

STATE REPRODUCTIVE COERCION AS STRUCTURAL VIOLENCE

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Editorial note: The legal landscape in the reproductive justice space is changing rapidly. The information contained in the following article is current at the time of publication and is provided with no guarantees of ongoing completeness, accuracy, or timeliness.

INTRODUCTION

Violence against women and other marginalized groups takes many forms among individuals and in society. The coexistence of interpersonal and structural violence is especially pronounced in the realm of reproductive autonomy. Reproductive coercion, a form of intimate partner violence, finds its structural-level twin in state policies on reproductive health care that are coercive in impact. Communities that are already underserved by the health care system and disproportionately affected by anti-choice reproductive health policies—including women of color, young women, low-income women, and undocumented women—are also the most at risk of reproductive coercion (Katz & Tirone, 2015).

Those who experience interpersonal reproductive coercion are additionally burdened by policies that shut down reproductive health care centers and make contraception and abortion care less accessible. Moreover, it is arguable that gendered and/or racialized power dynamics permeate many efforts to control a person's bodily autonomy and reproductive health. The influence of these power dynamics is observable whether control is exerted by a partner perpetrating intimate partner violence or a policymaker creating anti-abortion laws. This paper contends that policies that interfere with an individual's reproductive autonomy are systems-level manifestations of coercive intimate partner violence, likely influenced by the same power dynamics and desire to exert control, and with outcomes that replicate existing sociopolitical inequities.

While state reproductive coercion is a broad phenomenon, and multiple sites of reproductive coercion are considered herein, this paper will examine in more depth the role of reproductive health care centers in coercive reproductive health care policy (see Chamberlain & Levenson, 2012). Reproductive health care centers are the physical and ideological space in which interpersonal and structural levels of coercion collide. For the purposes of this paper, reproductive health care centers will be defined as licensed health care clinics whose primary purpose is the provision of comprehensive reproductive health services, including abortion care.

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Reproductive health care centers are primary sites of intervention for victims of reproductive coercion. They are also uniquely threatened by anti-choice policies.

This paper is divided into five parts. The first section, Reproductive Coercion, will provide an overview of interpersonal reproductive coercion. The second section, Structural Coercion, details federal and state-level policies that reduce access to abortion care and contraception. Disparate Impacts discusses demographic disparities in access to reproductive health care as well as risk factors for interpersonal reproductive coercion. Next, The Right to Bear Children addresses the flip side of this phenomenon, describing the ways in which some populations have faced coercive policies designed to restrict their ability to have children. The fifth section, Reproductive Health Centers: On the Front Lines, describes the important role that reproductive health care centers can play in screening for and intervening in intimate partner violence, including reproductive coercion. That section will also address the rising tide of policies designed to shut down these clinics. Overall, this paper will argue that historical and contemporary U.S. anti-choice policies are not simply parallel phenomena to, but also structural manifestations of, interpersonal reproductive coercion, and should be considered forms of violence unto themselves.

REPRODUCTIVE COERCION

Reproductive coercion is a form of intimate partner violence characterized by interference in a person's reproductive health and autonomy as a means of asserting power and control. Most commonly, reproductive coercion manifests as a male partner attempting to make a female partner pregnant against her will (Thaller & Messing, 2016). Miller et al. (2010) divide reproductive coercion into three categories: pregnancy coercion, birth control sabotage, and pregnancy outcome coercion. Pregnancy coercion includes demanding the partner become or remain pregnant and extends to sexual violence and threats of physical violence. Birth control sabotage involves hiding or destroying birth control pills, intentionally breaking condoms or covertly removing a condom during sex, or any other means of ensuring that a partner's contraceptive method be ineffective (Chamberlain & Levenson, 2012; Miller et al., 2010). Pregnancy outcome coercion is interference with an individual's decision of whether to terminate a pregnancy (Miller et al., 2014).

As research into the prevalence of reproductive coercion has mainly comprised community sampling, reported rates of this type of violence vary across studies. A review by Thaller and Messing (2016) found that close to five percent of women in the U.S. reported having experienced reproductive coercion, while results of a 2010 national survey found that 9% of U.S. women had experienced reproductive coercion at some point in their lifetimes (Black et al., 2011), and other estimates range up to 16% (Kovar,

2018). Thaller and Messing's (2016) review reported that between 14% and 74% of teenage mothers and women seeking reproductive health care or domestic violence services reported experiencing reproductive coercion. In their study of family planning clinics in the San Francisco area, Holliday et al. (2017) reported that reproductive coercion is significantly associated with race ($p < 0.001$).

For all women, other forms of intimate partner violence (defined herein as physical, sexual, or psychological harm by a current or former partner) are strongly associated with reproductive coercion (Thaller & Messing, 2016). One study of female undergraduate students found an association between contraceptive interference and psychological abuse, physical assault, and sexual assault (Katz & Sutherland, 2017). Experiencing reproductive coercion is also associated with a host of negative sexual health outcomes, including STIs (Kovar, 2018; Davis et al., 2018). There is a strong association between experiencing intimate partner violence and unintended pregnancy (Kovar, 2018; Moore, Frohwirth, & Miller, 2010; Silverman & Raj, 2014; Pallitto et al., 2013), which Miller et al. (2010) posit may be explained by the co-occurrence of reproductive coercion.

STRUCTURAL COERCION

Coercion regarding an individual's reproductive decision-making is a structural as well as an interpersonal phenomenon (Schoen, 2005; Solinger, 2007). The U.S. has a long history of laws and policies that assert power and control over childbearing people by interfering with their reproductive autonomy.¹ Individuals who experience reproductive coercion at the interpersonal level are often additionally burdened by such policies, further compromising their ability to control their own reproductive health and future (Heise, Moore, & Toubia, 1995).

Since the Supreme Court's decision in *Roe v. Wade* (1973), a primary issue in the fight over reproductive autonomy has been the de facto rather than de jure right to terminate a pregnancy. An example of reproductive health policy that is coercive in nature—but that does not explicitly defy the law as established by *Roe v. Wade*—is the Hyde Amendment, enacted in 1976, which bars federal funding for abortion except in cases of rape, incest, or life endangerment of the pregnant person (Hyde Amendment of 1976). The effect of this policy is that a low-income woman experiencing reproductive

¹The legal history of contraception in the U.S. provides a rich illustration of this point. The Comstock Act of 1873 forbade sending through the mail anything related to preventing conception—a ban that was not lifted until 1938 (Act of the Suppression of Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use of 1873). Although the pill was approved by the U.S. Food and Drug Administration for contraceptive use in 1950, many states banned the pill until the Supreme Court's 1965 decision in *Griswold v. Connecticut*, which ruled that married couples' right to privacy included the use of this form of contraception (Nikolchev, 2010; *Griswold v. Connecticut*, 1965). It was not until the Supreme Court's 1972 decision in *Eisenstadt v. Baird* that the pill was legalized as a form of contraception for all, regardless of marital status (*Eisenstadt v. Baird*, 1972).

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coercion who becomes pregnant unintentionally would not be able to utilize Medicaid to cover abortion care (Barot, 2012). The coercive partner may be unlikely to facilitate the termination of the pregnancy. Given the frequent, or even near-universal, co-occurrence of financial abuse with other forms of intimate partner violence (Adams, 2011), that woman is unlikely to have her own funds available to pay for an abortion out of pocket. In this way, a woman experiencing reproductive coercion in her home is met with the coercive impact of federal policy when she seeks reproductive health care. That is, on both the interpersonal and institutional levels, a woman's choice as to whether she continues her pregnancy is subject to coercive pressure.

Many more restrictions on access to birth control and abortion exist at the state level. Nineteen states ban abortion after 20 weeks gestation, with varying degrees of exception for conditions that threaten the pregnant person's life or health (Guttmacher Institute, n.d., "An Overview"). For someone experiencing abuse and/or trying to raise the funds for an abortion, these bans may mean that their abortion is illegal by the time they are able to access it (Finer et al., 2006; Donohoe, 2005). Twenty-six states require a provider to administer an ultrasound or share information about receiving an ultrasound before performing an abortion (Guttmacher Institute, n.d., "Requirements"). Twenty-seven states mandate a waiting period of 18 to 72 hours between receiving state-written counseling and the abortion procedure in most cases (Guttmacher Institute, n.d., "Overview"). Some states, such as Virginia, require that in most cases, the waiting period follow the mandated ultrasound (Guttmacher Institute, n.d., "Requirements"). It is apparent that these policies are designed to inconvenience and dissuade the pregnant person from choosing abortion. Much like interpersonal reproductive coercion, these types of laws interfere with an individual's reproductive health decision-making by causing psychological distress and presenting material barriers (Ely et al., 2017).

New coercive reproductive health policies are being enacted at a fast rate. For example, new 2018 federal regulations (first introduced as Interim Final Regulations in October 2017) expanded the kinds of exemptions employers can claim from the Patient Protection and Affordable Care Act's contraception coverage guarantee (82 FR 47838; Sobel, Salganicoff, & Rosenzweig, 2018). As a result, more people who receive health insurance from their employer or university may not be able to afford contraception (Goldstein, 2018; Sobel et al., 2018; Dreweke, 2018). Another example of policies that are coercive in effect is the 2017 reinstatement of the Mexico City Policy (Mexico City Policy of 2017). This policy denies federal funding to foreign nongovernmental organizations that provide services or information related to abortion (Mexico City Policy of 2017). More recently, this "gag rule" has been extended to American organizations (Compliance With Statutory Program Integrity Requirements, 2019). If upheld by the courts, this rule would restrict domestic, Title X-funded organizations' ability to

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offer information about or referrals for abortion care. This would deny tens of thousands of people vital information on the full range of reproductive health care options available to them (American Academy of Pediatrics and Society for Adolescent Health and Medicine, 2018; New York State Office of the Attorney General, 2019). In addition, the new rule may have the effect of shutting down some health care centers and influencing the services provided by others, including Planned Parenthood, due to the requirement of having “physical and financial separation” between institutions providing abortions and those relying on Title X funding (Compliance With Statutory Program Integrity Requirements, 2019).

DISPARATE IMPACTS

Communities most at risk of experiencing interpersonal reproductive coercion are also those most impacted by coercive state policies. A 2012 Planned Parenthood fact sheet on reproductive coercion reports that women in low-income households, as well as Black, Indigenous, and immigrant women, experience sexual assault and intimate partner violence at higher rates than White and high-income women (Planned Parenthood Federation of America, 2012). Meanwhile, research shows that women of color and teenagers who are pregnant or raising children are at higher risk of reproductive coercion (Holliday et al., 2017; Miller et al., 2010; Thaller & Messing, 2016). In one study, 37% of Black women, 29.2% of multiracial women, 24% of Latina women, and 18.4% of Asian, Pacific Islander, or other non-White women had experienced reproductive coercion, compared to 18% of White women (Holliday et al., 2017).

Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer (2010) found that racial and socioeconomic disparities in family planning outcomes are influenced by health system factors, such as the scarcity of abortion providers in rural areas and limits on Medicaid funding. Reproductive health services, which are already difficult to access for low-income, uninsured, rural, or young patients, are made even less accessible by policies that make abortion and contraception more expensive and reproductive health centers less geographically widespread. For example, the American Academy of Pediatricians and Society for Adolescent Health and Medicine warned that the aforementioned Title X “gag rule” would disproportionately impact Black, Latinx, and young low-income people and exacerbate existing racial and socioeconomic disparities in access to care (AAP & SAHM, 2018).

In other words, many of the demographic risk factors for interpersonal reproductive coercion also signal more vulnerability to reduced reproductive health care access in the face of coercive policies (Dehlendorf et al., 2010). When it comes to reproductive health and autonomy, the actions of individual abusers and anti-choice policymakers mutually reinforce one another within a system that burdens certain groups of women more than others.

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THE RIGHT TO BEAR CHILDREN

While both abusive partners and abusive policies can attempt to force an individual into continuing an unintended pregnancy, interpersonal and structural reproductive coercion can also take the form of preventing healthy pregnancy and childbirth. In relationships where interpersonal reproductive coercion is present, an abusive partner may force a partner who becomes pregnant into having an abortion or may physically abuse them to induce a miscarriage (Silverman & Raj, 2014). In the United States, state legislatures, judges, and physicians have long held the political and socioeconomic power to prevent those deemed unfit from becoming parents. There is a distinction to be made between the act of coercing one's partner into ending a pregnancy and policies that mandate sterilization or coerce individuals into long-term forms of birth control; that distinction is the level of power behind the coercion, not the coercive intent.

Miller and Silverman (2010) discuss control of pregnancy outcomes as a form of reproductive coercion, stating: "... [O]nce their female partner is pregnant, abusive male partners may enact behaviors to control the outcomes of the pregnancy including violent acts to attempt to induce miscarriage and coercion to ... terminate the pregnancy" (p. 511). Anecdotal research also suggests that abusive partners may force women to get sterilized (Hathaway, Willis, Zimmer, & Silverman, 2005).

Just as abusers may coerce a partner into not getting pregnant or into terminating a pregnancy, the state also has a long history of interfering with an individual's right to become pregnant and have children. Perhaps the most glaring example of this type of interference in reproductive autonomy is the role of eugenics-oriented ideology in U.S. public policy. The American eugenics movement was born in the late 19th century and reached its peak in the 1930s, targeting poor people, people of color, people with disabilities, and people with mental illnesses² (Washington, 2008). Margaret Sanger, who was at the time developing the network of family planning clinics that would become Planned Parenthood, was a vocal and active supporter of eugenics (Latson, 2016). By the 1930s, more than 30 states had laws mandating sterilization for people with intellectual disabilities, people receiving welfare, and/or anyone deemed to have genetic defects; these policies were upheld and encouraged by the Supreme Court in *Buck v. Bell* (1927) (Washington, 2008). As late as the 1960s, "southern states subjected black patients to medically unnecessary sterilizations in state-run hospitals, and

² While this period is commonly considered the span of the American eugenics movement, the relationship between reproductive health policy and population control goes back much farther. For example, laws banning abortion throughout the 1800s were motivated by "fears that the population would be dominated by the children of newly arriving immigrants, whose birth rates were higher than those of 'native' Anglo-Saxon women" (National Abortion Federation, n.d.).

often informed consent was misleading or absent” (Simmons & McLean, 2017, p. 36).

The lasting power of this ideology was illustrated by the myth of the “crack baby” during the 1980s crack cocaine epidemic (National Advocates for Pregnant Women, 2018). This moral panic—over the fallacy that fetuses exposed to crack in utero would be born with uniquely severe and lasting defects, including a predisposition towards violence—led to the implementation of mandated long-acting reversible contraceptive (LARC) programs, which disproportionately impacted the reproductive freedom of Black and/or low-income women who were the targets of the panic’s racist and classist rhetoric (ACLU, 1994; Sagatun-Edwards, 1998).

Throughout the 1990s, women receiving public assistance, teenage mothers, and women in the court system were compelled to get the LARC Norplant, a practice with the explicit goal of controlling the growth of “the underclass” (Roberts, 1999). Women convicted of drug use during pregnancy were frequently presented by judges a choice between jail time or Norplant (ACLU, 1994). Between 1991 and 1993, more than a dozen state legislatures introduced bills intended to coerce certain groups of women into LARC use, such as by conditioning receipt of public assistance upon Norplant implantation (ACLU, 1994). In 1996, the states of South Dakota, South Carolina, and Oklahoma allowed their state Medicaid programs to fund the implantation of Norplant, but restricted funding for the device’s removal—arguably an overt sterilization initiative for Medicaid recipients (Arnow, 1996).

Even while governments were actively pushing LARCs, a cautionary appraisal of Norplant published in *Social Service Review* in 1995 asserted:

When fertility control resides, at least in part, outside of the woman and her partner’s control, there is a very real risk of coercion on the part of health professionals and other persons in positions of authority who, for whatever reason, might want to limit her ability to conceive and bear children. (Gehlert & Lickey, 1995, p. 328)

That “whatever reason” wondered at by Gehlert et al. seems to be the legacy of the American eugenics movement—the belief that some people should not be allowed to decide for themselves whether or when to have children (Dixon-Mueller, 1993).

LARCs remain popular among individuals as a powerful tool for controlling their own reproductive lives. What is concerning is that they also remain popular among policymakers and others in positions of power interested in engineering population controls. In 2014, a scholarly commentary on the growing popularity of LARCs encouraged “a moment for reflection and reassessment” to avoid repetition of past targeted abuses (Higgins, p. 238). Higgins compares contemporary LARC zeal to the push behind Norplant in the 1990s: “As with Norplant, policymakers

have suggested incentive programs in which poor women receive cash in exchange for having a LARC method inserted, and such programs may be in practice already” (Higgins, 2014, p. 239). Despite cautions like Higgins’s, the coercion continues. In a 2016 qualitative study, young women reported believing that health care providers disproportionately recommended LARCs to marginalized women and that their own preferences for LARC selection or removal had not been honored by a provider (Higgins, Kramer, & Ryder, 2016). Interrogatory case studies in New York supported findings that physicians may exhibit racial bias both in recommending LARCs to their patients and in their willingness to remove such devices (Simmons & McLean, 2017). As late as 2017, a Tennessee judge ordered that inmates be granted a reduced sentence in exchange for Nexplanon implantation (Simmons & McLean, 2017).

While discussion of reproductive coercion often focuses on individuals forced into unintended pregnancies, the right to choose to get pregnant and safely carry out that pregnancy is an equally essential component of reproductive freedom—one that is infringed upon by policies as well as by partners.

REPRODUCTIVE HEALTH CENTERS: ON THE FRONT LINE

As the research involving reproductive coercion indicates (Grossman, White, Hopkins, & Potter, 2014; Sonfield, 2011), reproductive health care centers that provide abortions are on the front lines of the sociopolitical fight over reproductive freedom. They are uniquely positioned as intervention points for interpersonal reproductive coercion. If adequately trained and given appropriate resources, reproductive health care providers can be highly effective at screening for reproductive coercion (along with other forms of intimate partner violence) and intervening in it (American College of Obstetricians and Gynecologists, 2013; Miller et al., 2010; Miller et al., 2011). This role means that they are also key sites of data collection for research into reproductive coercion as a form of intimate partner violence.

Where reproductive health care centers exist in adequate supply and are financially accessible, there is great potential for them to act as front-line intervention sites for reproductive coercion (ACOG, 2013; Miller et al., 2010; Miller et al., 2011). For example, a 2009 California pilot study randomized four family planning clinics to either provide their patients with an intervention measure or not. Among women who reported experiencing intimate partner violence in the preceding three months, patients who received the designated intervention had a 71% reduction in their odds of experiencing pregnancy coercion compared to the control group (Miller et al., 2011). The American College of Obstetricians and Gynecologists (ACOG) recommends that providers screen for intimate partner violence and reproductive coercion, as well as provide at-risk patients with education

on reproductive coercion, harm reduction strategies, and the option to use undetectable LARCs with which an abusive partner cannot tamper easily (2013). Miller et al.'s 2010 study of reproductive coercion among family planning clinic patients concluded with the same recommendations.

Despite, and perhaps because of, their importance, reproductive health care centers are uniquely at risk under the rising tide of coercive reproductive health policies. Policies that shut down these health centers impact research on reproductive coercion, withhold resources for those experiencing intimate partner violence, and deny patients much-needed health services. There are numerous policies being proposed and already in place that limit the existence or capacity of reproductive health care centers.

Targeted regulations of abortion providers, or TRAP laws, are one way that governments try to close reproductive health care centers. TRAP laws are mainly enacted on the state level. A common method that TRAP laws use to force the closure of reproductive health care centers is to regulate these centers like hospitals by requiring that they have more complex, high-risk surgical capacities. For example, legislators have written TRAP bills (e.g. Alabama's Women's Health and Safety Act) designating reproductive health care centers as ambulatory surgical centers, meaning that the centers would need hallways wide enough to fit gurneys or particular sprinkler systems (Women's Health and Safety Act of 2016; see also Becker, 2014). Underfunded community clinics that cannot meet the financial burdens of these licensure requirements are instead forced to close their doors. After the Virginia legislature passed a set of TRAP restrictions in 2013, the Virginia Department of Health estimated that the average cost of compliance would be around \$1 million per clinic (Guttmacher Institute, n.d., "Targeted Regulations"). In the two years after Texas enacted new TRAP restrictions, the number of women in that state who lived 100 miles or more from an abortion clinic tripled (Guttmacher Institute, n.d., "Targeted Regulations"). Fewer clinics mean that hassles associated with transportation, child care, or time away from work force pregnant people to wait longer before accessing abortion care (Ely, Rouland Polmanteer, & Caron, 2019). This is a significant burden for people with lower incomes; the median cost of an abortion more than doubles between 10 and 20 weeks gestation (Guttmacher Institute, n.d., "Targeted Regulations").

Reproductive health care centers are the first line of defense for many women experiencing interpersonal reproductive coercion. At the policy level, the first line of defense against structural reproductive coercion must be stopping laws and regulations that force these clinics to shut down, putting reproductive health care out of reach for those who need it.

CONCLUSION

Reproductive coercion is a form of intimate partner violence in which an abuser attempts to exclude the victim from participation in decision-making about their own reproductive health and future. At its core, reproductive coercion is about asserting and maintaining power and control by denying the victim their right to reproductive self-determination. When state policies make contraception and abortion care inaccessible to some people, they are, in effect, replicating reproductive coercion on a structural level. Those who are likelier to experience interpersonal reproductive coercion at the hands of an abusive partner—mostly members of marginalized populations—are also more likely to face reduced access to contraception and abortion care by dint of being the same groups disproportionately affected by coercive state policies (Grace & Anderson, 2016). Simultaneously, women who are poor, women of color, and women living with disabilities or addiction have long been at the receiving end of eugenic policies that try to deny them the right to have children at all.

Research has shown that barriers to abortion services may cause or exacerbate trauma for patients seeking such care (Ely et al., 2017). Policies that reduce access to abortion—and to reproductive health care centers generally—therefore have deleterious mental health impacts in addition to the economic and physiological hardships they impose. The stress and trauma effects of coercive reproductive health policies are yet another parallel between the micro and macro levels of abuse and should further inform our understanding of the harm that these policies can cause. Pushing back against coercive policies that impede reproductive autonomy appears to be essential for effecting harm reduction for vulnerable women.

Reproductive health care centers exist at the intersection of interpersonal and structural reproductive coercion. These clinics can be an invaluable safe space where providers can screen patients for reproductive coercion and intervene if necessary. They prescribe contraception and provide abortion care. They are also important vehicles for advancing research on reproductive coercion. Yet anti-choice policies, such as TRAP laws, aim to shut down these health centers, leaving vulnerable communities without access to a range of health care services and without that front-line intervention for intimate partner violence.

The similarities between micro- and macro-level reproductive coercion outlined here should underscore the urgent necessity that social workers engage in advocacy that addresses not just interpersonal reproductive coercion, but structural coercion as well. As Ely and Dulmus (2010) point out in their call for social work policy practice around abortion rights, the social work profession has an unparalleled history of commitment to advocacy, including being “the only human service profession with a professional policy statement indicating the support of access to abortion

services as an important component of social justice” (Ely & Dulmus, 2010, p. 668). Ely and Dulmus’s encouragement is only more pressing today. The legal precedents that underpin fundamental reproductive rights in the U.S. are imperiled; the newly majority-conservative Supreme Court faces a pipeline of cases that could be used to undermine rulings such as *Roe v. Wade* (1973) and *Whole Woman’s Health v. Hellerstedt* (2016)³ (Haberhorn, 2018). Meanwhile, state legislatures are working to reduce access to contraception, close reproductive health care centers, and criminalize abortion. In just one southern state—Virginia—more than 170 such policies have been introduced since 2008, including a set of more than 30 TRAP regulations enacted in 2013 (NARAL Pro-Choice Virginia, n.d.). As a macro-level incarnation of interpersonal reproductive coercion, restrictive reproductive health policies are structural violence. Structural violence should be countered with structural intervention. Social workers hold the professional mandate to engage in policy practice around this issue, including promoting proactive protections and opposing coercive policies wherever they appear.

³ In *Roe v. Wade* (1973), the Supreme Court of the United States invalidated a Texas law that prohibited abortion except when necessary to save the life of the pregnant person, and in doing so, held that the right to privacy extended to the decision of whether to have an abortion and that governmental interference in that decision is subject to strict judicial scrutiny. The ruling in *Roe* did allow for states to ban abortions after fetal viability except when necessary to preserve the life or health of the pregnant person. In *Whole Woman’s Health v. Hellerstedt* (2016), the Court held that two provisions of a Texas TRAP law that threatened to shut down the state’s abortion clinics were unconstitutional as they imposed an undue burden (i.e. impeding access without providing medical benefit) on the right to access abortion care. The Court held that in future cases, the benefits of such laws must be weighed against the burdens they impose (NARAL Pro-Choice America Foundation, 2017).

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