress at the national and subnational levels. This mechanism, called Voluntary National Reviews(VNR), is a country-led process that tracks progress on SDGs, relying on rigorous evidence and data and focusing on people who are furthest behind. The process consists of different stages: national consultations, regional meetings, and the presentation of member state VNR reports at the annual UN High Political Forum (HPF).

The comprehensive review process aims to provide for open participation from multiple stakeholders. Furthermore, it is designed as a multilateral mechanism to enable member states to share experiences and lessons with each other. Most importantly, it seeks to strengthen accountability to citizens in implementing the 2030 Agenda.

Since 2016, 187 countries have submitted or announced plans to present their VNR reports to the High Political Forum. All OECD countries except the U.S. have submitted at least one VNR; many have submitted multiple reports.

In general, there has been high participation from all member states in the VNR process. Likewise, civil society organizations worldwide have also shown high engagement in the process in their own countries, as well as in the multilateral dialogue; civil society representatives from different countries meet annually at regional meetings and at the HPF to review progress at the regional level and engage in dialogue with governments and other parties.

Additionally, as part of civil society engagement in the VNR process, organizations produce SDG "spotlights" or "shadow reports." These reports provide independent assessments. They typically evaluate the country's progress toward the goals and offer recommendations to policymakers and stakeholders. Depending on the scope and mission of a civil society organization producing a SDG spotlight, reports can include a full evaluation of all 17 goals or focus on one or a set of related goals.[53] These types of reports become particularly significant where there is a lack of civil society engagement in the official production of a VNR report. Overall, they serve to raise awareness and provide an accountability tool for civil society to monitor and hold accountable their governments on the critical equity goals embodied in the 2030 Agenda.

The United States is the only developed country within the United Nations that has never submitted a VNR on its progress in implementing the 2030 Agenda, and in the wake of the Dobbs decision, there are compelling reasons to be proactive. This report is intended to serve as a spotlight report on U.S. progress to date on indicators most relevant to reproductive health and well-being, and their intersection with racial and gender equity.

SDG 3. Ensure Healthy Lives and Promote Well-Being For All Ages: Target and indicators related to reproductive and sexual health

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	
3.1.1. Maternal mortality ratio	
Level of Analysis	State and National
Level of Disaggregation	Race/ethnicity
Years of Analysis	2018 – 2021
Data Sources	Underlying Cause of Deaths, CDC Wonder https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html: dataset provides death counts by place of residence, age group, race/ethnicity, gender, and cause of death.
Benchmark	OECD countries, Maternal and infant mortality OECD family database: https://stats.oecd.org/index.aspx?queryid=30116

3.2 By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	
3.2.1 Under-five mortality rate – per 1,000 live births	
Level of Analysis	State and National
Level of Disaggregation	Race/ethnicity
Years of Analysis	2016 – 2021
Data Sources	Underlying Cause of Deaths, CDC Wonder https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html: dataset provides death counts occurring within the United States by place of residence, age group, race/ethnicity, gender, and cause of death. Live Births, CDC Wonder https://wonder.cdc.gov/natality-expanded-current.html: dataset provides counts of live births occurring within the United States by place of residence, mother's race and age, delivery method, congenital anomalies, and others.
Benchmark	OECD countries, Mortality rate, under-5 (per 1,000 live births) – OECD members. World Bank Data, https://data.worldbank.org/indicator/SH.DYN.MORT
3.2.2. Neonatal mortality rate – per 1,000 live births	
Level of Analysis	State and National
Level of Disaggregation	Mother's race and ethnicity
Years of Analysis	2015 - 2021
Data Sources	Infant Deaths, CDC Wonder https://wonder.cdc.gov/lbd.html: dataset provides infant death counts and rates occurring within the United States by mother's place of residence, child's age, the underlying cause of death, birth weight, maternal race and ethnicity, and others.
	Mortality rate, neonatal (per 1,000 live births) - – OECD members. World Bank Data, https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=OE

3.7	**By 2030, ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programs**
3.7.2 Adolescent birth rate (aged 15-19 years) per 1,000 women in that age group	
Level of Analysis	State and National
Level of Disaggregation	Race/ethnicity
Years of Analysis	2015 − 2021
Data Sources	Live Births, CDC Wonder, https://wonder.cdc.gov/natality-expanded-current.html: dataset provides counts of live births occurring within the United States by place of residence, mother's race and age, delivery method, congenital anomalies, and others. Single Race Population Estimate, CDC Wonder https://wonder.cdc.gov/single-race-population.html - dataset provides single-race population estimates by year from the U.S. Census Bureau
Benchmark	Adolescent fertility rate (births per 1,000 women ages 15-19) - OECD members. World Bank Data, https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=OE

3.8	**Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, adequate, quality, and affordable essential medicines and vaccines for all**
3.8.1 Coverage of Essential Health Services	
Level of Analysis	State and National
Level of Disaggregation	Race/ethnicity, age, parental status, and marital status
Years of Analysis	2010 − 2021
Data Sources	American Community Survey (ACS), IPUMS US https://usa.ipums.org/usa-action/variables/live_search: dataset provides U.S. census microdata from the American Community Surveys.
Benchmark	N/A

Notes

1. As of December 1, 2022. For the specific states that banned abortion in 2022 after the Dobbs decision, see list on p. 4. Bans are currently enjoined by the courts in three of these states: Arizona, North Dakota, and Wyoming.

2. All references to women and girls in this report are to reproductive age women, as self-identified in public data, ages 15-49. Biologically female people who give birth overwhelmingly self-identify as women. Birthing people include trans men, nonbinary individuals, and gender diverse individuals who do not self-identify as women. Data in U.S. official sources, such as the Census, the American Community Survey, and the CDC, is reported in binary categories of male and female. Considering how the data is reported and the self-identification of most people impacted, we use terms women, girls, and mothers throughout this report.

3. "An Overview of Abortion Laws," Guttmacher Institute, June 24, 2022, https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.

4. Diana Greene Foster, *Turnaway Study: Ten Years, A Thousand Women, And The Consequences Of Having-Or Being Denied* (Scribner, 2021).

5. For an example of the application of a human rights framework to reproductive healthcare, see Maria Isabel, Jane Cottingham, and Eszter Kismodi, "Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations," Geneva: World Health Organization, 2014.

6. All findings in this report are based on the Gender Equity Policy Institute (GEPI) analysis, unless otherwise noted. For maternal mortality, neonatal mortality, and teenage birth rates, GEPI analyzed data from the National Center for Health Statistics, Centers for Disease Control and Prevention. Datasets were obtained from the National Vital Statistics, Natality Records 2007-2021, Mortality 1999-2021, Linked Birth / Infant Deaths Records 2017-2020, and Single-race Population Estimates, United States, 2010-2021, accessed through CDC Wonder, https://wonder.cdc.gov/. Hereafter, GEPI Analysis of CDC data. For a detailed explanation of data sources and analysis, see methodology, available online at https://thegepi.org/state-of-reproductive-health-US-methodology

7. "The 17 Sustainable Development Goals," United Nations. Department of Economic and Social Affairs. Accessed October 20, 2022. https://sdgs.un.org/goals.

8. "Five Countries Yet to Conduct Voluntary National Review," SDG Knowledge Hub, IISD, March 24, 2022, https://sdg.iisd.org:443/news/five-countries-yet-to-conduct-voluntary-national-review/.

9. States classified as supportive recognize abortion as a fundamental right for women and provide a supportive environment for women's access to abortion care, contraception, and other sexual and reproductive health services. States classified as restrictive continue to permit legal access to most abortion procedures, but impose various regulations on abortion care, reproductive healthcare, and contraceptive access that are not medically necessary. The final category includes those states that banned abortion in 2022 after the Dobbs decision, either through the passage of new bans or the enforcement of trigger or pre-Roe bans. All states in the banned category previously imposed many restrictions on abortion care and other reproductive healthcare. See methodology for more information about data sources, year ranges, and state group analysis, https://thegepi.org/state-of-reproductive-health-US-methodology

10. All references to women in this report are to reproductive age women, as self-identified in public data, ages 15-49.

11. GEPI Analysis of Georgetown U.S. Women, Peace, and Security Index and Indicators, https://giwps.georgetown.edu/the-index/

12. "The 17 Sustainable Development Goals," United Nations. Department of Economic and Social Affairs. Accessed October 20, 2022. https://sdgs.un.org/goals.

13. See Appendix 2, Table 1 for more detail on indicators and data sources.

14. "OECD Family Database - OECD," accessed January 16, 2023, https://www.oecd.org/els/family/database.htm.

15. GEPI Analysis of CDC data, 2015 – 2021.

16. U.S. Department of Health and Human Services Office of Population Affairs, "Trends in Teen Pregnancy and Childbearing" (Health and Human Services Office of Population Affairs, 2022), https://opa.hhs.gov/adolescent-health/reproductive-health-and-teen-pregnancy/trends-teen-pregnancy-and-childbearing.

17. GEPI Analysis of CDC data, 2015 – 2021.

18. As of 2021. (GEPI Analysis of CDC data, 2015 – 2021) Mandy S. Coles et al., "How Are Restrictive Abortion Statutes Associated with Unintended Teen Birth?" The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 47, no. 2 (August 2010): 160–67, https://doi.org/10.1016/j.jadohealth.2010.01.003.

19. SIECUS, Sex Ed State Law and Policy Chart (Washington DC: SIECUS, 2022), https://siecus.org/wp-content/uploads/2021/09/2022-Sex-Ed-State-Law-and-Policy-Chart.pdf

20. Sarah Varney, "Abortion Bans Skirt a Medical Reality: For Many Teens, Childbirth Is a Dangerous Undertaking," Kaiser Health News, October 7, 2022, https://khn.org/news/article/abortion-bans-teen-childbirth-dangerous/.

21. GEPI Analysis of National Survey of Family Growth (NSFG), 2019.

22. Colleen L. MacCallum-Bridges and Claire E. Margerison, "The Affordable Care Act contraception mandate & unintended pregnancy in women of reproductive age: an analysis of the National Survey of Family Growth, 2008–2010 v. 2013–2015," Contraception 101, no. 1 (2020): 34-39.

23. Whitney S. Rice et al., "Dispersion of Contraceptive Access Policies across the United States from 2006 to 2021," Preventive Medicine Reports 27 (June 1, 2022): 101827, https://doi.org/10.1016/j.pmedr.2022.101827.

24. Usha Ranji et al., "Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey," KFF (blog), February 17, 2022, https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.; Kaiser Family Foundation, "State Requirements for Insurance Coverage of Contraceptives," Kaiser Family Foundation, May 1, 2022, https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of-contraceptives/.

25. Kaiser Family Foundation, "State Requirements for Insurance Coverage of Contraceptives," Kaiser Family Foundation, May 1, 2022, https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of-contraceptives/.

26. Brittni Frederiksen et al., "Contraception in the United States: A Closer Look at Experiences, Preferences, and Coverage" (Kaiser Family Foundation, November 3, 2022), https://www.kff.org/womens-health-policy/report/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage/.

27. The CDC defines maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." See "NVSS - Maternal Mortality - Evaluation of Changes," August 3, 2020, https://www.cdc.gov/nchs/maternal-mortality/evaluation.htm.; Donna L. Hoyert, "Maternal Mortality Rates in the United States, 2020" (Center for Disease Control and Prevention, February 23, 2022), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm.

28. See Appendix 2 for specific targets. "Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births) - OECD Members Data," accessed January 16, 2023, https://data.worldbank.org/indicator/SH.STA.MMRT?locations=OE.

29. GEPI Analysis of CDC data, 2018 – 2021.

30. GEPI Analysis of CDC data, 2018 – 2021.

31. Dovile Vilda et al., "State Abortion Policies and Maternal Death in the United States, 2015–2018," American Journal of Public Health 111, no. 9 (August 2021): 1696–1704, https://doi.org/10.2105/AJPH.2021.306396.

32. Comparisons are for U.S. women by race/ethnicity overall. Due to confidentiality constraints, CDC public data only provides statistics representing more than nine deaths. Thus, there is insufficient data to disaggregate maternal mortality rates by race and ethnicity for each state group. (GEPI Analysis of CDC data, 2018 – 2021.)

33. GEPI Analysis of CDC data, 2018 – 2021.

34. Linda Villarosa, Under the Skin by Linda Villarosa: The Hidden Toll of Racism on American Lives and the Health of Our Nation (New York: Doubleday, 2022), quotation on p. 2. See also "Systemic Racism and Reproductive Injustice in the United States: A Report for the UN Committee on the Elimination of Racial Discrimination," July 15, 2022. https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report_Systemic-Racism-and-Reproductive-Injustice.pdf.

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36. GEPI analysis of CDC data, 2018 – 2021.

37. U. S. Government Accountability Office, "Maternal Health: Outcomes Worsened and Disparities Persisted During the Pandemic" (U. S. Government Accountability Office, October 19, 2022), https://www.gao.gov/assets/730/723432.pdf.

38. Foster, *Turnaway Study*.

39. Most women denied abortions because of the suspension of abortion care services in 2020 would have given birth in 2021.

40. The high maternal mortality rate in Texas can be attributed to multiple factors including lack of access to abortion (see https://www.ansirh.org/research/ongoing/wecount-post-dobbs-project), limited sexual health education (see SIECUS Sex Ed State Law & Policy Chart), and limited public assistance for insurance (See https://www.propublica.org/article/the-extraordinary-danger-of-being-pregnant-and-uninsured-in-texas).

41. Roosa Tikkanen et al., "Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries" (Common Wealth Fund, November 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.

42. GEPI Analysis of Kaiser Family Foundation, "Medicaid Postpartum Coverage Extension Tracker," KFF, December 8, 2022, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

43. GEPI Analysis, ACS 2021.
44. The neonatal mortality rate is defined as the number of deaths during the first 28 days of life per 1,000 live births. GEPI Analysis of CDC data, 2015 – 2021.

45. OECD Countries with higher neonatal mortality rates than the U.S. are Mexico, Colombia, Costa Rica, Turkey and Chile. World Bank, "Mortality Rate, Neonatal (per 1,000 Live Births) - OECD Members Data," accessed January 13, 2023, https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=OE.

46. GEPI Analysis of CDC data, 2015 – 2021.

47. Brad N. Greenwood et al., "Physician–Patient Racial Concordance and Disparities in Birthing Mortality for Newborns," Proceedings of the National Academy of Sciences 117, no. 35 (August 17, 2020): 21194–200, https://doi.org/10.1073/pnas.1913405117.

48. Adam Searing and Donna Cohen Ross, "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies" (Georgetown University Health Policy Institute Center for Children and Families, May 9, 2019), https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/.

49. GEPI Analysis of Georgetown U.S. Women, Peace, and Security Index and Indicators, 2020, https://giwps.georgetown.edu/usa-index/.

50. GEPI analysis of ACS, 2021.

51. The U.S. Bureau of Labor Statistics defines the working poor as working more than half the year and still living under the poverty line. U.S. Bureau of Labor Statistics, "A Profile of the Working Poor, 2020: BLS Reports" (U.S. Bureau of Labor Statistics, September 2022), https://www.bls.gov/opub/reports/working-poor/2020/home.htm.

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53. For examples of Spotlight reports, see: "Gender Equality on the Ground: Feminist Findings and Recommendations for Achieving Agenda 2030. Women 2030 Global Shadow Report," accessed January 16, 2023, https://www.women2030.org/wp-content/uploads/2021/01/Global-shadow-report-Women2030-Dec-2020.pdf.; "Spotlight on Sustainable Development 2021: Demanding Justice Beyond Rhetoric. Global Civil Society Report on the 2030 Agenda and the SDGs," accessed January 16, 2023, https://www.globalpolicy.org/sites/default/files/download/_Spotlight_2021_web_gesamt_c.pdf.; "Beyond Non-Commitment: Make Equal Opportunities and Biodiversity a Universal Priority," accessed January 16, 2023, https://www.sdgspotlight.nl/wp-content/uploads/2021/06/Beyond-non-commitment-The-Netherlands-SDG-10-15-ENG.pdf.

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Our Mission

Gender Equity Policy Institute is a nonprofit organization dedicated to advancing opportunity, fairness, and well-being for all people through research and education exposing the gender impacts of the policies, processes, and practices of government and business.

Our Work

We conduct and publish research on the best practices for accelerating gender equity. We analyze and rate public policies and business practices to identify the effects on people of all genders, with particular attention to the impacts on groups, such as women, people of color, and LGBTQ+ people, who have been systematically disadvantaged by discrimination, bias, and structural inequality. By educating policymakers, business leaders, and advocates about the inequities embedded in seemingly neutral economic and political processes, we provide the tools and knowledge that leaders need to rebalance systems, guarantee equal benefits and opportunities, and secure a just and sustainable future for all people.

Media Contact
press@thegepi.org

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