

AFTER *DOBBS*:

Implications for Health, Equity, and Health Services Research

March 4, 2024



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EXECUTIVE SUMMARY

The aftershocks of the *Dobbs v. Jackson Women's Health* decision overturning the constitutional right to abortion continue to reverberate through the U.S. health care system as patients and clinicians navigate the uncertain, politically charged, and changing terrain of reproductive and maternal health care. Since the June 2022 U.S. Supreme Court reversal of *Roe v. Wade*—the landmark case that had assured a constitutional right to abortion for nearly a half-century—judges and lawyers, rather than pregnant people in consultation with their physicians, increasingly are deciding what care pregnant people can receive in some states. Fear of prosecution hangs over clinicians and patients if they misstep among the landmines of varying and vague state abortion bans and restrictions and other laws affecting pregnant people. While *Dobbs* altered reproductive rights for all pregnant people and their families, those most adversely affected include people with low incomes, racial and ethnic minorities, adolescents, and people living in rural areas—all of whom already face significant health disparities and inequities.¹

Almost 1 in 3 women of reproductive age—an estimated 21.5 million women—now live in states that either totally ban abortion or after six weeks.²

Beyond enabling states to criminalize abortion, which the American College of Obstetricians and Gynecologists characterizes as “an essential component of comprehensive medical care,”³ the *Dobbs* decision is impacting access to cancer and other care more broadly for pregnant people and women of reproductive age, as well as hindering obstetric training among medical residents. To examine post-*Dobbs* impact on health and equity, [AcademyHealth](#), supported by [The Commonwealth Fund](#), convened researchers, clinicians, and legal and policy experts in late 2023 to:

- Foster a common understanding of the myriad consequences of *Dobbs*, including and beyond the immediate impacts on abortion access and reproductive health.
- Encourage dialogue, understanding, and partnerships among reproductive health researchers, community partners, other stakeholders, and the broader health services research (HSR) community.
- Highlight ethical and other challenging aspects of conducting and reporting research on abortion access and related health impacts and potential ways to resolve these challenges.
- Center equity in all aspects of research given the disproportionate burden of *Dobbs* on low-income populations, communities of color, and other historically excluded communities.

As of November 2023, 14 states had banned abortion outright, while others were trying to ban or severely curtail access to abortion, according to the Kaiser Family Foundation (KFF) [Abortion Policy Tracker](#). Nearly all state abortion bans include some exceptions that generally fall into four categories: to prevent the pregnant person's death; when there are risks to the pregnant person's health; when pregnancy results from rape or incest; and presence of a lethal fetal anomaly.⁴ In practice, however, the exceptions often are vague and unclear, creating uncertainty for clinicians and hospitals about what interventions are legal—even in an emergency.

The full report—**After *Dobbs*: Implications for Health, Equity, and Health Services Research**—summarizes the November discussion, including the legal context and background of access to abortion; the broad and sometimes unintended consequences of *Dobbs*; the role of state policy in access to reproductive and other health care for pregnant people and those of reproductive age; research considerations; and priority research topics. Key report highlights include:

Documenting the Ripple Effects of *Dobbs*

In the world's wealthiest country, being pregnant or a newborn, especially for Black, Hispanic/Latino, and American Indian or Alaska Native people, is increasingly dangerous.⁵ Poverty, violence, and inadequate and inequitable access to high-quality maternal, newborn, and postpartum care collide in dangerous ways all too often for women and children. In America, homicide is the most frequent cause of death for pregnant and postpartum women—more than twice as likely as other causes, including hypertension, hemorrhage, and infection.⁶

The U.S. maternal death rate is more than double that of other high-income countries, and significant inequities exist by race, ethnicity, and other demographic and socioeconomic characteristics.⁷ Between 2018 and 2021—before *Dobbs*—overall U.S. maternal mortality nearly doubled from 17.4 deaths to 32.9 deaths per 100,000 births, with particularly large increases among Black and American Indian or Alaska Native women.⁸ Additionally, for every major racial or ethnic group, pre-*Dobbs* maternal death rates were higher in states with restrictive abortion policies compared to states with less restrictive policies. Similarly, abortion-restriction states have fewer maternity care providers, more maternity care “deserts,” higher overall death rates for women of reproductive age, and greater racial inequities across their health care systems.⁹

Beyond the Right to Choose. While people may perceive the *Dobbs* decision as primarily affecting a woman's right to choose an abortion, the impacts on women extend to treatment during pregnancy that might threaten the fetus; other medical care like cancer treatment for

women of reproductive age; clinician training and practice in states with abortion restrictions; and accurate data collection. Quality and access to care problems are exacerbated in low-income communities and for Black, Native American, and Hispanic/Latino populations, which already experience worse access to care, poorer outcomes, and discrimination due to poverty and race, and are more likely to live in states with abortion restrictions. Some states with the most restrictive abortion laws also have higher rates of poverty, creating even greater barriers to the ability to seek abortion care out of state.

The Role of State Legislators and Research. While the states have long been the locus of anti-abortion and other efforts to curtail reproductive health care access, including gender-affirming care, the overturning of the constitutional right to abortion means state legislatures are now the sole forum for deciding what medical care, including abortion, is accessible to people. This creates an imperative for health services researchers to develop and advance evidence on the impact of the *Dobbs* decision and related state laws for state policy decisionmakers.

Existing and Evolving Abortion-Related Research. Current research efforts generally focus on five broad domains: abortion incidence, abortion access, workforce impacts, provider behavior; and broader health and social impacts. Three major research efforts are underway to collect abortion incidence data and document shifts in access to abortion care: the Society of Family Planning [#WeCount project](#); the Guttmacher Institute [Monthly Abortion Provision Study](#); and the University of Texas at Austin [Project SANA](#), the Self-managed Abortion Needs Assessment Project. On the access front, the [Abortion Access Dashboard](#) uses geographic information system software and mapping to report publicly on a range of metrics related to U.S. abortion care facilities. Other research centers studying local, regional, and national abortion access include [Resound Research for Reproductive Health](#); [OPEN, the Ohio Policy Evaluation Network](#); [RISE, the Center for Reproductive Research in the Southeast](#) at Emory University; [CONVERGE](#) at the University of Pittsburgh; and [CORE, the Collaborative for Reproductive Health Equity](#) at the University of Wisconsin.

Community-Engaged Research Critical in Reproductive and Maternal Care. Community engagement takes place along a continuum, commonly ranging from seeking input for a discrete part of a research study, such as recruiting participants, to community-based participatory research where researchers and community members collaborate on all aspects of the research. By enabling the voices of low-income and marginalized individuals, successful community engagement produces better and more actionable evidence to inform reproductive and maternal health policy and includes respecting community knowledge and understanding community characteristics, differences, and needs.

Conflicting Legal and Ethical Obligations to Protect Patient Privacy. Health care providers must both accurately capture and record medical details, including reproductive care, in legal medical records and only disclose health information as authorized by federal law. At the same time, patients need to know their confidential information will be protected by physicians, hospitals, and other providers.

Identifying Research Priorities. Conducting rigorous research to understand and document the range of consequences stemming from *Dobbs* will be critical to informing evidence-based policies related to reproductive and maternal health care. To begin the work of setting research priorities for the field and drawing on the breadth and depth of the day's discussion, the approximately 80 participants identified research priorities across six domains:

- Access, availability, and safety of abortion services.
- Other reproductive health care, including maternal and perinatal care and outcomes.
- Non-reproductive health care and outcomes, including mental and behavioral health, disability, and chronic disease.
- Health care workforce implications, including training impacts, reproductive health deserts, and clinician burnout.
- Care financing and delivery issues, including Medicaid, safety-net providers such as federally qualified health centers, and data privacy.
- Broader societal impacts, including employment, education, and poverty.

Health services researchers can contribute meaningfully to the evidence base regarding the impact of the *Dobbs* decision, leveraging the field's multidisciplinary and methodologic strengths and expertise in analyzing large datasets—in particular for the study of research questions in the domains of health care workforce and care financing and delivery. Sample research questions ripe for HSR in these domains include:

- What is the impact of *Dobbs* on health care workforce shortages?
- Does abortion provision via telehealth/telemedicine help with physician burnout and access?
- What is the impact of *Dobbs* on federal and state level financing for sexual and reproductive health care?
- What excess costs is *Dobbs* creating in the health care system (due to lack of abortion access)?
- What is the impact of *Dobbs* on interpersonal violence (IPV)?
- How, collectively, do state laws shape economic and other forms of equity between genders?

The research agenda emphasizes the importance of applying an equity lens to the conduct of research on the questions identified. To conduct this research effectively and responsibly, forming partnerships among health services researchers and communities (i.e., via community-led or community-engaged research), as well as with researchers in reproductive health and rights who are expert in the unique considerations for conducting abortion-related research, is essential. The research agenda at the end of this brief provides a starting point for future collaboration among these research communities to explore the myriad impacts of *Dobbs* on health, equity, and society.

INTRODUCTION

With the *Dobbs v. Jackson Women's Health* decision, the U.S. Supreme Court upended the nation's reproductive and maternal health care landscape in June 2022 by overturning *Roe v. Wade*—the landmark case that had assured a constitutional right to abortion for nearly a half-century. The aftershocks of the 6-3 *Dobbs* decision that returned abortion regulation to the states hit within days as states like Texas immediately made abortion illegal in almost all circumstances. Almost 1 in 3 women of reproductive age—about 21.5 million women—live in states that either totally ban abortion or after six weeks.¹⁰ Other states like Michigan and California enshrined abortion protections in state constitutions and expanded access to services.

“Really understanding the intersectional context of race and the impacts of racism and the dynamics of racism on the uneven distribution of policies and outcomes is critical to think about, and it's really important that we center our research and our work with equity in mind.”

The reverberations of the *Dobbs* ruling continue to ripple through the health care system and beyond, forcing patients and clinicians to navigate the politically charged and uncertain terrain of reproductive and maternal health care delivery in America. As judges and lawyers rather than physicians increasingly decide what care can be provided to pregnant women in some states—as exemplified in late 2023 when a Texas woman whose fetus had a deadly chromosomal anomaly was forced to leave the state to end her pregnancy¹¹—fear of prosecution hangs over clinicians and pregnant people if they misstep among the landmines of varying and vague state abortion bans and restrictions and other laws affecting pregnant people. While *Dobbs* altered reproductive rights for all pregnant people and their families, those most adversely affected include people with low incomes, racial and ethnic minorities, adolescents, and people living in rural areas—all of whom already face significant health disparities and inequities.¹²

Since a draft of the *Dobbs* opinion was leaked to the news media six weeks before the Supreme Court ruling on June 24, 2022, the decision ending federal constitutional protection for abortion access was hardly a surprise. Regardless, the ruling's impact on the U.S.

reproductive and maternal health care landscape was swift and sizeable. Beyond enabling states to criminalize abortion, which the American College of Obstetricians and Gynecologists characterizes as “an essential component of comprehensive medical care,”¹³ the *Dobbs* decision is impacting access to cancer and other care more broadly for pregnant people and women of reproductive age.

To examine post-*Dobbs* impact on health and equity, [AcademyHealth](#), supported by [The Commonwealth Fund](#), convened researchers, clinicians, and legal and policy experts in late 2023 to identify research priorities and evidence to inform policymakers, especially state legislatures and the courts, as they traverse the changing topography of sexual, reproductive, and maternal health care in the United States. Key goals included:

- Fostering a common understanding of the myriad consequences of *Dobbs*, including and beyond the immediate impacts on abortion access and reproductive health.
- Encouraging dialogue, understanding, and partnerships among reproductive health researchers, community partners, other stakeholders, and the broader HSR community.
- Highlighting ethical and other challenging aspects of conducting and reporting research on abortion access and related health impacts and potential ways to resolve these challenges.
- Centering equity in all aspects of research given the disproportionate burden of *Dobbs* on low-income populations, communities of color, and other historically excluded communities.

“Really understanding the intersectional context of race and the impacts of racism and the dynamics of racism on the uneven distribution of policies and outcomes¹⁴ is critical to think about, and it's really important that we center our research and our work with equity in mind,” said Laurie C. Zephyrin, M.D., M.P.H., M.B.A., senior vice president for Advancing Health Equity at The Commonwealth Fund.

This brief summarizes the daylong November discussion, including the legal context and background of access to abortion; the broad and sometimes unintended consequences of *Dobbs*; the role of state policy in access to reproductive and other health care for pregnant people and those of reproductive age; research considerations; and priority research topics.

U.S. LEGAL CONTEXT OF REPRODUCTIVE RIGHTS



In the mid-20th century, the U.S. Supreme Court began to recognize the right to privacy as a core value of modern society—what lawyers call substantive due process, or the principle that the Constitution protects certain fundamental rights from government interference, said Sara Rosenbaum, J.D., professor emerita of health law and policy and founding chair of the Department of Health Policy at the Milken Institute School of Public Health, George Washington University.

“Out of that right to privacy came many things, including access to contraception—that’s the very famous *Griswold* decision [1965]. The right to marry the person who one loves, that was *Loving versus Virginia* [1967], which of course was an interracial marriage decision, but actually was decided not on race grounds but on privacy grounds. And of course, same-sex marriage [*Obergefell v. Hodges*, 2015],” Rosenbaum said. “All of these issues arose out of this fundamental recognition by the Court that in modern society—in a world of what is called ordered liberty—the expectation of privacy over the most intimate choices is foundational.”

“It is not an overstatement to say that the power granted states by *Dobbs* is so strong that a state can lawfully, at this point, compel childbearing under extremely unsafe circumstances.”

In 1973, citing the right to privacy, the Supreme Court ruled in *Roe* that access to abortion was a constitutional right, prompting “a tremendous amount of legal fallout” as many states attempted to limit *Roe*’s reach and scope, she said. By 1992, the “first really serious effort” to overturn *Roe*, *Planned Parenthood v. Casey*, reached the Supreme Court, which upheld the constitutional right to abortion but allowed greater state abortion restrictions, including banning abortion of a viable fetus—generally about 22 weeks gestation—under any circumstances except when the mother’s health was at risk. “The pre-viability period was sacrosanct, and the Court was very clear that for a decision as enormous as the constitutional right to abortion as a dimension of privacy, the Court should stand by its decisions no matter what individual justices thought about the decision,” Rosenbaum said, describing the *Casey* ruling.

In contrast, the *Dobbs* decision, in the words of Justice Samuel Alito, ruled both *Roe* and *Casey* were “egregiously wrong” on a constitutional right to privacy encompassing abortion. Moreover, Alito opined that the principle of *stare decisis*—or societal reliance on a past court decision—was misplaced in this case, because as Rosenbaum sarcastically described Justice Alito’s position, “There was no need any longer in the United States for abortion. . . . Women can have it all. I mean, literally, they can have childcare, they can get jobs, nobody is prejudiced against single-parent families any longer, society has moved on, we have birth control, lots of job opportunities, et cetera, et cetera, et cetera. So, the entire notion that you needed to protect abortion was completely wrong. Society was in a very different place from 1973.”

Dobbs essentially closed the window on a federal constitutional right to abortion and left regulation of abortion to the individual states—an important point for researchers to keep in mind, Rosenbaum noted, because states have “absolute power” to regulate medical care, including abortion post-*Dobbs*. “It is not an overstatement to say that the power granted states by *Dobbs* is so strong that a state can lawfully, at this point, compel childbearing under extremely unsafe circumstances,” she said.

Another critical consideration for researchers is that state abortion regulations vary tremendously, with Rosenbaum saying, “You’re really going to have to understand the nuanced distinctions from one state to another—that’s true on the nature of a ban, the scope of the ban, the exceptions to a ban, how those exceptions are worded, and how those exceptions have been enforced. This is an area where you’re going to have to have, in my opinion, a lot of interplay with legal experts.”

As of November 2023, 14 states had banned abortion outright, while others were trying to ban or severely curtail access to abortion, according to the KFF [Abortion Policy Tracker](#). State restrictions so far do not impose criminal penalties on people for seeking abortions and instead target physicians, health care providers, and others who help someone get an abortion.¹⁵ Nearly all state abortion bans include some exceptions that generally fall into four categories: to prevent the pregnant person’s death; when there are risks to the pregnant person’s health; when pregnancy results from rape or incest; and presence of a lethal fetal anomaly.¹⁶ In practice, however, the exceptions often are vague and unclear, creating uncertainty for physicians and other clinicians as well as hospitals about what interventions are legal (see **Exhibit 1**).

Another factor contributing to hospital and physician uncertainty is the interface between state abortion bans and a federal law requiring

most hospitals to provide emergency stabilizing care. Since 1986, the [Emergency Medical Treatment and Labor Act](#) (EMTALA) has required Medicare-participating hospitals to screen people for emergency medical conditions if they present in a hospital’s emergency department (ED). If the patient has an emergency medical condition, the hospital must provide stabilizing treatment within its capability or transfer the patient to another medical facility.

As states implemented abortion bans after *Dobbs*, the U.S. Department of Health and Human Services (HHS) issued [guidance](#) in July 2022 underscoring that hospitals and physicians under EMTALA must provide stabilizing care, including abortion in medically appropriate circumstances, when a patient presents in the ED with an emergency medical condition. Multiple lawsuits related to EMTALA and state abortion bans have been filed in Texas and Idaho, initially resulting in conflicting federal court decisions. In the Idaho case, the federal trial court ruled the state’s near-total abortion ban was preempted by EMTALA, while in Texas, the court blocked enforcement of the HHS EMTALA guidance. In early 2024, the U.S. Supreme Court agreed to hear the Idaho case and reinstated Idaho’s near total abortion ban while the case is resolved.¹⁷ The only exception to Idaho’s abortion ban is to prevent the death of the pregnant woman, and upholding the law could lead to other states adopting a “death-only standard” rather than a broader exception based on risk to the pregnant person’s health, according to Rosenbaum.

The medical care system is in “complete meltdown” over the confusion spawned by *Dobbs*, Rosenbaum said, resulting in “tremendous inability . . . to control maybe the most crucial issue of all, which is whether you can intervene with a pregnant person in an emergency, in a health endangering situation.” Rosenbaum added that it’s unclear whether “public discourse can be powerful enough to allow medicine to make some reasonable decisions again, and whether medicine does.”

Exhibit 1. State Abortion Ban Exceptions Often Impracticable

- In practice, health and life exceptions to abortion bans are often unworkable, except in the most extreme circumstances, and have sometimes prevented physicians from practicing evidence-based medicine.
- Abortion bans and restrictions have led physicians to delay providing miscarriage management care. Many states allow the removal of a dead fetus or embryo, but pregnant people who are actively miscarrying may be denied care if there is still detectable fetal cardiac activity or until the miscarriage puts the life of the pregnant person in jeopardy.
- Mental health exceptions are rare despite 20% of pregnancy-related deaths being attributable to mental health conditions.
- Law enforcement involvement often needed to document rape and incest, which can prevent survivors from accessing abortion care. Furthermore, survivors in states with restricted abortion care can have difficulty finding an abortion provider.
- In many states, there are multiple abortion bans. In some of these states, the exception provisions often are at odds with each other, creating confusion among patients and providers.

Source: Adapted from Felix, Mabel, et al. “A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services.” *KFF*, 18 May 2023.

DOCUMENTING THE RIPPLE EFFECTS OF *DOBBS*



In the world's wealthiest country, being pregnant or a newborn, especially for Black, Hispanic/Latino, and American Indian or Alaska Native people, is increasingly dangerous. Poverty, violence, and inadequate and inequitable access to high-quality maternal, newborn, and postpartum care collide in dangerous ways all too often for women and children. In America, homicide is the most frequent cause of death for pregnant and postpartum women—more than twice as likely as other

seeking an abortion are estimated to have incomes below the federal poverty line,²⁰ or \$24,860 annually for a family of three in 2023. Similarly, people with low incomes are more likely to face health-related social needs like safe housing, healthy food, and transportation.

U.S. Already Facing a Maternal Health Crisis

The U.S. maternal death rate is more than double relative to other high-income countries, and significant inequities exist by race, ethnicity, and other demographic and socioeconomic characteristics.²¹ Between 2018 and 2021—before *Dobbs*—overall U.S. maternal mortality nearly doubled from 17.4 deaths to 32.9 deaths per 100,000 births, with particularly large increases among Black and American Indian or Alaska Native women.²² Additionally, for every major racial or ethnic group, pre-*Dobbs* maternal death rates were higher in states with restrictive abortion policies compared to states with less restrictive policies (**Exhibit 2**). Similarly, abortion-restriction states—many of which have high concentrations of racial and ethnic minority women in poverty—have fewer maternity care providers, more maternity care “deserts,” higher overall death rates for women of reproductive age, and greater racial inequities across their health care systems.²³

Beyond deteriorating access to the full range of evidence-based reproductive and maternal health care, including abortion care, health equity experts fear fallout from *Dobbs* will lead to broader economic

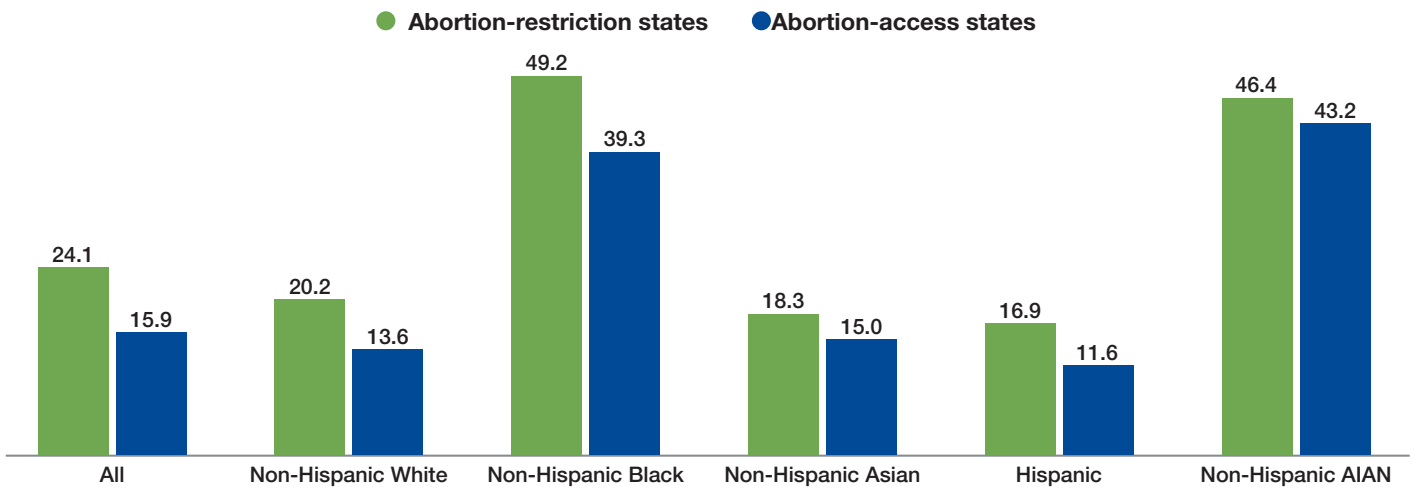
“Beyond deteriorating access to the full range of evidence-based reproductive and maternal health care, including abortion care, health equity experts fear fallout from *Dobbs* will lead to broader economic impacts on women, children, and families and wider health disparities and inequities.”

causes, including hypertension, hemorrhage, and infection.¹⁸ Similarly, Medicaid, the joint federal-state health program for people with low incomes, covered more than 2 in 5 births (41%) in 2021. Among Black and Hispanic pregnant people, the share of Medicaid-covered deliveries was 64% and 58%, respectively, in 2021, according to the Centers for Disease Control and Prevention (CDC).¹⁹ Moreover, restricting access to abortion care will likely impose additional economic consequences on women and families since almost one-half of people

impacts on women, children, and families and wider health disparities and inequities, according to Zephyrin of The Commonwealth Fund. “How do we document that—how do we make sure that these ripple effects don’t go missing in the void of no data and no infor-

mation ... the research that can hopefully come from this and that’s happening can really drive policy and systems change at the local level” she said, underscoring the importance of centering research “with equity in mind.”

Exhibit 2. Maternal Deaths per 100,000 Births, by Race/Ethnicity and State Abortion Policy, 2018–2020



Note: AIAN - American Indian or Alaska Native.

Data: Centers for Disease Control and Prevention, “National Center for Health Statistics Mortality Data on CDS WONDER,” last updated Dec. 22, 2021.

Source: Eugene Declercq et al., The U.S. Maternal Health divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions (Commonwealth Fund, Dec. 2022). <https://doi.org/10.26099/z7dz-8211>



BEYOND THE RIGHT TO CHOOSE



While people may perceive the *Dobbs* decision as primarily affecting a woman's right to choose an abortion, the impacts on women extend beyond the right to choose, according to Susan C. Scrimshaw, Ph.D., a medical anthropologist and interdisciplinary health equity researcher who presented at the meeting about threats to women's health and access to care. "When we think of *Dobbs*, the first thing we think about is the choice to have an abortion or not... But the other issues, the unintended consequences of *Dobbs* emerge just as large—maybe even larger," she said. Those issues include medical treatment during pregnancy that might threaten the fetus, other medical care for women of reproductive age, clinician training and practice in states with abortion restrictions, and accurate data collection.

Medical Treatment During Pregnancy

In states with abortion bans and narrow exceptions, a wide range of treatment for pregnant woman is threatened, including management of incomplete spontaneous abortions—or miscarriages—and treatment of hemorrhage, infection, and water breaking; management of ectopic pregnancies, pre-eclampsia, and fetal anomalies; cancer treatment; and treatment for other urgent conditions such as organ transplants and mental health and substance use disorders. "We now have stories in the news media of women who are being forced to carry pregnancies to term when they know there is no chance that that child is going to survive; treatments for cancer that can be abortifacient are not permitted in many states for pregnant women," Scrimshaw said.

Quality and Access to Care Impacted

Pointing out that most of women's lives are spent not pregnant, Scrimshaw described how care for any woman of reproductive age can become ensnared in abortion restrictions, saying, "This is care throughout a woman's life, and what's really interesting is that legislatures are starting to decide what is the reproductive lifespan. We have instances of a girl as young as 7 not getting a treatment she needed and women over 60 not getting treatments they need because they're female. Risk to future fertility also increases with a denial of appropriate care, particularly again, in the case of some of these pregnancy complications."

Quality and access to care problems also are exacerbated in low-income communities and for Black, Native American, and Hispanic/Latino populations, which already experience worse access to care and outcomes and are more likely to live in states with abortion restrictions. "It's no longer possible to provide high-quality care in many states—it already wasn't happening particularly well—but we're seeing more and more women's health care deserts," Scrimshaw said. Similarly, access to preventive care is likely to decline since many abortion clinics in states where the procedure is now banned offered other services to their communities, including parenting support programs, pediatric care, cancer screenings, and tests for sexually transmitted infections. "The end of *Roe* impacts the ability of people—not just women—of men, women, and children, but particularly women, to receive adequate medical and preventive care."

State Abortion Restrictions Becoming a Physician Workforce Issue

A recent *Journal of General Internal Medicine* study based on a social media survey of 2,000 current or future physicians found that about 8 in 10 “would prefer to work or train in states with preserved abortion access.”²⁴ According to Scrimshaw, “Training and treating problem pregnancies is largely not available in states with abortion restrictions, so if you have a [patient with a] spontaneous abortion with a hemorrhage, you may not have gotten the training in doing the dilation and curettage that you’ll need to do to save that woman’s life, but certainly, to have a major impact on stopping the hemorrhage. Training and health care delivery in dermatology, oncology and other specialties can be impacted because of the restrictions that I mentioned earlier.” Additionally, providers in multiple specialties worry that adequate health care will not be available to them or family members.

Chilling Effect on Reproductive and Maternity Care Data Collection and Quality

Citing the case where Vanderbilt University Medical Center turned over medical records of transgender patients to the Tennessee Attorney General’s office for an investigations of potential billing fraud,²⁵ Scrimshaw said concerns that reproductive and maternity health care data will be impounded by state authorities are influencing accurate data collection and reporting. For example, 19 Republican state attor-

neys general in July 2023 joined in protesting a proposed federal rule to shield medical records of people who cross state lines to obtain legal abortion or gender-affirming care from investigations in their home state.²⁶ The [proposed rule](#) would prohibit disclosure of medical records of people who seek reproductive health care in a state where the care is legal to officials or litigants in their home state where the care is illegal.

Additionally, some states will no longer collect data on pregnancy outcomes to avoid recording adverse outcomes, while others are blocking access to prenatal testing for fetal anomalies, Scrimshaw said, adding, “Apps to track menstrual cycles pose a risk to women in states where the data may be used against them.” As state lawmakers and the courts increasingly substitute their judgment for physicians and other clinicians, Dr. Scrimshaw closed by saying women and pregnant people deserve:

- The right to decide the timing, spacing, and number of pregnancies.
- Access to safe and acceptable means to prevent pregnancy.
- The right to safely terminate a pregnancy.
- The right to state-of-the-art care before, during, and after pregnancy.
- Access to safe, effective, and respectful intrapartum care that honors a person’s choices within the bounds of safety.
- Care that is affordable, respectful, timely, and within reach in terms of distance, transportation, and hours.
- Privacy and confidentiality.



STATE POLICY TAKES CENTER STAGE: MEDICAID AND STATE LEGISLATORS



By virtue of the large share of births covered by Medicaid and the *Dobbs* decision returning abortion regulation exclusively to the states, state policymakers—both appointed and elected—now play a pivotal role in access to reproductive and maternal health care.

Medicaid

Medicaid typically pays for 40% to 50% of all births in a state, but the share ranges from a high of 60% in Louisiana to a low of 17% in Utah.²⁷ Many pregnant people and children are covered by Medicaid managed care plans run by private companies, according to Mohammad Dar, M.D., an internist and former state Medicaid official who presented at the meeting. Moreover, Medicaid agencies vary widely in available staff, with more economically advantaged states typically devoting more resources to Medicaid administration. For example, some states might have 10 medical directors to oversee Medicaid benefits, including reproductive and maternal care, while others—likely about half—have only one or two medical directors to cover the whole Medicaid benefit, he said. Strained or inadequate medical oversight could affect the quality of care in the Medicaid program.

After *Roe v. Wade* established a constitutional right to abortion in 1973, Congress enacted the Hyde amendment in 1977, which prohibits the use of federal funds to pay for abortion except in cases of rape,

incest, or if the pregnancy endangers the woman's life. Dar noted that "Medicaid is allowed to cover abortion-related care and the Hyde amendment did not prohibit Medicaid agencies from covering abortion, but it meant that they had to use their own state-only and non-federally matched dollars to do so. States that you would probably expect to be covering this area, given political landscapes, have chosen to do so.... I think part of this intersection and now with *Dobbs* just further heightens the disparities that were there." However, people working in Medicaid agencies are "not always, even in your most anti-abortion state, focused on the politics alone. They chose to come work in the safety net. They are passionate about the nuance in the issues and the outcomes of the population, and you may find them a more receptive audience than you would expect necessarily," he said.

Given the growing restrictions on abortion and potentially contraception, now is the time to push state Medicaid programs to improve women's health care generally and maternal and newborn care specifically, according to Dar, who coauthored a 2022 *JAMA* commentary—"Medicaid's Moment for Protecting and Promoting Women's Health."²⁸ "If outcomes matter, this is the time to talk about all sorts of wraparound support. Given the circumstances, shouldn't any abortion-restrictive state cover further perinatal health programs in the Medicaid program? Should this state now be providing these sorts of care coordination programs or improving their data reporting? Those

are pieces where both those working in the agencies as well as the advocacy community can continue to make a push,” he said. “If they can’t get that home run of trying to overturn what *Dobbs* has taken us to today, at least continue pushing in a better direction.”

Noting the disjointed nature of care delivery and state Medicaid programs’ reliance on claims-level data to monitor care, identifying pregnant people in time to intervene to improve outcomes can be challenging. According to Dar, reliance on claims-level data “also presents challenges for us, coming ahead, to measure impact on what is going on in our states, across our states, whether you are a state where the legal framework of the land has shifted greatly or not greatly, where you still may be getting an influx from other populations.” Moreover, Medicaid operates in a care delivery environment where local health systems “place care based on what makes money, and that is not aligning necessarily in several realms with what the population needs—whether it’s more mental health support, substance use support, these all interlace with perinatal outcomes. The birthing centers—they’re closing them while the ortho building is staying open,” he said.

Role of State Legislators and Research

While the states have long been the locus of anti-abortion and other efforts to curtail sexual and reproductive health care access, including gender-affirming care, the overturning of the constitutional right to abortion means state legislatures are now the sole forum for deciding what medical care is accessible to people. “State legislatures are where anti-abortion advocates and policymakers have been chipping away for decades and have really normalized many of the bans and restrictions,” said Fran Linkin, M.P.H., director of reproductive health research at the nonprofit [State Innovation Exchange \(SiX\)](#), which educates state legislators about a range of issues, including reproductive health, rights, and justice.

“There are legislators with progressive values in every state that are working to push back, call out, move legislation, shift narratives, and publicly draw the connections between strategies that are happening to dismantle abortion rights, trans health care, and the very process of democracy itself,” Linkin said. For example, SiX provides more than 625 state lawmakers with “trainings, technical assistance, relationship building on a wide range of topics, including abortion, contraception, maternal health, gender-affirming care, and more ... in partnership with local, state, and national groups and advocates.”

While state legislators have “incredibly consequential jobs in our society,” by almost any measure—race, age, class, educational attainment, sexual orientation, and gender identity and expression—“they are far from being representative of their states,” which undermines the principle of representative democracy, Linkin said. “The role of research in this conversation—there is such a breadth and depth of data analysis and recommendations that have already been done in our field and that only continues to grow and evolve. It is really important that we make it accessible to state legislators who are looking to be informed by evidence in the lived experiences of people who are seeking to access, provide, and support care.”

State legislators use research both for proactive and defensive opportunities, and research can help guide legislators in what not to legislate just as importantly as what to legislate, Linkin said, adding, “Whenever researchers can refute nonscientific or junk science opposition claims that are thrown around on their state house floors constantly, that is really helpful as well. From my experience, state legislators are looking to learn. Research helps them understand the reality of what people are experiencing ... to build policy that is actually responsive to their community’s needs.”

While evidence is necessary, it is insufficient without translation and explanation, Linkin said, noting, “Some legislators do want the whole journal article, but it’s helpful if they get a little summary first so that they know where they can go. They need to cite rigorous evidence.... Terrible research is being thrown at them, and it’s in the state record in many of these debates and in these policies.”

“From my experience, state legislators are looking to learn. Research helps them understand the reality of what people are experiencing ... to build policy that is actually responsive to their community’s needs.”

EVALUATING THE IMPACT OF *DOBBS*: EXISTING AND EVOLVING RESEARCH



Since access to abortion care was by no means optimal or equitable before *Dobbs*, centering equity in research to evaluate the decision's impact is critical, according to Sonya Borrero, M.D., M.S., a professor and director of the Center for Innovative Research on Gender Health Equity (CONVERGE) at the University of Pittsburgh, who provided an overview of ongoing research related to abortion care. As illustrated in **Exhibit 3**, existing research focuses on five broad domains: abortion incidence, abortion access, workforce impacts; provider behavior; and broader health and social impacts.

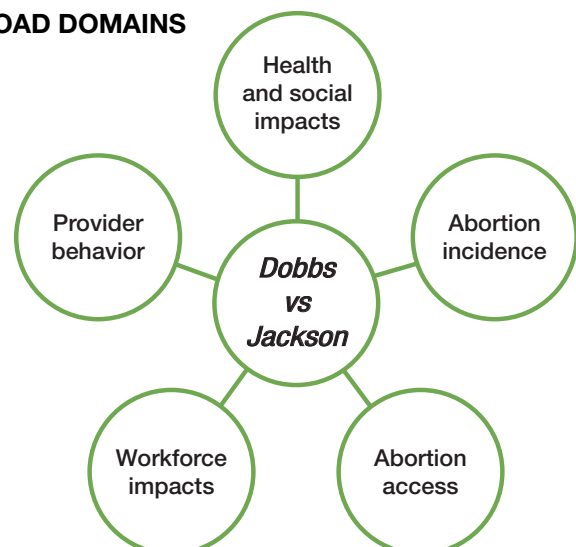
Abortion Incidence

While the CDC compiles and publishes annual abortion statistics using information provided by state health departments, the CDC data are incomplete because several states, including California, do not report abortion incidence. In other states, there can be variation in reporting requirements and completeness. Three major research efforts are underway to collect abortion incidence data and document shifts in access to abortion care: the Society of Family Planning [#WeCount](#) project; the Guttmacher Institute [Monthly Abortion Provision Study](#); and the University of Texas at Austin [Project SANA](#), the Self-managed Abortion Needs Assessment Project. Both [#WeCount](#) and the [Monthly Abortion Provision Study](#) rely on samples of abortion providers to collect information on the numbers of abortions provided and use imputation methods to estimate abortion frequency within the formal health care system. In contrast, [Project SANA](#) studies and tracks self-managed abortion (SMA), which typically occurs outside of the

formal health care system, using the medications mifepristone and misoprostol available through online sources such as Aid Access, an online nonprofit that provides abortion medication to all 50 states and the District of Columbia. In December 2023, the U.S. Supreme Court agreed to hear a case challenging the Food and Drug Administration's approval of mifepristone after an appeals court moved to restrict patients' access to the medication used in more than half of U.S. pregnancy terminations.²⁹

Exhibit 3. Existing Research Domains to Evaluate *Dobbs* Decision

BROAD DOMAINS



“I would caution that some of the traditional or the tried-and-true methods of health services research like claims-based data really cannot be employed well because of the systematic exclusion of abortion coverage by payers and because of the highly stigmatized nature of this health service.”

“These are requests, so we don’t know if people are using them. I do think the prevalence of SMA has been increasing dramatically since *Dobbs*, and so this task of establishing abortion incidence is no small one,” Borrero said. “It also calls into sharp clarity that we may never know true abortion incidence, and we really do need to develop some innovative strategies for capturing fully anonymous, safe, and representative self-reported data on abortion. I know there are some efforts ... I’m sure others are thinking about randomized response techniques to support safe self-disclosure of abortion.”

Access to Abortion Care

The [Abortion Access Dashboard](#) uses geographic information system software and mapping to report publicly on a range of metrics related to U.S. abortion care facilities, including location, appointment availability as of a certain date, and average travel time and distance to the nearest abortion facility. There are other research centers around the country studying local, regional, and national abortion access, including [Resound Research for Reproductive Health](#); [OPEN, the Ohio Policy Evaluation Network](#); [RISE, the Center for Reproductive Research in the Southeast](#) at Emory University; [CONVERGE](#) at the University of Pittsburgh; and [CORE, the Collaborative for Reproductive Health Equity](#) at the University of Wisconsin.

Much of the research related to abortion access “is community partnered and uses mixed methods to understand the range and frequency of health outcomes but also qualitative data to understand people’s lived experiences,” Borrero said, adding specific research efforts are examining “the effect of *Dobbs* on the ability to receive an abortion, the type of abortion received, the time and financial costs required to access abortion care, and gestational age at the time of abortion.”

Health Care Workforce Research

One early data point—where new physicians choose to do their residencies—indicates that states with abortion bans may experience problems attracting the best candidates to train in their states. While overall applicants to obstetrics and gynecology (OB-GYN) residencies declined 5% nationally in 2023, states with abortion

bans saw double the decline (11%) in OB-GYN residency applicants, according to results from the Association of American Medical Colleges’ first residency match post-*Dobbs*.³⁰ Nonetheless, all OB-GYN residency slots did fill. Nationally, overall applicants for emergency medicine residencies, where many obstetric complications are first treated, also dropped dramatically. Other research includes the [Reproductive Health Workforce](#) project at the George Washington University Fitzhugh Mullan Institute for Health Workforce Equity, where researchers are using administrative data such as IQVIA and Transformed Medicaid Statistical Information System, or T-MSIS, datasets to examine changes in provision of contraception services and workforce composition and OB-GYN geographic movement since *Dobbs*.

Provider Behavior

Advancing New Standards in Reproductive Health, based at the University of California San Francisco, is conducting the [Care Post-Roe Study](#), which documents health care providers’ experiences delivering care in states with laws restricting abortion. “This study collected de-identified stories of clinical care that differed from the usual standard of care due to new laws,” Borrero said. “Health care providers have described detailed cases of care in which they were forced to deviate from evidence-based or usual care due to laws restricting abortion, and most of these narrative reports really describe cases of substandard care for pregnant patients.”

Beyond reproductive and maternal care, care is affected for non-pregnant people with serious chronic conditions, disabilities, and substance use “who are often understudied in this space, but for whom abortion restrictions may be uniquely catastrophic,” Borrero said. For example, non-pregnant people with rheumatic disease have reported being unable to get methotrexate—a drug for rheumatic conditions that can cause fetal abnormalities, known as a teratogen—that can also be used for SMA. Along with concerns that patients might subvert the drug to do self-managed abortion, Borrero said clinicians “worry that a person who becomes pregnant while using a teratogen that they prescribed might be forced to bear a child with congenital anomalies, potentially exposing the clinician to personal and/or legal consequences.”

Broader Health, Social, and Economic Impacts

To capture *Dobbs*’ broader impact, researchers are using an array of HSR methods, including survey-based data to examine health, economic, and social consequences of being unable to access abortion care; pregnancy and contraceptive preferences and behaviors; and impacts on non-reproductive health outcomes such as chronic disease management. Others are using administrative and claims data, which is quite limited, and difference-in-differences methodologies to examine associations between state abortion

policies and broader population-level outcomes such pregnancy-related morbidity and mortality and contraceptive and teratogenic medication provision.

“I would caution that some of the traditional or the tried-and-true methods of health services research like claims-based data really cannot be employed well because of the systematic exclusion of abortion coverage by payers and because of the highly stigmatized nature of this health service,” Borrero said.

Partnering with Communities and Abortion Researchers

Many researchers whose work was highlighted at the meeting look beyond quantitative data by using qualitative and mixed-methods study designs, including partnering with people with lived experience and community-based organizations, to study and collect firsthand information about people’s reproductive health care experiences. Researchers “have cultivated longstanding and deep relationships with community organizations that are most impacted by equitable reproductive health care access because we know that abortion restrictions disproportionately impact disinvested communities. Because of the long history of reproductive abuses targeting these various communities, it is so critical to partner with community organizations, including reproductive justice organizations, to avoid misinterpretation of data and causing more harm,” Borrero said. (See *Community-Partnered Research Approaches* for more detailed discussion.)

“I want to encourage us . . . not to just focus on what the negative impact could be but also . . . to stretch ourselves to look at some of the other positive impacts as well.”

Similarly, partnerships between HSR and abortion researchers can create opportunities to more comprehensively understand the broader impacts of abortion policies and help move abortion-related research more to the mainstream because, like abortion care, abortion-related research has been “sidelined in academia and in science,” Borrero said, adding, “So, if people who have not yet been engaged in this research area are interested, I think it’s really critical to collaborate with abortion researchers who have developed a wealth of expertise and innovative strategies to deal with obstacles.”

Another participant urged researchers to look beyond just the negative impact of *Dobbs* and examine policies in states that have improved access to reproductive and maternal health care, saying, “I want to encourage us—there are two sides here to the coin—and not to just focus on what the negative impact could be but also really help researchers . . . to stretch ourselves to look at some of the other positive impacts as well.”

Federal Research Funding

Responding to a question about availability of National Institutes of Health (NIH) funding for abortion-related research, a participant noted that multiple NIH institutes offer funding opportunities across the range of reproductive, maternal, and child health care, along with broader impacts on treatment of other conditions such as cancer and rheumatoid arthritis, post-*Dobbs*. For example, the National Institute of Child Health and Human Development (NICHD) has a current Notice of Special Interest soliciting [Research on the Impact of Policy Changes and Emerging and Evolving Public Health Crises on NICHD Populations of Interest](#). The NICHD populations of interest are neonates, infants, children, adolescents, and young adults, pregnant and post-partum and nursing people, individuals of reproductive age, and individuals with intellectual, developmental, or physical disabilities, as well as the families of these individuals. Similarly, the National Institute on Minority Health and Health Disparities in October 2023 published a funding announcement for [Understanding the Impact of Healthcare System and Clinician Factors on Disparities in Maternal Morbidity and Mortality](#). The U.S. Department of Veterans Affairs also prioritizes funding for reproductive health, including abortion and related health implications, according to a participant.

COMMUNITY-PARTNERED RESEARCH APPROACHES



Two reproductive health and equity researchers—one from academia, Monica McLemore, Ph.D., M.P.H., R.N., and the other from a reproductive health nonprofit, Terri-Ann Thompson, Ph.D., but both with expertise in engaging communities and people with lived experience in research—stressed the importance of authentic and meaningful community research partnerships. “We think it’s really important for the health services researchers, the funders, our colleagues, and collaborators to really understand not just community-based approaches but also how to do it, how to do it well, how to do it ethically, and to really avoid some of the missteps.... We want to give you both the sort of unintended consequences as well as some best practices that we’ve learned over time,” said McLemore, a professor at the University of Washington School of Nursing.

“Quant is not the king of the dance anymore, quite frankly. Maybe it’s mixed methods, right? But I really want to encourage us to move beyond just quantitative methods. They are necessary, they are important, but we really need to be giving more voice to the data,” said Thompson, a senior research scientist at [Ibis Reproductive Health](#).

Conducting community-engaged research in academia generally is challenging, but research related to abortion or other politically charged issues can be particularly difficult. “I’ve actually had the fortune of doing community-engaged research in both academic and non-academic spaces, but ultimately, I felt more fulfilled doing this work in non-academic spaces because of administrative

challenges that arise—around payment, around overhead, around subcontracts—that make it really difficult sometimes for academicians to work authentically and in a way that actually feels fair, quite frankly, with community organizations,” Thompson said. Additionally, academic institutions aren’t “too happy about acknowledging the political and social responsibility side to sexual and reproductive health, and so there was some censorship as you think about dissemination, as you think about activation of the work ... I have had much more success in being able to move findings from paper to courthouse to advocates to providers and to students than I ever was in academia.”

Academic researchers also can face obstacles to community engagement because “sometimes we are affiliated with institutions that have been harmful, and what we actually really need is truth, reconciliation, and apology,” McLemore said. “I would love to see some people planning their grants around that—to be able to apologize for historic harms and be able to build the community to be able to work together on projects.”

Another meeting participant who conducts community-engaged research stressed that researchers should be mindful that communities are diverse, saying, “There’s not one community—there’s communities. And what I see is a lot of people assuming that everyone—and I’ll just take Black folks working in reproductive health—that that is one community, as if there are not divisions, there are not differences of opinion ... you find that a lot in reproductive health research.

“Academic researchers also can face obstacles to community engagement because sometimes we are affiliated with institutions that have been harmful, and what we actually really need is truth, reconciliation, and apology.”

I think it's really, really important to acknowledge that and the fact that you're going to find, just as with any kind of research, better allies, better people, more qualified to do certain kinds of work in communities. So, I think there is a little bit of ... 'Well, if we have these Black folks on our project, then it means that we're engaged in community-based research.' I think that it's also a problem in reproductive health research that is often dominated by White women and Black women organizations in communities doing the work. I think an understanding of that power dynamic is really essential moving forward in reproductive health research.” Similarly, numerous differences and nuances exist among Hispanic/Latino communities and tribal communities.

Calling Out Abortion Stigma

Historically, stigma literally meant a scar or a brand from a hot iron. Today, stigma “most often refers to a set of negative and often unfair beliefs that a society or group of people have about something.”³¹ Despite abortion being among the most common and safe medical procedures provided worldwide, abortion stigma is pervasive and adversely affects individuals, sexual and reproductive health care providers, and researchers by creating hostile and threatening care and work environments.³² Keeping stigma in mind across the research process from study design to dissemination is an important aspect of community-engaged research, according to McLemore. “So, if you're new to either sexual and reproductive health research, and/or abortion research more specifically, really being in partnership with a community will also help you to identify when you are either using stigmatizing language, stigmatizing questions, or reinforcing notions of stigma that we think are relatively harmful.”

Community Engaged Research Framework

Community engagement takes place along a continuum, commonly ranging from seeking input for a discrete part of a research study, such as recruiting participants, to community-based participatory research (CBPR) where researchers and community members collaborate on all aspects of the research. Beyond CBPR, McLemore said, is a less-studied approach known as community-directed research “where we work in partnership side by side—experts by education,

experts by experience—really developing research questions and trying to do projects that are meaningful both clinically, as well as socially, as well as politically.”

Successful community engagement to produce better and more actionable evidence to inform policy includes respecting community knowledge and understanding community characteristics, differences, and needs. “My philosophy about community engagement as a framework to research is really based on three beliefs. The first is that I believe that the. The second is that I believe that my skills as a public health researcher are to be used in service of the community.... Thirdly, I believe working with a community helps to center the ‘why’ and the ‘who we do the work for,’” Thompson said.

“I've had folks come to me and say, ‘That is just too much work. I can't be bothered to do all of that because it takes too much time,’” she continued. “Yes, community-based participatory research does take a lot of time, and maybe you're not funded to do work in that way, but it does not mean you can't involve the community in other ways. So, I do encourage you to look to resources on community engagement.”

Community Research Capacity

While community-engaged research can play an important role in studying reproductive health care, including abortion services, community capacity may be limited, and funders and researchers need to consider how to support and build community capacity for research participation. “A lot of the community-based organizations that people want to work with are already currently overtaxed, and I worry that as more and more people want to be able to get good data and to do community engagement, that we've under-resourced our community partners to be able to participate in community engagement,” McLemore said.

Nonetheless, researchers can seek creative ways to partner with community organizations and leverage their knowledge. “Let's also remember that these community organizations are deeply resourced in many ways that aren't just money or monetary or financial and, as we think about this work, we really need to acknowledge the fact that it's two different organizations bringing different kinds of resour-

“Being in partnership with a community will also help you to identify when you are either using stigmatizing language, stigmatizing questions, or reinforcing notions of stigma that we think are relatively harmful.”

es and different kinds of power into the relationship, right? So, a partnership, it's not top down or bottom up—it's iterative, and we're constantly switching off in terms of who's leading and who's bringing resources into the space," Thompson said.

Another way to help support community capacity for research is for "more funders, especially in the philanthropic world, as well as in the intramural world at academic institutions, really starting to think about investing in early career people who want to do community-embedded work, and perhaps funding fellowships for them to be embedded in community-based organizations, as opposed to just having academic mentors," McLemore said.

Dissemination Beyond Journal Articles

In a symbiotic way, researchers and community organizations together can make research more meaningful and actionable and amplify findings to policymakers in ways neither can do alone. For example, Thompson recounted how a reproductive justice organization "reached out to us to collect data alongside them, qualitative data, because they were told quite frankly that their stories weren't

valued without a research study, without a citation, without some sort of publication." On the flip side, articles published in peer-reviewed journals are less likely to capture policymakers' attention without translation and explanation, so McLemore encouraged researchers to think beyond journal articles for dissemination of findings. "I'm just saying gray literature is helpful—community-based organizations can help you to disseminate those things—be thinking about the other kinds of products that can come out of your research that have nothing to do with peer-reviewed papers."

"My philosophy about community engagement as a framework to research is really based on three beliefs. The first is that I believe that the community knows best. The second is that I believe that my skills as a public health researcher are to be used in service of the community... Thirdly, I believe working with a community helps to center the 'why' and the 'who we do the work for.'"



A NEW PARADIGM FOR EQUITABLE MEASUREMENT: USING RACISM—NOT RACE—AS A RISK FACTOR



As researchers examine the impact of curtailing access to the full range of safe, high-quality, and equitable reproductive care, including abortion, and maternal care, they have an opportunity to design and validate new measures. For example, more than half a million Black women and birthing people give birth annually in U.S. hospitals, where they are much more likely to experience adverse pregnancy-related outcomes compared to non-Black pregnant people. Most approaches to perinatal quality measurement, safety, and improvement evaluate hospital performance using outcome measures—like a vaginal birth or normal infant weight—usually based on patient clinical and physical characteristics, including race, as risk factors.

“Outcome-only measures cannot, do not, and will likely never capture the patient and community experiences of care—specifically the hidden narratives of preventable, predictable, and unfair hurt and harm of reproducing, birthing, lactating, parenting, and partnering for pleasure and/or family-building while Black in any U.S. system,” said Karen A. Scott, M.D., M.P.H., who designed and coauthored a study in 2020 that validated the first and only Patient-Reported Experience Measure of Obstetric Racism® (PREM-OB Scale® suite).³³

“Consider the image and messaging of a Black mother and child who achieved birth outcomes based on traditional standards of quality and safety,” Scott said, referencing a slide with an image of a Black mother and newborn and a list of birth outcomes: full-term pregnancy, absence of medical conditions/comorbidities; optimal prenatal

care; vaginal birth with a small laceration with repair; normal weight infant; healthy infant; and infant latched well to breast/chest/body.

“We will likely label this birth and the birthing hospital as high-performing, high-quality, and safe. However, when asking the Black mother to describe her experience of care, she shared a memory of holding her child during a routine repair of an uncomplicated laceration. ‘Though he put me back together, I still don’t feel whole.’ The critical questions we need to consider: Is this a safe or unsafe Black birth? Who gets to define, measure, monitor, and report on safety? Who gets to determine accountability mechanisms for approval or denial of reimbursement based on safety? What is the proximity between these structures and systems of power, decision making, and Black mothers and birthing people in terms of equity, inclusion, belonging, and justice?” Scott asked.

“Obstetric racism, as defined by Dána-Ain Davis, Ph.D., is both an event and framework that explains how U.S. maternal health systems devalue, dehumanize, control, and abuse Black women and their babies in ways that track the long histories of anti-Black racism and eugenics.”

Highlighting nuanced differences of measures based on system intention, community impact, and opportunities for innovation, disruption, and transformation, Scott said, “The system intention is to evaluate hospital performance of quality and safety using outcome measures usually based on a patient’s physical or clinical characteristic. In reality, outcome measures evaluate the physical performance of any birthing body—but let’s say a Black birthing body—and the response to the quality of care and generations and centuries of structural and systemic violence, control, injustices, and dominance.... So, our recommendation is to supplement outcome measures with validated patient-reported experience measures that actually evaluate hospital performance based on hospital treatment or mistreatment of Black mothers and birthing people.”

Being Safe vs. Feeling Safe

Obstetric racism, as defined by Dána-Ain Davis, Ph.D., “is both an event and framework that explains how U.S. maternal health systems devalue, dehumanize, control, and abuse Black women and their babies in ways that track the long histories of anti-Black racism and eugenics,” said Scott, who coauthored a recent commentary in *BMJ Quality and Safety*, titled “[Emotional safety is patient safety](#),” that used obstetric racism as an exemplar to justify the need for a new patient safety paradigm. Other research has found that patients conceptualize safety as “feeling safe” rather than “being safe” and view safety differently than clinicians.³⁵ For patients and families, “patient experience” and “patient safety” are almost interchangeable.

“The current quality and patient safety paradigm lacks the historical contextualization and contemporary implications of obstetric racism as a well-defined, measurable, predictable, and preventable never event,” she said. “We must interrogate and reconcile being safe as defined by systems with feeling safe as defined by patient experienc-

es and community wisdom. If we don’t, then we create and perpetuate systemic and testimonial injustices and thereby cover up the realities of hurt and harm.”

PREM-OB Scale® Suite

Validated with over 900 Black women and people as patient, community, and content experts across 348 hospitals and 34 states, including D.C., the PREM-OB Scale® suite generates three independent scores of obstetric racism that evaluates hospital performance based on humanity, kinship, and racism, Scott said, adding, “We found that each score did not vary by self-reported clinical characteristics, including maternal BMI, gestational age, and mode of delivery, demonstrating that our PREM-OB Scale® suite measures obstetric racism independent of clinical risk.”

The PREM-OB Scale® suite uses narratives and numbers to describe the type, frequency, and severity of acts of obstetric racism and identifies opportunities for improvement in naming, measuring, monitoring, preventing, and mitigating acts of obstetric racism, Scott said, serving as “an interpretative tool to uncover acts of obstetric racism in any free text found in patient handoffs, electronic health records, peer reviews, chart audits, maternal mortality, morbidity reviews, data abstractions, and legal documents such as depositions.”

The tool examines the association between experiences of obstetric racism and hospital prioritization of survival over feeling safe using this statement: “The hospital made me feel that because my baby and I survived birth, my experiences in labor, birth, and postpartum did not matter.” Black mothers and birthing people who agreed or strongly agreed with this statement were six to eight times more likely to experience anti-Black racism or misogynoir—a term describing the intersectional sexism and racism Black women experience—disrupted kinship, and dehumanization.



DATA CONSIDERATIONS



High-quality data are essential to accurately measure and document the cascading health and social effects of the *Dobbs* decision, according to the National Academies of Sciences, Engineering, and Medicine (NASEM) Standing Committee on Reproductive Health, Equity and Society, which held a [public workshop](#) in October 2023 to explore data needs post-*Dobbs* (see Exhibit 4 for examples of data issues identified at the NASEM meeting). Key questions discussed at the NASEM workshop included:

- How has the landscape of available data changed after the *Dobbs* decision?
- What data are currently available, from what sources, and which populations do the data cover?
- What data are needed to understand the full scope and impact of the *Dobbs* decision across society, including health, economic, social, and policy implications?
- What new considerations for data generation, data integrity, data-sharing, patient privacy, and legal implications must be considered since the *Dobbs* decision?

Using the NASEM workshop as a backdrop to illustrate the complexity of data considerations, the AcademyHealth meeting discussion focused on health care providers' often confusing and conflicting legal and ethical obligations related to patient privacy and sexual, reproductive, and maternal health care; threats to electronic health record (EHR) interoperability and health information exchange (HIE) to improve care delivery; and opportunities to establish new measures and data collection related to reproductive and maternal health care.

Conflicting Legal and Ethical Obligations to Protect Patient Privacy

Since 2000, the federal [HIPAA Privacy Rule](#) has set a national floor to protect people's medical records and other individually identifiable health information—collectively defined as protected health information (PHI)—from unauthorized disclosure. The rule applies to covered entities that conduct certain health care transactions electronically, including health care providers like hospitals and physicians, health plans, and health care clearinghouses, as well as covered entities' business associates.

Even before *Dobbs*, and certainly after, covered entities, particularly clinicians who must maintain the “sacred trust” of patient confidentiality, have faced conflicting legal and ethical obligations. They must both accurately capture and record medical details, including reproductive care, in legal medical records and only disclose health information as HIPAA authorizes for treatment, payment, and operations and as appropriate for research, and when compelled by law to do so, according to Peter J. Embí, M.D., M.S., professor and chair of Biomedical Informatics at Vanderbilt University Medical Center. Embí coauthored a 2022 journal article—“[Dobbs and the future of health data privacy for patients and healthcare organizations](#)”—outlining HIPAA requirements and possible practices and policies to better safeguard reproductive health information.³⁶

Exhibit 4. Examples of Data Gaps and Data Quality Issues Post-*Dobbs*

Data Gaps

- Self-managed abortions
- Special populations, including adolescents
- Health care provider attitudes and practices toward individuals/members of different racial/ethnic and socio-economic groups
- Multiple perspectives and multiple levels
- Health care finances—insurance, transportation, co-pays, medication
- Barriers—transportation availability, missing work/school, child-care, reproductive health service hours(including abortion access), language/clear communication
- Data on health outcomes, including longitudinal data
- Historical, longitudinal, public data on state policies
- Timing of data to assess temporal links to policy changes

Data Quality

- Risks to individuals of providing data need to be understood
- Accurate recording of clinical encounters, records
- Socially desired responses rather than honest responses
- Meanings of questions can be interpreted differently
- Distrust of researcher, research in general, and clinicians
- Granularity is an issue—cannot probe in-depth
- Important contextual factors may be neglected including social and cultural factors

Source: NASEM Reproductive Health, Equity, and Society - A Workshop to Explore Data Needs in the Wake of the *Dobbs* v. Jackson Women's Health Organization Decision, October 5, 2023.

Patients share information with clinicians “that they don’t share with anyone else, and they need to know that it’s going to be protected, whether that’s at the level of the physician, the nurse, the pharmacist, or whether that’s at the level of the health care organization and violating that or putting that at risk really puts the entire health system at risk,” Embí said.

Threats to HIE and EHR Interoperability to Improve Patient Care

More robust HIE can improve care delivery and support evidence-based research, Embí continued, “But the *Dobbs* decision starts to bring up very serious concerns about the implications for that related to exchange between entities or between states. Even without exchange, just actually what it is that we should even be capturing about our patients should they seek care elsewhere, and then, for instance, return to a state like Tennessee? What should actually be documented about the abortion care that they got elsewhere?”

Other possible actions to protect patient privacy include record segmentation for pregnancy-related care, similar to safeguards for mental health or HIV/AIDS, that “raise the bar in terms of what level of access different individuals can have” because privacy threats are not just external but come from within as well. “In states like Texas and others—where you’re starting to see laws that even encourage vigilantism around identifying who might be engaging in what are now illegal activities and being able to essentially turn people in—is there going to be some perverse incentive now for those who have access to the record to actually provide that information to law enforcement and think they’re going to have some level of protection?” Embí asked.

Health Privacy as a Moving Target

Stressing the importance of moving toward national health data exchange to improve health care and research, Nichole Sweeney, J.D., a health privacy expert, also emphasized that health privacy is dependent on where the data is held and by whom. The protections, if any, change based on where the data originates and where it is disclosed— “it’s a moving target for consumers and researchers, alike,” and lacks adequate safeguards in certain circumstances. “The consequence of having an interoperable health care system is that—when we are at a place where we weaponize data ... criminalize health data—and the laws are different in different states and dependent on where and how data is held, there are very real consequences. Weaponization of data isn’t new. It has been going on for a very long time, and if it’s new to you, it’s because it hasn’t happened to you, or you haven’t seen it happen to you. ... It continues to be critical that we help people understand when and how data is protected.”

Along with health care organizations having a “game plan” ready to deal with reproductive and other medical records requests that threaten patient confidentiality, Sweeney suggested that allowing individuals whose PHI is improperly disclosed a private right of action to sue under HIPAA could help discourage improper disclosures. “There isn’t a [federal] personal right of action if my data is breached or if somebody uses my data for other than treatment, payment, and operations purposes,” the privacy expert said. “So, we don’t have those immediate disincentives without specific state law; I find when actions are connected with monetary penalties that can come from the real people that are really affected, behavior starts to change.”

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Certificates of Confidentiality

One tool researchers can consider to help protect sensitive, identifiable information is a [certificate of confidentiality](#) (CoC) issued by NIH and other HHS agencies for federally funded research. The CDC, Health Resources and Services Administration, Indian Health Service, Substance Abuse and Mental Health Services Administration, and Food and Drug Administration are among agencies offering CoCs. The Agency for Healthcare Research and Quality, however, does not issue CoCs and has its own privacy regulations. CoCs cover research funded by applicable HHS agencies, and in the case of NIH, are automatically deemed to be issued for any NIH-funded research that collects or uses identifiable, sensitive information that was ongoing on or after December 13, 2016. Additionally, NIH will consider issuing a CoC for a non-funded NIH research project if the topic falls within the [NIH mission](#) or [HHS health-related research mission](#).

Dating to 1970, CoCs were prompted by people’s fear of prosecution if they participated in research related to illegal drug use. The 2016 21st Century Cures Act expanded CoC scope to all research involving sensitive, identifiable information, but gaps remain, including lack of clarity about disclosure if required by other federal, state, and local laws and mingling research data and medical records in EHRs.³⁷ For instance, NIH guidance indicates researchers must disclose a research participant’s identifiable, sensitive information if required by other federal, state, or local laws, giving examples of requirements for public health reporting of communicable diseases or child or elder abuse reporting. The exception raises questions about CoC protections in states with fetal personhood laws, like Georgia,³⁸ that extend legal rights to a fetus or embryo pre-viability, opening the door for child abuse or other charges against pregnant people who allegedly endanger their fetuses, for example, by using illegal drugs.³⁹

“We all share the concern about what courts will do now and abortion exceptionalism. . . . It’s always good research practice, don’t collect more data than you absolutely need, and that obviously applies even more so to anything identifiable,” said Marian Jarlenski, Ph.D., M.P.H., a professor and reproductive health and equity researcher at the University of Pittsburgh.

Chilling Effect on Research

Concerns about protecting research participants’ confidentiality are starting to deter people from the field of reproductive health research, Embí said, adding, “I’m starting to see researchers, post-docs, junior faculty change their research focus areas—actually stop doing research in this area and others where they feel that they could be potentially putting their participants at risk. . . . It would be a travesty not to continue the work that they’re leading.”

Threats directed at researchers who study abortion and gender-affirming care also can prompt people to change their research focus, said a physician researcher at a reproductive health organization who was targeted early in her career. “Sometimes researchers are targeted with well-organized hate or smear campaigns. Providing tools and resources to support them could help promote the longevity of researchers in this area, especially for junior researchers.”

Data and Measurement Opportunities

Despite data obstacles, there are opportunities to “conduct rigorous health services research on abortion and pregnancy and contraception and other reproductive health care,” Jarlenski said. “We have some policy opportunities coming down the pike, and we can think about evidence to support such policies,” the researcher said, citing a proposed rule to improve access to care in Medicaid managed care. “It would be great to think about states putting in some structural measures of access to reproductive health services there. So, maybe we can’t be super granular with claims data, but what we can do is think about structural factors.”

Other opportunities include investing in person-reported outcome measures and how such data can be combined or merged with administrative data, as well as focusing on state-specific studies that capture the state context, including what data are available. “I think these state studies are incredibly important in understanding what is available in data. You know, in some state Medicaid programs, you may really be able to measure induced versus spontaneous abortion care—work with your Medicaid partners—whereas that’s not the case in other states,” Jarlenski said. “In health services research, we like national data—we like to pool across states—but that might not be appropriate here. If we want to understand average effects across these state projects, we can do a meta-analysis, for example.”

“Despite data obstacles, there are opportunities to conduct rigorous health services research on abortion and pregnancy and contraception and other reproductive health care.”

MOVING FORWARD AND SETTING RESEARCH PRIORITIES



Even before *Dobbs*, pregnancy in America was high risk relative to other wealthy nations, and the rippling and cascading effects of *Dobbs* portend even greater danger for pregnant people and others going forward. As one bioethicist said shortly after the *Dobbs* ruling, absolute opposition to abortion “must come from a place of simply not understanding all the complexities, because we know from very clear statistics that many people will die because of this decision.”⁴⁰

Conducting rigorous research to understand and document the range of consequences stemming from *Dobbs* will be critical to informing evidence-based policies related to reproductive and maternal health care. To begin the work of setting research priorities for the field and drawing on the breadth and depth of the day’s discussion, the approximately 80 participants worked together in breakout sessions to discuss and identify research priorities across six domains. Throughout the day, the discussion emphasized the numerous equity and intersectionality facets of challenges to people’s health. These are presented before the summary of the research questions in the six domains. Finally, participants surfaced numerous cross-cutting issues that researchers and policymakers must take into account in the area of unique data needs, opportunities for collaboration and partnerships, and threats or challenges anticipated. These are presented together in additional sections after the initial six domains:

- Access, availability, and safety of abortion services.
- Reproductive care and outcomes beyond abortion, including maternal and perinatal care.

- Non-reproductive health outcomes, including mental and behavioral health, disability, and chronic disease.
- Workforce implications, including training impacts, reproductive health deserts, and clinician burnout.
- Care financing and delivery issues, including Medicaid, safety-net providers such as FQHCs, and data privacy.
- Broader societal impacts, including employment, education, and poverty.

Centering Equity in the Study of Research Questions

Participants in each breakout session discussed how to apply an equity lens to the study of research questions within their respective domains. They emphasized the need to include populations that often are excluded from research because of protection concerns or practical challenges, including people whose primary language is other than English, people who are incarcerated, people with disabilities, and adolescents. Similarly, it is important for researchers to examine how intersectionality of identities and social determinants of health can affect reproductive health outcomes from both a policy perspective and a social context and social capital perspective. To that end, partnering with community-based organizations, Medicaid programs, abortion funds, and community health centers to conduct reproductive health research is critical.

Research Domain: Access, Availability, and Safety of Abortion

In this domain, participants stressed the need to define abortion services and encourage research standardization to consistently collect and analyze data about who is getting abortions, what kinds of abortions they are getting and at what gestational ages, and what the implications are for both health outcomes and equity. A full list of research priorities is available in the appendix. Example research priorities include:

- Comparing differences in outcomes and care experience in states with abortion bans and restrictions vs. states that are expanding access to abortion, especially for people with intersecting historically marginalized identities.
- Examining downstream implications of evolving abortion access, availability, and quality, such as changes in clinical care/practice, innovations such as self-managed abortion, and the impact of *Dobbs* on the administrative burden of obtaining care.
- Exploring the sources people use to find information about where to obtain abortion services and support (e.g., transportation, child care) and the impact of mis/disinformation on the experience of seeking care.

Research Domain: Reproductive Health Care and Outcomes Beyond Abortion: Maternal and Perinatal Care, etc.

In this domain, participants discussed the ripple effects of the *Dobbs* decision into other areas of reproductive health care, such as prenatal care, postpartum mental health, maternal mortality and morbidity, and contraception—especially the mechanisms by which abortion restrictions affect these outcomes.^{41,42,43} In addition, participants questioned the related administrative and legal burdens of accessing pregnancy-related care. They also emphasized the importance of qualitative research approaches to generate hypotheses and interpret relationships, especially when quantitative datasets do not adequately capture related information (i.e., abortion services). Example research priorities include:

- Examining the full spectrum of perinatal health care, including contraception and assisted reproductive technology, and studying fundamental questions, such as the impact on pregnancy health outcomes and on infant deaths due to congenital anomalies.
- Conducting research on the mechanisms in outcomes or trends related to changes associated with abortion bans or protective abortion policies. If mortality changes, for example, what is the mechanism? Is it for cardiovascular reasons? Is it related to mental health or substance use disorder during pregnancy or the postpartum period?

- Studying the impact of *Dobbs* for contraceptive options in states with varying abortion access and the policy approaches employed to either expand or further limit access to contraceptive care.

Research Domain: Non-Reproductive Health

In this domain, participants discussed the need to define what is meant by nonreproductive health outcomes and identify potential populations of interest related to, for example, mental and behavioral health outcomes, disability, and chronic conditions. Example research priorities include:

- Examining the impact on clinicians working in nonreproductive health specialties, including changes in their training or practice, and general access to nonreproductive health care services and whose access is affected and how access differs in terms of travel time and costs.
- Identifying gaps in the research related not only to impact and outcomes related to nonreproductive health care but also studying people's experiences and involving communities and stakeholders in developing research questions.
- Using multi-level conceptual models to guide research and conducting research to examine misinformation or disinformation related to effects on nonreproductive health care like oncology.

Research Domain: Health Care Workforce

In this domain, participants discussed the need to explore how to motivate and excite people around working in sexual and reproductive health to ensure there are sufficient numbers of clinicians who can provide services that communities need. Similarly, there is little knowledge about the training, education, competency, and other data related to clinicians providing abortion care. Moreover, there is a need to evaluate team-based care and interprofessional teams within a context of burnout, as well as evaluate the effectiveness of telehealth and abortion care provision. Example research priorities include:

- Looking at abortion stigma as a human resource issue, building on existing resources to reduce and intervene related to stigma and ways to proactively deal with anti-abortion misinformation.
- Identifying what happens to those practicing who cannot deliver care that they know is merited and what does that mean for their choice to practice in certain areas, certain geographies, or for the next generation of trainees and which specialties they choose to go into.
- Studying doulas and their role not only in the full spectrum of maternity care work but also in self-managed medication abortions at home, as well as exploring how to better involve doulas in the research enterprise.

Research Domain: Care Financing and Delivery

In this domain, participants discussed the need to partner with Medicaid programs and private payers to examine trends in reproductive and maternal health care access, quality, and costs, including the cost impact of *Dobbs* on an already stressed health care system. They also stressed the need to examine the potential impact of siloing abortion care and pregnancy care apart from the rest of the health care delivery system in response to data privacy concerns. This will limit the ability to understand the long-term outcomes for pregnant people who, for example, have preeclampsia or gestational diabetes. Example research priorities include:

- Conducting descriptive research to document changes in the regulatory landscape and health care delivery system to understand emerging trends and causes.
- Studying the impact of *Dobbs* on federal and state level financing for sexual and reproductive health care.
- Identifying the implications of losing reproductive history in people's core medical records (i.e., the impact of data protection provisions).

Research Domain: Broader Societal Impacts

In this domain, participants discussed examining the long-term socioeconomic consequences of lack of access to safe abortion and/or abortion denials not only on pregnant people but on children, families, and communities, including the impact on people who rely on women as informal caregivers. They also stressed the importance of studying the impact of abortion access on educational attainment, employment, the gender wage gap, productivity levels, intimate partner violence, and people staying in partnerships longer than they otherwise would because of an unintended pregnancy. Example research priorities include:

- Documenting the mental health impact on women who have to carry a fetus with a congenital abnormality to term.
- Exploring the impact on fetal tissue collection in states with abortion restrictions or bans.
- Monitoring misinformation and disinformation related to abortions in a highly charged atmosphere of political polarization generally and the potential impact on the democratic process itself.

Unique Data Needs and Issues

In addition to generating the questions within their domain, breakout session participants considered the unique issues and needs that

could arise when conducting the research, such as data availability, security, completeness, and quality. Many breakout groups discussed the importance of qualitative and mixed methods to capture people's experiences, especially given the limitations of quantitative data regarding abortion. Existing tools, like the PREM-OB Scale[®] suite, were elevated for enabling more complex analysis. One issue that arose across groups was the need to study these questions within intersectional and small populations in the U.S. and the difficulty of small sample sizes, which leads to suppression of findings. Applying statistical techniques from other fields may be one solution, or meta-analyses that would encourage reporting of smaller results with appropriate caveats, so that another investigator could combine them with other datasets in the future.

Opportunities for Collaboration

Each breakout group also spent time thinking creatively about the potential partnerships and collaborations that HSR should explore to study these research questions. Existing networks and collaboratives within the HSR community surfaced, such as networks of Medicaid researchers, in addition to collaborations across disciplines to benefit from a variety of research methods and statistical techniques. Entities beyond the HSR enterprise may also be beneficial for building capacity within both the clinical and research workforce, including community organizers working to counter mis- and disinformation—or vocational or criminal justice re-entry programs responsible for training and educating the next generation of the workforce. Finally, researchers studying the impacts of policies regarding access to gender-affirming care are grappling with similar issues and encountering parallel challenges to those in the reproductive health research space.

Anticipating and Preparing for Threats and Challenges to Conducting This Research

Finally, participants discussed the threats and challenges to the conduct of research on the impact of the *Dobbs* decision. Legal issues were a common concern, such as a lack of legal definition of abortion and the subsequent variations in interpretations of the law that would affect research quality. Groups anticipated that sustainability in funding for this research, particularly from government funders, would be a challenge: there was mixed understanding even within the workshop participants about the implications of the Hyde amendment for limitations on abortion *research* (as opposed to abortion care). Participants also highlighted the need to coordinate training for both the current and next generations of researchers who want this education and could implement the research agenda.

NEXT STEPS & RECOMMENDATIONS



Participants at the November 2023 workshop generated a robust agenda for research within priority domains from the most immediate and direct—access to abortion care itself—to the broadest societal levels. All actors in the HSR ecosystem—funders, researchers, journals, health systems, and policymakers—have a role to play in building capacity for, and raising the visibility, of this research to understand the myriad impacts of the *Dobbs* decision on health and equity.

First and foremost, research funders—both federal agencies and private philanthropy—should be a catalyst and facilitator for generating evidence for care and policy by increasing the funding available to answer the questions in this agenda. In addition, federal agencies have a critical role to play in ensuring adequate data are collected and made available to conduct the research. This will require sustaining existing data collections as well as launching additional collections, such as bolstering the CDC’s abortion surveillance efforts. Finally, federal agencies play another essential role in this rapidly evolving space in providing guidance and clarification for researchers on best practices for data quality, security, and privacy.

At the state level, the research community can contribute additional state-specific evidence on abortion incidence and access as well as health system impacts and broader societal ripple effects of *Dobbs* by expanding capacity for such research, such as through learning networks and collaboratives (e.g., [OPEN](#), the [Ohio Policy Evaluation Network](#); [RISE](#), the [Center for Reproductive Research in the Southeast](#) at Emory University; [CONVERGE](#) at the University of Pittsburgh; the [State-University Partnership Learning Network \(SUPLN\)](#); and the

[Medicaid Outcomes Distributed Research Network \(MODRN\)](#)). State legislators and agencies, which now play an outsized role in abortion regulation, can look to state-based researchers for translation and explanation of the evidence base to inform their research and health care policies.

Research training programs and professional societies can respond to the needs of both current researchers and the next generation of investigators by enhancing their educational offerings regarding unique ethical and legal considerations and methodological approaches for conducting reproductive health-related research. Qualitative and mixed methods are particularly valuable tools for health services researchers who endeavor to study the impact of *Dobbs*. Training programs also could play a role in educating the actors who shape the research ecosystem, such as the Institutional Review Boards (IRBs) that regulate research studies involving human subjects and may be less familiar with the established methods of conducting reproductive health-related research ethically and responsibly.

As a field, HSR can contribute to strengthening and amplifying the evidence base on the impact of the *Dobbs* decision by learning from and partnering with experts in reproductive health and rights who have been conducting abortion research for decades. Engaging communities in this work via community-engaged or community-led research is also essential to understanding the full range of impacts, as is strengthening the field’s understanding of the limitations of large datasets that HSR customarily relies upon (e.g., claims, surveys, EHR) when conducting abortion and other reproductive health-related research.

CONCLUSION

HSR has the potential to contribute to the evidence base regarding the broad impacts of the *Dobbs* decision on health and equity—and subsequently translate research into policy and practice to improve health and health care. The research agenda generated by participants in the November 2023 workshop provides a starting point for the field, presenting research questions of interest across six domains and four cross-cutting areas. HSR is especially primed to explore questions in two of these domains—the implications for the health care workforce and impacts on care financing and delivery.

The research agenda, available in the pages that follow, emphasizes additional considerations for researchers working in this arena. Most important is the application of an equity lens in conducting this research, and a list of suggestions from workshop participants precedes the proposed research questions themselves to emphasize this point. Also included are participants' recommendations for addressing the unique data needs and issues researchers encounter in this space, ideas of collaborations and partnerships to carry out this work effectively, and threats and challenges to keep in mind.

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APPENDIX A: COMPLETE LIST OF RESEARCH QUESTIONS AND CONSIDERATIONS RAISED

GENERATED NOVEMBER 1, 2023

Equity Considerations for Conducting Research on the Impact of the *Dobbs* Decision

- Explore who is most impacted. What has stayed the same and what has changed and/or been exacerbated since *Dobbs*, with a particular emphasis on states that have enacted laws criminalizing and/or restricting abortion? What exceptions are made? For whom?
- What are the barriers to access writ large, and nuances within cultural and economic sub-populations?
- Reflect diversity of the US population, including:
 - o For some Hispanic/Latino communities: lack of access due to fear of deportation, disparaging treatment, language barriers
 - o Native communities: culturally inappropriate and disrespectful care experiences
 - o LGBTQ communities, including adolescents
 - o Recognize diversity within groups such as Hispanics/Latinos, African Americans and Native Communities
- Explore differential access to resources and programs: Explore disparity in possible interventions on top of already existing disparities: Are options equally available to everyone? What inequities are layered on top of already existing inequities and how will this exacerbate already existing disparities?
 - o Coverage: Virtual providers not accepting Medicaid
 - o Payer source, language barriers, digital form of payment, geography, awareness of options
- How do we change the way that the word “equity” has been reframed as a stigmatized word?
 - o Equity is not something that is race-specific, but something that we all need
 - o How do we transition and add power to this language?
- Who is analyzing this research? Ensure that analysts and authors identify with the communities who are in need—and engage the community in conducting community-directed and/or engaged research where possible.
- Need an intersectional lens that accounts for race, ethnicity, gender, class, age, socio-economic status, rurality, etc.
 - o What role do insurance coverage and comorbidities due to structural inequities/systemic racism play?
 - o Rurality: Difficulty accessing basic health and pregnancy care as well as abortion care: impact living in rural communities, how long they are traveling, whether they are using medication abortion.
 - o What is the impact for low income, undocumented immigrants living in rural communities?
 - o In states with lack of abortion and parental leave, lack of childcare is an additional challenge for people who need to cross state lines or have multiple provider visits and waiting periods before being able to access abortion.
 - o Access to telehealth or other services (e.g., broadband access) varies.

- Consider the influence of culture in how families seek information and explore how to address misinformation in a way that aligns with their values.
- Policies to extend postpartum Medicaid don't extend to people without legal status (in most states). Research is needed to assess the impact of efforts to provide some support for people who are forced to continue pregnancy they didn't plan—and for groups who are denied such support.
- Avoid ascribing outcomes to individual factors. In economic research especially, we can sometimes pathologize people and ascribe outcomes to poor decisions—rather than poor options. Emphasize the structural and systemic nature of these problems (i.e., not the result of individual decision-making).
- Be careful about carving out other reproductive health services, from an ethics standpoint because this has been done to isolate abortion from other health services. We don't want to reify that distinction or institutionalize it within our research.
- Address the lack of diversity in the health care workforce
 - The SCOTUS decision on race in college admissions impacts this
- Keep risk profiles of providers from different backgrounds in mind.
- Mitigate risks for providers (anti-abortion violence, protests, threats, etc.)
- Build up and acknowledge the work that full spectrum doulas provide.
- Ensure that training for sexual and reproductive health comes from communities most impacted by inequities.
- Address safety for communities and researchers involved in work: How can universities and communities work together to make sure everyone is safe in conducting and sharing findings from research?
- Abortion funds (organizations that provide financial assistance to people seeking abortion) can be a partner for research, as they play an increasingly critical role. Especially for marginalized communities, abortion funds have become much more important in financing and connecting people to services and with logistical services.
- As more technology is deployed in the health care space (AI, health apps, etc.) there are many equity considerations. People may opt-out of some of these tools out of fear of their data being shared, and may miss out on health benefits.
- Consider overlapping attacks on this group and trans rights; trans folks not having access to gender-affirming care. Acknowledge outcomes to this community.
- Look at unique populations: impacts of post *Dobbs* on incarcerated and other special groups, such as those supported by the VA and DOD.
- Address gaps to strengthen our ability to understand equity considerations.
 - We are combining some populations.
 - We are missing data on disabled folks.
 - We are missing data on non-cisgender folks who are trying to access care.
- Conduct more qualitative and mixed methods research (i.e., for grater triangulation of data).
- Community engagement and community-directive efforts are important in defining research questions, methods, language, which allows us to:
 - Validate and respect perspectives
 - Strengthen accuracy of information by hearing directly from the community
 - Respond to communities' priorities and needs
 - Share and report back to communities research findings so that they can use the information for their own settings, as well as support further dissemination of the research to other stakeholders.

- Useful tools and frameworks for conducting research with a health equity lens:
 - o [Tree analogy framework from A Clear Pathway to Progress and a Framework for Advancing Health Equity](#):.
 - Focus on social determinants/influencers, structural determinants, and their impact on health outcomes.
 - Theory of change that considers all the various components and where you can intervene at all those levels.
 - Helps to think about where you are intervening in terms of health equity.
 - o [National Institute on Minority Health and Health Disparities Research Framework](#)
 - o [Taking Action to Advance Health Equity](#)
 - o [It's Not Just About Abortion: Incorporating Intersectionality in Research About Women of Color and Reproduction](#)

Research Agenda Domain 1: Access/Availability/Safety of Abortion Services

- How is the landscape of pregnancy options, counseling support, and subsequent navigation support changing? What actions can we take to address this?
- What are the implications of *Dobbs* for self-managed abortions? What are people using? What are health outcomes?
- What is the impact of *Dobbs* on quality of care?
- What are the implications for necessary follow-up appointments?
- What are the medical risks of seeing a doctor from another state and not being able to see a doctor in-state?
- What is the impact of *Dobbs* on post-abortion care?
- What is the impact of *Dobbs* on access to mifepristone?
- Who benefits from policy changes (e.g., telehealth expansion)?
- What is involved with seeking an abortion in banned/restricted states? What are the implications for gestational period?
- Who is getting abortions? Who is not?
- How have practices/clinical care changed due to restrictions?
- How does abortion access differ for people in rural areas? In Southern areas? Are there telehealth options? What is available to them?
- How is the South left out of innovations?
- What are implications in absence of telehealth and mailing options (namely in states with restrictions)?
- How does access to transportation impact access?
- Has access increased due to the rise of alternative approaches (e.g., self-managed abortions)?
- What innovations/workarounds have emerged?
- What is the impact of *Dobbs* on mental health outcomes related to the experience of getting an abortion (including traveling to care)?
- What is the impact of *Dobbs* on the administrative burden of obtaining abortion care?
 - o In places where there is access on paper, how can we document the impacts of administrative burden?
- What are the impacts of “good” policies in response to *Dobbs*? How can these be disseminated to increase uptake?
- Who is benefitting from “good” policies? Are they equitable in their framing?
- Where is mis/disinformation coming from? Who is it impacting? How do we identify sources and combat it?
- How do people get information on where to get services and funding support?
- What are the impacts of 100 mile checkpoints/immigration laws? What are the implications for migrants?
- How are attorneys communicating/translating the law to doctors?

Research Agenda Domain 2: Reproductive Health Care and Outcomes Beyond Abortion: Maternal and Perinatal Care, etc.

- What is the impact of *Dobbs* on maternal mental health?
- What is the impact of *Dobbs* on maternal mortality, especially the Black maternal mortality rate?
- What role do racism and misogynoir play in the outcomes experienced by Black, Hispanic/Latino and Native women?
- What is the impact of *Dobbs* on maternal health outcomes, especially those measured late in pregnancy (e.g., maternal complications)? (Basic descriptive studies)
- What is the impact of *Dobbs* on prenatal care?
- What are better/more appropriate measures to study quality of maternity care? How might we improve methods and measurement of issues during pregnancy (mistreatment, misogynoir, etc.)?
- What is the impact of *Dobbs* on other epidemiological outcomes (e.g., preterm birth rates)?
- What is the impact of *Dobbs* on access to other reproductive health services in states with varying abortion access?
- What is the impact of *Dobbs* on the separation between pregnancy/maternal health and abortion research (“abortion aversion”)?
- What is the impact of *Dobbs* on the administrative/legal burden of pregnancy-related care?
- What are the mechanisms by which abortion restrictions are impacting outcomes?
- What is the impact of *Dobbs* on contraceptive options?
- How are conservative parties trying to extend limitations into other reproductive services (abortifacients)?
- What is the impact of crisis pregnancy centers (CPCs) on different groups?

Research Agenda Domain 3: Non-Reproductive Health Outcomes: Mental/ Behavioral Health; Disability; Chronic Disease; etc.

- What are protective policies that support (e.g., FMLA, social welfare policies like augmented impact or health insurance) when someone has a baby that they did not intend to have?
- What is the impact of *Dobbs*, especially the experience of being denied care, on adverse experiences? On weatherization?
- What is the impact of *Dobbs* on infant and child health outcomes?
- What is the impact of *Dobbs* on development and early childhood? What is the cumulative impact of these experiences?
- What is the impact of *Dobbs* on mental health outcomes?
- What is the impact of different policies in different states on women’s mental health (e.g., depression, anxiety, behavioral health, substance abuse)?
- There are a number of medical conditions that might lead individuals to decide to terminate a pregnancy. What are long-term consequences to their health when they can no longer make this choice?
- What is the impact of *Dobbs* on quality of life/general well-being?
 - o What is the impact of *Dobbs* on people’s ability to travel?
 - o What is the impact of *Dobbs* on to move within and across states with freedom?
- What is the impact of *Dobbs* on access to medications?
- Will the move toward/normalization of self-managed abortion (SMA) lead to changes more broadly in self-care? (i.e., Will this normalize self-management in other areas of health?)

Research Agenda Domain 4: Health Care Workforce Implications: Training Impacts; Reproductive Health Deserts; Clinician Burnout, etc.

- What is the impact of *Dobbs* on health care workforce shortages?
- How can we be attentive to the workforce issues without centering the workforce unnecessarily in a way that reduces access? How do we ensure that those who desire clinical support gain access?
- How did the *Dobbs* decision exacerbate the existing shortages in the abortion care workforce? How might we restore and rebuild access?
- What is the impact of *Dobbs* on health care workforce training and pipeline development?
- How can we think differently about training programs for the current workforce and training opportunities for the future workforce?
- How do we train existing providers without requiring that they take on more student debt and ensuring they are committed to their communities?
- What is the training background of the people who provide abortions? (Lack of descriptive data) What affects this (e.g., cost and training structure in many states, etc.)?
- What are viable career pathways for abortion care provision?
- How might we address barriers (stigma, lack of funding, politicization, etc.) for people discouraged from pursuing careers in this field?
- How do we improve sexual and reproductive health training for school nurses?
- What is the impact of *Dobbs* on care delivery (e.g., team-based care)?
 - In research, how do we avoid conflating *people* and *sites* providing care?
- What is the impact of *Dobbs* on who is practicing and how they are practicing?
- What is the impact of *Dobbs* on other clinicians providing care to individuals (primary care, OB/GYN, specialists)? How do individuals seeking treatment get the support that they need, outside of abortion-specific care?
- How do we unbundle abortion care in similar ways to what happened during the pandemic and move towards more person-centered care provision? How do we support these models monetarily?
- How do we improve care coordination following an abortion?
- Does abortion provision via telehealth/telemedicine help with physician burnout and access?
- What is the moral injury impact for clinicians who are confronted with terrible conditions where they cannot help their patients because of state laws (on top of the burden of the past few years from burnout and understaffing)? What is the impact on burnout? What are the generational impacts on us and our health care system?
 - Document reality via stories for policymakers.
- How do we rebuild the reproductive health care workforce?
- How do we bring a more personal/moving motivation to legislators to understand policy issues related to the *Dobbs* decision and the health care workforce?
- What does the future health care workforce in this field look like? Where are the shortages going to be?
 - What are the policy implications?
- How can we address stigma in the health care workforce as a human resource issue?
- How are abortion services advertised given the political climate?
- How might we move towards a system that qualifies anti-abortion efforts as domestic terrorism?

Research Agenda Domain 5: Impact on Care Financing and Delivery Issues: Medicaid, Safety Net Providers, FQHCs, Data Privacy, etc.

- What are the implications of losing reproductive history (i.e., impact of data protection provisions) in people's core records?
- Will we see a decline in outcomes and quality of care in states with abortion restrictions?
 - Ex: PP of Missouri runs a bus to do abortions across the border in Illinois, and then patients are unable to be seen in their respective states following the abortion.
- Should we apply data protections to all reproductive health care, specific segments, or to health care writ large?
- What would the consequences be if no health care data could be used for legal proceedings?
- What is the impact of *Dobbs* on care deserts, including for the broad range of reproductive health care services?
 - Often providers provide many different services, including reproductive health. There's a need to document and study the impacts of *Dobbs* on access to all services.
- What is the impact of *Dobbs* on federal and state level financing for sexual and reproductive health care?
- What excess costs is *Dobbs* creating in the health care system (due to lack of abortion access)?
 - Given that most people of reproductive age on Medicaid are in managed care, what is the best way to answer the cost question?
- What are the levers to get people to care, particularly in the Southeast US? What messages are effective (e.g., in conservative states where anti-abortion sentiment is high)?
 - How can we use the muscle of the federal government to drive change?
- Develop guidance for states on what they can do without fear of pursuit by the feds.
- How might we use litigation to force people to care? (underutilized as a tactic) Providers are afraid of sanctions from the state, but should hospitals be afraid of malpractice claims stemming from a lack of needed care?
 - Can we incentivize or require through law/litigation some level of abortion care in hospital settings?

Research Agenda Domain 6: Broader Societal Impacts: Employment; Education; Poverty; etc.

- What is the impact of *Dobbs* on educational attainment? On people's choices of where to attend college?
- What are the opportunities to support adolescent parents in educational attainment and economic advancement?
- What is the impact of *Dobbs* on labor markets and the workforce? How have productivity levels increased/decreased based on decisions in response to *Dobbs*?
- What labor practices, beyond state laws (minimum wage), affect access to care? What are the economic impacts?
- What is the impact of *Dobbs* on the gender wage gap?
- What is the impact of *Dobbs* on stigma and political polarization?
- What are the impacts of *Dobbs* as yet another attack on autonomy for people with disabilities?
- How do state policy responses to *Dobbs* align with other policies (e.g., postpartum Medicaid coverage, Medicaid expansion, medical leave, low state minimum wage)?
- What have states with abortion restrictions done in terms of pro-family policies (based on evidence) to support individuals who are unable to access abortion?
- What is the impact of *Dobbs* as a social driver of health?
- What is the impact of *Dobbs* on interpersonal violence (IPV)? What are the effects of *Dobbs* on people staying longer/living in partnership situations where they otherwise would not?
- What is the impact of *Dobbs* on internal family/household economics and power dynamics?

- What is the impact of *Dobbs* on housing insecurity?
- What is the impact of *Dobbs* on food insecurity?
- What is the impact of *Dobbs* on caregiving? On women in particular as informal caregivers?
- What are the compounding consequences of unintended pregnancy for someone forced to carry a pregnancy to full term?
- What is the impact of *Dobbs* on childcare and parental leave?
- What is the impact of *Dobbs* on substance use and family policing?
- What is the impact of *Dobbs* on others in the families and communities of individuals affected?
- How, collectively, do state laws shape economic and other forms of equality between genders? How do reproductive health policies affect general equality, feelings of participation and belonging in society, and economic opportunity for gender and other groups traditionally marginalized?
- When decisions like *Dobbs* come out, what are we (the research community) being distracted from? What advocacy is neglected as we focus on the most urgent issue?
- What are the broader, downstream impacts on research itself?
- What does this mean for limits or bans on fetal tissue collection?
- What are the economic impacts of *Dobbs* related to access, availability, and affordability of care for families/households?
 - Examine the extent to which seeking out/obtaining abortion can be a catastrophic health expenditure.
- What are the economic impacts of unplanned children on the immediate economic situation of a family/household? What harms emerge?
- What are the long-term economic effects of *Dobbs* on economic inequality?
- What is the impact of the categorization of people as “individuals of childbearing age” and resulting forms of social control (e.g., punitive legislation)?
- How does *Dobbs* affect participation in the democratic process overall?
- Beyond the US, what are the international impacts of *Dobbs* (whether direct or indirect)?
 - Has the view of the US changed (e.g., perception of the US as an anti-equality country)?

Unique Data Needs and Issues

- Need to understand how numbers and methods are changing in order to put abortion in context:
 - Standardized definitions of abortion: How will lack of technical definition of abortion impact research? What happens if there is no shared agreement? How do we use other measures (e.g., population based surveys)?
 - Where can we draw causal relationships in comparison to correlations with research?
- There are inherent risks in age data in certain landscapes (e.g., transporting minors across state lines).
- An inventory of how Medicaid claims data could be helpful to monitor maternal health over time in relation to *Dobbs* and to the extent that abortions are captured
 - Extent to which claims data are useful and identify gaps
- At the level of law enforcement (hospital), how can we articulate where the decision is being made and how people are impacted?
- Lack of government investment in basic information has resulted in privatized surveillance system for abortion
- Primary data collection and funding issues
 - Who can fund new primary data collection?
- Abortion information is not adequately captured in current data sets

- o Pragmatic data and policy issues. Medicaid does not always cover abortion, so if you use Medicaid to study childbirth, you are necessarily leaving out abortion because it is not reimbursed or paid for in the same way. Many people access abortion services outside of the insurance system so it is not always captured in claims data. There is a disparity in data between maternal health and abortion.
- o There is a division between contraception and abortion in part because data are not collected at a good level nationally. Abortion is not reflected in national statistics. Even pregnancy rates are not adequately captured. NCHS published its first pregnancy report in 10 years. We don't even have good data on pregnancy rates in the United States.
- We often want to study intersectionality and small populations in the US, but we're limited with small sample sizes. The result is that we suppress findings because they're not sufficiently conclusive. It may be a mistake to not mention those findings at all, which reinforces that it's not important, but discussing it (recognizing limitations) would be a better approach
 - o Are there other techniques we can employ? What are limitations of imputation?
 - o What statistical techniques from other fields could we apply?
- How do we aggregate data to protect individuals while also reducing stigma?
- How do we ensure that we have enough context in order to avoid stigmatizing with data presentation?
- Qualitative research is critical from the perspective that we are capturing people's experiences and given the limitations of quantitative data. We should aspire to develop measures that could capture that information.
 - o Qualitative data will be more complete. The challenge will be confidentiality.
 - o Use existing measures and tools, such as the PREM-OB Scale® suite, as part of the research being conducted to enable comparison data across complex topics.
- The landscape is changing so quickly, which puts the onus on descriptive research to illuminate what is happening, prior to working towards causal analyses.
 - o Interdisciplinary work is much more important within this context, as well.
- How do we get community-generated big data sets (e.g., services provided by doulas)? What methods can we use?
- What is the impact on privacy of algorithms and deployment of data solutions that use reproductive data in a predictive manner to help manage care?
 - o Especially if the quality of these data vary by patient group (due to mistrust, lack of access, etc.) this could pose a big issue in terms of equity.
 - o Tele-abortion care is already working in this space. Trying to match state laws with the broader digital framework that exists in health care delivery is posing a difficult question/growing pains. We need to figure out these regulatory aspects.
- There has been a lack of understanding between disciplines about what each other is doing, what it means, and its value. We need to build on each other's work.
- Recognize a lack of data to answer a certain question as an opportunity to make a research recommendation
- Offer concrete tools for developing trust with respondents across states and systems of care.
- Need for various kinds of data: Opportunity for quantitative synthesis or meta-analysis that would encourage us to report even smaller results with caveats, in hopes that someone would later group them together

Opportunities for Collaboration and Partnerships

- Bans on gender affirming care/targeting trans and gender non-conforming folks: Where are overlaps and where are differences?
- Collaborations between researchers and health centers and clinicians
- Collaborate with research organizations across disciplines and research domains: We need quantitative and qualitative data, community input, staff/provider-patient interactions, which requires communication and level-setting/learning.
 - o Employ statistical techniques from other fields to study the experiences of smaller and intersectional populations in the US
- Community health centers and FQHCs: We need to understand how community health centers are impacted and what they are experiencing as well as how state context impacts provision of care.

- Collaboration with community organizing partners on issues of information and disinformation.
- Community partnerships are critical, particularly around care delivery topics and getting at the cost impact issues. How can community engagement inform these questions?
 - o Document what is already happening in communities and replicate this. Generate evidence and scale up around what has already been working.
 - o There are intersections as well as tensions between reproductive and non-reproductive spaces.
- Health Systems/Payers
 - o Two Medicaid networks: [Medicaid Outcomes Distributed Research Network \(MODRN\)](#), where states come together and share data, and the [Medicaid Data Learning Network \(MDLN\)](#) for researchers using T-MSIS Analytic Files.
- Federal government: Abortion information should be included in PRAMS survey or other nationally representative surveys.
- Work with schools and education systems (especially public schools) to expose kids in school to the wide array of health care careers (in addition to doctors, nurses, etc.), as well as careers in research?
- Who can fund professional organizations for simulation activities (decisional assessment, value clarifications, etc.)? Train more people how to do those things.
- Partner with criminal justice programs and systems to introduce training and education into criminal justice settings (e.g., re-entry programs, workforce development programs, vocational schools, etc.).
- Collaborate with people who study the workforce and connect that work with the study of reproductive and abortion care following *Dobbs*.
- Partner with legal scholars and working in partnership on legal epidemiology.
- Partnership between research community and state Medicaid agencies. There is a trove of data and never enough people or people with the correct skills to answer these questions.
 - o Could we leverage the role of researchers in answering these questions, while allowing the states to design the questions, to mutual benefit to solve a problem?
- Need collaboration and consensus on datasets, which will help treatment, cost, research, etc. Define these as a community.
- Collaborate across different arenas of pregnancy (abortion access, maternal mortality, etc.), e.g., organizations like Pregnancy Justice. Restrictions on abortion do not just impact those who seek abortion, but those who continue with pregnancy, as well.

Threats and Challenges Anticipated

- Legality: The definition of abortion in law is not based in medical terms or how researchers want to define it. What is the law and how is it interpreted?
- Concern with need for data quickly and how this will impact quality of research and level of engagement.
- Responsibility of researchers to report systematic roots of disparities: Unintended harms and our responsibility as researchers in terms of messaging and interpretation of data. We need to present disparities in a way that does not blame those populations experiencing them. We have to take care in terms of framing and avoid blaming individuals. Emphasize these are systemic issues and not individual issues that we need to be focusing on. There is inherent danger with these polarized topics
- Sustainability of funding/funding challenges:
 - o Mixed understanding of the impact of the Hyde amendment on abortion research—whether the restriction is limited to provision of abortion services or if there are appropriations riders on federal funding of abortion research.
 - o Government should play a leadership role for sustainability of funding, but could be an issue if there are administrative changes.
- Stigma: Concern about using the word “abortion” leads to use of “reproductive services access” or other terms because we don’t know how Congress will respond.
- Develop a guide or tip sheet about navigating IRB to surmount barriers.
- What is the place for tackling misinformation (especially intentional, e.g., campaigns, etc.) in the research landscape? What is the value in this?

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- Intentional misinformation: The community may tell you what they need, but you then are responsible for relaying and amplifying those messages.
 - Prepare researchers to analyze poorly conducted research that leads to further misinformation.
 - Tension between the needs of the current workforce and future workforce in both health care provision and health services research. A coordinated way to bring all current workforce who want training together would be value but does not currently exist. Who do we focus on?
 - Provider burnout (recruiting research participants, getting the information that we need)
 - Sustainability of the workforce under inhumane conditions
 - Issue of the state as a coercive partner and the impact of state-enforced pregnancy and a loss of human rights. There isn't much literature on this, except in regards to other countries (Iran, China, Romania).