Women's Reproduction: Issues and Inequalities in the 21st century

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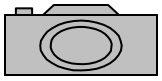
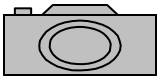
Social class, race/ethnicity, nationality, religion, sexuality, ability, geographical location and other factors can have a profound impact on women's reproductive health. This fact sheet provides snapshots of selected trends, issues, and inequalities surrounding conception, pregnancy, abortion, and infertility in the United States. It includes policy implications and resources for instructors, activists, practitioners, and others seeking information.



Snapshots of trends, issues & inequalities



Women continue to have unintended pregnancies.
About 50% of U.S. women are between the reproductive ages of 15 to 44.[i] Annually, about 6 million of these women will become pregnant, half with pregnancies unintended.[ii] About half of all unintended pregnancies end in abortion[iii]. Based on current rates, 1 in 3 American women will have an abortion by the time they are 45.[iv] Unintended pregnancy is more likely to occur to younger, low income, minority, and cohabiting women.[v]

Teenage pregnancies continue.
Although teen pregnancies steadily declined in the period from 1990-2004 (38% overall),[vi] in 2006, the teen birth rate climbed 3%.[vii] Black and Hispanic teens have much higher rates of pregnancy than non-Hispanic whites.[viii]

Racial and class differences in pregnancy and birth rates are "persistent".
In 2006, the mean age for a woman's first birth was 25 years.[ix] Women ages 25-29 have the highest pregnancy rates, but rates for women 30 and older have risen since the early 1990s.[x] Black and Hispanic women under 30 have much higher birth rates than White women.[xi] Poor women are more likely to give birth at younger ages than more affluent women.[xii] Preterm-related infant death rates are nearly 3X higher for Black women, and nearly 2X as high for Puerto Rican women than White women.[xiii] One in four women who gave birth in 2005 was living in poverty. Southern states (excluding Florida) had higher than average rates of mothers in poverty.[xiv]

Reproductive fertility therapies and technologies make childbearing possible for some.
An estimated 8-12% of women of childbearing age are infertile.[xv] For most of those seeking treatment, "therapies" are a low-tech mix of advice on how to get pregnant and avoid miscarriage, and diagnostic testing.[xvi] Reproductive technologies have also enabled more lesbian women to become pregnant.[xvii] In 2005, about 1% of all live births (52,041 infants) in the U.S. resulted directly from assisted reproductive technologies (ART).[xviii]

Multiple births are increasingly common for some groups of women.
Between 1980 and 2002, twin rates increased by 65% and triplet+ births grew over 500%.[xix] These large increases are attributed to fertility technologies and an increase in births to women over 30.[xx] White women are most likely to have twins or triplets.[xxi]

While women expect physician-attended hospital birth and prenatal care, large racial disparities exist.
Over 4 million live births occur yearly in the U.S.[xxii] 99% of these births occur in the hospital,[xxiii] a marked contrast to a century ago when nearly every birth occurred at home.[xxiv] While most White women (86%) receive first trimester prenatal care,[xxv] Black, Hispanic, and American Indian women are much less likely to have access to and to receive this care.[xxvi]

Caesarean rates continue to increase. Nearly a third of births are now delivered by c-section.
The U.S. has one of the world's highest C-section rates, at 31.1% of all births.[xxvii] The World Health Organization (WHO) suggests rates of 10-15% to protect the health of women and infants and to keep healthcare costs low.[xxviii]

Medical monitoring and technologies accompany most hospital labor and deliveries.
In 2001, 84.8% of births were monitored by electronic fetal monitoring (EFM), 67% by ultrasound.[xxix] In 2006, 22.3% of labors were induced.[xxx] Black women are less likely to receive technologies such as amniocentesis, ultrasound, and drug intervention to stop premature labor.[xxxi]

Women continue to die of preventable deaths from complications of pregnancy.
Women today experience similar birthing complications as in the early 20th century, but they are less likely to die from them. In 1900, 900 American women died for every 100,000 live births.[xxxii] Today that number (with significant variation between racial groups, see Table 1 below), is12.1.[xxxiii] In 2005, 440 U.S. women died from complications of pregnancy.[xxxiv] The risk of dying from these complications has remained the same for the past 2 decades.[xxxv]Black, Hispanic, Asian, immigrant and women over 35 years are more likely to die of pregnancy complications than younger, white nonimmigrant women. [xxxvi]

While almost 99% of maternal and 90% of neonatal deaths occur in the developing world"[xxxvii] - the U. S. ranks poorly worldwide for its infant and maternal mortality.
Daily, 1600 women and more than 10,000 newborns worldwide die from preventable complications during pregnancy and childbirth. In 2008, the U.S. ranked behind 41 countries for its rate of infant mortality and behind 32 countries for its rate of maternal mortality. [xxxviii]

Low-income and women of color are disproportionately disadvantaged in reproductive outcomes.
Selected racial differences and inequalities are illustrated in Table1.

Table 1: Comparison of U.S. Reproductive Outcomes By Race

	White	Black	Hispanic	American Indian/ Alaska native	Asian/Pacific Islander
Fertility rates (live births per 1,000 women 15-44)[xxxix]	**68**	**72.1**	**101.5**	**63.1**	**67.5**
Abortion rate (per 1,000 women 15-44) [xl]	**16.1**	**47.2**	**21.1**	**+**	**+**
Maternal Mortality rate (per 100,000 live births) [xli]	**8.1**	**31.2**	**10.1**	**+**	**+**
Infant Mortality rate (per 1,000 live births)[xlii]	**6.78**	**13.60**	**5.5**	**8.45**	**4.67**
***Rate of Preterm-births (< 37 weeks) [xliii]**	**11.8**	**18.1**	**12.2**	**14.2**	**10.9**
Teen birth rates (per 1,000 women 15-19)[xliv]	**26.6**	**63.7**	**83.0**	**55.0**	**17.0**
Percentage of births to unmarried mothers[xlv]	**31.7 %**	**69.3%**	**48.0%**	**63.5%**	**16.2%**
#Triplet or Higher Order Birth Rate[xlvi]	**208.1**	**94.0**	**75.7**		
Percentage women late or no prenatal care [xlvii]	**3.2%**	**5.7%**	**5.4%**	**7.9%**	**3.0%**
Percentage infants with low birth rates [xlviii]	**7.07%**	**13.4%**	**6.79%**	**7.45%**	**7.89%**
Percentage infants with very low birthrate [xlix]	**1.2%**	**3.1%**	**1.5%**	**1.3%**	**1.1%**

+ Data not available in these reports.
* Disparities also exist *within* the Hispanic category. For instance, infant mortality rates vary from 7.8 for Puerto Ricans to 4.6 for Cubans.
^ The percentage of births to unmarried mothers reached a record high in 2006.
# The number of live births and other higher order (more than 3) deliveries per 100,000 live births.

What Do Women Need in order to Address Reproductive Inequalities?

The National Women's Law Center describes quality health care as the "right care, right time, for the right reason.[l]" Reproductive health requires wide-ranging care: contraceptives, emergency contraception, abortion services, and care before, during, and after pregnancy. Federal policies (e.g. abstinence-only education,[li] lack of universal health care), state policies (e.g. refusal of reproductive services[lii]) and lack of local resources (information, clinics, and therapies) impact women's knowledge of alternatives, access, and outcomes. Women need all of the following.

Affordable and accessible information, care, and services including:

Fertility treatments:

- While most states have fertility clinics, women of color, poor and uninsured women, lesbians, and women with disabilities are less likely to have access to these services.[liii]
- High tech infertility services are cost-prohibitive. The average cost of one in-vitro cycle (IVF), which may need to be repeated, is $12,400.[liv] Medicaid and most private insurance companies do not cover ART or IVF. In fact, only 15 states require private insurance companies to cover some part of these treatments.[lv] To contain costs, uninsured women often have multiple embryo transfers which result in multiple births, and carry health and monetary costs for mother and fetuses.[lvi]

Birth control:

- Poor women are more likely to have access to contraceptives but less likely to have access to infertility treatments. Middle class women are less likely to have contraception coverage and more likely to have infertility coverage.[lvii]
- Many teens lack information about and access to birth control and comprehensive sex education.[lviii] African American, Hispanic, and economically disadvantaged teens are less likely than White teens to have birth control instruction before first intercourse.[lix]
- Comprehensive sex education, widely supported by health professionals, was replaced by abstinence-only programs under the George W. Bush administration. Various studies showed these programs to be ineffective in promoting abstinence over-time, stopping or delaying teen sex, and reducing the number of sexual partners. A 2009 *Pediatrics* study "found that teens who take virginity pledges are just as likely to have sex as those who do not, but they are less likely to use condoms or other forms of contraception when they become sexually active." [lx] Barack Obama has indicated "a strong record of support for what he calls "common sense approaches" to preventing unintended pregnancy and HIV, namely "comprehensive sex education that teaches both abstinence and safe sex methods."[lxi]

Emergency contraception and abortions:

- Emergency contraception (EC) has been FDA approved since 2006. States have adopted a range of policies that expand or restrict access. These include (among other things) limiting emergency room availability and information and mandating pharmacists to fill prescriptions or allowing them to opt out.[lxii] Only women 18 and over can get EC without a prescription. Regardless of availability, cost may prohibit women from obtaining it.[lxiii]
- Access to abortion is a key issue. 87% of all counties in the U.S. have no abortion provider.[lxiv]
- State restrictions on abortion vary.
    - Forty-six states allow health care providers to refuse to provide abortion services.[lxv]
    - Thirty-five states have parental consent or notification laws for minors.[lxvi]
    - Thirty-two states have mandatory counseling.[lxvii]
    - Twenty-four states have waiting periods.[lxviii]
    - Four states have limitations on private insurance coverage for abortion.[lxix]

Pregnancy care:

- A "key factor" in reducing racial and ethnic disparities in maternal and infant health is adequate healthcare.[lxx]At least 50% of women who die from pregnancy complications die preventable deaths due to lack of access to care.[lxxi]
- Although midwife-attended births are less expensive and have positive outcomes, they are underutilized. A Pew/UCSF report called midwifery an "essential element of comprehensive care for women."[lxxii] Women frequently enlist midwives in Europe, Australia, New Zealand, and Japan. In 2006, in the U.S., midwives attended only 7.9% of all births.[lxxiii] American Indian women were 2X as likely to have midwife-attended hospital births as any other group of U.S. women.[lxxiv]

Insurance coverage of all reproductive care. Affordable deductibles and co-pays.

- The National Women's Law Center calls health insurance "the single most significant factor in determining an individual's access to care."[lxxv] But, in 2003, 1 in 5 women of reproductive age had NO health insurance.[lxxvi] Women of color, especially Latinas, are less likely to be covered by insurance than White women.[lxxvii]
- Medicaid is now the largest health insurance plan.[lxxviii] It provides health care to over 11% of all women of reproductive age.[lxxix] In 2006, Medicaid covered 41% of all births.[lxxx] Medicaid funds often fail to cover many procedures including infertility treatments, some prenatal tests, and pregnancy aftercare.[lxxxi] Further, the Hyde Amendment prevents federal funds to be used for abortion services. This means that Medicaid will not pay for abortion except under extreme circumstances such as rape, incest, or life endangerment. Further state restrictions on Medicaid funding for abortion inhibit access. This can delay abortions making them more expensive and risky. Only 32 states allow Medicaid funding for abortion in extreme circumstances.[lxxxii]
- In 1994, nearly 50% of insurance plans did not cover any type of contraceptives. Through legislative activism, 72% of employer plans now cover all methods approved by the Food and Drug Administration (FDA).[lxxxiii] At the same time, however, some policies allow religious and moral opt-out clauses, and/or limit coverage to specific types of insurers or types of insurance policy holders[lxxxiv]
- Private insurance does not cover all costs and women with insurance may have difficulty affording deductibles and co-pays. Pregnant women with no insurance are faced with increasingly expensive delivery costs. In 2005, a hospital vaginal delivery with no complications cost, on average $6,973 while a hospital cesarean with no complications cost, on average almost twice that, $12,544.[lxxxv]
- Women who switch jobs during a pregnancy may lose their medical insurance coverage or may experience a lapse of insurance coverage. While group insurance policies that cover maternity costs are obligated to cover new employees (some may have waiting periods), private insurance providers of individual policies can consider pregnancy a pre-existing condition.[lxxxvi]

Women-centered technologies and access to alternative care.

Pregnancy care:

- The natural process of pregnancy has become medicalized as part of a large industry that encourages medical (and often costly) solutions that do not necessarily enhance outcomes for women or babies.[lxxxvii] For instance, standard procedures such as electronic and internal fetal monitoring and ultrasound have been associated with increased cesarean rates, and internal monitoring with risk of infection.[lxxxviii] In 2007, only <u>one</u> U.S. hospital met the six characteristics of "mother-friendliness" adopted by the Coalition to Improve Maternity Services [lxxxix]

Fertility:

- Successful medical procedures can have unintended and negative consequences for women. For instance, the fertility therapy ART, with its multiple embryo transfer, is associated with significantly increased rates of multiple births (35% of ART births are multiples compared with 3% in the general population). Mothers of multiples face a range of health issues which are much more likely to result in extended hospitalization and increased risk of cesarean.[xc]

Multiple births carry these risks to infants: pre-term delivery, low birth weight, growth restrictions, long hospitalizations, heightened risk of cerebral palsy, and death.[xci]

- Overall, women must be able to opt for medicalized solutions, to refuse them, or to integrate medical and nonmedical approaches. Midwives can provide individualized, safe, effective, less costly care with improved outcomes. They should be recognized legally as independent practitioners capable of such.[xcii]

Culturally competent care.

- The U.S. Department of Health and Human Services Office of Minority Health recommends that patients receive effective, understandable, and respectful care "provided in a manner compatible with their cultural health beliefs, practices, and preferred language." They also recommend that health organizations "implement strategies to recruit, retain, and promote" diverse providers representative of their patients.[xciii]
- Health care providers may create a chilly climate that discourages lesbian women from disclosing pertinent information. Weisz (2009) cites a number of challenges including "Inappropriate and negative exchanges with health care providers have included episodes of hostility, sexist and demeaning comments, withholding information, inappropriate jokes, less physical contact with clients, and inappropriate mental health referrals (83)[xciv]" Informed providers can create LGBT friendly offices through posters showing same sex couples, newsletters and information containing specific LGBT concerns, and gender neutral language on intake forms.[xcv]
- Culturally competent care also means representation in health care providers. Women of color remain underrepresented in health professions. For instance, according to the National Women's Law Center in 2004, over 80% of nurses were white.[xcvi] In 2006, of physicians whose race/ethnicity was known, only 14.8% of all physicians were women of color.[xcvii]

LEARN MORE

The following resources point out differences and inequalities where culturally competent care is vital. Some of these also list specific steps to achieve it.

Selected Books and Articles

Block, Jennifer. 2008. *Pushed: The Painful Truth About Childbirth and Modern Maternity Care.* DeCapo Press.

Davis-Floyd, Robbie and Christine Barba Johnson. 2006. *Mainstreaming Midwives: The Politics of Change.* Routledge.

Flavin, Jeanne. 2008. *Our Bodies, Our Crimes: The Policing of Women's Reproduction in America*. NYU Press.

Journal of Social Issues. 2005. 61 (1). [Entire edition devoted to reproductive technologies].

Gomez, Laura. 1997. *Misconceiving Mothers: Legislators, Prosecutors and the Politics of Prenatal Drug Exposure*. Philadelphia: Temple University Press.

Luker, Kristin. 1997. *Dubious Conceptions. The Politics of Teenage Pregnancy.* Harvard University Press.

Packer, Corinee A. 1996. *The Right to Reproduce: A Study in International Law.* Abo Akademi University: Institute for Human Rights.

Powderly, Kathleen E. 1995. *Contraceptive Policy and Ethics: Illustrations from American History.* Hastings Center Report, 25(1).

Roberts, Dorothy. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* New York: Vintage Books.

Solinger, Rickie. 2007. *Pregnancy and Power: A Short History of Reproductive Politics in America*. N.Y. Press.

Taylor, April. 1999. "High-Tech, Pop-a-Pill Culture: 'New Forms of Social Control for Black Women." Pp. 242-254 in Jane Silliman and Ynestra King (eds.) *Dangerous Intersections: Feminist Perspectives on Population, Environment, and Development*. Cambridge: South End Press.

Wajcman, Judy. 1994. "Delivered into Men's Hands? The Social Construction of Reproductive Technology." Pp. 153-175 in Gita Sen and Rachel C Snow (eds.) *Power and Decision: The Social Control of Reproduction.* Boston: Harvard University Press.

Wagner, Marsden. 2006. *Born in the USA How A Broken Hospital System Must Be Fixed To Put Women and Children First.* Berkeley: University of California Press.

Selected Videos

Born in the USA. 2000. http://www.itvs.org/born in theusa
I had an Abortion. 2005. http://www.wmm.com/filmcatalog/pages/c693.shtml
Making Babies. 2005. http://www.pbs.org/wgbh/pages/frontline/shows/fertility
Maybe Baby. 2006. http://www.newday.com/films/MaybeBaby.html
Ms Conceptions. 1995. http://www3.nfb.ca/collection/films/fiche/?id=32778
Pregnant in America. 2008. http://pregnantinamerica.com
Silent Choices. 2007. http://www.newday.com/films/SilentChoices.html
The Business of Being Born. 2007. http://www.thebusinessofbeingborn.com
The Education of Shelby Knox. 2005. http://www.pbs.org/pov/pov2005/shelbyknox
The Last Abortion Clinic. 2005. http://www.pbs.org/wgbh/pages/frontline/clinic/view
The Pill. 2003. http://www.pbs.org/wgbh/amex/pill/

Websites

Research and Policy Organizations

The Guttmacher Institute http://www.guttmacher.org
Centers for Disease Control http://www.cdc.gov/women/az/reprhlth.htm
Kaiser Network.org http://www.kaisernetwork.org/
National Center Education in Maternal/Child Health http://www.ncemch.org
National Center On Minority Health and Health Disparities http://www.ncmhd.nih.gov
National Council for Research on Women http://www.ncrw.org/resources/reprorights.htm

Advocacy and Resources for Women

Boston Women's Health Collective http://www.ourbodiesourselves.org/ about/ default.asp
Center for Reproductive Rights http://reproductiverights.org/
Childbirthconnection.org http://www.childbirthconnection.org
Coalition for Improving Maternity Care http://www.motherfriendly.org/mfci.php
Feminist Majority Foundation http://www.feminist.org/rrights
International Cesarean Awareness Network http://www.ican-online.org
NARAL Pro-Choice America http://www.prochoiceamerica.org
National Asian Woman's Health Organization http://www.nawho.org
National Women's Health Alliance http://nwhalliance.org

National Medical Associations/Non-Profit Medical Organizations

American College of Nurse Midwives http://www.midwife.org
American College of Obstetricians and Gynecologists http://www.acog.org
American Medical Women's Association http://www.amwa
American Society for Reproductive Medicine http://www.asrm.org
Med Students for Choice http://www.ms4c.org/
Midwives' Alliance of North America http://www.mana.org
Planned Parenthoods http://www.plannedparenthood.org/
Pro-Choice Resources http://www.prochoiceresources.org/
Society for Assisted Reproductive Technology http://www.sart.org

For Those Without Internet Access

National Women's Health Information Center http://www.4woman.gov. 1-800-994-9662.

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